2019

Wallowa County Comprehensive Needs Assessment

FINAL REPORT

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Foreword

The Northeast Oregon Network, Wallowa Valley Center for Wellness, Wallowa Memorial Hospital, Winding Waters Medical Clinic, Building Healthy Families, and the Wallowa County Local Advisory Committee to the Eastern Oregon Coordinated Care Organization have joined together to develop and deliver the 2019 Wallowa County Community Health Needs Assessment. The information included in this report will be prioritized and incorporated into the action plans and strategies of our community health partners, other community agencies and businesses. The Northeast Oregon Network conducted the assessment design, data collection, analysis and reporting, with feedback and input from the partners listed above at key points in the process

The data within this report is based on data obtained from written survey responses from community members as well as qualitative input from providers and community partners in Wallowa County that were conducted beginning in January 2019 through April 2019. The surveys taken by community members were focused on adults ages 19 and older, with a few supplemental questions focused on children's health access. It also integrates data from a comprehensive secondary data source review and an integration assessment.

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Executive Summary

This section includes a summary of community health-related data collected from adults in Wallowa County who chose to participate in a countywide health assessment survey in the winter of 2019. The findings are based on self-administered surveys using a structured questionnaire and were distributed to two groups of people. The first group of people was a randomly generated list of 1,096 people from Wallowa County receiving a mail out survey, with a return rate of 35%. The second group consisted of an oversampling of high-risk community members who needed assistance to complete surveys due to physical or mental health disabilities, and/or healthy literacy issues. This second group was recruited from the partner organizations, who had surveys on site and offered to assist community members with completing them. In addition to community members' surveys, the assessment also involved a comprehensive survey of relevant health and socio-demographic secondary data sources, and an integration of care assessment conducted with a group of representatives from partner organizations.

The multiple data sources were integrated into a single grid that cross walks multiple data sources by categories, with rankings for each indicator. The 113 indicators are broken down into four broad topics and 42 categories as follows:

- Health Conditions: 16 categories and 22 indicators
- Issues of Health Concern: 13 categories and 31 indicators
- Access and Utilization: 6 categories and 13 indicators
- Social Needs and Resources: 7 categories and 47 indicators

Each indicator is ranked on a scale of 1-5 where at least one piece of county comparison data exists using the methodology noted in Section C of this report. Where no pieces of comparable data exist, the indicator is left unranked, with the intention that a community group or organization utilizing the grid would rank it based upon their anecdotal knowledge of the community. The survey has now been repeated twice in the community, giving a comparison point between 2016 and 2019 for survey data. Where there wis a 10% or greater improvement, the change direction is noted with a green arrow. Where there was a 10% or greater decrease in performance, the change direction is noted with a red arrow. Any indicator within 10% either direction is marked with a yellow arrow.

The three charts below represent a good visual summary of the current status of the health and well-being of Wallowa County. Following the grid there is a summary of the significant highlights form the secondary data, including any major changes from 2016 data. Finally, there are a few summary highlights from the integration assessment.

Areas of Strength			
Health Conditions	**Issues of Health Concern**	**Access to and Utilization of Care**	**Social Needs and Resource**
Asthma prevalence	Inadequate Prenatal Care rate	Dental Visit in the Last Year rate	3rd Grade Reading Proficiency rate
COPD prevalence and mortality rate	Adult Obesity rate		3rd Grade Math Proficiency rate
Type II Diabetes prevalence	Low Birth Weight rate		Homeless Student rate
Stoke mortality rate			
Marijuana use prevalence			

Areas of Average Performance

Health Conditions	Issues of Health Concern	Access to and Utilization of Care	Social Needs and Resource
Arthritis/Chronic Back Condition prevalence	2-Year-Old Up to Date Immunization rate	Health Coverage	% of Families with Severe Housing Cost Burden
Heart Disease prevalence and mortality rate	Adult 65+ Flu Vaccination rate	% of Adults Needing Urgent Physical Health Care Who Got It	% of Individuals Under Poverty Level
High Blood Pressure prevalence	Start of Prenatal Care in the 1st Trimester rate	% of Adults Connected to a Personal Doctor	Rate of social associations per 10,000
Adult Depression prevalence	High Cholesterol rate		Food environment index
Adult Binge Drinking prevalence (male and female)	% of Adults Meeting CDC Recommendations for Aerobic and Strengthening Activities		% of Children with Preschool Enrollment
Alcohol Induced Mortality Rate	Cigarette Smoking rate		% of Children in Foster Care
Risky Opioid Prescribing rate	Adults with Insufficient Sleep rate		% of Referrals to Juvenile Justice per 1,000
Years of Potential Life Lost	Preventable Hospitalization rate for Medicare Enrollees		
Presence of One or More Chronic Condition prevalence	Days of poor physical and mental health for adults		
Total Death rate	Colorectal Cancer Screening rate		
	Cholesterol Screening rate		
	Teen Pregnancy Rate		

Areas of High Need

Health Conditions	Issues of Health Concern	Access to and Utilization of Care	Social Needs and Resource
Cancer prevalence and mortality rate	Tobacco Use During Pregnancy Rate	% of Adults Having Dental Coverage	% of Population Living with Food Insecurity
Flu and Pneumonia mortality rate	% of Adults Consuming 7+ Sodas per Week	% of Adults Needing Oral Health Care Who Never Got It	% of Population Living Under 200% of Poverty Level
Unintentional Injury mortality rate	% of Adults who had Medical Advice to Reduce Sodium		% of Population with Access to Exercise Opportunities
Suicide mortality rate	Preventable Hospitalization Rate		Child Abuse/Neglect Victims per 1,000

	Among the General Population		
Heavy drinking prevalence (male and female)	% of Adults with a Disability age 18-64		% of Foster Care Placement Stability
Alcohol Involved Motor Vehicle mortality rate	% of Adults with Blood Sugar Screening in the Last Year		% of Child Food Insecurity

The secondary source data was analyzed comparing the previous assessment conducted in 2016 to the current assessment data. Listed below are a few notable changes:

- There has been a small but steady increase in population since 2010.
- The median age continues to increase.
- While lower than the state percentage, there has been an increase in the percentage of the population between the ages of 5-19.
- The median family income increased by 46% since 2016.
- Wallowa County continues to have a high high school graduation rate.
- Tobacco use during pregnancy has decreased by 40% since 2010 but remains much higher than state and national averages.
- Food insecurity for people of all ages remains a persistent concern.
- Those that are severely rent burdened has also not changed substantially since 2016 but does remain lower than other rural areas in the state.
- Rates of heavy drinking remain high among both males and females, and alcohol involved motor vehicle fatalities have increased by 27%, remaining among the highest in the state.
- There has been substantial improvement in rates of asthma, high blood pressure and high cholesterol.
- The rate of Type II Diabetes has also reduced substantially.
- There has been an increase in flu and pneumonia death rates, while there has been a corresponding decrease in influenza vaccination rates among adults over 65.
- The rate of obesity in adults has decreased by 26%.
- Death rates due to injury and trauma, including suicide, remain higher than state and national averages, and areas of high need in the county.
- Finally, rates of abuse and neglect among children has increased by 211% since 2016, a significant concern.

The integration assessment provided a good overview of where integration was happening from the view of the partners, especially in the areas of mental health and physical health, and mental health and substance use treatment. There were quite a few areas of moderate integration. Areas of greatest integration need were generally identified in the areas of housing, food and education. Interestingly, the more structured prioritization exercise that assessed areas of greatest need and areas of greatest benefit for integration found a clear convergence only in the areas of physical health and food.

