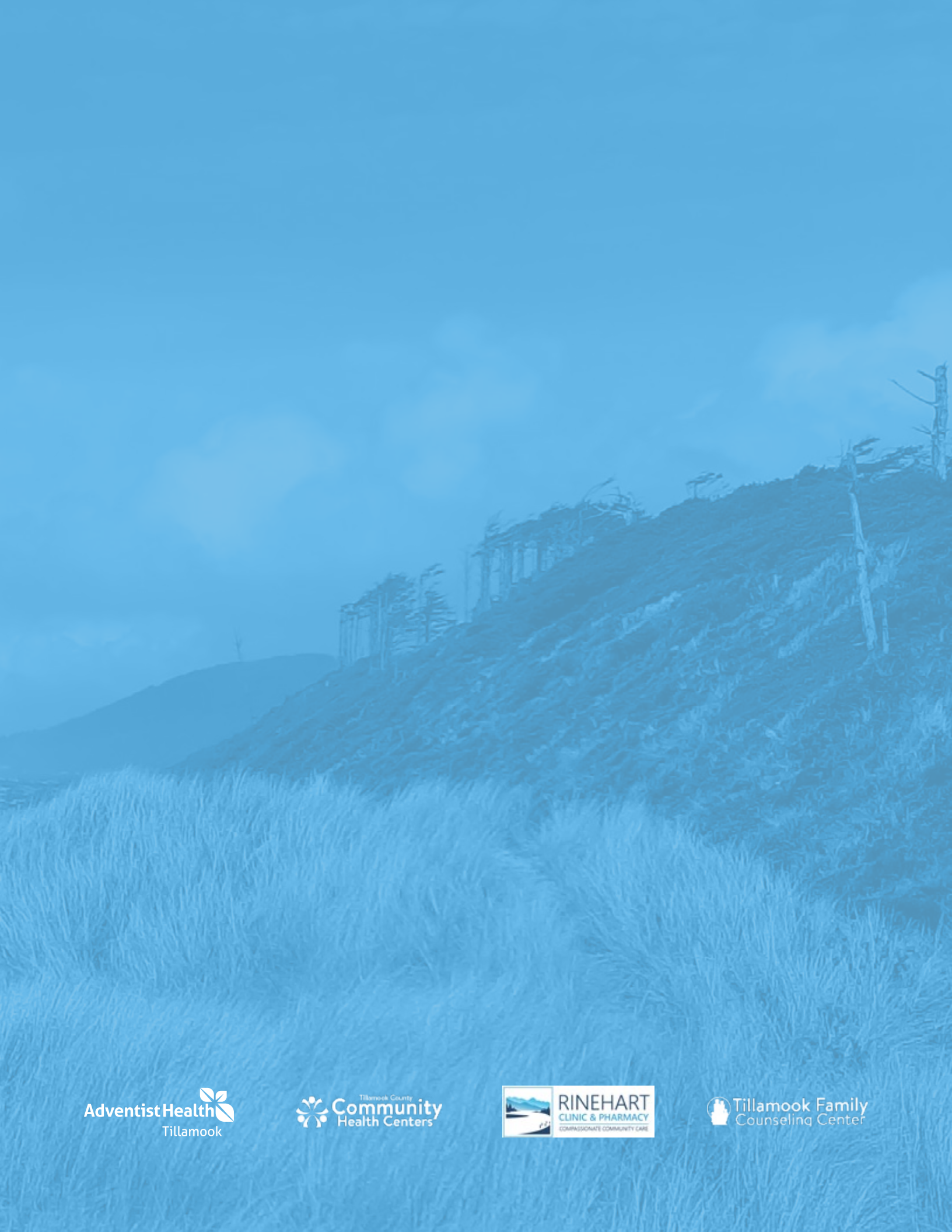
COMMUNITY HEALTH NEEDS ASSESSMENT

2022

Tillamook County


Adventist Health
Tillamook
Tillamook County
Community
Health Centers
RINEHART
CLINIC & PHARMACY
COMPASSIONATE COMMUNITY CARE
Tillamook Family
Counseling Center

Executive Summary

Non-profit health systems, community-based organizations and public health agencies across the country all share a similar calling: to provide public service to help improve their community members' lives. One area of public service where these entities share responsibility is ensuring all community members have the opportunity to live a healthy life.

The Community Health Needs Assessment (CHNA) is one way public service agencies support the health of their communities. These assessments are required of non-profit hospitals and public health departments every three and five years, respectively, to understand the health needs of the communities they serve. The purpose of this assessment is to engage the communities in identifying community health needs, and to align resources across the community benefit functions of a non-profit hospital, strategies of public health, and services of community-based organizations to drive towards improved health for all.

For 2022, Tillamook County took this requirement one step further with the vision of designing a story-centric and people-centric CHNA. We envisioned a concise report that the entire community could contribute to and access, regardless of public health context or reading ability. This process involved input from community focus groups and key informant interviews representing the broad interests of the community served by hospitals and collaborative organizations. In addition, input was gathered from local public health officials, community-based organizations, medical providers, students, parents, and members of selected underserved, low-income and minority populations. We intentionally prioritized understanding the social and health needs of uninsured or underinsured, low-income and minority persons in the community (see description of Focus Group participants, Section III.B).

To conduct this assessment, we used secondary and primary data from focus groups and key informant interviews conducted between October 2021 – January 2022. A local Steering Committee (see Section I.E) reviewed data and prioritized community health needs over the course of three meetings (data collection planning, data review and needs prioritization) taking place between November 2021 – April 2022. This group determined the following final community health priority areas:

Access to Care

Financial Stability

Housing

In this report, you will first find a Community Summary that introduces the community served by our hospital and lists the prioritized community health needs. The Community Summary is a brief overview of the main points from the CHNA followed by an in-depth and detailed report including:

Our Partners: CHNA Steering Committee (see Section I.E)

Description of Hospital and Community Served (see Section II)

Significant Identified Health Needs and Priority Areas Selected (see Section III)

Data Collection and Analysis (see Section IV)

Prioritization Process (see Section IV)

Next Steps (see Section IV.C)

We hope this report is leveraged by all local partners and community members, empowering them to own the potential of healthy living for all. The entire report is published online and available in print form by contacting community.benefit@ah.org.

Table of Contents

What if . . .

Everyone from newborns to older patients easily received the unique care they needed?

Families and individuals had jobs and the financial resources they needed to live a safe and healthy life?

Affordable housing was available to all?

Community Vision Summary

Taking a step toward a healthier, better life

This is the vision of the future as seen through the Community Health Needs Assessment, or CHNA. The goal of the CHNA is to leverage community stakeholders and data to identify and maximize resources and to focus on meeting the most significant health needs of our community over the next three years.

Members of the CHNA Steering Committee – comprised of healthcare, civic, public, and business leaders – led this process of identifying and addressing health needs for a healthier community. These members took a deep look at where people live, learn, work and play to discover areas of opportunity that, through collaboration, could be strengthened and lead to a healthier you, stronger families and safer communities.

This CHNA involved interviews with Chamber of Commerce, community-based organizations, economic businesses, family services, healthcare, higher education, the Hispanic community, managed care, mental health, Public Health, and transportation. We also conducted a statewide survey and gathered public data. Through this process, we learned about our community members' current state of health and listened to their greatest concerns for their friends and family.

There were 10 significant health needs focusing on the social determinants of health identified through this in-depth analysis and discussion. These needs were access to care, community safety, COVID, education, environment & infrastructure, financial stability, health conditions, health risk behaviors-illicit drugs, housing and mental health. The Steering Committee then selected high priority needs based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period, which were: access to care, financial stability and housing.

The following pages share opportunities where you, your family and your community can drive change for improved well-being.

Join us to activate our diverse community, improve lives, and make a "what if" dream into a powerful "what is" reality.

What if . . .

Everyone from newborns to older patients received the unique care they needed, thanks to good **Access to Care**

Families and individuals had jobs and the financial resources they needed to live safe and healthy lives, with access to organizations that can help when needed to ensure **Financial Stability**

Affordable housing was available to all, providing all community members with **Housing Security**

Getting to know our Tillamook County CHNA service area*

Tillamook County is nestled in the fertile Oregon Coast Range and recognized for its plentiful region of dairy farms. Tillamook, or "Land of Many Waters," is comprised of 75 miles of coastline, four bays, nine rivers, and is home to the Tillamook Cheese Factory—attracting many tourists. Tillamook City, the largest city in the county, has a population of 4,971 with a majority age group of older adults (65+) making up 25.3% of the population. The total population of the area included in this needs assessment is 27,216 people.

The Tillamook County Fair, summer parades, rodeos, and unity of the community contribute to the small-town rural feel of this community. Residents are 89.4% non-Hispanic, 10.6% Hispanic and have a median household income of $55,214 of which 62.83% is spent on housing and transportation.

Among this population, 15.96% of children live in poverty and 4.81% of students are unhoused, compared to the state average of 3.99% and national average of 2.77%.

Let's begin with an overview of the last three years including a closer look at community member comments, priorities and numbers that guided the decision-making process towards a path to better health, wholeness and hope.

**This service area represents Tillamook County's primary service areas (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve, creating the Tillamook County CHNA service area.*

What if our community worked together and made life all-around better? What if we offered various pathways to meet our diverse needs, so every member of our community experienced better health, prosperity and longevity?

CHNA 2019 successes and lessons learned

Before we look ahead, let's look back at a few highlights from our 2019 CHNA prioritized health needs to see what we've accomplished and learned since then. Over the last three years, we've focused on housing, mental health, access to care, chronic disease and physical environment.

Working together with the community, we created strategies designed to educate and break down barriers to care and well-being for Tillamook residents. In partnership with Tillamook County Housing Commission and CARE, Inc., we provided support and funding toward transitional housing and shelter for our vulnerable community members.

Despite the challenges due to COVID-19, we were still able to remain a leading member of the Tillamook County Wellness coalition helping reduce the number of people at risk for developing Type 2 diabetes and increasing enrollment in lifestyle management programs. In addition to all these things, we worked to increase access to primary care through health insurance enrollment and free/discounted prescriptions.

The COIVD-19 global pandemic caused extraordinary challenges for Tillamook County, leading us to pivot our focus to helping patients and families stop the spread of the virus, and provide access to free vaccines for all throughout the county.

Access to Care

COMMUNITY VOICES

- Interviewees noted that difficulty managing healthcare appointments could be a source of stress for community residents.
- Interviewees noted that it is difficult to get basic medical appointments and that anything other than a primary care visit requires extensive travel time.
- Limited public transportation infrastructure, including paid car options like taxi and Uber, make it difficult for people to get to the doctor, according to interviewees.
- One interviewee noted that only one doctor in the emergency medical plaza speaks Spanish.

- "There aren't enough qualified childcare centers to be able to care for children for people who have to go to work or go to doctor appointments."
- "The long delays in getting specialty care can lead to worse health outcomes over time."

Tillamook is known for spectacular landscapes, a wide variety of activities and friendly people. Still, as is common in other regions, there are challenges and concerns.

Comments center around challenges that come with trying to secure reliable health care. Managing appointments can be stressful, and

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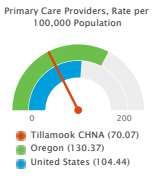
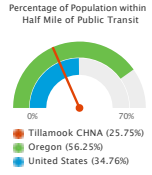
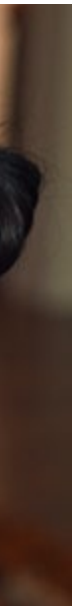




Hospital Beds Dashboard

Report Area	Total Population	Licensed Beds	Staffed Beds	ICU Beds	Licensed Beds, Rate per 100,000 Pop.	Staffed Beds, Rate per 100,000 Pop.	ICU Beds, Rate per 100,000 Pop.
Tillamook CHNA	26,611	48	24	3	183.02	93.43	**14.95**
Clatsop County, OR	39,764	83	48	8	208.73	120.71	20.12
Tillamook County, OR	26,787	49	25	4	182.92	93.33	14.93
Oregon	8,381,426	18,460	15,016	1,676	220.25	179.16	20.00
United States	654,334,868	1,872,694	1,602,386	183,514	286.20	244.89	28.05



Community Health Needs Survey:

State of Oregon Survey Region

Those surveyed selected Access to Care as a top health concern.

English Language Responses 26%

Spanish Language Responses 19%

See Section V. B. for more information.

residents have learned that securing appointments beyond a primary care request means extensive travel time.

Another concern is the shortage of non-English speaking providers and interpreters. Specialty providers, such as pediatrics and OB/GYN, are in short supply. And, there are public transportation barriers.

To complicate residents' ability to secure care, there is a shortage of mental health providers compared to Oregon as a whole, with 169 providers per 100k people in the Tillamook area compared to 312 in Oregon. Compounding this, access issues are greater for some groups than others. 6.1% of residents are uninsured, but the rate jumps to 17.7% for Black people and 13.8% for Native Americans or Alaska Natives.

Tillamook residents openly shared their concerns and ideas. By working together, there can be a vision that becomes the solution.

Find Access to Care resources in your community to live better, longer.

Columbia Pacific CCO
503-488-2822, colpachealth.org

Tillamook County Transportation District
503-815-8283, nworegontransit.org/contact-us-tctd

Connect Oregon
oregon.uniteus.com

Community Action Resource Enterprises (CARE)
503-842-526, careinc.org

Uninsured Population by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Some Other Race	Multiple Race
Tillamook CHNA	4.90%	17.65%	13.81%	5.11%	5.15%	3.92%
Clatsop County, OR	7.24%	10.34%	6.94%	9.45%	2.01%	12.10%
Tillamook County, OR	4.76%	17.65%	13.81%	5.11%	5.15%	3.92%
Oregon	5.19%	7.03%	12.33%	5.10%	16.84%	8.11%
United States	5.93%	9.94%	18.99%	6.44%	19.79%	10.67%

Financial Stability

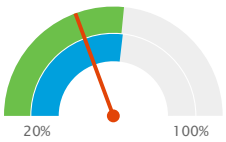
COMMUNITY VOICES

- It was noted that residents who get a college education often have to leave the region due to limited job opportunities.
- There is a belief that poverty can become the norm for families across generations, according to members of the community.
- Residents shared that limited income decreases the opportunity to relocate for better work opportunities.
- Interviewees noted that needing to pay for private insurance is a major financial burden for some.
- "COVID greatly limited work options for people, which has a huge impact on financial stability."

- Many noted that it is not possible to generate the needed workforce locally, requiring outside hiring, which has been a challenge.
- Many people rely on mobile homes for housing, despite many mobile home parks being in disrepair, as described by interviewees.
- Interviewees felt that reducing the number of vacation rentals in the area would be a way to increase housing for residents.

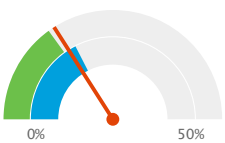
SECONDARY DATA INFOGRAPHIC STATS:

Labor Force Participation Rate



Tillamook CHNA (50.97%)
Oregon (62.52%)
United States (62.97%)

Percent Population Under Age 18 in Poverty



Tillamook CHNA (15.96%)
Oregon (15.02%)
United States (17.48%)

Income – Median Household Income

Report Area	Total Households	Average Household Income	Median Household Income
Tillamook CHNA	11,010	$69,813	$55,214
Clatsop County, OR	16,019	$73,880	$57,466
Tillamook County, OR	11,075	$69,997	$54,268
Oregon	1,642,579	$88,137	$65,667
United States	122,354,219	$91,547	$64,994

Find Health Conditions – Financial Stability resources in your community to live better, longer.

Community Action Resource Enterprises
503-842-5261, careinc.org

Community Action Team Programs
503-397-3511, cat-team.org

Connect Oregon
oregon.uniteus.com

Community Health Needs Survey:

State of Oregon Survey Region

Those surveyed selected Financial Stability as a top health concern.

English Language Responses 76%

Spanish Language Responses 63%

See Section V. B. for more information.

The term financial stability means different things to Tillamook's residents. To some it is safe housing, healthy foods or everyday necessities. Understanding that financial stability impacts each resident, working toward brighter futures is a goal powered by hope and optimism.

Data provides a look into challenges facing Tillamook. About half of the working-age population participates in the workforce; 16% of children under the age of 18 are living in poverty, compared to 15% in Oregon. Poverty level rates are staggering for children who are Native American or Alaska Natives (87.9%) and Native Hawaiian or Pacific Islanders (80.6%).

Average household and median household incomes are lower in Tillamook ($55,214) than in Oregon ($65,667) and the US ($64,994).

Residents confirmed concerns, reporting that $15 per hour wages leave people struggling to find housing. They shared how medication costs impact people with chronic conditions. Interviewees said that when they did secure a job, the hours offered did not generate a reliable income.

Surveys showed that financial stability is a significant need. Efforts underway focus on supporting change and inspiring courage that leads to greater opportunities.