Survey and Assessment Methodology

Entities participating: Wallowa County LCAC, Wallowa Valley Center for Wellness, Wallowa Memorial Hospital, Winding Waters Medical Clinic, Building Healthy Families and Northeast Oregon Network

Purpose: To produce a joint community health assessment that will provide data for Public Health Annual Planning, Mental Health Biennial Planning, Hospital Community Benefit Planning and Reporting, LCAC health improvement planning, Health Provider planning, and other community health improvement efforts. The assessment focuses on both child and adult health and social concerns.

The assessment was conducted in four phases:

- Phase 1 consisted of a comprehensive review of secondary data sources, including demographic, health, and sociodemographic topics. Data was obtained for both prevalence and mortality rates for Wallowa County, the State or Oregon, and the United States as a whole. Where available, 2010 and 2016 assessment data are provided as reference point for any changes.
- Phase 2 consisted of a household survey focused largely on access to care and social determinant of health needs assessment, data that largely was not available from secondary sources.
- Phase 3 consisted of a n integration of care assessment, using guidelines recommended by the Oregon Health Authority for Coordinated Care Organizations. This involved providers, health and human services, and community partners meeting together for an afternoon for structured qualitative data collection.
- Phase 4 consisted of a comprehensive analysis that was intended to cross walk the three above listed data sources. In prior years we have had access to Medicaid data, but were unable to obtain it this year from the Medicaid payer. The primary output was a Health and Community Indicator Ranking Grid, that allows for an overall ranking for 113 different indicators. The grid also shows the direction of change from the 2016 assessment to the 2019 assessment.

Secondary Data Source Methodology

Data was collected nationally, for the state of Oregon, and for the county of Wallowa to compare demographic, socioeconomic, occupational, and health data to a similar assessment previously conducted in 2010 and 2016. The data is broken up into columns as follows:

- Indicator by category
- Previous 2010 and 2016 assessment data
- Current Wallowa County Data
- County rank, if available
- Oregon data
- US data
- Year the data was collected
- Data source

Data Sources**:** Please see the electronic version for data source citations due to space limitations.

The collected data came from a variety of different sources and although all data in each category does not always come from the same year, each parameter was collected from the most recent source that could be found. There were also some indicators that had the same data from different sources, so note that some indicators are listed twice. This will allow the reader to note the differences in data for the same indicators depending upon source and year.

The term "ND" means that there was no data available from the listed source. Data labeled "CNAS" is from the current Needs Assessment Survey and can be found in the Community Health and Indicator Ranking Grid. Where possible aggregated data is used, as it provides for the most statistically reliable data given the small population size of Wallowa County. Common data sources are as follows:

- United State Census Bureau in which most of its data came from the years 2013-2017.

- Oregon Health Authority which provided the majority of the data for the vital statistics parameter with data from either 2011-2017 or 2013-2017.
- State Office of Rural Health Service Area Profile was also used to cross reference more current vital statistic data which was collected from 2013-2017.
- Centers for Disease Control Data, which is variable.
- County Health Ranking Data for 2019. Base data sources vary in their years, and are often aggregated.

Other data sources are listed in the data set under the column "Sources." There is a column for county rankings, however county rankings were not available for most indicators. The data that county rankings were provided for came from:

- State of Oregon County level public health data sets including BRFSS data;
- County Health Rankings;
- Children's First County Data Books.

Generally, data for Wallowa County and the state of Oregon came from the same source, while national data had to be collected from a different source.

Table Color Coding

The data was briefly analyzed and highlighted according to numbers that had significant discrepancies. For the specific highlighted data, Wallowa County was compared with state and national data to distinguish big discrepancies in rates for the indicator. The data highlighted in green shows significant data that has positive implications for the community, the data in red shows data that has negative implications to the community. Data highlighted in yellow is has significant differences from state and national data but does not necessarily have positive or negative implications.

There have been significant changes from the 2016 assessment to the 2019 assessment in terms of county level data that is available. One key source, the Community Health Status Indicators from the Centers for Disease Control for Small Communities is no longer available. The Addictions and Mental Health Unit at the State level has undergone significant changes and no longer provides county level data on mental health and addictions related issues. The state has changed how it calculates and presents a lot of its vital statistics data. It also did not have updated Behavioral Risk Factor Surveillance System data at the county level until June of 2019. The data available at this point is only a subset of the data available during prior years. It is unclear if the data is not yet analyzed and available, or if the state is no longer going to provide that county level data. Finally, Wallowa County has not participated in the Oregon Healthy Teen survey since 2008, meaning there is little to no data available on adolescents in the county.

Community Health Needs Assessment Survey

The 10-page community survey was developed with input from the above listed community partners and based on already vetted questions with existing benchmarks (i.e. Behavioral Risk Factor Surveillance System questions). New questions were created only when there were no existing standard, validated questions available for that topic. The evaluator on the project, Annie Larson, PHD, vetted the survey. The survey consisted of six sections:

1.) Access to Care questions for adults
2.) Questions regarding economic and social needs
3.) Questions regarding the presence of health promoting social factors, based upon the Blue Zone factors associated with healthy longevity
4.) Questions regarding health care conditions and impacts
5.) Demographic questions
6.) Supplemental questions regarding Access to Care for children under 18 living in the home.

The survey administration consisted of two sampling methods; a random mail out, and a place based assisted survey. For the random component, surveys were mailed to a random sampling of approximately 1/3 (1096) household in Wallowa County. Surveys were sent with an introductory letter from all of the assessment partners, and a stamped return envelope. Attention was given to health literacy concerns, but it should be noted that the survey required a moderate level of literacy, even with the use of plain language, due to the length and

complexity. After a three week return period, a second follow up mailing with a follow up letter and stamped return envelope was mailed to the entire sample. Surveys were anonymous.

In order to meet a sample size that could ensure reliability, validity and generalizability, 375 surveys needed to be returned, a 34% return rate of all surveys mailed. The number was met, with 381 surveys were returned, a 35% return rate. Surveys were answered by individuals; even though they were mailed to households, questions were at the individual response level.

In order to address concerns about health literacy, a second smaller nonrandom sample was conducted. Each provider originations had surveys on site, and asked individuals if they would like to complete a survey and if they needed assistance. They only completed a survey if someone was not mailed one at home, in order to avoid duplication of responses. If an individual received one at home but needed assistance, they brought the survey in to the organization, were assisted, and mailed it back in their return envelope. Survey responses were tracked by each partner site, and by whether assistance was provided. Assistance was provided for physical or mental health disabilities that made completing the survey difficult, or for health literacy issues. Seventy-six surveys were returned from partner site organizations as having been administered with assistance, providing a good oversampling for individuals struggling with lower health literacy levels. Assisted surveys were given to five partners. Only two sites, Winding Waters Medical Clinic and Wallowa Valley Center for Wellness, returned assisted surveys.

The 381 surveys returned overall were down somewhat from the 461 surveys returned in the 2016 assessment. We did meet the power calculation number, and the surveys represent 5.3% penetration rate for the entire population. By comparison, the national, state and county level Behavioral Risk Factor Surveillance (BRFSS) surveys usually have a 1-2% penetration rate. Only 63 survey responses answered the supplemental children, so data for children under 18 was a smaller sample size.

Community Health Needs Assessment Survey Analysis

Survey responses were coded using a numerical system for each answer choice, allowing for calculation for results. Data was entered into an excel spreadsheet, and to ensure data accuracy, was reentered a second time so that discrepancies could be identified, and errors resolved. An PHS evaluator conducted cross tab analysis using STATA, which were then used to create graphical presentations of basic frequency distributions for each question for the population as a whole. Frequency distributions were also created for the following sub populations:

- Adults age 65 and older
- Low Income adults
- Adults living in families with children under 18 in the household
- Those that were assisted with a survey and/or reported some type of disability.

Child data from the supplemental questions was also reported separately. Because a high percentage of respondents, 53.5%, either refused to give their income category or didn't know, the low-income category was created using a combination of reported income, and Oregon Health Plan as in insurance status, since the qualifying income levels correlate with low income status.

In one final analysis, the social need and social resource questions were combined to create an overall social need (termed Problem) and social resource (termed Need) that was stratified by the above listed population groups.

Frequencies only are included in the Health and Community Indicator Ranking Grid. All Graphs are included in the final report narrative. Because we asked the same questions from 2016 to 2019, using the same random and assisted sampling methods, and met the power number, changes for the entire population sample from one time period to the other can be considered to be reliable and generalizable. Because the sample sizes for the sub

population are small, the results cannot be considered reliable and generalizable between the time periods for these groups.

Integration of Care Assessment

The integration of care assessment replaced the provider survey from the 2016 assessment. Very few providers answered the survey in 2016, despite multiple follow up calls, rendering the data largely meaningless. Since that time, the Oregon Legislature passed a requirement for all Coordinated Care Organizations (CCO) to conduct an integration of care assessment and add integration goals to their community health improvement plans. While not required by the Wallowa County partners, the guidelines and format given the CCOs can also provide a useful review of integration of care in Wallowa County. Since this has been a long-term goal of many partners, the assessment partners decided to conduct this assessment.

Eleven individuals from 8 partner organizations came tighter for a four-hour collaborative qualitative data collection exercise, assessing integration of care efforts across nine different health and social service domains. Data is reported in a visual quadrant for each area and is also integrated into a grid that indicates areas of high integration, and areas partners expected to be of high benefit for further integration.

Eastern Oregon Coordinated Care Organization Medicaid Utilization Data

For the 2016 assessment we were able to obtain analyzed data for the Medicaid population from the Eastern Oregon Coordinated Care Organization. We were unable to obtain any analyzed or raw data from the EOCCO for this assessment, despite multiple requests from multiple assessment partners. If this data is obtained at a later point, it could be integrated via an assessment update.

Final Grid Analysis

All the strands of the community needs assessment are combined (with the exception of the nitration survey results, which was qualitative and not appropriate to integrate into the grid) into one Health and Community Indicator Ranking Grid. This gird is designed to be used by organizations and community coalitions for meaningful community health improvement planning. The next section of this report is a detailed list of notations helpful in interpreting the grid. The notations are provided in a separate listing rather than in a subscript due to space and readability considerations with the grid.

The grid combines current prevalence and mortality data from a validated secondary data source, data from the 2010 and 2016 assessments, prevalence rates for the 2019 survey as a whole and sub populations. The secondary data source prevalence rates are presented in both age adjusted and unadjusted rates where appropriate, as is the mortality data. Where available, county rankings are provided, usually against other Oregon counties. Where relevant, mortality rates are provided. State and national prevalence rates are provided in age adjusted forms, as are mortality rates where relevant. National goals are presented, usually form Healthy People 2020, although the Top Performers in the United States on the County Health Ranking were also used as a benchmark.

NEON has provided a ranking based on a 1-5 system where at least one piece of comparable data to county rates is available. The ranking methodology and calculation is described in the next section. Green represents an area of strength, yellow represents an area of average performance, and red indicates an area of need. In cases where there was not at least one comparable data source, no ranking was given.

A new column was added this time, one indicating the direction of change from the 2016 assessment. The 10% change method was utilized, as that is the standard performance improvement goal measurement method used most commonly in Healthy People 2020. Where there was greater than 10% improvement, a green up arrow is

used. Where there is a decrease in improvement of 10% or more, a red down arrow is used. Where the change was within 10% either way, a yellow sideways arrow was used.

Given that organizational and group priorities will vary based upon organizational missions, mandates and funding sources, a column is provided for each community or organization to rank each indicator differently based upon their community view point. While the blank columns previously added for Organizational priority and Ability to Impact have been taken off due to space and readability, they can still be added by each site to aid in the health improvement planning process. Each organization would rank the Organization Impact for each indicator on a scale of 1-5 (1 high priority, 5 low) in terms of the priority to its mission and the organizations understanding of the community. The Ability to Impact rating is also rated on a 1-5 scale. One indicates the organization has a high ability to impact the measure, a five indicates a low ability to impact. When the ranking columns and the ability to impact columns are viewed in conjunction with each other, community health improvement planning priorities can become clearer. When the priority is high and the ability to impact is high, that represents an easy area of success with high impact. Where the priority is moderate and the ability to impact is high, that represents an ability to move an average area into an area that is excelling. Where the priority is high and the ability to impact is low, that represents and area for long term planning, collaboration and funding development in order to address. Of course, those areas representing strengths should be celebrated and maintained.

Notes for Interpreting the Grid and Description of Ranking Methodology

- Oregon Healthy Teen Survey has not been completed in Wallowa County since 2008, so there is no current data available for youth mental health, physical health, substance abuse, or other risk factors.
- Some data is suppressed due to very small sample size.
- Please note that when comparing 2010 to 2016 and 2019 prevalence rates pulled from the OHA Chronic Disease Report that the numbers are not comparable. The state changed their statistical calculation methods between 2010 and 2016 and advised that the reports are not comparable.
- Complete secondary data sources can be found in the secondary data source tables.
- If data is not present for 2010 it is because that measure was not collected in any comparable way at that point in time.
- CNA stands for Community Needs Assessment and includes all data, secondary and primary source.
- CNAS stands for Community Needs Assessment Survey and is self-report data that was obtained via a household survey.
- Age Adjusted rates are provided in order to be comparable to other counties, the state and US rates.
- Unadjusted rates are provided to give some idea of the actual population numbers in the county impacted by that measure.
- No preventative health screening data was available. BRFSS numbers suppressed due to small sample size.
- AOD stands for Alcohol and Other Drug.
- The 2010 Needs Assessment Survey utilized different sampling methods from the 2016 and 2019 surveys, and thus do not have comparable demographics. The 2010 survey was stratified by location and populations but was nonrandom. The 2016 and 2019 surveys utilized primarily mail out methods, with some on site assistance, and was randomized for the mail out portion.
- Survey data from 2010 for the Social Needs and Resources section is for Union, Baker and Wallowa counties. Wallowa County specific data was not available.
- See the Survey Sample Demographic Comparison Table for information on how the 2016 and 2019 survey samples differ in demographics, and how the 2019 survey sample differs from the overall Wallowa County demographics. Generally, as is the case with mail out surveys, the population is disproportionately older and female.
- The “low income” category on the grid is not designated based off income data. Of the participants of the survey, 53.5% refused to answer income questions, or did not know their income. This category is based on those that answered the income questions, and those enrolled in Oregon Health Plan.
- The “assisted” category on the grid consists of individuals who were not part of the random mail out sample but were included in a non-random selection of individuals offered the survey directly by partner staff. Survey locations were the Wallowa County LCAC, NEON service sites, the Wallowa Valley Center for Wellness, Winding Waters Medical Clinic, Mountain View Medical and Building Healthy Families. This sample size consists of 76 individuals, and represents a population with health disabilities, health literacy needs, or both, that required assistance in order to complete the survey. Surveys were returned only from the Winding Waters Medical Clinic and Wallowa Valley Center for Wellness sites.