Children in Poverty by Race, Percent

Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Some Other Race	Multiple Race
Tillamook CHNA	13.82%	0.00%	87.93%	0.00%	3.64%	3.99%
Clatsop County, OR	8.05%	No data	0.00%	0.00%	0.00%	7.87%
Tillamook County, OR	13.82%	0.00%	87.93%	0.00%	3.64%	3.99%
Oregon	11.53%	36.31%	25.18%	12.47%	21.67%	15.28%
United States	10.58%	31.80%	31.16%	10.58%	27.24%	17.63%

Housing

COMMUNITY VOICES

- Residents noted an increase in housing stock as one of the biggest, most immediate needs.
- Having to spend large portions of income on housing directly affects residents health, according to interviewees.
- One resident shared hopes for a future where leaders in the community come together to address affordable housing issues.
- "Housing, more than any other financial demand, is the biggest cause of fiscal insecurity."

- Some noted that there is a challenge based on the amount of available land, and how to allocate it for housing versus commercial use.
- "The high cost of rent makes it extremely difficult for people to save enough money to buy a house."

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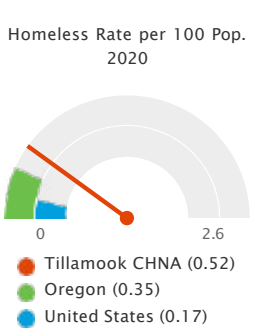
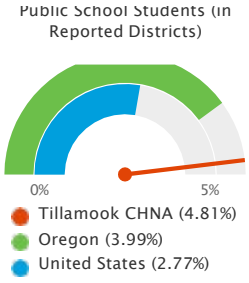
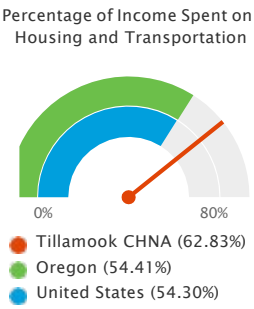






Community Health Needs Survey:

State of Oregon Survey Region

Those surveyed selected Housing as a top health concern.

English Language Responses 62%

Spanish Language Responses 44%

See Section V. B. for more information.

Find Housing resources in your community to live better, longer.

Tillamook County Housing Commission
503-842-2034, co.tillamook.or.us/bc-hc

Connect Oregon
oregon.uniteus.com

Community Action Resource Enterprises (CARE)
503-842-5261, careinc.org/housing-assistance

Finding a safe and secure living space is challenging for residents of Tillamook County, with many feeling unsure about what tomorrow will bring. Research has shown that Tillamook residents face hardships with access to safe housing and the increased risk of being unhoused is among the most critical concerns.

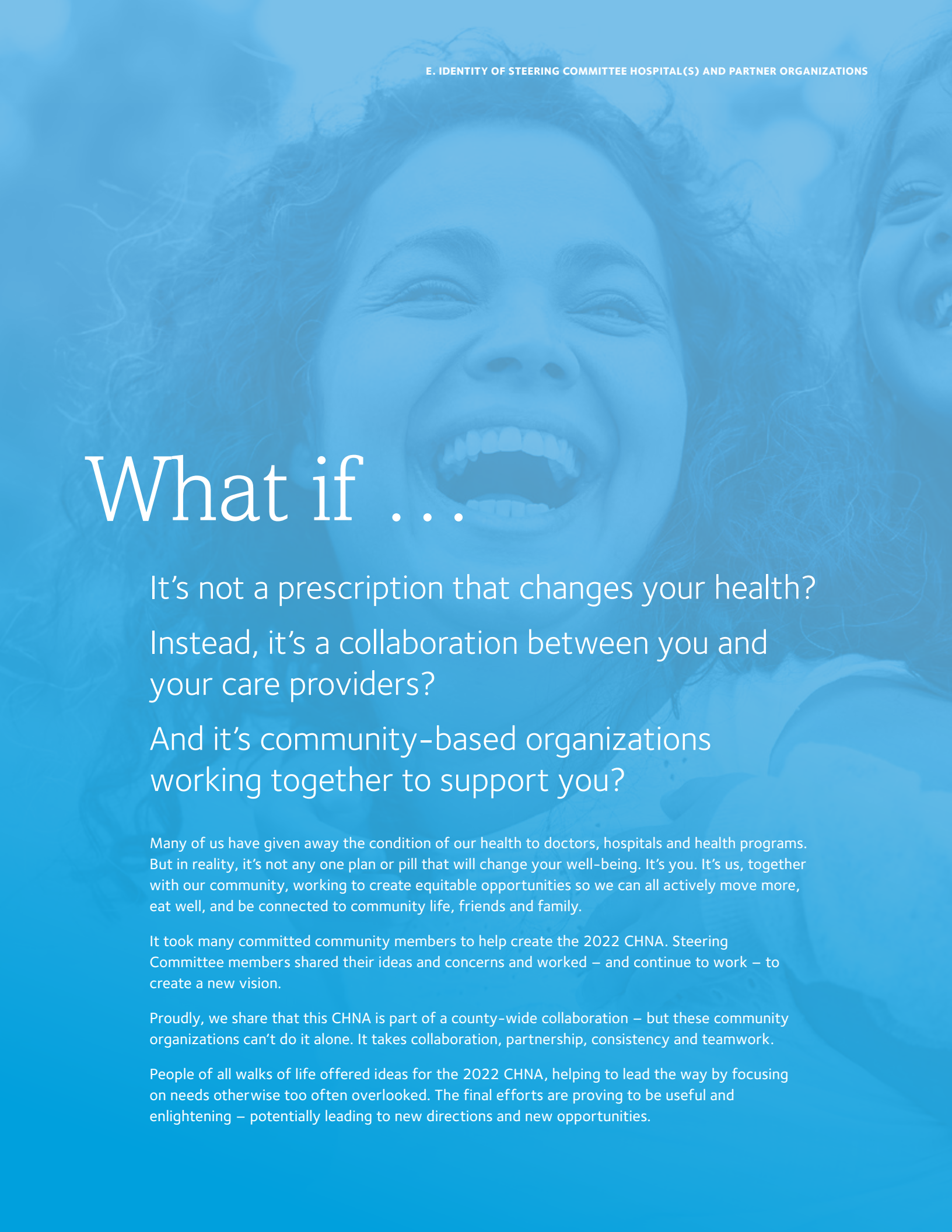
Limited availability of housing along with high home and rental costs are major contributors to financial instability. A survey showed that the unhoused population is higher than the state overall and higher than the U.S. rate. A high rate of 4.8% of students have no home, impacting their health and overall well-being which can create barriers to opportunities for a brighter future.

Residents shared that housing is a significant cause of fiscal insecurity, and that over 30% of housing stock is rentals. There is also a belief that people from urban areas outside the community purchase housing units frequently, decreasing options for locals. This also drives up the cost, meaning much of their income is spent on housing, leaving little for basic necessities.

These are somber realities, but the encouraging focus on bringing health to the Tillamook community continues. Together with the community, we can tackle these issues to ensure a future full of health, wholeness and hope.

Renter – Occupied Households by Race Alone, Percent

Report Area	White	Black	Asian	Native American or Alaska Native	Some Other Race	Multiple Races
Tillamook CHNA	28.97%	100.00%	48.44%	48.98%	36.17%	45.79%
Clatsop County, OR	38.44%	79.41%	33.50%	67.80%	28.69%	56.83%
Tillamook County, OR	28.79%	100.00%	48.44%	48.98%	36.17%	45.79%
Oregon	35.10%	66.65%	37.70%	52.29%	58.08%	51.27%
United States	29.88%	57.55%	39.97%	44.77%	57.52%	47.99%



What if . . .

It's not a prescription that changes your health?

Instead, it's a collaboration between you and your care providers?

And it's community-based organizations working together to support you?

Many of us have given away the condition of our health to doctors, hospitals and health programs. But in reality, it's not any one plan or pill that will change your well-being. It's you. It's us, together with our community, working to create equitable opportunities so we can all actively move more, eat well, and be connected to community life, friends and family.

It took many committed community members to help create the 2022 CHNA. Steering Committee members shared their ideas and concerns and worked – and continue to work – to create a new vision.

Proudly, we share that this CHNA is part of a county-wide collaboration – but these community organizations can't do it alone. It takes collaboration, partnership, consistency and teamwork.

People of all walks of life offered ideas for the 2022 CHNA, helping to lead the way by focusing on needs otherwise too often overlooked. The final efforts are proving to be useful and enlightening – potentially leading to new directions and new opportunities.

To all who helped, we say **THANK YOU**. To those who now see the needs and opportunities, we welcome you. Change changes. Let's work together to inspire health, wholeness and hope in our community.

We thank the Tillamook County CHNA Steering Committee, which collaborated and partnered to create the 2022 CHNA. Through a series of three collaborative meetings, engagement of community members, and reviewing data, each committee member brought their unique perspective and view as seen through their job and the work they performed during the development of the CHNA.

Anadelia Aguilar
Care Coordinator, Tillamook County Community Health Centers

Mary Faith Bell
County Commissioner, Tillamook County Board of Commissioners

Mis Carlson-Swanson
Director, Oregon Food Bank

Abby Carroll
Manager of Benefits & Well-Being, Tillamook County Creamery Association

Terre Cooper
Director, Tillamook County EDC

TJ Fiorelli
Housing Coordinator, Tillamook County Department of Community Development

Paul Fournier
PIO, Tillamook County Sheriff's Department

Nathan George
City Manager, City of Tillamook

Jennifer Guarcello
Director of Education Foundation & Communication, Tillamook School District

Frank Hannah-Williams
Director, Tillamook Family Counseling Center

Michelle Jenck
Director, Adventist Health Tillamook

Susie Johnson
Mobile Housing Coordinator, CARE, Inc.

Nancy Knopf
Community Health Partnership Manager, Columbia Pacific CCO

Dusti Linnell
Associate Professor (Practice), Oregon State University Extension

Kim Lyon
Executive Director, Northwest Regional Education Service District

Nat Macias
Oregon State University Extension

Gail Nelson
Chief Executive Officer, Rinehart Clinic

Diana M. Niño
Communications Manager, Consejo Hispano

Doug Pilant
Executive Director, Tillamook Transportation District

Jim Prinzing
Manager, Pelican Brewing & Kiwanda Hospitality Group

Jake Pugh
Program Manager, Northwest Senior & Disability Services

Marlene Putman
Public Health Administrator, Tillamook County Community Health Centers

Kaylan Sisco
Executive Director, Tillamook County Family YMCA

Erin Skaar
County Commissioner, Tillamook County Board of Commissioners

Jeff Slamal
Executive Director, Nehalem Bay Health District

Adele Spegman
Community Member

Peter Starkey
Executive Director, CARE Inc.

Ross Tomlin
President, Tillamook Bay Community College

Nicole Vertner
Director of Business Development, Adventist Health Tillamook

II. About Us

A. Adventist Health Tillamook

Adventist Health Tillamook is a 25-bed critical access medical center with key service areas including 24-hour ambulance and emergency services, clinical outpatient therapy services, imaging, laboratory, medical and surgical services. We are proud to serve the rural community of Tillamook found on the northern Oregon coast that ordinarily would not have access to many of the advanced medical services we offer.

B. Adventist Health

Adventist Health is a faith-inspired, nonprofit integrated health system serving more than 80 communities on the West Coast and Hawaii. Founded on Adventist heritage and values, Adventist Health provides care in hospitals, clinics, home care agencies, hospice agencies and joint-venture retirement centers in both rural and urban communities. Our compassionate and talented team of 34,000 includes associates, medical staff physicians, allied health professionals and volunteers driven in pursuit of one mission: living God's love by inspiring health, wholeness and hope. Together, we are transforming the American healthcare experience with an innovative, yet timeless, whole-person focus on physical, mental, spiritual and social healing to support community well-being.

C. Tillamook County Community Health Centers

Tillamook County Community Health Centers (TCCHC), is a Federally Qualified Health Center primarily serving the residents of Tillamook County. TCCHC is committed to providing quality, compassionate, affordable and accessible services without discrimination based on race, color, national origin, religion, gender, disability, political beliefs, age, sexual orientation or religious creed. No one is refused service due to an inability to pay. The Center offers a wide array of services throughout the county in its facilities and mobile clinic to meet the diverse bio-psycho-social needs of the community. The Centers provide medical, behavioral, and dental/oral health services. TCCHC also provides comprehensive public and environmental health services for the community. The mission of TCCHC is to promote and protect the health of all people in Tillamook County.

D. Tillamook Family Counseling Center

The Tillamook Family Counseling Center (TFCC) is a comprehensive behavioral health services provider serving youth, adults and their families in Tillamook County. The agency was incorporated in 1983 and has been successfully operating in Tillamook County since that time. TFCC serves the community out of its main office in Tillamook, and in North Tillamook County at its Rockaway Beach location. As a private, non-profit agency, TFCC is certified by the Health Systems Division of the Oregon Health Authority. Additionally, the agency is certified by the Oregon Department of Human Services to provide services and supports for individuals with Intellectual and Developmental Disabilities.

E. Rinehart Clinic

Rinehart Clinic (soon to be known as Nehalem Bay Health Center & Pharmacy) is a Community Health Center in Wheeler, Oregon. The clinic's mission is delivering compassionate team-based health care and wellness education to improve the lives of ALL in our community.

Rinehart Clinic has been operating in one form or another since 1913. The clinic's long history provides the care team a comprehensive understanding of the community's health and wellness needs, and the ability to adapt as those needs change.

Rinehart Clinic also operates Neah-Kah-Nie (NKN) Student Health & Wellness Center, the only certified school-based health center in Tillamook County. The center, located at Neah-Kah-Nie High School, is open to all students and staff in the NKN School District.

F. Who We Serve

DEMOGRAPHIC PROFILE

The following zip codes represent Tillamook County's primary service area (PSA), accounting for 75% of hospital discharges. Additionally, we took a collaborative approach and expanded our PSA by inviting Steering Committee members to include the zip codes of those they serve.

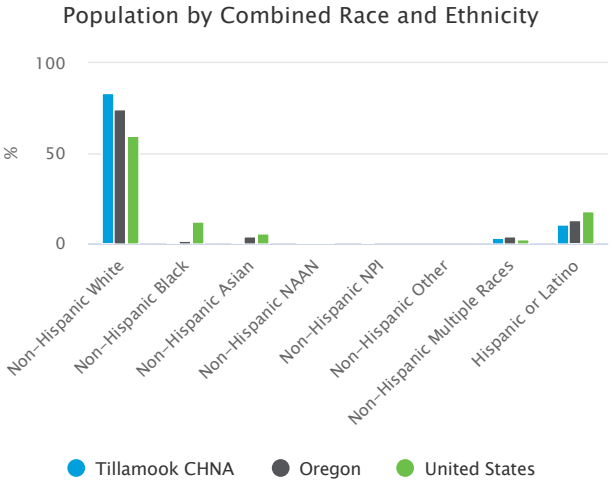
The Tillamook County CHNA market has a total population of 27,216 (based on the 2020 Decennial Census). The largest city in the service area is Tillamook, with a population of 4,971. The service area is comprised of the following zip codes: 97107, 97118, 97131, 97136, 97108, 97147, 97122, 97149, 97134, 97130,97135, 97141, 97112.

Total Population

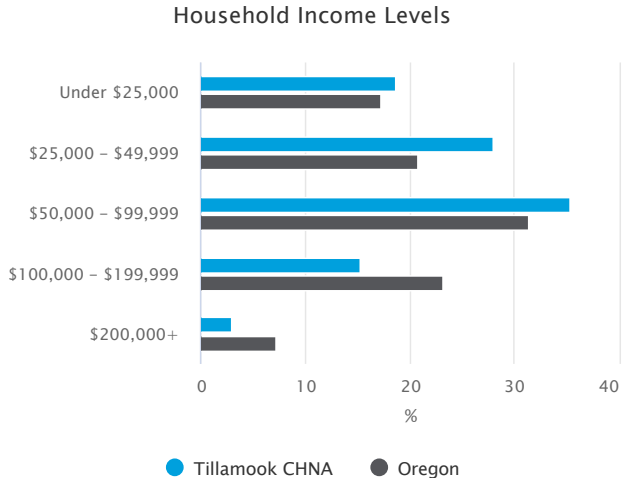
27,216

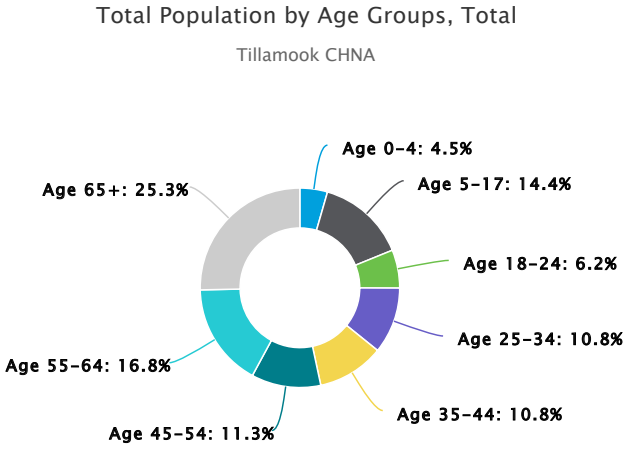
69.82%
of the population owns their home

30.18%
of the population rents their home



Note: NAAN = Native American or Alaska Native, NPI = Native Hawaiian or Pacific Islander.