- When County Rank is provided by County Health Rankings as the source, it is not a direct rank on the measure. The County Health Rankings does not rate individual measures, but groups them into categories of measures.
- All County Health Rankings come from the year 2019.
- All County Health Rankings listed for each year is an aggregate for several years of data. There are different years associated with different measures.

CNAS Indicator Ranking Calculation Method

CNAS Rankings were given a range of one to six, depending upon data available. If all data fields are available for a measure, the ranking reflects a combination of the county's relative performance to other counties, state averages, national averages, and national goals. If all six fields are available, it also represents a combination of performance based on prevalence and mortality. If all six fields are not available, then the calculations are made with the available fields, and the denominator is reduced accordingly. There needs to be at least one comparable data field in order to create a ranking. The ranking is more relevant with more conquering data fields available for comparison.

The CNSA Ranking is scored with the following criteria:

1.) Wallowa County ranking compared to other Oregon counties, or in some cases, against a national sample of similar size. In the above grid, whether a low score is positive or negative is dependent upon the nature of the indicator. For purposes of the ranking calculation, all ranks were converted to a low/positive, high/negative continuum.
2.) Percent difference from the state prevalence.
3.) Percent difference from the national prevalence.
4.) Percent difference from the national goal or benchmark, either prevalence or mortality depending upon the goal measure.
5.) Percent difference from the state mortality rate.
6.) Percent difference from the national mortality rate.

Scores are assigned as follows for the county ranking:
1 pt – those with a county ranking of 1-12
2 pts – those with a county ranking of 13-24
3 pts – those with a county ranking of 25-36

Scores for percent difference between prevalence and morality rates are assigned as follows:
1 pt - If county performs better than the state, national or benchmark by greater than 20%,
2 pts - If the county is within a 20% plus or minus of the state, national or benchmark
3 pts - If the county performs worse than the state, national or benchmark by 20% or more

Once a score is obtained, it is assigned a rating based upon which quintile it falls into when the area between the minimum and maximum scores is divided evenly into five sections. Those scores falling in the first quintile are colored green, for a strength area. Those scores falling into the second and third quintiles are marked yellow, for areas where the status is average compared to others, but progress can be made. Those areas falling into the fourth and fifth quintiles are marked red, as an area of high need.

Survey Sample Demographics Comparison to Entire County Demographics

The table below is provided in order to compare the county Census/ACS demographics data of the county in 2016 to 2017-18 in order to note any changes. The demographics of the 2019 Community Needs Assessment Survey (CNAS) is also provided in order to determine variance in the survey population from the county population as a whole.

Indicator	2016 Census/ ACS Survey Unless Noted % of county	2019 CNAS Survey % of total	2017 or 2018, as indicated Census/ACS Survey % of county
Age			**2018**
0-14	15.1	0	20.3
15-19 years	5.7	0.1	4.7
20-24 years	3.2	5.6	3.0
25-34 years	8.6	8.5	9.8
35-44 years	9.2	10.3	10.3
45-64 years	32.2	31.3	27.6
65-74 years	15.0	24.1	8.1
75-84 years	7.5	18.0	3.8
85+ years	3.6	5.6	3.5
Don't know	*	0.1	*
Refuse	*	0.1	*
Missing	*	1.6	*
Gender			**2018**
Male	49.2	44.4	49.4
Female	50.8	50.9	50.6
Refuse		1.8	
Missing		2.9	
Race/Ethnicity			**2017**
Hispanic/ Latino or Spanish Origin	2.6	2.6	2.7
White	93.5	86.7	95.6
Black	0.5	0.8	0.2
American Indian or Native	0.8	1.6	0.2
Asian or Pacific Islander	0.5	0.8	0.4
Other	2.1	2.6	0.4
Don't Know	0.0	1.0	0.0
Refused	0.0	3.4	0.0
Missing	0.0	5.0	0.0
Relationship Status			**2017**
Married	58.0	59.1	59.1
Divorced	11.6	12.3	11.6
Widowed	9.2	11.0	8.5
Never Married, Single	19.5	6.9	18.9
Member of Unmarried Couple	*	5.2	*
Refuse	*	1.3	*
Separated	1.6	1.8	1.8
Missing	*	3.9	*

Education	Age 25+		Age 25+ 2017
No School	*	0.5	*
Grade 1-8	*	1.3	*
Grade 9-11	*Less than HS completion* 4.6	3.4	*Less than HS completion* 5.1
HS Diploma	32.6	24.9	30.5
Some College	35.6	31.8	36.6
College Grade	14.3	23.9	16.1
Graduate Degree	10.9	10.8	9.6
Don't Know	*	0.3	*
Refuse	*	0.8	*
Missing	*	3.4	*
Employment			
Retired		44.9	
Employed Full Time		22.3	
Self-employed Full Time		8.9	
Employed Part Time/Seasonally		9.4	
Homemaker		5.5	
Self-employed Part Time/Seasonally		7.9	
Out of Work >1 Year		4.2	
Currently Seeking Employment		1.6	
Refuse		1.8	
Student		1.0	
Don't Know		1.0	
Out of Work <1 Year		1.0	
Missing		4.7	
Living Situation			**2017**
Homeowner	70.3	74.3	68.0
Renter	29.7	17.6	32.1
Residing in Rent Free Place	*	3.4	*
Refuse	*	0.8	*
Don't Know	*	0.5	*
Homeless	*	0.8	*
Missing	*	4.2	*
Income			
<$25,000	30.9	10.5	29.9
$25,000-$49,999	28.6	12.9	25.8
$50,000 +	40.4	21.0	44.3
Don't Know	*	9.4	*
Refuse	*	35.4	*
Missing	*	10.8	*
Adults Living in Household-Surveys Only			
0 to 1 Adult		24.7	
2 Adults		54.9	
3 Adults or more		9.4	
Don't Know		0.3	
Refuse		0.8	
Missing		8.1	

Children Living in Household-Surveys Only			
No Child		71.7	
1 Child		5.2	
2 Children		7.3	
3 Children or more		3.7	
Don't Know		0.8	
Refuse		1.8	
Missing		9.2	

* indicator not included in data collection

HEALTH AND COMMUNITY INDICATOR RANKING GRID: WALLOWA COUNTY 2019

HEALTH AND COMMUNITY INDICATOR RANKING GRID 2019	County Rates									State Rate	National Rate	Goal or benchmark	County Ranking	Direction of change from last assessment	Ranking: 1=Area of Strength 2-3+Average Area 4-5=Area of High Need
	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
Health Conditions															
Arthritis/ Chronic Back Condition	12% Age Adjusted	12.4% Age Adjusted 20% unadjusted, 2010-2013	23.40% Age Adjusted, 33.35% Unadjusted 2014-2017	NA	NA	NA	NA	NA	NA	23.7% Age Adjusted 2014-2017	22.7% Age Adjusted 2013-2015	HP2020 Goal: 35.5%	6		3
Asthma	No data available	13.6% age adjusted 2012	6.2% Age Adjusted, 8.2% Unadjusted 2017-2017	11.81	7.65	6.9	15.9	6.58	3	11.00% Age Adjusted 2014-2017	7.9 % Age Adjusted 2017	HP2020 Goal: 49.6 ED Visits per 10,000	2		1
Cancer Survivors as a % of total population	No data available	3.7% Age Adjusted, 6.2% Unadjusted 2010-20163 155 Deaths per 100,000 crude	14.9% Age Adjusted, 16.5% Unadjusted 2017-2013 136.2 Deaths per 100,000 age adjusted 2011-2017 227.9 per 100,000 crude 2013-2017	NA	NA	NA	NA	NA	NA	7.1% Age Adjusted 2014-2017 160.9 per 100,000 age adjusted	5% Age adjusted 2019 152.5 Deaths per 100,000 age adjusted	HP2020 Goal: 161.4 deaths per 100,000	36	Survivor prevalence data may be unreliable due to small sample size Deaths: 	4