III. Significant Identified Health Needs, Primary, Secondary Data & Written Comments

A. Significant Identified Health Needs

Steering Committee members, alongside their staff, boards and constituencies reviewed and discussed a presentation of significant identified health needs, which was a list of the top five needs across each data source (see section V for methodology). They then voted to select priorities that demonstrated the greatest need based on severity and prevalence, intentional alignment around common goals, feasibility of potential interventions, and opportunities to maximize available resources over a three-year period. From the list of significant identified health needs in the table, the following three health needs were prioritized as a high priority need, based on the criteria considered (see Section IV. A for full prioritization methodology): Access to Care, Health Risk Behaviors and Mental Health.

TABLE OF SIGNIFICANT IDENTIFIED HEALTH NEEDS

High Priority Needs	
Access to Care	**See Sections III.C - E**
Financial Stability	**See Sections III.C - E**
Housing	**See Sections III.C - E**
Lower Priority Needs	
Community Safety 211info.org/get-help/employment/	This community has higher rates of unemployed and out-of-school youth aged 16-19 than the state or the US, major vehicle crash mortality, and injury mortality.
Housing-Unhoused 211info.org/get-help/housing-shelter/	The limited number of available housing units and the overall high cost of living are critical drivers to homeless. 57% of those surveyed identified homelessness as a health need in the community.
Health Risk Behaviors 211info.org/get-help/mental-behavioral-health/	This community has higher rates of adult smoking, teen birth rates, and low birthweight births than the rest of the state. There are concerns among interviewees that illicit drug use is a pervasive problem as well.
Health Conditions 211info.org/get-help/health-care/	The prevalence rates of diabetes, heart disease, and cancer are higher than the state average. Similarly, mortality rates for liver and lung disease are also elevated compared to Oregon as a whole.
Education 211info.org/get-help/education/	Difficulty recruiting and retaining teachers, coupled with limited afterschool options, hamper educational opportunities for students. Adequate and reasonably priced childcare access is also a problem for many families.
COVID 211info.org/get-help/health-care/	Around 60% of those surveyed identified COVID as a community health need.
Environment & Infrastructure 211info.org/get-help/transportation/	With limited public transportation in a rural area it is often difficult for many to access needed services. Land use also affects housing and recreational opportunities.
Mental Health 211info.org/get-help/mental-behavioral-health/	The need for mental health services has grown during COVID while the number of providers and the overall range of services has either been reduced or not matched the expanded need. Around 60% of those surveyed consider mental health a community health need.

B. Primary, Secondary, and Survey Data Overview

This Community Health Needs Assessment was developed using four separate sources of primary and secondary data. This mixed methods approach is considered a preferred practice for needs assessments because it allows for the greatest understanding of community needs from the broadest range of perspectives. Primary data refers to data collected and analyzed specifically for this project, while secondary data refers to data compiled and analyzed by external groups and utilized here.

Qualitative primary data collection involved focus group interviews with local service providers and service recipients and individual key informant interviews with local leaders. These were conducted in person and virtually. Direct quotes were taken from a transcription of key informant interviews and are intended to be 100% accurate but could not be verified in all situations. This information was collected by the Adventist Health Community Well-Being team and evaluation consultants from the Center for Behavioral Health Integration. Secondary data was amassed and analyzed across 45 different data sets by the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES). Finally, survey data sets of registered voters in the community were collected and analyzed by Pollfish, a web-based market research firm. A detailed explanation of data collection methodology can be found in Sections IV and V.

In total, five focus groups were conducted with 81 participants, and 13 key informant interviews were held. Survey data was gathered in an Oregon statewide survey. See Section V. B. for more information.

DESCRIPTION OF PARTICIPANTS

The CHNA Steering Committee (membership found in Section I. E) identified vulnerable populations and worked with local organizations to coordinate focus groups and key informant interviews to ensure that minority populations – the voices of those with chronic disease, low incomes and the underserved – were heard. Analytical methods for focus groups and key informant interviews found in Section IV. B.

FOCUS GROUPS

- Five (5) focus groups
- Eighty-one (81) people participated

Focus group comments were gathered during in-person, virtual and hybrid focus groups, typically running 90-minutes.

KEY INFORMANTS

- Thirteen (13) individual interviews

During 60-minute interview key informants shared their greatest concerns around health needs, health equity and social determinants of health for those they serve.

PARTICIPATING ORGANIZATIONS

Adventist Health Tillamook, Columbia Pacific CCO (serving the Oregon Health Plan), Consejo Hispano, Northwest Senior & Disability Services (a local intergovernmental agency), Oregon Food Bank, Oregon State University Extension Service, Pelican Brewing Company, Tides of Change, Tillamook Chamber of Commerce, Tillamook County, Tillamook County Family YMCA, Tillamook County Office of Education, Tillamook County Transportation District, Tillamook Bay Community College, Tillamook Seventh Day Adventist Church and West Business Development Center

REPRESENTED RACE/ETHNICITIES

Hispanic, Multi-Race and White

REPRESENTED POPULATIONS

Community-based organizations focusing on education, higher education, low-income, medically underserved, minority populations, food insecure, providers, student populations.

The three high-priority health needs are described in further detail on the following pages.

SURVEY RESULTS

OREGON SURVEY REGION

Survey Results of Top Needs

See Section V. B. for more information.

Needs	English	Spanish
Financial Stability-Cost of Living	76%	63%
Housing- Cost	62%	44%
Mental Health	59%	39%
COVID	59%	63%
Housing-Unhoused	57%	19%
Food Security	34%	33%
Access to Care-Primary	26%	19%
Employment	26%	34%
Environment & Infrastructure	17%	15%
Education	14%	14%
Access to Care-Senior	13%	15%

C. Access to Care

Accessing healthcare reliably and consistently requires multiple factors to work in the favor of community members. There must be an adequate-sized provider network, few environmental barriers to attending appointments, and personal resources to successfully advocate for your own care. Tillamook County has challenges in several of these domains.

The availability of primary care providers is extremely limited in Tillamook County, with 70.07 primary care providers per 100,000 population as compared with 130.37 in Oregon and 104.44 in the United States. A shortage of mental health providers as compared to Oregon is also seen, with 169.11 mental health care providers per 100k people in Tillamook County compared to 312.16 in Oregon. The number of intensive care unit hospital beds is also limited, with 14.95 beds per 100k people as compared to 20 in Oregon and 28.05 in the United States.

While the percentage of uninsured people (6.1%) is lower than in Oregon (6.6%) and in the US (8.7%), when considering uninsured by race, the rates jump to 17.7% for Black people and 13.8% for Native American or Alaska Natives. The rate of uninsured Hispanics is 15.6%. This provides a major problem in accessing healthcare for many racial and cultural minorities.

Only 26% of the population lives within half a mile of public transportation. This is less than half of the rate of Oregon as a whole, which creates a substantial barrier for many.

Within the reported area, 9.7% of people ages 25 and above do not have a high school diploma. This rate is higher than the overall rate in Oregon (8.9%). Those who chose 'Some other race' have a percentage of 52.4% without a high school diploma and for the Native American or Alaskan Native population the rate is 15.4%.

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PRIMARY COMMENTS

FOCUS GROUPS COMMENTS (PARAPHRASED FROM PRIMARY DATA INTERVIEW NOTES)

- Interviewees noted that difficulty managing healthcare appointments could be a source of stress for community residents.
- Interviewees noted that it is difficult to get basic medical appointments and that anything other than a primary care visit requires extensive travel time.
- Limited public transportation infrastructure, including paid car options like taxis and Uber, make it difficult for people to get to the doctor, according to interviewees.
- One interviewee noted that only one doctor in the emergency medical plaza speaks Spanish.
- Residents shared that effective and trustworthy interpreters are necessary when explaining health symptoms and are often unavailable.
- Along with very limited translation services, interviewees expressed concern that not many types of medical information are available in Spanish or other languages.
- Elderly residents navigating the healthcare system without family support undergo additional barriers to healthcare access, per focus group participants.
- Many residents noted that they have to travel long distances for pharmacy or medical specialty services.

KEY INFORMANT COMMENTS

- "There aren't enough qualified childcare centers to be able to care for children for people who have to go to work or go to doctor appointments."
- "The long delays in getting specialty care can lead to worse health outcomes over time."
- "Specialty providers like pediatrics and OB/GYN services are in short supply."
- "A way to increase access would be to expand the hours services are available so that appointments outside traditional work hours were an option."
- "One challenge in hiring more healthcare providers is the lack of housing options for them."
- Residents noted that when they have to choose what to spend their limited income on, healthcare services are often neglected.
- Residents noted that healthcare providers would benefit from education on providing culturally sensitive services.

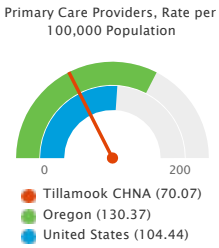
Secondary Data Summary

Access to Care

Availability - Primary Care - Primary Care Providers

This indicator reports the number of providers with a CMS National Provider Identifier (NPI) that specialize in primary care. Primary health providers include practicing physicians specializing in general practice medicine, family medicine, internal medicine, and pediatrics. The number of facilities that specialize in primary health care is also listed (but are not included in the calculated rate). Data are from the latest Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) downloadable file.

Report Area	Total Population (2020)	Number of Facilities	Number of Providers	Providers, Rate per 100,000 Population
Tillamook CHNA	27,209	4	19	**70.07**
Clatsop County, OR	41,072	13	40	97.39
Tillamook County, OR	27,390	4	19	69.37
Oregon	4,237,256	1,091	5,524	130.37
United States	334,735,155	117,465	349,603	104.44



Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services, CMS - National Plan and Provider Enumeration System (NPPES). July 2022. Source geography: Address

Primary Care Physicians, All, CMS NPPES July 2022

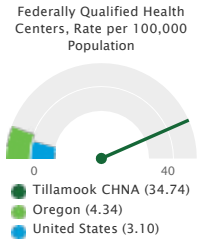
Primary Care Physicians, All, CMS NPPES July 2022
Tillamook CHNA

Availability - Hospitals & Clinics - FQHCs, Rate Per Low-Income Population

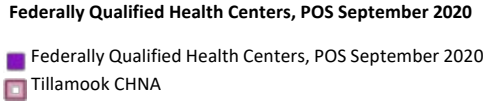
This indicator reports the number of Federally Qualified Health Centers (FQHCs) in the community. This indicator is relevant because FQHCs are community assets that provide health care to vulnerable populations; they receive extra funding from the federal government to promote access to ambulatory care in areas designated as medically underserved.

Within the report area, there are 4 Federally Qualified Heath Centers. This means there is a rate of 34.74 Federally Qualified Health Centers per 100,000 total population.

Report Area	Total Population (2020)	Number of Federally Qualified Health Centers	Rate of Federally Qualified Health Centers per 100,000 Population
Tillamook CHNA	11,515	4	34.74
Clatsop County, OR	41,072	2	4.87
Tillamook County, OR	27,390	4	14.60
Oregon	4,237,256	184	4.34
United States	334,735,149	10,363	3.10



Note: This indicator is compared to the state average.
Data Source: US Department of Health & Human Services, Center for Medicare & Medicaid Services, Provider of Services File. September 2020. Source geography: Address

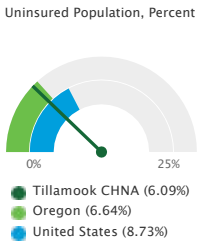


Barriers - Medical Insurance - Population without Medical Insurance

The lack of health insurance is considered a *key driver* of health status.

In the report area 6.09% of the total civilian non-institutionalized population are without health insurance coverage. The rate of uninsured persons in the report area is less than the state average of 6.64%. This indicator is relevant because lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services that contributes to poor health status.

Report Area	Total Population (For Whom Insurance Status is Determined)	Uninsured Population	Uninsured Population, Percent
Tillamook CHNA	26,158	1,593	6.09%
Clatsop County, OR	38,986	3,233	8.29%
Tillamook County, OR	26,217	1,567	5.98%
Oregon	4,135,531	274,414	6.64%
United States	321,525,041	28,058,903	8.73%



Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

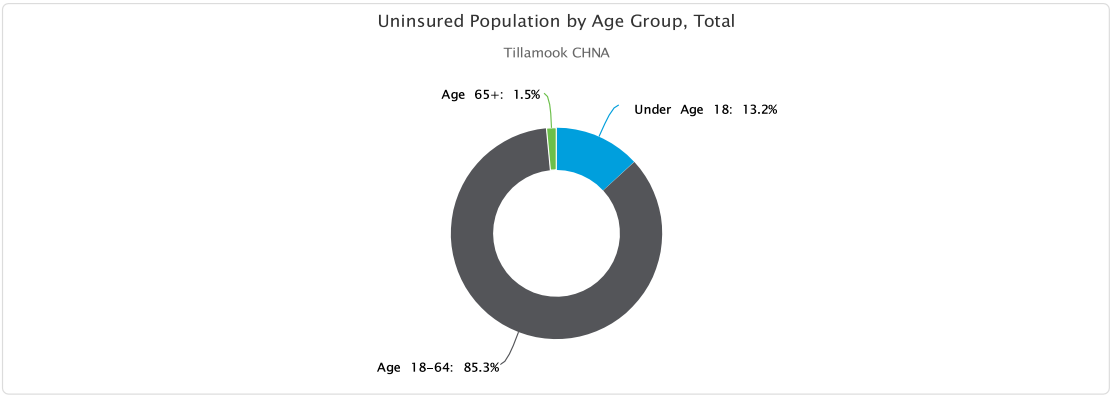
Uninsured Population, Percent by Tract, ACS 2016-20

- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed
- Tillamook CHNA

Uninsured Population by Age Group, Total

This indicator reports the total uninsured population by age group.

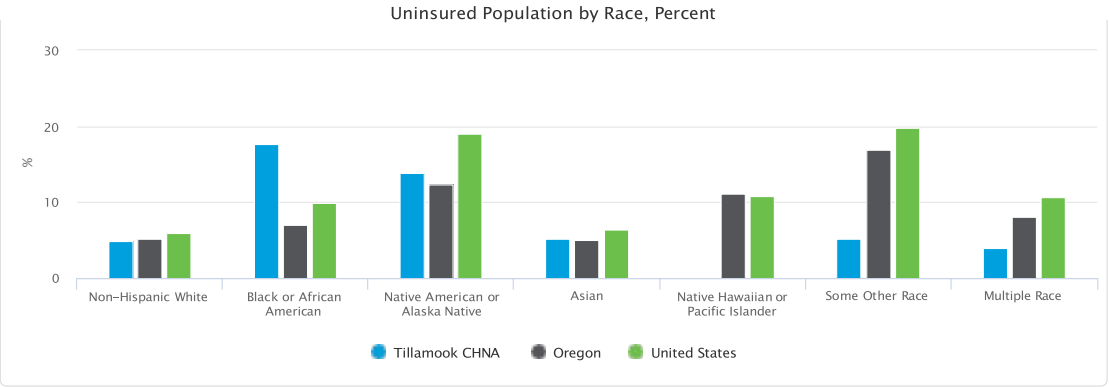
Report Area	Under Age 18	Age 18-64	Age 65+
Tillamook CHNA	210	1,359	24
Clatsop County, OR	216	2,976	41
Tillamook County, OR	210	1,333	24
Oregon	32,250	238,053	4,111
United States	4,016,835	23,640,483	401,585



Uninsured Population by Race, Percent

This indicator reports the percentage of uninsured population by race alone.

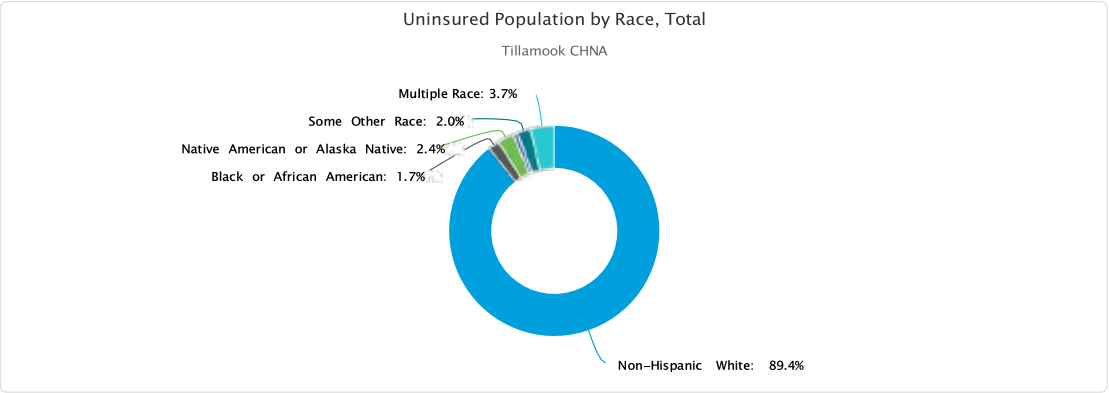
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Tillamook CHNA	4.90%	17.65%	13.81%	5.11%	0.00%	5.15%	3.92%
Clatsop County, OR	7.24%	10.34%	6.94%	9.45%	22.52%	2.01%	12.10%
Tillamook County, OR	4.76%	17.65%	13.81%	5.11%	0.00%	5.15%	3.92%
Oregon	5.19%	7.03%	12.33%	5.10%	11.07%	16.84%	8.11%
United States	5.93%	9.94%	18.99%	6.44%	10.79%	19.79%	10.67%



Uninsured Population by Race, Total

This indicator reports the total uninsured population by race alone.

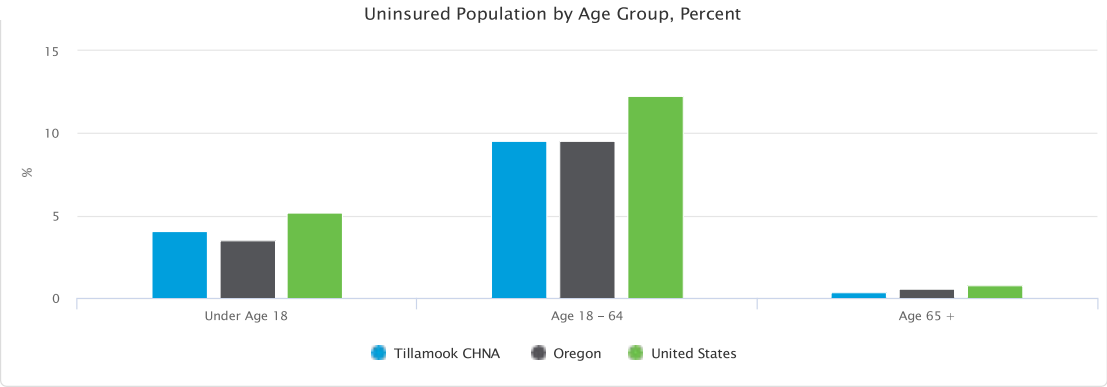
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Tillamook CHNA	1,081	21	29	9	0	24	45
Clatsop County, OR	2,354	27	17	41	25	11	313
Tillamook County, OR	1,055	21	29	9	0	24	45
Oregon	161,015	5,372	5,497	9,556	1,802	23,391	20,605
United States	11,475,294	3,972,510	497,979	1,179,390	64,404	3,281,019	1,776,683



Uninsured Population by Age Group, Percent

This indicator reports the percentage of uninsured population by age group.

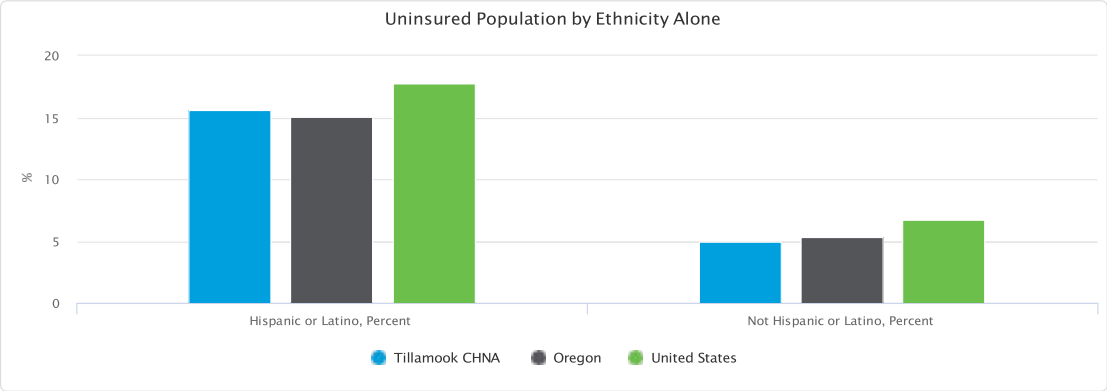
Report Area	Under Age 18	Age 18 - 64	Age 65 +
Tillamook CHNA	4.05%	9.53%	0.36%
Clatsop County, OR	2.72%	13.35%	0.47%
Tillamook County, OR	4.05%	9.36%	0.35%
Oregon	3.51%	9.55%	0.57%
United States	5.18%	12.26%	0.79%



Uninsured Population by Ethnicity Alone

This indicator reports the uninsured population by ethnicity alone.

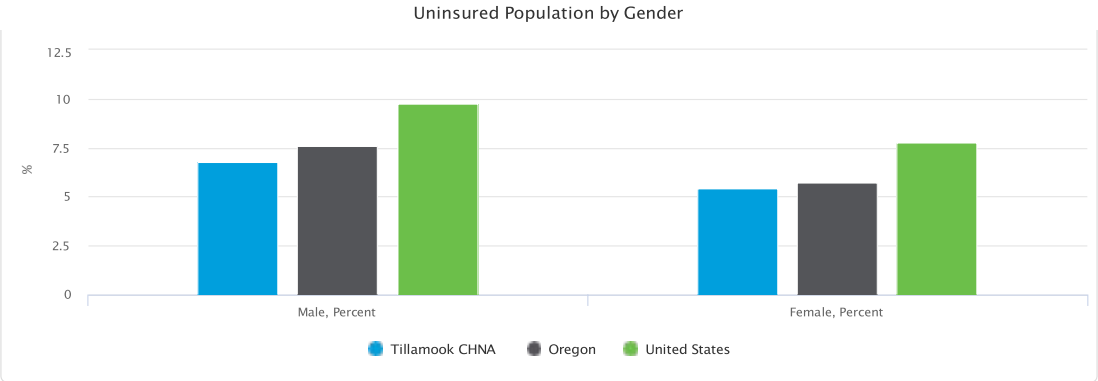
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Tillamook CHNA	422	1,171	15.64%	4.99%
Clatsop County, OR	484	2,749	14.16%	7.73%
Tillamook County, OR	422	1,145	15.88%	4.86%
Oregon	82,449	191,965	15.08%	5.35%
United States	10,382,464	17,676,439	17.72%	6.72%



Uninsured Population by Gender

This indicator reports the uninsured population by gender.

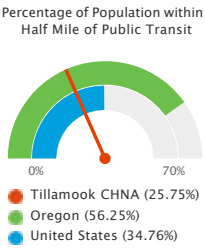
Report Area	Male	Female	Male, Percent	Female, Percent
Tillamook CHNA	875	718	6.78%	5.42%
Clatsop County, OR	1,873	1,360	9.82%	6.83%
Tillamook County, OR	849	718	6.58%	5.39%
Oregon	154,936	119,478	7.59%	5.70%
United States	15,300,004	12,758,899	9.74%	7.76%



Barriers - Transportation - Distance to Public Transit

This indicator measures the proportion of the population living within 0.5 miles of a GTFS or fixed-guideway transit stop. Transit data is available from over 200 transit agencies across the United States, as well as all existing fixed-guideway transit service in the U.S. This includes rail, streetcars, ferries, trolleys, and some bus rapid transit systems.

Report Area	Total Population	Population Within 0.5 Miles of Public Transit	Percentage of Population within Half Mile of Public Transit
Tillamook CHNA	25,897	6,669	**25.75%**
Clatsop County, OR	38,562	16,133	41.84%
Tillamook County, OR	26,076	6,755	25.91%
Oregon	4,081,943	2,295,985	56.25%
United States	322,903,030	112,239,342	34.76%



Note: This indicator is compared to the state average.
Data Source: Environmental Protection Agency, EPA - Smart Location Database. 2019. Source geography: Tract

Population Living Near a Transit Stop, Percent within 0.50 Miles by Block Group, EPA SLD 2019

- Over 80.0%
- 60.1 - 80.0%
- 20.1 - 60.0%
- Under 20.1%
- No Population Within 0.50 Miles
- Tillamook CHNA

C. Financial Stability

Many of the health needs in Tillamook County are directly or indirectly related to financial stability. When an individual or family is struggling financially it greatly affects their ability to maintain adequate physical and mental health. There are many challenges to financial stability for community members, and progress in any given community need should be measured with that in mind.

Only about half of the working age population is participating in the workforce in Tillamook County. Sixteen percent of children under 18 years of age are living in poverty, as compared to 15% in Oregon. When examining poverty levels by race though the numbers tell a very different story, the rates are especially staggering for children who are Native American or Alaska Natives (87.9%) and Native Hawaiian or Pacific Islanders (80.6%). These groups are undoubtedly experiencing significantly greater health disparities than the overall population.

The average household income and the median household income are both lower in Tillamook ($55,214) than in Oregon ($65,667) and the US ($64,994). Making approximately $10,000 less than the state and national average means that many individuals and families in the area will struggle to cover basic expenses.

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PRIMARY COMMENTS

FOCUS GROUPS COMMENTS

- Residents noted that those who get a college education often have to leave the region due to limited job opportunities.
- There is a belief that poverty can become the norm for families across generations, according to community members.
- Residents shared that limited income decreases the opportunity to relocate for better work opportunities.
- Interviewees noted that paying for private insurance is a major financial burden for some.
- Interviewees expressed concern that people making wages in the $15/hour range are still struggling to find stable housing, with many resorting to homelessness at least part-time.
- According to interviewees, the cost of medication drives financial instability for some people with chronic conditions.
- Many interviewees reported securing jobs but not getting enough hours to earn a reliable income.
- Community members noted that prevailing wages are not a match for the local housing market — or both rental and mortgage.
- Several interviewees suggested that an increasing number of people are living with their family of origin or in congregate housing to save money.
- Community members noted that when having to choose between healthcare and food, residents have to choose food.
- Increased wages are often outpaced by increased prices, according to interviewees.

KEY INFORMANT COMMENTS

- "COVID greatly limited work options for people, which has a huge impact on financial stability."
- Many noted that it is impossible to generate the needed workforce locally, requiring outside hiring, which has been a challenge.
- Many people rely on mobile homes for housing, despite many mobile home parks being in disrepair, as described by interviewees.
- Interviewees felt that reducing the number of vacation rentals in the area would be a way to increase housing for residents.
- Housing costs affect the lower and middle class, it is believed that only the wealthy can afford housing, according to interviewees.
- Community members noted that the high cost of childcare creates financial burdens for many families, leading some to leave the workforce altogether.

Secondary Data Summary

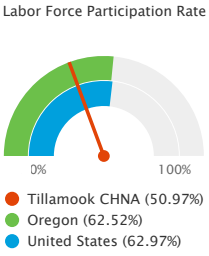
Financial Stability

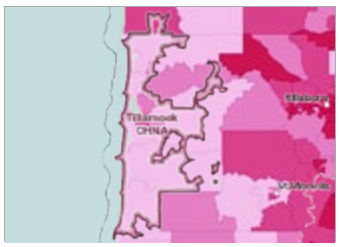
Employment - Labor Force Participation Rate

The table below displays the labor force participation rate for the report area. According to the 2016 – 2020 American Community Survey, of the 22,177 working age population, 11,303 are included in the labor force. The labor force participation rate is 50.97%.

Report Area	Total Population Age 16+	Labor Force	Labor Force Participation Rate
Tillamook CHNA	22,177	11,303	**50.97%**
Clatsop County, OR	33,005	18,986	57.52%
Tillamook County, OR	22,236	11,281	50.73%
Oregon	3,408,422	2,130,784	62.52%
United States	261,649,873	164,759,496	62.97%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: County





Labor Force, Participation Rate by Tract, ACS 2016-20

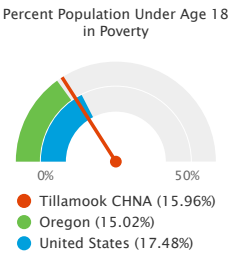
- Over 66.0%
- 60.1% - 66.0%
- 54.1% - 60.0%
- Under 54.1%
- No Data or Data Suppressed
- Tillamook CHNA

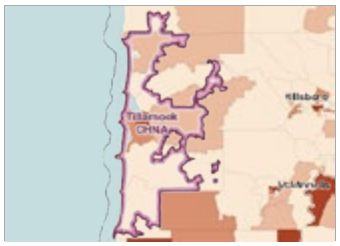
Income - Childhood Poverty Rate

In the report area 15.96% or 776 children aged 0-17 are living in households with income below the Federal Poverty Level (FPL). This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

Report Area	Total Population	Population Under Age 18	Population Under Age 18 in Poverty	Percent Population Under Age 18 in Poverty
Tillamook CHNA	26,046	4,861	776	**15.96%**
Clatsop County, OR	39,114	7,349	757	10.30%
Tillamook County, OR	26,105	4,861	776	15.96%
Oregon	4,096,744	847,858	127,349	15.02%
United States	318,564,128	72,065,774	12,598,699	17.48%

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract





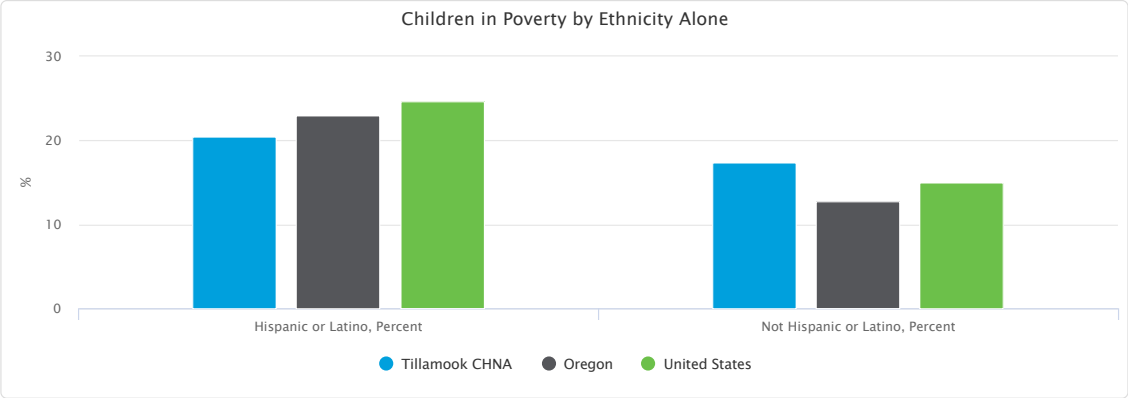
Population Below the Poverty Level, Children (Age 0-17), Percent by Tract, ACS 2016-20

- Over 30.0%
- 22.6 - 30.0%
- 15.1 - 22.5%
- Under 15.1%
- No Population Age 0-17 Reported
- No Data or Data Suppressed
- Tillamook CHNA

Children in Poverty by Ethnicity Alone

This indicator reports children aged 0-17 living in households with income below the federal poverty level by ethnicity alone.

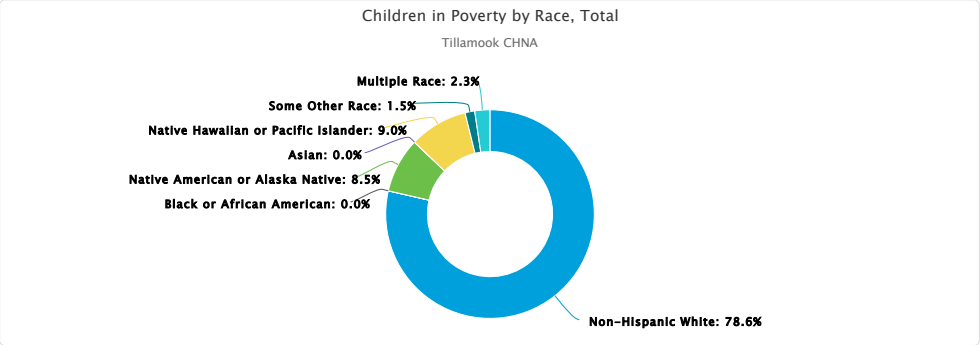
Report Area	Hispanic or Latino	Not Hispanic or Latino	Hispanic or Latino, Percent	Not Hispanic or Latino, Percent
Tillamook CHNA	187	589	20.46%	17.45%
Clatsop County, OR	263	494	19.86%	8.20%
Tillamook County, OR	187	589	17.02%	15.66%
Oregon	43,840	83,509	23.06%	12.70%
United States	4,487,018	8,111,681	24.68%	15.05%



Children in Poverty by Race, Total

This indicator reports the total children aged 0-17 living in households with income below the federal poverty level by race alone.