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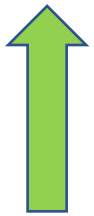
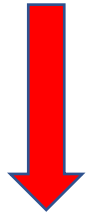
	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
COPD/ Lower respiratory diseases	No data	2.6% Age adjusted 4.5%* Unadjusted, 2010-2013 60.8 Deaths per 100,000, crude	2.5% Age Adjusted, 3.9% Unadjusted 2014-2017 27.4 Deaths per 100,000 age adjusted 2011-2017 55.6 per 100,000 crude 2013-2017	NA	NA	NA	NA	NA	NA	5.6% Age Adjusted 2014-2017 41.4 Deaths per 100,000 age adjusted	6.5% Crude Rate 2017 40.9 Deaths per 100,000 age adjusted	HP2020 Goal: 102.6 deaths per 100,000	2	Prevalence  Deaths: 	**1**
Type II Diabetes	7.9%	9.2% Age Adjusted, 11.9% Unadjusted 2010-2013 37.6 Deaths per 100,000, crude 2011-2017	5.1% Age Adjusted 8.4% Unadjusted 2014-2017 25 Deaths per 100,000 crude 2011-2017	8.4	8.67	17.24	3.17	11.84	2 Pre-diabetes	8.6% age adjusted 2014-2017 27.6 Deaths per 100,000 crude 2011-2017	11% age adjusted 2017 21.5 Deaths per 100,000 Age adjusted 2017	HP2020 Goal: 66.6 diabetes related deaths per 100,000	2	Prevalence and Deaths 	**1**
Flu and Pneumonia	20.6 per 100,000 crude, 2002-2006	17.4 Deaths per 100,000 crude 2010-2014	30.6 Deaths per 100,000 crude 2013-2017	NA	NA	NA	NA	NA	Na	11.5 Deaths per 100,000 crude 2013-2017	14.3 Deaths per 100,000 crude 2017	NA	NA		**5** **Only crude rates available so comparability compromised**

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Heart Disease	4% Coronary Heart Disease, age adjusted 179.2 deaths per 100,000 crude, 2002-2006	4.1%* Coronary Heart Disease Age adjusted, 6.4%* Coronary Heart Disease unadjusted, 2010-2013 283.6 deaths per 100,000 crude 2010-2014	1.9% Coronary Heart Disease Age Adjusted, 3.8% Unadjusted 2014-2017 159.6 deaths per 100,000 age adjusted, 2011-2017 330.7 per 100,000 crude 2013-2017	NA	NA	NA	NA	NA	NA	3.4% Coronary Heart Disease age adjusted, 2014-2017 133.3 deaths per 100,000 age adjusted 2011-2017	4.2% Coronary Heart Disease age adjusted, 2017 165 deaths per 100,000 age adjusted 2017	HP2020 Goal: 103.4 deaths per 100,000	1	Prevalence  Deaths: 	**2**
High Blood Pressure	30.3% age adjusted 2010-2014	51.6% age adjusted, 54.8% unadjusted 2010-2013	22% age adjusted, 31.3% unadjusted 2014-2107	33.33	23.24	27.59	12.7	27.63	NA	26.7% age adjusted 2014-2017	32.2% age adjusted 2017	HP2020 Goal: 26.9%	5		**2**
Stroke	4% age adjusted 2006-2009 65.5 deaths per 100,000 crude 2002-2006	Numbers too small to report 75.2 deaths per 100,000 crude 2010-2014	Numbers too small to report 30.3 deaths per 100,000 age adjusted 2011-2017 58.4 per 100,000 crude 2013-2017	NA	NA	NA	NA	NA	NA	2.7% age adjusted 2014-2017 38.1 deaths per 100,000 age adjusted 2011-2017	3% age adjusted 2017 37.6 deaths per 100,000 age adjusted 2017	HP2020 Goal: 43.5 death per 100,000	NA	Deaths: 	**1**

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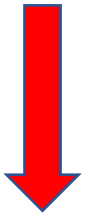
	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
Injury/ Trauma	43.3 deaths per 100,000 crude 2002-2006	75.2 deaths per 100,000 crude 2010-2014	63.4 deaths per 100,000 age adjusted 2011-2017 86.1 per 100,000 crude 2013-2017	NA	NA	NA	NA	NA	NA	42.1 deaths per 100,000 age adjusted 2011-2017	52.2 deaths per 100,000 age adjusted 2016	HP2020 Goal: 53.7 deaths per 100,000	NA		**5**
Mental Health: *Suicide (no teen data)*	20.2 deaths per 100,000 crude 2002-2006	28.9 deaths per 100,000 Crude 2010-2014	27.9 deaths per 100,000 age adjusted 2011-2017 30.6 per 100,000 crude 2013-2017	NA	NA	NA	NA	NA	NA	17.7 deaths per 100,000 age adjusted 2011-2017	14 deaths per 100,000 age adjusted 2017	HP2020 Goal: 10.2 per 100,000	NA		**5**
Depression (no teen data)	No data	20.8% age adjusted 2010-2013	16.9% age adjusted 2014-2017	17.59	27.51	37.93	23.81	30.26	Anx: 10 Dep: 6 ADHD: 10	25.6% age adjusted 2014-2017	20.5% unadjusted 2017	HP 2020 Goal: 5.8% for adults 7.5% for adolescents	2		**2**
Oral Health: *Dental Caries*:	28% adults self-report	36.1% adults self-report	No data available	19.16	25.41	18.97	28.57	15.79	NA	No data available	31.6% of adults age 20-44 2017	*HP2020 Goal: 25%*	NA		**NA**
	31% under 18 self-report	24% under 18 self-report	Current data not released yet	NA	NA	NA	NA	NA	13	Current data not released yet	18.6% of children age 5-19 2017	HP2020 Goal: Age 3-5: 30% Age 6-9: 49% Age 13-15: 48.3%	NA	NA	**NA**

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	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
Substance Abuse *Binge Drinking (male and femal)*	No comparable data	No comparable data	19.2% age adjusted 2014-2017	NA	NA	NA	NA	NA	NA	18.3% age adjusted 2014-2017	17.4% age adjusted 20017	HP2020 Goal: 24.2%	35	NA	3
Heavy Drinking (male and female)	No comparable data	No comparable data	14% age adjusted 2014-2017	NA	NA	NA	NA	NA	NA	7.7% age adjusted 2014-2017	6.3% age adjusted 2017	HP2020 Goal: 25.4%	36	NA	4
Alcohol Induced Deaths	20.2 deaths per 100,000 crude 2002-2006	17.4 deaths per 100,000 crude 2010-2013	30.6 deaths per 100,000 age adjusted 2014-2017 13.9 per 100,000 crude 2013-2017	NA	NA	NA	NA	NA	NA	38.2 deaths per 100,000 age adjusted 2014-2017	No data more current than 2012	NA	NA		3
Motor Vehicle Fatalities that are Alcohol Involved	No data	44% age adjusted 2015	56% age adjusted 2018	NA	NA	NA	NA	NA	NA	31% age adjusted 2018	23% age adjusted 2016	NA	5		4
Marijuana Use	No data	No data	13.4% age adjusted 2014-2017	NA	NA	NA	NA	NA	NA	17.6% age adjusted 2014-2017	30% unadjusted 2017	NA	5	NA	1
Risky Prescribing >90 MED Individuals per 1,000 Residents from a Single Source	No data	11.11	4.88	NA	NA	NA	NA	NA	NA	4.48	No comparable data	NA	NA		2
Potential Years of Life Lost	5111	7,500	7,100	NA	NA	NA	NA	NA	NA	6,000	7,432	NA	NA		3
One of More Chronic Disease	No data	46% age adjusted 2010-2013	50% age adjusted 2014-2017	NA	NA	NA	NA	NA	NA	53.5% age adjusted 2014-2017	60% age adjusted 2018	NA	6		2