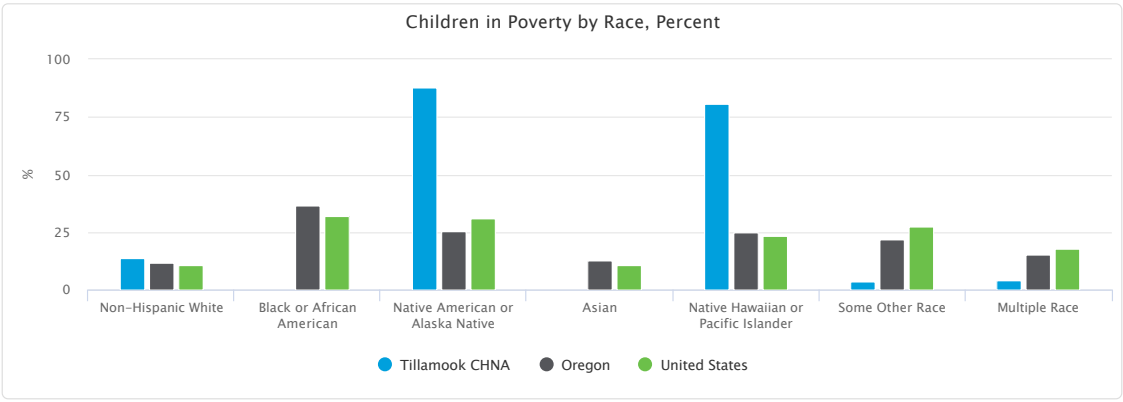
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Tillamook CHNA	470	0	51	0	54	9	14
Clatsop County, OR	421	0	0	0	0	0	73
Tillamook County, OR	470	0	51	0	54	9	14
Oregon	61,336	6,963	2,577	4,194	1,025	8,864	14,330
United States	3,805,465	3,169,873	214,829	388,057	34,982	1,282,237	1,163,442



Children in Poverty by Race, Percent

This indicator reports percent of children aged 0-17 living in households with income below the federal poverty level by race alone.

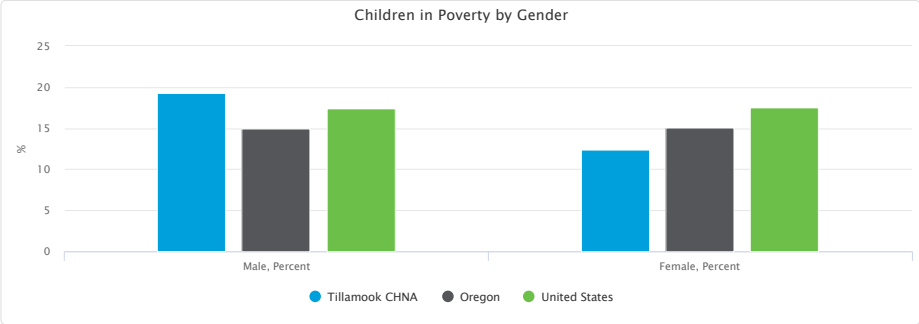
Report Area	Non-Hispanic White	Black or African American	Native American or Alaska Native	Asian	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race
Tillamook CHNA	13.82%	0.00%	87.93%	0.00%	80.60%	3.64%	3.99%
Clatsop County, OR	8.05%	No data	0.00%	0.00%	0.00%	0.00%	7.87%
Tillamook County, OR	13.82%	0.00%	87.93%	0.00%	80.60%	3.64%	3.99%
Oregon	11.53%	36.31%	25.18%	12.47%	25.12%	21.67%	15.28%
United States	10.58%	31.80%	31.16%	10.58%	23.24%	27.24%	17.63%



Children in Poverty by Gender

This indicator reports children aged 0-17 living in households with income below the federal poverty level by gender.

Report Area	Male	Female	Male, Percent	Female, Percent
Tillamook CHNA	486	290	19.22%	12.44%
Clatsop County, OR	336	421	8.71%	12.06%
Tillamook County, OR	486	290	19.22%	12.44%
Oregon	65,230	62,119	15.01%	15.03%
United States	6,414,903	6,183,796	17.43%	17.54%

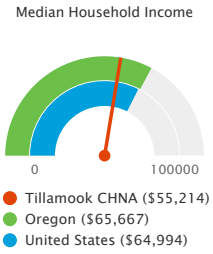


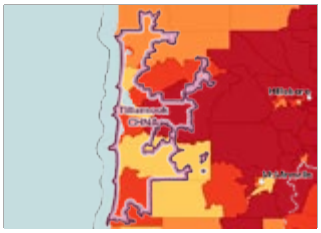
Income - Median Household Income

This indicator reports median household income based on the latest 5-year American Community Survey estimates. This includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. There are 11,010 households in the report area, with an average income of $69,813 and median income of $55,214.

Report Area	Total Households	Average Household Income	Median Household Income
Tillamook CHNA	11,010	$69,813	**$55,214**
Clatsop County, OR	16,019	$73,880	$57,466
Tillamook County, OR	11,075	$69,997	$54,268
Oregon	1,642,579	$88,137	$65,667
United States	122,354,219	$91,547	$64,994

Note: This indicator is compared to the state average.
Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract





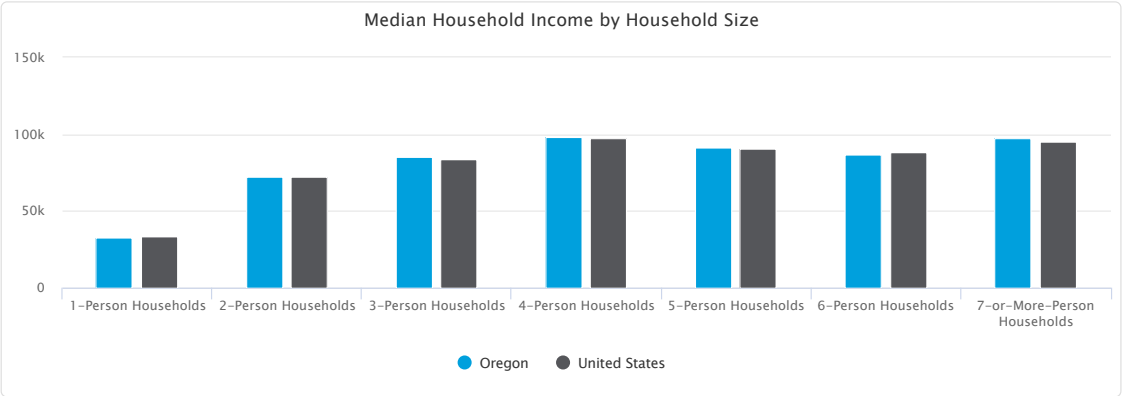
Median Household Income by Tract, ACS 2016-20

- Over $70,000
- $60,001 - $70,000
- $50,001 - $60,000
- Under $50,001
- No Data or Data Suppressed
- Tillamook CHNA

Median Household Income by Household Size

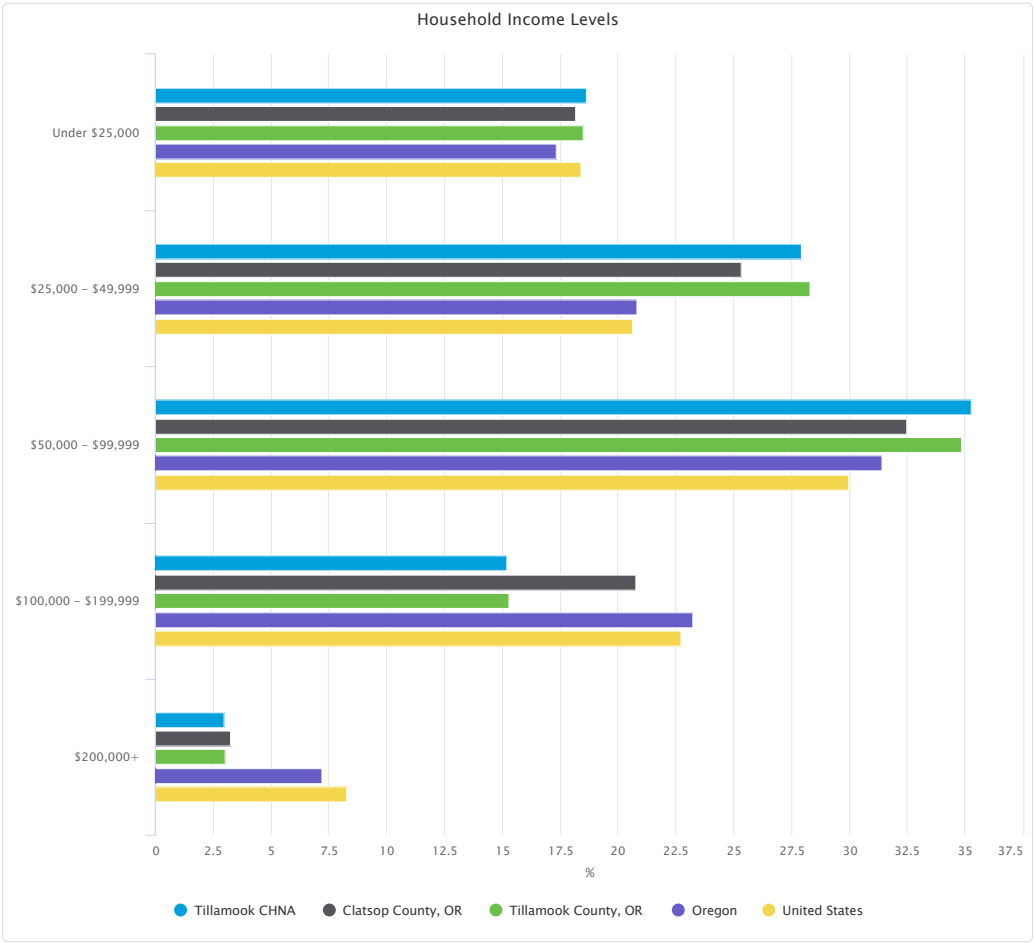
This indicator reports the median household income of the report area by household size.

Report Area	1-Person Households	2-Person Households	3-Person Households	4-Person Households	5-Person Households	6-Person Households	7-or-More-Person Households
Tillamook CHNA	No data	No data	No data	No data	No data	No data	No data
Clatsop County, OR	$31,685	$70,226	$80,120	$83,269	$107,386	$52,188	$88,839
Tillamook County, OR	$25,870	$65,483	$68,850	$63,098	$64,271	$87,171	$52,457
Oregon	$32,766	$71,969	$85,587	$98,482	$91,740	$86,484	$97,594
United States	$33,265	$72,238	$84,033	$97,660	$90,979	$88,413	$94,924



Household Income Levels

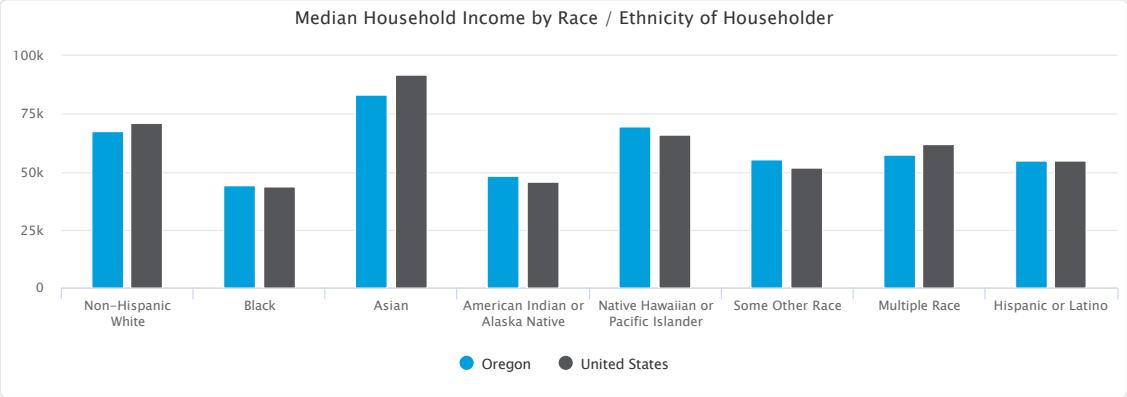
Report Area	Under $25,000	$25,000 - $49,999	$50,000 - $99,999	$100,000 - $199,999	$200,000+
Tillamook CHNA	18.62%	27.93%	35.28%	15.21%	2.96%
Clatsop County, OR	18.18%	25.31%	32.48%	20.78%	3.25%
Tillamook County, OR	18.51%	28.31%	34.83%	15.31%	3.04%
Oregon	17.31%	20.83%	31.43%	23.22%	7.22%
United States	18.41%	20.64%	29.95%	22.73%	8.26%



Median Household Income by Race / Ethnicity of Householder

This indicator reports the median household income of the report area by race / ethnicity of householder.

Report Area	Non-Hispanic White	Black	Asian	American Indian or Alaska Native	Native Hawaiian or Pacific Islander	Some Other Race	Multiple Race	Hispanic or Latino
Tillamook CHNA	No data	No data	No data	No data	No data	No data	No data	No data
Clatsop County, OR	$58,356	$21,307	$40,889	$105,721	No data	$76,989	$57,221	$53,565
Tillamook County, OR	$54,601	No data	$100,500	No data	No data	$60,645	$57,083	$54,199
Oregon	$67,331	$44,138	$83,125	$48,225	$69,547	$55,422	$57,283	$54,797
United States	$70,843	$43,674	$91,775	$45,877	$65,804	$51,900	$61,870	$54,632



D. Housing

Challenges with stable housing and increased risk of unhoused are a reality for many in the Tillamook County community. The limited housing stock coupled with exceedingly high home and rent costs are a major contributor to financial instability. When community members lose their housing it also becomes much more difficult to regain it.

The unhoused population in total in Tillamook in a point in time count in 2020 was 141 or 0.52 per 100 people. This rate is notably higher than the state's reported rate of 0.35 and higher than the US's rate of 0.17.

A high rate of 4.8% of public-school students are unhoused, impacting health and the ability to have sufficient conditions to access education.

Among housing conditions and substandard housing, 3.46% of renter-occupied units lack telephone service, which is higher than the state (2.55%) and the US (2.59%) rates. Affordability and housing costs, by calculating the percentage of household income needed for housing and transportation costs comes up to a high rate of 62.8% as compared to 54.4% in Oregon and 54.3% nationally.

100% of Black residents in the area rent their homes, as compared to 29% of whites, 48% of Asians, 49% of Native Americans or Alaska Natives, and 46% of multi-race persons. The accumulation of wealth through real estate and the more transient nature of renting impact not only the current generation but also future generations. A similar picture is depicted with owner-occupied households, with 71% of white people owning their homes and 0% of Black community members.

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PRIMARY COMMENTS

FOCUS GROUPS

- Residents noted an increase in housing stock as one of the biggest, most immediate needs.
- According to interviewees, having to spend large portions of income on housing directly affects residents' health.
- One resident shared hopes for a future where leaders in the community come together to address affordable housing issues.
- Interviewees shared that low wage earners, older residents and people on Medicaid are seen as struggling with housing options to a greater degree than most.
- It is recommended to form a county-level housing commission to explore additional options for increasing housing availability, residents noted.
- Interviewees emphasized how numerous vacation rentals decrease available housing for locals.

KEY INFORMANT COMMENTS

- "Housing, more than any other financial demand, is the biggest cause of fiscal insecurity."
- Some noted that there is a challenge based on the amount of available land and how to allocate it for housing versus commercial use.
- "The high cost of rent makes it extremely difficult for people to save enough money to buy a house."
- Interviewees stated that as much as 50% of the local housing stock is used as rental properties, creating major barriers to housing access for residents.

- "The geography and somewhat isolated nature of the community may dissuade some developers."
- The increase in vacation and short-term rentals, and the rate of second home ownership by non-locals, is believed to have increased in recent years, it was noted.
- It was reported that inadequate housing would lead people not to take jobs in the area.

Secondary Data Summary

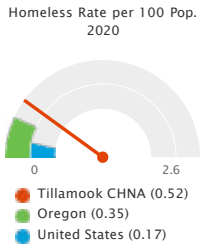
Housing

Homelessness - Homeless Population

This indicator reports the total homeless population as estimated from Point-in-Time (PIT) count in 2020. Data is obtained from HUD's Annual Homeless Assessment Report (AHAR).

As of year 2020, the homeless population is 141 in total or 0.52 per 100 total population within the report area. This rate is higher than the state's reported homeless rate of 0.35 per 100 population.

Report Area	CoC Name	Total Population 2020	Overall Homeless 2020	Homeless Rate per 100 Pop.
Tillamook CHNA	No data	27,319	141	**0.52**
Oregon	No data	4,237,256	14,655	0.35
United States	No data	334,735,155	578,165	0.17



Note: This indicator is compared to the state average.
Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR). 2020. Source geography: CoC

Population Change 2019-2020: Overall Homeless

Report Area	CoC Name	Overall Homeless 2019	Overall Homeless 2020	Difference	% Difference
Tillamook CHNA	No data	178	141	-37	-0.2%
Oregon	No data	15,876	14,655	-1,221	-0.1%
United States	No data	564,719	578,165	13,446	0.0%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR).

Population Change 2019-2020: Overall Chronically Homelesss

Report Area	CoC Name	Overall Chronically Homeless 2019	Overall Chronically Homeless 2020	Difference	% Difference
Tillamook CHNA	No data	40	28	-12	-0.3%
Oregon	No data	4,902	4,339	-563	-0.1%
United States	No data	105,352	120,134	14,782	0.1%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR).