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Total Death Rates All Causes Age Adjusted	726 deaths per 100,000 2002-2006	811.8 deaths per 100,000 2009-2012	825.2 deaths per 100,000 2013-2017	NA	NA	NA	NA	NA	NA	853.6 deaths per 100,000 2013-2017	731.9 deaths per 100,000 2017	NA	NA		3
Issues of Health Concern															
Immunization *Children 2 Year Old Up to Date Rate(4:3:1:3:3:1:4)*	77.8% 2009 (can't compare 2010 to any other periods due to change in calculation methods)	59% 2014	69% 2018	NA	NA	NA	NA	NA	NA	69% 2018	73.2% 2017	HP2020 Goal: 80%	NA		3
Adult Flu Ages 65+	66.5%	46.5% 2010-2013	31% 2018	NA	NA	NA	NA	NA	NA	40% 2018	59.6% 2018	HP2020 Goal: 70%	8		2
Prenatal Care *Start in 1st Trimester*	78%	77.2% 2014	78.9% 2017-2015	NA	NA	NA	NA	NA	NA	81% 2018	77.3% 2017	HP2020 Goal: 77.9%	NA		3
Inadequate Prenatal Care *(Less than 5 prenatal visits or care began in the 3rd trimester)*	9.3% 2002-2006	3.5% 2009-2012	3.54% 2013-2017	Na	NA	NA	NA	NA	NA	6% 2013-2017	6%, 2017	HP2020 Goal: 22.4%	NA		1
Tobacco Use During Pregnancy	22.6%	15.8% 2014	13.6% 2016	Na	Na	NA	NA	NA	NA	9.5% 2017	6.9% 2017	HP2020 Goal: 1.4%	NA		5
Low Birth Weight	5.5% 2001-2007	8.5% 2006-2012	6% 2011-2017	Na	NA	NA	NA	NA	NA	6% 2011-2017	8.28% 2017	HP2020 Goal: 7.8%	10		1

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Teen Pregnancy *(15-19 aggregate) per 1000 births*	11.5 per 1000 births 2002-2006	15 per 1000 births 2009-2012	28.9 per 1000 births 2013-2017	NA	NA	NA	NA	NA	NA	49.2 per 1000 births 2013-2017	18.8 per 1000 births 2017	HP2020 Goal: 36.2 per 1000 births	NA		**2**
Nutrition, Exercise and Weight *Adult Obesity*	19.5% Age adjusted 20.8% unadjusted 2006-2009	22.2% age adjusted, 22.9 unadjusted 2010-2013	16.4% age adjusted 23.8 unadjusted 2014-2017	NA	NA	NA	NA	NA	NA	28.6% age adjusted 2014-2017	31.3% Crude rate 2017	HP2020 Goal: 30.5%	1		**1**
High Cholesterol	32.4% age adjusted 44.4% unadjusted 2006-2009	68% Age adjusted, 66% unadjusted 2010-2013	19.7% age adjusted 29.2% unadjusted 2014-2017	NA	NA	NA	NA	NA	NA	28.3% age adjusted 2014-2017	33% age adjusted 2017	HP2020 Goal: 13.5%	2		**2**
% of Adults Meeting CDC Recommendations for Aerobic and Strengthening Activities	No data, measure changed	No data, measure changed	22.5% age adjusted 23.5% unadjusted 2014-2017	64.8 Exercise in the last month	71.9 Exercise in the last month	62.1 Exercise in the last month	76.2 Exercise in the last month	57.9 Exercise in the last month	NA	22.7% age adjusted 2014-2017	20.3% unadjusted 2017	No HP2020 Goal as BRFFSS Measure changed	14	NA	**3**
% of Adults Who Consumed 7+ Sodas a Week	No measure	No data	28.1% age adjusted 25.8% unadjusted 2014-2017	NA	NA	NA	NA	NA	NA	13.2% age adjusted 2014-2017	No data	NA	36	NA	**5**
Medical advice to reduce sodium	No measure	No data	18.3% age adjusted 23.6% unadjusted 2014-2017	NA	NA	NA	NA	NA	NA	14.8% age adjusted 2014-2017	No data	NA	25	NA	**5**
Tobacco Use *Cigarette Smoking*	17.9% age adjusted 15.6% unadjusted 2006-2009	8.6%* age adjusted, 9.1%* unadjusted 2010-2013	14% age adjusted 14.7% unadjusted 2014-2017	NA	NA	NA	NA	NA	NA	17.6% age adjusted 2014-2017	14% age adjusted 2017	HP2020 Goal: 12%	6		**2**
Smokeless Tobacco (males)	15.6%	11.7 age adjusted 13.6% unadjusted 2010-2013	Sample size too small	NA	NA	NA	NA	NA	NA	4.3% age adjusted 2014-2017	3.4% age adjusted 2016	HP2020 Goal: 0.2%	NA	NA	**NA**

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E-Cigarette Use	No data	No data	Sample size too small	NA	NA	NA	NA	NA	NA	4.3% 2014-2017	5% 2017	NA	NA	NA	**NA**
Adults with Insufficient Sleep	No measure	29% 2014	28% 2016	NA	NA	NA	NA	NA	NA	31% 2016	No data	County Health Ranking Top Performer: 27%	NA	NA	**3**
Preventable Hospitalizations	17.3 per 1000 2006-2008 7,200 per 100,000 Medicare Enrollees 2006-2007	17.9 per 1,000 2012-2014 4,600 per 100,000 Medicare Enrollees 2012	20.8 per 1000 2015-2017 2,942 per 100,000 Medicare Enrollees 2016	NA	NA	NA	NA	NA	NA	8.5 per 1000 2015-2017 2,903 per 100,000 Medicare Enrollees 2016	No comparable data	County Health Ranking Top Performer: 2,765 per 100,000 Medicare Enrollees		General Population: ↓ Medicare Enrollees: ↑	**5** General population **3**
Morbidity: *No Poor Physical Health Days in the last 30 days*	65.7% age adjusted 64.3% unadjusted 2006-2009	71.6% age adjusted, 71.4% unadjusted 2010-2013	Current data not released yet	54.3	55.6	48.2	71.4	51.3	NA	Current data not released yet	Current data not released yet	HP2020 Goal: 79.8%	NA	NA	**5** Compared to goal only
Of those with poor physical health days, mean/month	4.4 2003-2009	3.1 2006-2012	3.7 2016	14.2	15.9	15.1	11.7	16.2	NA	3.8 2016	4 2017	County Health Ranking Top Performer: 3	10	↓	**3**
Mental Health: No Poor Mental Health Days in the last 30	65.8%	70.6% unadjusted 71.5% age adjusted, BRFSS 2010-2013	Current data not released yet	60.6	66.3	34.5	49.2	40.8	NA	Current data not released yet	Current data not released yet	HP2020 Goal: 80.1%	NA	NA	**5** Compared to goal only
Of those with poor mental health days, mean/month	2.2 2003-2009	1.5 2006-2012	4.1 2016	10.4	12.7	15.3	7.4	10.0	NA	4.5 2016	3.9 2017	County Health Rankings Top Performer: 3.1	10	↓	**3**
Oral Health: No Poor Oral Health in the last 30 days	No Data	82.3% CNAS self-report	No data	78.7	78.6	60.3	90.5	68.4	No dental emerg:: 66.7	No data	No data	No comparable HP2020 Measure	NA	↔	**NA**

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	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
Of those reporting poor oral health in last 30 days, mean days/month	No data	18.2 CNAS self-report	No data	15.9	13.8	14.7	30.0	12.6	NA	No data	No data	No comparable HP2020 Measure			NA
Limitations due to Health Status *At least 1 day in last month*	20.4%	11.2% age adjusted, 18.6% unadjusted 2010-2013	Current data not released yet	28.9	24.0	41.4	25.4	28.9	NA	Current data not released yet	No Current Data	NA	NA	NA	NA
% of those who reported at least 1 day who reported 30 days	No data	19.4%	NA	7.9	36.2	29.2	6.3	9.2	NA	No data	No data	NA	NA		NA
Of those who reported limitations in last 30 days, mean days/month	1-10 day most frequently occurring range	11.2 mean days of limited activity, those with limitations	NA	13.3	16.6	14.3	11.8	16.2	NA	No data	No data	NA	NA		NA
Disability Status age 18-64	15.8% 2002-2006	17.3% 2009-2013	18.3% 2013-2017	18.9	19.9	37.9	4.8	35.5	No Data	11.6% 2013-2017	10.6% 2017	NA	NA		5
Screenings *Blood Sugar within the last 3 years*	No data	Sample size too small	54.1% age adjusted 69.3% unadjusted 2014-2017	NA	NA	NA	NA	NA	NA	64.8% age adjusted 2014-2017	No data	NA	25	NA	4
Current on Colorectal Cancer Screening	56.3% age adjusted Unadjusted not available 2006-2009	Sample size too small	68.9% unadjusted Age adjusted not available 2014-2017	NA	NA	NA	NA	NA	NA	68.7% age adjusted 2014-2017	67.7% unadjusted 2016	HP2020 Goal: 70.5%	12	NA	2

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Cholesterol in the last five years	65.2% age adjusted 82.5% unadjusted 1006-2009	86.5% age adjusted 91.1% unadjusted 2010-2013	75.7% age adjusted 78.8% unadjusted 2014-2017	NA	NA	NA	NA	NA	NA	77.2% age adjusted 2014-2017	85.9% unadjusted 2017	HP2020 Goal: 82.1%	18		**3**
Access to and Utilization of Care															
Have Health Care Coverage *Have medical coverage*	81% 2010 ED Data	91% 2015	94% 2013-2017	94.0	94.4	100.0	92.1	97.4	NA	9% 2013-2017	10.5% 2013-2017	HP2020 Goal: 100%	8		**2**
Have mental health coverage	No data	72% CNAS self-report	No data	48.8	33.7 (21.9 don't know)	74.1 (8.6 don't know)	57.1 (23.8 don't know)	63.2 (21.1 don't know)	NA	No data	No data	NA	NA		**NA**
Have dental coverage	No data	44% CNAS self-report	No data	43.8	21.9	70.7	73.0	64.5	NA	No data	77% 2016	HP2020 Goal: 55.3%	NA		**5** **Based on goal only**
Have vision coverage	No data	36% CNAS self-report	No data	40.0	28.1	34.5 (26.0 don't know)	63.5 (11.1 don't know)	46.1 (14.5 don't know)	NA	No data	No data	NA	NA	NA	**NA**
Have OHP	5.4%, 2006-2009	28.1% 2009-2012	28.5% 2013-2017	48.3	2.6	65.5	15.9	27.6	29%	25.2% 2013-2017	21% 2017	NA	NA	NA	**Rating not meaningful**
Need for Urgent Physical Health Care	42.1% CNAS self-report	44.2% CNAS self-report	No data	44.6	44.9	51.7	49.2	50.0	39.7	No data	No data	NA	NA		**NA**
Of those who needed it, % who always got care	45.6	54.4% CNAS self-report	No data	62.4	29.1	37.9	30.2	30.3	64	No data	No data	NA	NA		**NA**
Of those who needed it, % who never got care	4.4	9.2% CNAS self-report	No data	4.1	0.5	0	1.6	0	0	No data	4.7% 2007	HP2020 Goal: 4.2% unable to obtain care	NA		**2** **Based on goal only**
Need for Oral Health Care Past Year	No Data	29.0% CNAS self-report	No data	24.7	21.9	29.3	19.1	21.1	23.8	No Data	No Data	NA	NA		**NA**

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Of those who needed it, % who always got care	No data	42.5 CNAS self-report	No data	41.5	55.8	29.4	33.3	25.0	46.7	No data	No data	NA	NA		**NA**
Of those who needed it, % who never got care	No data	19.3% CNAS self-report	No data	16.0	11.6	29.4	16.7	12.5	0	No Data	5.5% 2007	HP2020 Goal: 5% unable to obtain care	NA		**5** Based on goal only
Need for Mental Health Care Last Year	No data	19.2% CNAS self-report	No data	16.5	14.3	41.4	17.5	30.3	19.1 (emerg.)	No data	No data	NA	NA		**NA**
Of those who needed it, % who always got care	No data	23.6% CNAS self-report	No data	41.3	32.2	67.7	36.4	69.6	16.7	No data	No data	Na	NA		**NA**
Of those who needed it, % who never got care.	No data	33.7% CNAS self-report	No data	31.8	53.6	12.5	8.3	4.4	8.3	No data	No data	NA	NA		**NA**
Connected to Personal Doctor	83.3% unadjusted, 2006-2009	80.3% age adjusted 83% unadjusted 2010-2013	Current data not released yet	89.5	86.7	89.7	93.7	29.1	90.5	Current data not released yet	76.9% unadjusted 2017	HP2020 Goal: 83.9%	NA		**2** Based on goal only
% who were seen in the last year.	47.6% CNAS self-report	71.2% of CNAS self-report	Current data not released yet	73.2	75.6	79.3	66.7	79.0	NA	Current data not released yet	70.4 % Unadjusted 2017	NA	NA		**NA**
Dental Visit in the Last Year	63% CNAS self-report	64.6% CNAS self-report	No data	59.8	58.2	55.2	63.5	51.3	NA	No data	No data	HP2020 Goal: 49%			**1** Based on goal only
Social Needs and Resources															
Financial Needs *% with any need for money for housing*	37.1 % CNAS self-report 2010	18% severe housing cost burden 2008-2012	17% severe housing cost burden 213-2017	12.6	8.7	29.3	19.1	17.1	NA	17% 2013-2017	15.2% 2017	County Health Ranking Top Performer: 7%	9		**3**
% with any need for money for food	34.2 % CNAS self-report 2010	16% 2013	15% Food Insecurity 2016	12.6	9.2	44.8	19.1	21.1	NA	13% Food Insecurity 2016	11.8% 2017	HP2020 Goal: 6%	8		**4**