Population Change 2019-2020: Overall Homeless Individuals

Report Area	CoC Name	Overall Homeless Individuals 2019	Overall Homeless Individuals 2020	Difference	% Difference
Tillamook CHNA	No data	118	108	-11	-0.1%
Oregon	No data	12,354	11,995	-359	0.0%
United States	No data	395,050	407,988	12,938	0.0%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR).

Population Change 2019-2020: Overall Homeless People in Families

Report Area	CoC Name	Overall Homeless People in Families 2019	Overall Homeless People in Families 2020	Difference	% Difference
Tillamook CHNA	No data	59	33	-26	-0.4%
Oregon	No data	3,522	2,660	-862	-0.2%
United States	No data	169,669	170,177	508	0.0%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR).

Population Change 2019-2020: Overall Homeless Veterans

Report Area	CoC Name	Overall Homeless Veterans 2019	Overall Homeless Veterans 2020	Difference	% Difference
Tillamook CHNA	No data	11	8	-3	-0.3%
Oregon	No data	1,438	1,329	-109	-0.1%
United States	No data	37,045	37,209	164	0.0%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR).

Population Change 2019-2020: Unsheltered Homeless

Report Area	CoC Name	Unsheltered Homeless 2019	Unsheltered Homeless 2020	Difference	% Difference
Tillamook CHNA	No data	126	107	-19	-0.1%
Oregon	No data	10,142	8,877	-1,265	-0.1%
United States	No data	208,510	223,961	15,451	0.1%

Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR).

Overall Homeless Trend over Time, 2007 through 2020

This indicator reports the 2007 to 2020 trend of the Point-in-Time count of overall homeless population by state.

Report Area	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Oregon	17,590	20,653	17,309	19,492	17,254	15,828	13,822	12,164	13,226	13,238	13,953	14,476	15,876	14,655

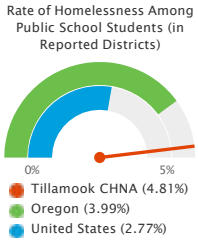
Note: No county data available. See data source and methodology for more details.
Data Source: U.S. Department of Housing and Urban Development, HUD Annual Homeless Assessment Report (AHAR).

Homelessness - Homeless Students

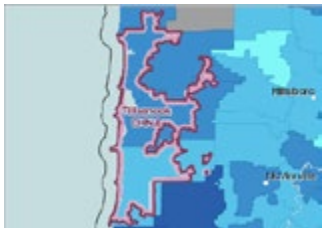
This indicator reports the number of homeless children and youth enrolled in the public school system during the school year 2019-2020. According to the data source definitions, homelessness is defined as lacking a fixed, regular, and adequate nighttime residence. Those who are homeless may be sharing the housing of other persons, living in motels, hotels, or camping grounds, in emergency transitional shelters, or may be unsheltered. Data are aggregated to the report-area level based on school-district summaries where three or more homeless children are counted.

In the report area, of all the 3,528 students enrolled in reported districts during the school year 2019-2020, there were 170 or 4.81% homeless students, which is higher than the statewide rate of 3.99%.
Note: Data are available for 100.00% school districts in the report area, representing 100.00% of the public school student population.

Report Area	Students in Reported Districts	Homeless Students	Homeless Students, Percent	Districts Reporting	Students in Reported Districts
Tillamook CHNA	3,528	170	**4.81%**	100.00%	100.00%
Oregon	573,005	22,839	3.99%	96.27%	99.89%
United States	47,386,316	1,311,089	2.77%	86.95%	97.47%



Note: This indicator is compared to the state average.
Data Source: US Department of Education, EDFacts. Additional data analysis by CARES. 2019-2020. Source geography: School District



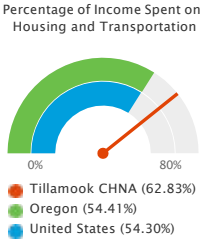
Homeless Students, Percent by School District (Elementary), ED*Facts* 2019-20

- Over 6.05
- 3.1 - 6.0%
- 1.1 - 3.0%
- 0.1 - 1.0%
- No Data or Data Suppressed
- Tillamook CHNA

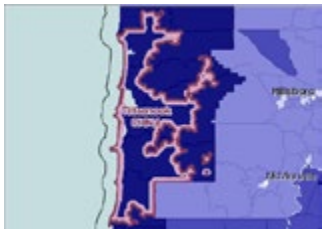
Housing Costs - Housing + Transportation Affordability Index

This indicator reports information about location affordability. Affordability is calculated by estimating the percentage of household income needed for combined housing and transportation costs for a family earning the Area Median Income (AMI). The expected values for housing and transportation are modeled by the US Department of Housing and Urban Development (HUD) using data from the US Census Bureau and the US Department of Transportation.

Report Area	Total Households	Median Household Income	Percentage of Income Spent on Housing	Percentage of Income Spent on Transportation	Percentage of Income Spent on Housing and Transportation
Tillamook CHNA	10,096	43,792	25.06%	37.77%	**62.83%**
Oregon	1,545,745	54,253	25.83%	28.59%	54.41%
United States	117,716,237	57,081	26.36%	27.93%	54.30%



Note: This indicator is compared to the state average.
Data Source: Partnership for Sustainable Communities (HUD, DOT, and EPA), Location Affordability Portal. 2012-16. Source geography: Tract



Location Affordability Index, Family at AMI, Percent Income Spent on Housing and Transportation by Tract, HUD & DOT 2012-16

- Over 60.0%
- 55.0 - 60.0%
- 50.0 - 54.9%
- Under 50.0%
- No Data
- Tillamook CHNA

Housing Quality - Renter Occupated Households

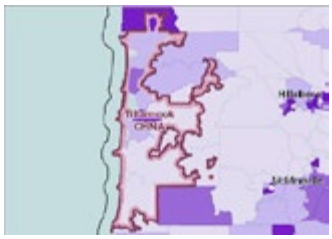
Tenure provides a measurement of home ownership, which has served as an indicator of the nation's economy for decades. This data covers all occupied housing units, which are classified as either owner occupied or renter occupied. These data are used to aid in the distribution of funds for programs such as those involving mortgage insurance, rental housing, and national defense housing. Data on tenure allows planners to evaluate the overall viability of housing markets and to assess the stability of neighborhoods. The data also serve in understanding the characteristics of owner occupied and renter occupied units to aid builders, mortgage lenders, planning officials, government agencies, etc., in the planning of housing programs and services.

Renter-Occupied Housing

All occupied housing units that are not owner occupied, whether they are rented or occupied without payment of rent, are classified as renter occupied.

Report Area	Total Occupied Housing Units	Renter-Occupied Housing Units	Percent Renter-Occupied Housing Units
Tillamook CHNA	11,010	3,323	30.18%
Oregon	1,642,579	611,573	37.23%
United States	122,354,219	43,552,843	35.60%

Data Source: US Census Bureau, American Community Survey. 2016-20. Source geography: Tract

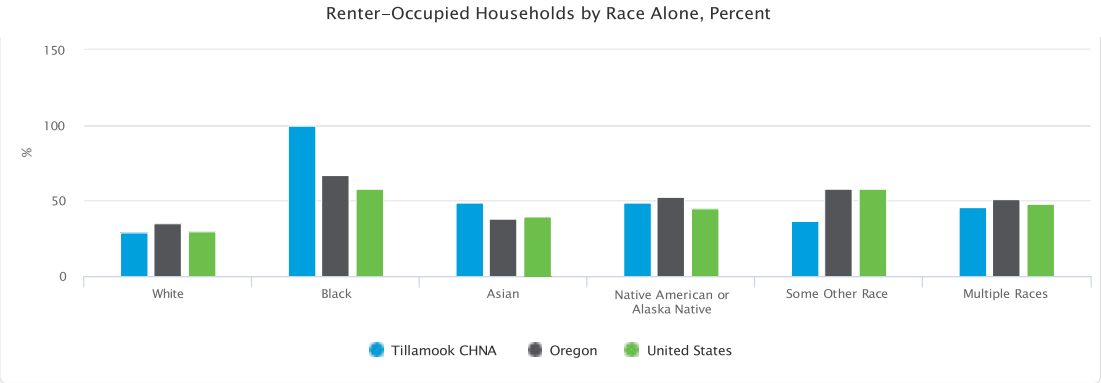


Renter-Occupied Housing Units, Percent by Tract, ACS 2016-20

- Over 38.0%
- 30.1 - 38.0%
- 22.1 - 30.0%
- Under 22.1%
- No Data or Data Suppressed
- Tillamook CHNA

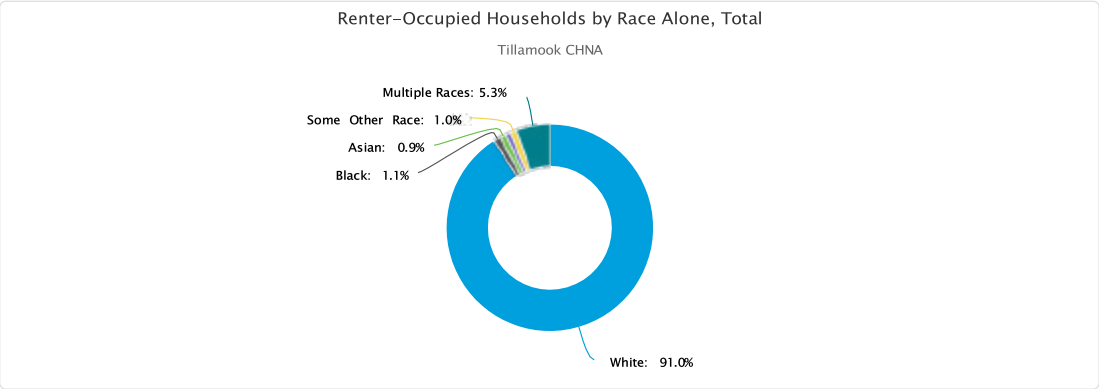
Renter-Occupied Households by Race Alone, Percent

Report Area	White	Black	Asian	Native American or Alaska Native	Some Other Race	Multiple Races
Tillamook CHNA	28.97%	100.00%	48.44%	48.98%	36.17%	45.79%
Oregon	35.10%	66.65%	37.70%	52.29%	58.08%	51.27%
United States	29.88%	57.55%	39.97%	44.77%	57.52%	47.99%



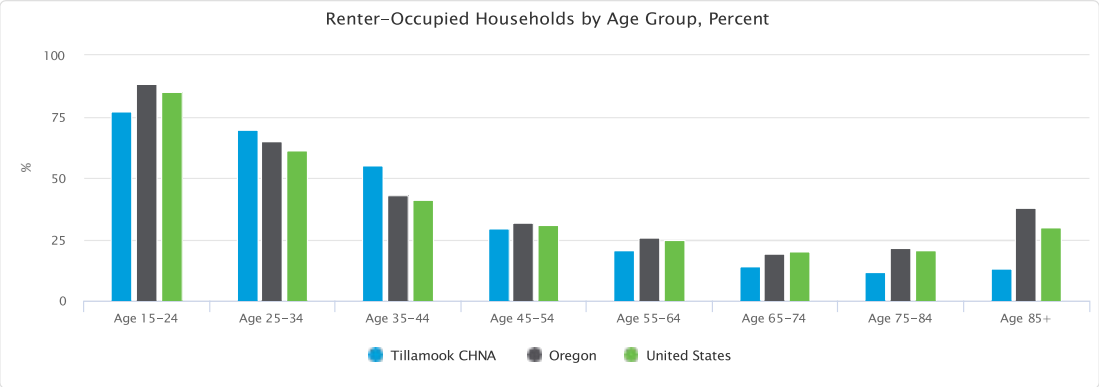
Renter-Occupied Households by Race Alone, Total

Report Area	White	Black	Asian	Native American or Alaska Native	Some Other Race	Multiple Races
Tillamook CHNA	3,003	35	31	24	34	174
Oregon	498,189	18,674	24,199	8,534	21,624	37,271
United States	27,314,937	8,645,300	2,378,711	391,542	2,630,082	2,095,545



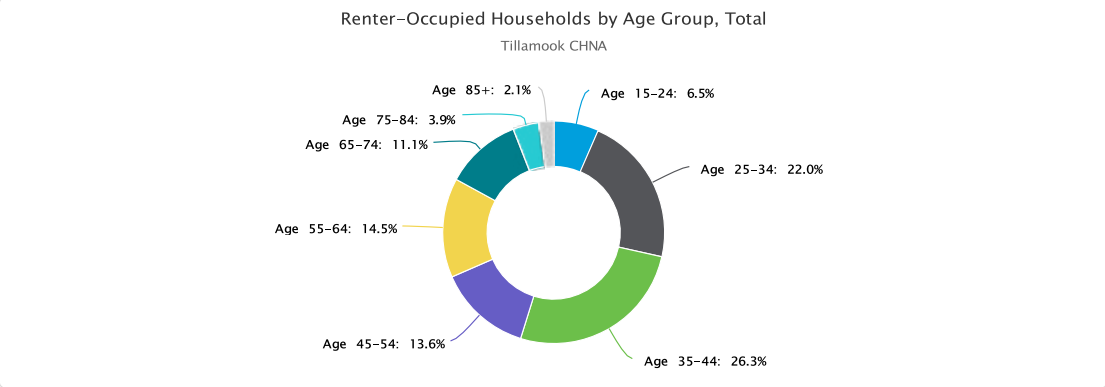
Renter-Occupied Households by Age Group, Percent

Report Area	Age 15-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+
Tillamook CHNA	77.22%	69.72%	55.00%	29.42%	20.63%	14.17%	11.76%	13.22%
Oregon	88.46%	64.90%	42.80%	31.66%	25.85%	18.96%	21.40%	37.62%
United States	85.02%	61.01%	41.18%	30.93%	24.82%	20.29%	20.35%	30.14%



Renter-Occupied Households by Age Group, Total

Report Area	Age 15-24	Age 25-34	Age 35-44	Age 45-54	Age 55-64	Age 65-74	Age 75-84	Age 85+
Tillamook CHNA	217	730	875	453	482	369	128	69
Oregon	58,510	163,899	122,475	86,987	79,297	51,666	26,835	21,904
United States	3,777,531	11,411,607	8,594,183	6,918,579	5,925,087	3,739,266	1,932,636	1,253,954



F. Written Comments

We value your input in our community health needs assessment and invite you to submit comments on this CHNA to community.benefit@ah.org. At the time of this CHNA report development, no written comments about the previous CHNA Report or adopted implementation strategy were received.

G. Data Limitations

Focus group and key informant interviews were conducted solely with volunteers, which could affect the representativeness of the information collected. Broad-scale community engagement is difficult in geographically large, rural communities and large, high-population areas. Some of the secondary data sets used in this needs assessment were collected prior to COVID-19. The survey was conducted statewide, and it is unclear how well statewide data reflects beliefs in the Tillamook region. As a result, it is not possible to know the full impact COVID-19 has had on the lives of the communities studied or the impact it had on data collection. It is likely sensitivity to COVID-19 affected focus group participation at a minimum. Despite these limitations, the data provided can be seen as an accurate reflection of community health needs.

Scan the QR code for the full Secondary Data Report

IV. Identification of Community's Priority Health Needs

A. Criteria and Process Used for Prioritization of Health Needs

The local Steering Committee (membership found in Section I. E) was responsible for identifying the community health needs to include in the new CHNA. To facilitate this process, a series of meetings were held in each community to 1) present the results of the CHNA data collection process and 2) prioritize the significant identified health needs.

The first part of this series involved Adventist Health System staff and a consultant presenting the primary and secondary data analysis findings to the Steering Committee. The primary data collection included focus groups, key informant interviews, and a Statewide survey, while the secondary data collection included a review of 120 metrics used to determine factors having the greatest impact on community health. Each Steering Committee received a 90-minute data presentation of these results, highlighting the top five needs for each data source and the supporting data that led to their inclusion (see Section V for methodology). A conversation about the findings was a part of these data reviews, but the determination of priority needs was not included, the main goal of these meetings being the provision of information to drive the data-driven decision-making required for the high priority needs selection. At the end of the meeting the Steering Committee was provided with two prioritization tools, data slides and a robust secondary data report to review before the next meeting. The committee members were also asked to discuss the data with their colleagues and organizational leadership and to complete a brief poll a few days prior to the prioritization meeting. The poll allowed them to identify the three-to-five needs they viewed as most important, based on the criteria provided during the 90-minute data presentation to the CHNA steering committee (see Prioritization Tools #1 and #2).

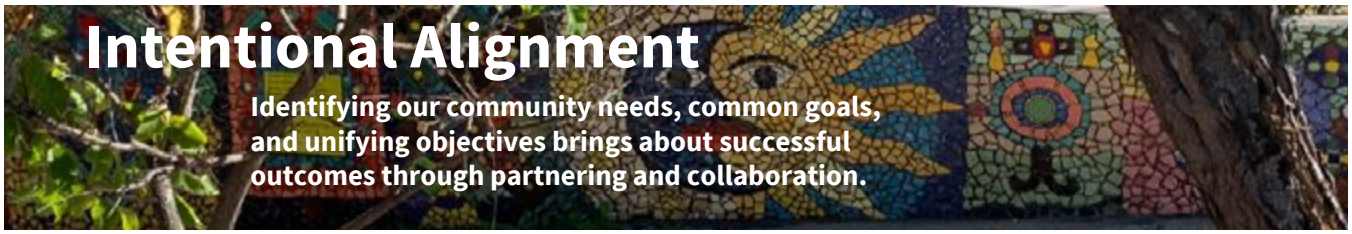
The prioritization meetings were designed to build consensus around the high priority community health needs identified by the steering committee members. The meetings were facilitated by Adventist Health System staff and relied on the CHNA data presented at the prior meeting, the poll results, and an extensive conversation between members. Each meeting concluded with committee members prioritizing the list of significant identified needs (with typically three-to-five needs selected as high-priority).

B. Next Steps

The next step in our CHNA process includes the development of the Community Health Implementation Strategy (CHIS). The CHIS implementation consists of a long-term community health improvement plan that strategically identifies and implements evidence-based solutions and programs to address our priority needs.

We believe the power of community transformation lies in the hands of the community. The voices we have heard have an impact and influence the next steps of creating a strategy to improve the health needs of the community for all. If you would like to learn more, share ideas or stay connected, please contact us at community.benefit@ah.org.

PRIORITIZATION TOOL #1



Intentional Alignment

Identifying our community needs, common goals, and unifying objectives brings about successful outcomes through partnering and collaboration.

CRITERIA FOR CONSIDERING WHICH HEALTH NEED TO ADDRESS

Operations

Tracked and shared progress/data

'Quick Wins' through collaboration

Political willingness

Partners
Resources Assets

Existing orgs/programs addressing all/parts of Need

CBO's are focused on this Need

Community willingness

Finance

Gov. or public funding available when applying collaboratively

Available grants for this *Need*

Need meets the vision/mission of Gov. or philanthropic orgs

Equity

Current Orgs/programs addressing *Need* with Safety-Net pop.

Everyone will benefit

Addressing *Need* could lessen absenteeism at work/school

PRIORITIZATION TOOL #2

Feasibility: High feasibility means there is alignment and/or resources in place to take actional steps to address this Need in a 1-3 year timeframe. Low feasibility means it will take more than 3 years to show a community benefit by addressing this Need.

Impact: High impact means the most community members, or the community members most in need, will benefit from addressing this Need. Low impact means this priority will not benefit a large part of the community, or that the people who will benefit are not in need.

example

	Less Impact	High Impact
High Feasibility	Community Vitality	Education Food Security Housing
Less Feasibility	Environment & Infrastructure	Mental Health

V. Process and Methods to Conduct the CHNA

A. Secondary Data Methodology

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Introduction

Since the passage of the 2010 Patient Protection and Affordable Care Act, non-profit hospitals are required to complete a community health needs assessment (CHNA) at least every three years. The purpose of the CHNA is to better align the community benefit functions of non-profit hospitals with the needs of the communities which they serve. To this end, requirements for completing a CHNA are broadly defined by the Internal Revenue Service (IRS)[1] to include "identifying and prioritizing community health needs" (Pennel, 2015), which must involve the input from "broad interests of that community" (IRS). Best practices for CHNAs as defined by the CDC, the AHA Community Health Improvement (AHCI) and others all specify the inclusion of both primary and secondary data (Barnett, 2012; Institute of Medicine, 2010; Stoto & Ryan-Smith, 2015; AHCI, 2017). In practice, however, there is little consensus on how this data is used to define community health needs.

While much research exists on the subject of population health measurement, research findings specific to quantitative analysis in Community Health Needs Assessments are limited. Among the existing literature, authors find "wide-ranging diversity in CHNA approaches and report quality".

Best practices for utilizing secondary data

One reason for this is the lack of guidelines or even requirements for incorporating secondary data into an assessment of community needs. Despite this, evaluators agree that utilizing both primary and secondary data to prioritize community health needs is a "best practice".

Several common issues with secondary data which hinder its ability to define health priorities have been defined in the literature. These include the lack of data availability at the appropriate levels of disaggregation (both geographic and for population subgroups), the lack of real-time or current data, and the lack of appropriate benchmarks (Stoto, Davis, & Atkins, 2019).

This document describes the methodological approach used to identify health needs using secondary data.

Basic Approach

Health needs scores for target communities in each of 12 priority areas (categories) were determined using quantitative analysis of secondary data from standard, national sources. First, metrics were selected which best represented each category based on a review of multiple health measurement frameworks. Next, metrics were scored based on three criteria relevant to the mission of "helping people live longer, better." These criteria include: impact on short-term health (well-being); impact on long-term health (life expectancy); and severity within the reference community relative to state benchmarks. Final health needs scores for each priority area were developed with possible scores ranging from 1 to 100. Higher health needs scores indicate 1) a comparatively high degree of correlation between the underlying metrics within the health needs category and the outcome variables (well-being

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and life expectancy), and 2) a high level of need in the community compared to other areas of the state. Figure 1 depicts this process, which is further described below.

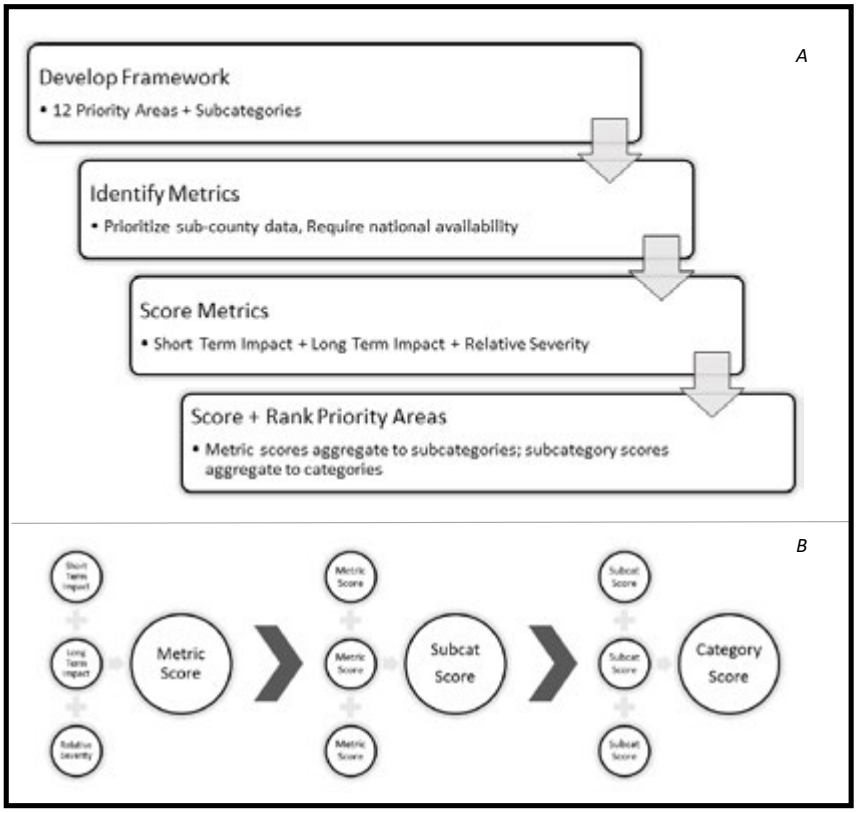

Figure 1. A. Approach to framework and scoring methodology development. B. Diagram of scoring approach.

Framework Development

A set of 12 priority conceptual areas were identified from a review of past cycle CHNAs. In order to generate a score or rank for these priority needs areas, our first task was to operationalize them by selecting appropriate data by which to measure each one. To this end, a landscape scan of available data was performed by evaluating existing population health measurement frameworks. Four primary frameworks were evaluated:

- Well-Being in the Nation (WIN) Measurement Framework
- National Committee for Vital and Health Statistics (NCVHS) Measurement Framework for Community Health & Well-Being
- County Health Rankings & Roadmaps

[1] https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3

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- Healthy People 2030 Leading Health Indicators

Attributes for each indicator within the frameworks were identified, including data source, geographic level, extent, time period, and update frequency. Next, indicators were filtered and removed from the list based on our inclusion criteria: ability to represent the reference community (e.g., geographic scale), recency, update frequency, and source reliability. Indicators from each framework were assigned to each of the 12 categories, with some indicators assigned to multiple categories. Indicators which did not correspond into the 12 categories were not included in the analysis. Additionally, indicators representing similar concepts (e.g., poverty, childhood poverty, household poverty) were reduced to a single metric.

Next, indicators were grouped into subcategories within each priority health needs category. The final framework consists of more than 100 individual metrics across the 12 categories, each with a minimum of two subcategories (CARES, 2022).

Metric Scoring

Scores are generated for metrics (e.g., obesity prevalence) to represent the criteria mentioned above (length of life, quality of life, and severity). To operationalize the first two criteria, we measure the degree of correlation between each metric and two outcome variables: a short-term goal (well-being, measured by physical and mental health status[2]) and a long-term goal (length of life, measured by life expectancy at birth[3]). This approach was adopted in part to reflect the hospital system's mission of "helping people live longer, better".

Metrics with strong negative relationships with the outcome variables (scoring below -.40) were removed from the framework[4].

To address the third criterium, we calculate the relative severity of each metric for each target community using a z-score. A z-score is a measure which quantifies the position of a raw data value (e.g., the value for one metric for a community) in relationship to the mean and distribution of all values (e.g., the value for one metric for all other areas). For this work, the calculated value for each community for a metric (e.g., obesity) is compared against the value for all counties within the community state (e.g., obesity rates for all counties in California). In this way, communities can be compared against geographic areas with similar geographic size and heterogeneity. Furthermore, z-scores for a given community are compared against a fixed number and definition of geographic areas, which exist independent of the number of communities or hospitals assessed within a state.

[2] Source: BRFSS PLACES 2018 Poor Mental Health Days + Poor Physical Health Days
[3] Source: CDC NCHS USA LEEP
[4] Removal was preferred over inverting the score direction since indicators were selected which theoretically represented conditions for good health. One example of this removal occurred with the metric "access to grocery stores", where a lower density of grocery stores correlated with a higher life expectancy and well-being. It is predicted that this relationship is due to confounding factors or a limitation of the measurement definition selected, and not an indication that a higher density of grocery stores causes worse health.

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Transformation of Correlation Scores

To aid in interpretability, correlation scores within a single health need category and outcome category were converted to percentiles, such that the score for a single metric represents the percent of the total scores for all metrics.

Category Scores

Scores for each metric are based on three separate values as represented in Equation 1 below. Short-term and long-term health impact scores are identical for all communities, while the relative severity score is unique. To generate a *final* score for each metric, we calculate the weighted average of the short-term and long-term score and apply the z-score as an adjustment factor.

$$M_c = (ST_s + LT_s) * Z_{cs}$$

Equation 1. Metric scores. ST_s is the state-specific correlation score between the metric and the short-term outcome variable (self-reported health status), LT_s is the state-specific correlation score between the metric and the long-term outcome variable (life expectancy), and Z_{cs} is the area-specific relative severity score (z-score).

In this way, communities which perform better than average for a metric will see scores adjusted down (lower priority), and communities which perform worse than average will see scores adjusted up (higher priority).

Next, metric scores are aggregated to produce subcategory and category scores. Subcategory scores are calculated as the average of all final metric scores within a category. Finally, category scores are calculated as the average of all subcategory scores within a category.

$$SubC_c = \sum_c \frac{SubC}{n} \qquad Cat_c = \sum \frac{SubC}{n}$$

Presentation of Results

All final subcategory and category scores are transformed to a 100-point scale for ease of interpretation, where 100 is the maximum possible value (highest priority) and 1 is the lowest theoretical possible value (lowest priority).

Subcategory scores are transformed *independently* of category scores. The maximum "real" subcategory score may be as high as 7.0, which would transform to ~100, whereas the highest category score is only about 4.0, which also transforms to ~100. Therefore, subcategory scores can be compared with other subcategory scores, category scores may be compared with category scores; however subcategory scores and category scores cannot be compared.

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Limitations

This approach is subject to several limitations. First, the final selection of priority areas is heavily dependent on the structure of the measurement framework. In this work, the top-level framework was determined by the hospital system based on prior assessments; metrics were assigned to categories and grouped based on expert knowledge. However, changes to the organization of metrics within top-level categories, including the addition or removal of metrics or the reorganization of metrics within subcategories, are major drivers of category scores and results. A data-driven method for selecting a measurement framework would therefore improve the applicability of these results outside of the example health system.

Next, despite best efforts to identify relevant metrics at the community-level, availability of data to represent some priority health need concepts are limited. For example, data on the prevalence of overall homelessness is not available for small (e.g., sub-county) geographic areas. Without data sets that accurately represent prevalence within a community, the ability to score impact on health and well-being is limited.

An additional limitation is the flexibility of metric correlation scores with the outcome variables. Data analysis found scores to be influenced by the geographic scale and the geographic universe (e.g., state, region, or US total) at which relationships were assessed, and rescaling methods used to standardize data. Changes to one or more of these decisions produce a range of correlation scores. Ideally, relationships would be consistent across multiple geographic levels or groupings.

Finally, secondary data are hampered by lag in reporting. At the time assessments were performed (Spring, 2022), the latest available data on health behaviors, outcomes, and social determinants represented the 2019 calendar year, and in some cases, data were older still. Since the first aim of this work is to measure the *relationship* between certain factors and well-being and life expectancy, this temporal lag is of less importance. However, the significant events of 2020 and 2021 (e.g., the COVID-19 pandemic) are largely unrepresented in these data.

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B. Survey Methodology and Questions

Adventist Health used a well-known market research company to conduct a statewide survey in Oregon to better understand community needs. This survey provided the needs assessment team with a list of health needs that were incorporated into the full set of primary and secondary data, which the local Steering Committee used to determine the final community health priority needs. Surveyed residents were given a list of 11 community health needs and were asked to choose 1-5 of the needs that they felt most impacted community health. Responses were collected from 500 English and Spanish-language speakers, giving the needs assessment team a detailed understanding of community opinions on this topic. Pollfish was the market research company used for this survey, and their methodology is outlined in their own words below. For more details on the Pollfish methodology, visit www.pollfish.com.

Pollfish utilizes a new survey methodology called Random Device Engagement (RDE) to reach users engaged in using a mobile application who are identified only by a unique device ID. Through this process, surveys were conducted on mobile phones through the Pollfish survey platform. Comparable to third-party advertising companies, Pollfish pays mobile application developers to show Pollfish surveys within their applications. In addition, Pollfish uses non-monetary incentives like an extra life in a game or access to premium content to encourage participant participation. With additional layers of survey fraud prevention, including AI and machine learning, Pollfish removes potentially biased responses to maintain data quality.

Pollfish selects a random sample of United States users who fit the eligibility criteria set by the research team. The survey platform has more than 250 million users worldwide.

The following list shows how response options correspond to the community needs framework.

SURVEY QUESTION

Please choose the five things from this list that make it hard for you and others in your community to be healthy.

- Not being able to see a doctor or go to a hospital
- Not enough good jobs
- Lack of transportation
- Lack of senior care
- Poor schools
- Not enough affordable housing
- Limited affordable, healthy food
- COVID-19
- Homelessness
- Mental Health
- Cost of Living

NEEDS CROSSWALK

- Access to Care-Primary Care
- Financial Stability-Employment
- Environment & Infrastructure-Transportation
- Access to Care-Senior Care
- Education
- Housing-Cost
- Food Security
- COVID
- Housing-Unhoused
- Mental Health
- Financial Stability-Cost of Living

C. Focus Group and Key Informant Methodology and Guide

Primary data collection was designed to gather first-person input on community health needs directly from community members. Between October 2021 – January 2022, focus groups were conducted with community service providers and service recipients, and key informant interviews were conducted with community leaders. Focus group members participated in 1.5-hour virtual and/or in-person sessions, and key informant interviewees participated in 1-hour individual virtual interviews. Steering Committee members were responsible for identifying participants and scheduling both types of interviews. Any social service provider in the community was eligible for inclusion in the focus groups, and any social service director or other community leader was eligible for key informant interview involvement. An emphasis was placed on hearing from underserved and minority populations whenever possible.

The semi-structured interview guides (see Section V) used for both types of interviews were nearly identical. All focus groups and interviews began with participants identifying up to five high priority community health needs from their perspective, chosen from a standard list provided by the facilitator. This standard list was comprised of common community health needs based on the larger framework of social determinants of health used for secondary data collection (see Section V). The facilitators — a team of Adventist Health System staff and a consultant — then moved through a series of questions for each identified need, focusing on depth of need, examples of the impact of the need, attempts at addressing the need historically, barriers to reducing the need, and reasonable improvement goals over three years. The only variation in the focus group and key informant interview guides was the inclusion of additional prompts for key informants allowing for greater depth of response. A notetaker was present for each focus group and key informant interview, and all interviews were recorded. Note documents and audio recordings were provided to the qualitative analysis team, which were Adventist Health System staff and a consultant, to facilitate analysis. Focus groups were conducted in teams of two, with a lead facilitator and a notetaker. All focus groups were conducted in English or Spanish. In some cases, the facilitator was provided by a Steering Committee member, either due to language needs, expertise with a specific community group, or both.

Deductive analysis of all focus groups and key informant interview data was performed by coding all available data to a social determinants of health framework developed by Adventist Health and CARES. This framework contains twelve major categories and over 52 common community health needs subcategories. Open coding, combining all relevant codes, was done at the category and subcategory level utilizing Dedoose coding software. Focus group and key informant data were analyzed and coded into single or multiple subcategories. The number of subcategory comments was rolled up to the major category level. Axial coding, where common and highly relevant data codes were combined into themes, was conducted on all category and subcategory data, and major themes were developed for each of the top five-to-six categories/subcategories based on relative importance determined by the number of total codes and the review by the axial coding team.

Once major themes were identified, the primary data team, comprised of both facilitators and qualitative data analysts, reviewed themes and supporting data to determine the final community needs to include in the Steering Committee data reveal. The final needs were the themes that occurred most frequently, both in terms of the number of times specific needs were identified and the urgency, frequency, and intensity of the related comments. Combined with the identified survey and secondary data needs (the five largest needs of the 12 on which secondary data was collected), these themes represented the findings the Steering Committee used to determine (described in Section IV) the final set of high priority health needs included in this CHNA report. Primary interview data was presented as identified needs, a summary of the need, and supporting data taken from the qualitative analysis. Wherever possible, the supporting data was provided in the form of direct quotes from participants.

FACILITATOR'S SCRIPT

WELCOME

- Warmly introduce yourself and note taker
  - We're from Community Benefit Solutions.
  - If site host is present, thank them for bringing everyone together.
- Duration
  - Spend the next 90 minutes together (focus group).
  - Spend the next 60 minutes together (key informant).
- Share the "why" they are here and "what" we're asking of them
  - You're here today because we want to hear your opinions about the health needs of your community.
  - Every community has things that help people be healthy and things that make it harder to stay healthy.
  - This is part of a larger plan and your input will be put together with comments from others in your community into a Community Health Needs Assessment report. This will help your community organizations and leaders as they work toward identifying the challenges and barriers you're seeing so they can work to fix the problems you're facing in trying to stay healthy.
- More about a Community Health Needs Assessment report
  - The Community Health Needs Assessment is a public document and represents the collaborative work between community agencies and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address key community health needs.
- Your Acknowledgment
  - We'll be asking you questions today and you're free to answer only the questions you're comfortable with.
  - Please know that notable quotes/comments from today's meeting could appear in the CHNA and will be labeled as an Anonymous Community Quote – please rest assured that we won't share any names.
  - *"Today's Focus Group is being recorded to ensure we capture all the concerns, thoughts and ideas about the health and well-being of your community. Some comments might be highlighted in the CHNA report and will not list the individual's name."*
  - We want to hear from everyone, so please understand if we move from one comment to the next – we want to make sure everyone is heard.
  - Does anyone have any questions about this?
  - How about any problems being involved in this group?

ACTIVITY EXPLANATION

- We're going to do a brief exercise to start that will tell us what the biggest problems you see are.
  - Then we'll ask you questions about those problems.
  - As you look around the room, you'll see three posters on the wall.
  - They show photos of common problems people face, many of them related to health. (Editorial note: these photos portrayed social determinants of health, for participants to select from. In some cases participants were given printed versions of the photos when they requested them. This allowed all participants to be involved regardless of mobility.
  - Please take a few minutes to vote with the stickers you were given when you walked in.
  - *Place a sticker underneath the photo that shows problems that you think are the biggest difficulties in your community.*
  - *Which of these things causes the most problems for you or others who live here?*
  - *We're specifically interested in learning about things that make it hard for you or your family and friends to have good physical and mental health, and a good quality of life.*
  - Some of the descriptions are one word and really meant for you to share more with us about that – for instance, doctor - it could be, I can't get an appointment, there isn't a pediatrician near me.
  - We'll give you 10 minutes to walk around.

TALLY RESPONSES:

- Visually tally the votes and clearly call out the top five issues that were identified for the notetaker and audience to hear.
- Spend around 15 minutes going through these questions and the topic-specific follow-up questions.
- Repeat for as many problems as time allows, leaving five minutes to wrap up at the end.
- Use the same prompting questions for each of the five identified issues.

Question Prompters

1. One of the topics that many people identified is _____. For those of you that think this is a health problem in your community:
2. Another topic many people identified is _____. For those of you that think this is a health problem in your community:
3. People also said that _____ is a problem. For those of you that think this is a health problem in your community:

QUESTIONS:

- Why is this a big concern?
- How do you see it affecting people around you?
- What have people tried to do to address this problem?
- What else do you think should be done?
- What are the biggest barriers to fixing this problem?
- If this problem got better, how would your community look different in 3 years?
- How has this problem been affected by COVID-19?
- Do you think this problem affects everyone in your community equally?

  If not, why is that?

  Who is most affected by this?

CLOSING QUESTION:

- Are there other important health needs in your community that we have not already addressed?
- (Let audience introduce and talk through topics with any remaining time. If related to our categories, you can use topic-specific prompts below.)

CONCLUSION:

- Thank you all very much for your time today. The information you provided is very helpful for us, and we'll use it to help improve the health of your community.
- Next year, we will publish the Community Health Needs Assessment, summarizing our findings and action plans identified with the community.

  If you would like us to send you a text or email with a link to that report, just provide us with your information on the way out.
- As a thank you to you all, we have a gift card for you as you leave. **Good health to you all!**

TOPIC-SPECIFIC PROMPTS

ACCESS TO CARE

What are the main things that stop people from seeing the doctor when they need to?

CHRONIC CONDITIONS/PHYSICAL HEALTH

What are the most common medical conditions that people have in your community?

How do you know?

HEALTH RISK BEHAVIORS

Personal choices can affect people's health at times. These can include not exercising enough, an unhealthy diet, smoking, drug use, unsafe driving habits, and many others.

What risky health behaviors do you think might affect your community?

MENTAL HEALTH

How can you tell that mental health problems are showing up in your community?

FOOD SECURITY

What examples have you seen of people struggling to have enough food to eat?

How common of a problem do you think this is?

What is being done to help?

INFRASTRUCTURE

What transportation barriers exist in your community?

COMMUNITY VITALITY

What are the best things about living here?

PHYSICAL ENVIRONMENT

What kind of access do you have to nature?

What limits people's access to the outside world?

COMMUNITY SAFETY

What are the biggest threats to your safety in your community?

What is being done to address these safety concerns?

HOUSING

What are the biggest housing problems facing your community?

What impact do these problems cause?

FINANCIAL STABILITY

What kind of job opportunities are there around here?

EDUCATION

How would you describe the educational opportunities for kids?

What about for people going to college or going back to school?

INCLUSION & EQUITY

How culturally diverse is your community?

How well does your community embrace this diversity?

What examples are there of times when diversity issues were not handled well?

D. Adventist Health Tillamook 2019 Implementation Strategy Evaluation of Impact

Scan QR Code to read more about the full Community Health Plan Update

E. Purpose of the Community Health Needs Assessment (CHNA) Report

The Community Health Needs Assessment (CHNA) is a public document and represents the collaborative work between community stakeholders and the local hospital(s), partnering to identify, gather and analyze the health needs of their community. This process provides communities a way to prioritize health needs, assess local resources and plan to address key community health needs.

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, included new requirements for nonprofit hospitals in order to maintain their tax-exempt status. The provision was the subject of final regulations providing guidance on the requirements of section 501(r) of the Internal Revenue Code. Included in the new regulations is a requirement that all nonprofit hospitals must conduct a community health needs assessment (CHNA) and develop an implementation strategy (IS) every three years (https://www.govinfo.gov/content/pkg/FR-2014-12-31/pdf/2014-30525.pdf). The required written IS plan is set forth in a separate written document.

F. CHNA Consultants Used to Conduct the Assessment

IDENTITY AND QUALIFICATIONS

ADVENTIST HEALTH COMMUNITY WELL-BEING TEAM

The Adventist Health Community Well-Being Team coordinated the data collection, analysis and writing for these reports. The Community Well-Being team members listed below encompass highly relevant and diverse experience in healthcare, philanthropy and foundation, Medicaid managed care and quality improvement, public health and community health, consumer insights research and community benefit reporting. Those team members include:

Samantha Gomez, MPH, CHES®:
Project Manager

Amanjit "Amy" Lasher:
Administrative Director

Jesus Mora-Castro:
Public Health Intern

Janelle Ringer:
Project Manager

Paul Sandman, MBA, CPA:
Community Integration Analyst

Susan Passalacqua:
Project Manager

Jade Tuleu:
Project Manager

Lisa Wegley:
Project Manager

CARES

Founded in 1992, the University of Missouri Extension Center for Applied Research and Engagement Systems (CARES) develops and supports mapping, reporting, and collaboration systems that enable public, private, and nonprofit sector organizations to effectively address issues across topics like agriculture, the environment, business, community, health, safety, and youth. The CARES team integrates data, mapping, visualizations, and engagement tools to better serve communities and regions across the US, including vulnerable, rural, and underserved populations. CARES web-based technologies help organizations and policymakers make more informed decisions about access, address issues of equity, and support the allocation of public and private resources.

CARES staff have backgrounds in data science, Geographic Information System (GIS), database and geodatabase management, web design and user experience (UX), spatial analysis, programming, systems implementation and administration, and web-based content management. Additionally, significant experience in project management, user training and support, data documentation, and client design sessions directly supports the wide variety of projects at CARES.

Chris Barnett (barnettc@missouri.edu) serves as director for CARES.

Angela Johnson (johnsonange@missouri.edu) serves as assistant director and lead research project analyst for CARES.

For more information, please visit careshq.org/about/

CENTER FOR BEHAVIORAL HEALTH INTEGRATION

The Center for Behavioral Health Integration is a small collaborative of mental health professionals and researchers providing evaluation, training, and program implementation support to human service organizations.

www.c4bhi.org
Project Lead: Patrick Kinner
Evaluation Consultant
Oct 2018 - Present 3 years 8 months
New England

Providing evaluation, research, writing, and strategic planning support throughout the world of human services.

Patrick Kinner joins Adventist Health as an Evaluation Consultant with more than 10 years of experience helping organizations collect high-quality data to improve their services and share their successes. He holds a vast background working with large health systems, state public health offices, and with innovative entrepreneurs and organizations to improve systems and services across the human service spectrum. Every passionate and committed organization has a gap between what they hope to accomplish and what they actually accomplish. As an evaluation consultant, Kinner identifies those gaps to collect data to understand the causes and help you use that data to change minds and turn heads. This can take the form of small-scale internal evaluation projects or long-term research efforts to test, validate, and publish your theory of change. His work has been instrumental in helping organizations secure additional funding and partnerships, and in

making major structural changes in initiatives when necessary.

Project Lead: Keren Meital Kinner
Evaluation Consultant
January 2019 - Present
New England

Providing evaluation, data analysis and visualization services to human service organizations.

Keren's experience in the fields of mental health, education, and software development intersect as she helps organizations collect, understand, and act upon performance and cultural improvement data. In her role as a program evaluator, she focuses on quantitative and qualitative data analysis as well as data visualization through Tableau. With the help of regular and timely data visualization cycles, she helps organizations easily access and understand the latest information, inspect progress and back draw, and help identify new themes, gaps, learnings, and enhancements. Keren regularly works with universities, hospitals, health centers, and innovative entrepreneurs.

VI. Glossary of Terms, Definition of Health Needs

Glossary of Terms

ACCESS TO CARE:

Accessing care with reliable transportation at the right time and location is often a challenge. In addition, not having access to insurance, low-cost care, interpreters, and programming prevents many people from getting treatment. Helping families secure insurance, transportation and access through mobile health options can help them find the care they need.

COMMUNITY SAFETY:

Being safe in your neighborhood is key to developing a real sense of community: where neighbors engage and work toward the common goal of safety and friendship. This may include a formal neighborhood watch program with local police, or simply an ongoing awareness of what's happening, to ensure safe homes and safe people.

COMMUNITY VITALITY:

A sense of belonging, a place where people feel connected, where neighbors are encouraged to participate in their community across socioeconomic status, physical ability, race/ethnicity or other differences, and where businesses can thrive — this is the definition of community vitality. These are a few of the aspects of what makes a community a community, with neighbors supporting neighbors and preserving the quality of life for all to share.

EDUCATION:

Educational opportunities can deeply impact choices, quality of life and life span, from children to adults. Studies have documented that educational attainment affects health and develops a healthy sense of empowerment. As school-aged children grow in knowledge, so can parents – touching multiple generations with opportunities. Whether it is a kindergartener or a newcomer to the United States, education can improve futures.

ENVIRONMENT & INFRASTRUCTURE:

Clean water, clean air and accessible walkways and streets are key to healthy neighborhoods. Walking and biking require safe sidewalks and roads. In a digital world where access to high-speed internet provides opportunities to attend school, work, go to a doctor and conduct daily tasks, high-speed internet access is also an infrastructure necessity.

FINANCIAL STABILITY:

The definition of financial stability is broad and encompasses the ability to cover daily living expenses, allowing individuals to fully engage in life's opportunities. Things like safe housing, access to healthy foods and other necessities are impacted by financial stability. The gap between income and cost of living, along with a lack of stability, can be a barrier for individuals and families from securing the care and resources they need. Over time, the lack of financial means impacts health and physical, emotional, and social well-being.

FOOD SECURITY:

Food security is the ability of all people, at all times, to have physical, social and financial access to healthy and nutritious food. Food security also involves the ability to purchase preferred affordable healthy foods, cook and store them.

Today, that is a goal and a challenge, as costs increase, and access to finding affordable healthy options is limited.

HEALTH CONDITIONS:

Obesity, heart disease, cancer and diabetes – examples of chronic diseases – are the leading causes of death and disability in the United States. The conditions in which we live contribute to our well-being and influence our choices that can lead to potentially serious diseases. Access to clean and healthy food, water, air, safe schools, affordable housing, and reliable safety-net programs play a major role in the health and well-being of a community. These conditions can make a significant difference in combatting the leading causes of death and disability in the United States, such as obesity, heart disease, cancer and diabetes.

HEALTH RISK BEHAVIORS:

Each day, decisions are made that impact lives – directly and indirectly. These manners range from abuse of drugs and alcohol, to smoking, to misuse of medications. Relying on unhealthy food choices is another example of a behavior that can be a life-threatening health risk. But life changes, such as consistent physical exercise and healthier food choices, when supported by financial stability, equitable social conditions, and a healthy natural and built environment, offer the opportunity to change direction and live healthier lives. Sometimes, it's our opportunities and choices that lead to some of these serious diseases. Often, the conditions in which we live can influence and contribute to our health. Access to healthy foods, green space for exercise, quality of our air and schools, affordable housing and the reliability of safety-net programs often play a role in community health.

HOUSING:

The definition of housing varies from person to person, as individuals and families struggle to find safe housing – a place to rest and live that is affordable and in good condition. Today, families face a shortage of housing stock, long wait lists and complicated steps required to secure a place to live. Families may find that they can't afford housing, so they double up with another family or remain in a home that is too small or even unsafe. Efforts continue to address these very real concerns and to seek solutions.

INCLUSION & EQUITY:

The definition of inclusion and equity includes fairness, justice, prosperity, and opportunity – for all people of all ages to feel welcomed, with a fair chance to participate, thrive, and reach their full potential. Inclusion and equity reflect those social conditions, systems, and policies that make it so all individuals in a community have equal opportunities to live good lives.

MENTAL HEALTH:

Mental health includes our psychological, social and emotional well-being. It affects how we think, feel and act, and sometimes leads to behaviors like self-harm or self-medication. Mental health is important at every stage of life, and not knowing when or where to ask for help often leaves children, teens, adults and families feeling alone and helpless.

VII. Approval Page

2022 CHNA Approval

This community health needs assessment was adopted on October 20, 2022 by the Adventist Health System/West Board of Directors. The final report was made widely available on December 31, 2022.

This Community Health Needs Assessment was adopted by the respective boards of directors, October 2022, for Tillamook County Community Health Centers, Tillamook Family Counseling Center and the Rinehart Clinic (soon to be known as the Nehalem Bay Health Center and Pharmacy).

Thank you for reviewing our 2022 Community Health Needs Assessment. We are proud to serve our local community and are committed to making it a healthier place for all.

Eric Swanson, Mba, Fache, Nrp
Adventist Health Tillamook

Tillamook County

COMMUNITY HEALTH NEEDS ASSESSMENT