HEALTH AND COMMUNITY INDICATOR RANKING GRID 2019	County Rates									State Rate	National Rate	Goal or benchmark	County Ranking	Direction of change from last assessment	Ranking: 1=Area of Strength 2-3+Average Area 4-5=Area of High Need
	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
% with any need for money for utilities	40% CNAS self-report 2010	18.7% CNAS self-report 2016	No data	14.7	10.7	41.4	22.2	22.4	NA	No data	No data	NA	NA		**NA**
% with any need for money for insurance	42% CNAS self-report 2010	20.6% CNAS self-report 2016	No data	16.3	8.7	24.1	28.6	13.2	NA	No data	No data	NA	NA		**NA**
% with any need for money for doctor bills	44.6% CNAS self-report 2010	19.1% CNAS self-report 2016	No data	16.8	6.6	27.6	31.8	21.1	NA	No data	No data	NA	NA		**NA**
% with any need for money for prescriptions	41.3% CNAS self-report 2010	15.8% CNAS self-report 2016	No data	12.1	6.1	22.4	27.0	19.7	NA	No data	No data	NA	NA		**NA**
% with any need for money for dentist bills	47.7% CNAS self-report 2010	25.5% CNAS self-report 2016	No data	26.0	20.0	39.7	33.3	27.6	NA	No data	No data	NA	NA		**NA**
% with any need for money for child care/preschool	No data	3.8% CNAS self-report 2016	No data	4.7	NA	6.9	28.6	5.3	NA	No data	No data	NA	NA		**NA**
% worried about losing housing	No data	No data	No data	7.6	4.6	15.5	6.3	1.1	NA	No data	No data	NA	NA	NA	**NA**
% can't find affordable housing	No data	No data	No data	3.9	2.0	6.9	9.5	3.9	NA	No data	No data	NA	NA	NA	**NA**
% under poverty level	14%	13.4%	13.7%	NA	NA	NA	NA	NA	NA	14.9%	14.6%	NA	NA		**3**
% under 200% of poverty level	37.9%	34%	34.9%	NA	NA	NA	NA	NA	NA	33.9%	28%	NA	NA		**4**
Mental Health and Alcohol and Drug *% with any concerns about own AOD use*	NA	4.8	NA	5.0	2.0	8.6	6.4	6.6	NA	NA	NA	NA	NA		**NA**

HEALTH AND COMMUNITY INDICATOR RANKING GRID 2019	County Rates									State Rate	National Rate	Goal or benchmark	County Ranking	Direction of change from last assessment	Ranking: 1=Area of Strength 2-3+Average Area 4-5=Area of High Need
	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
% with any concern about others' AOD use	NA	23.9	NA	18.4	13.3	19.0	12.8	23.7	NA	NA	NA	NA	NA		**NA**
% with any need for help for own AOD use	8.3	1.1	NA	0.8	0.5	1.7	1.6	0	NA	NA	NA	NA	NA		**NA**
% with any need for help for others' AOD use	NA	12.8	NA	8.9	7.1	6.9	11.1	10.5	NA	NA	NA	NA	NA		**NA**
Mental health (anxiety, depression, stress) concerns for self	32.1	44.4	NA	14.7	24.5	56.9	66.7	57.9	NA	NA	NA	NA	NA		**NA**
Transportation and Housing *% with any need for transportation to work*	19.8% in general	7.8% transportation to work	NA	5.3	3.6	17.2	4.8	11.8	NA	NA	NA	NA	NA		**NA**
% with any problems with homelessness	NA	4.3%	NA	4.7	2.6	10.3	6.4	7.9	NA	NA	NA	NA	NA		**NA**
Health Literacy *% with any problem with reading well enough to fill out applications:*	7.6%	3.7%	NA	3.9	2.6	5.2	4.8	11.8	NA	NA	NA	NA	NA		**NA**
% with any problem completing medical forms	14.7%	11.3%	NA	11.2	9.7	20.7	4.8	21.1	NA	NA	NA	NA	NA		**NA**

HEALTH AND COMMUNITY INDICATOR RANKING GRID 2019	County Rates									State Rate	National Rate	Goal or benchmark	County Ranking	Direction of change from last assessment	Ranking: 1=Area of Strength 2-3+Average Area 4-5=Area of High Need
	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
% with any problem understanding medical information	17.5%	14.5%	NA	11.3	13.3	17.2	15.5	22.4	NA	NA	NA	NA	NA		**NA**
Social Support Needs *% with any concerns about support for work problems*	18.8%	10.7%	NA	7.9	5.1	12.1	15.9	10.1	NA	NA	NA	NA	NA		**NA**
% with any concerns about support for personal problems	21.8%	14.1%	NA	12.3	8.2	19.0	22.0	14.5	NA	NA	NA	NA	NA		**NA**
% who report feeling unsafe at home	NA	4.2%	NA	4.7	4.1	13.8	6.3	5.3	NA	NA	NA	NA	NA		**NA**
% who expressed interest in need for more: *--Family connection*	NA	23.2%	NA	16.5	7.1	22.4	27.0	18.4	NA	NA	NA	NA	NA		**NA**
--Social activities	NA	13.2 social associations per 10,000 population	20.2 social associations per 10,000 population	21.5	12.3	31.0	42.9	29.0	NA	10.3 social associations per 10,000	NA	Goal: 21.9 social associations per 10,000 population, Top U.S. Performers	17		**2**
--Opportunities to reduce stress	NA	28.6%	NA	28.4	16.3	44.8	49.2	36.8	NA	NA	NA	NA	NA		**NA**
--Sense of meaning and purpose	NA	21.6%	NA	16.3	11.7	31.0	20.6	26.3	NA	NA	NA	NA	NA		**NA**
--Opportunities to develop spiritual life	NA	15.5%	NA	11.6	9.7	17.2	14.3	21.1	NA	NA	NA	NA	NA		**NA**

HEALTH AND COMMUNITY INDICATOR RANKING GRID 2019	County Rates									State Rate	National Rate	Goal or benchmark	County Ranking	Direction of change from last assessment	Ranking: 1=Area of Strength 2-3+Average Area 4-5=Area of High Need
	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
% with any concerns about getting child care when needed	NA	4.7%	NA	8.9	0.5	6.9	30.2	4.0	NA	NA	NA	NA	NA		NA
% with any concerns about getting elder care when needed	NA	4.9%	NA	5.3	6.1	5.2	1.6	5.3	NA	NA	NA	NA	NA		NA
% with any need for parenting education/ support	NA	7.8%	NA	5.2	0.0	5.2	17.5	9.2	NA	NA	NA	NA	NA		NA
% with any need for preschool	NA	7%	NA	5.8	1.5	5.2	22.2	5.3	NA	NA	NA	NA	NA		NA
% with any need for teen activities	NA	15.3%	NA	8.1	2.0	10.3	36.5	13.2	NA	NA	NA	NA	NA		NA
% with any need for access to affordable place to exercise	NA	65% access to exercise opportunities	57% access to exercise opportuniti es	25.7	15.8	37.9	34.9	27.6	NA	88%	NA	Goal: 91% Access to exercise opportunities , Top U.S. Performers,	NA		5
% with any need for affordable places to buy healthy food	NA	6.8 food environment index	7.1 food environme nt index	36.7	25.0	53.4	57.1	42.1	NA	7.8 food environment index	NA	Goal: 8.7 food environment index, Top U.S.	NA		3
% with any need for opportunities/ education to improve eating	NA	19.3%	NA	17.3	0.5	25.9	22.2	25.0	NA	NA	NA	NA	NA		NA
Children's Social Concerns: % with Preschool Enrollment	Data not comparable	43.7%	43%	NA	NA	NA	NA	NA	NA	44.2%	48%	NA	15		3

HEALTH AND COMMUNITY INDICATOR RANKING GRID 2019	County Rates									State Rate	National Rate	Goal or benchmark	County Ranking	Direction of change from last assessment	Ranking: 1=Area of Strength 2-3+Average Area 4-5=Area of High Need
	2010 CAN (secondary data, unless there is none, then CNAS)	2016 CAN (secondary data, unless there is none, then CNAS)	2019 Secondary Data Source	2019 CNAS All Adults (%)	2019 +65 CNAS (%)	2019 Low Income CNAS (%)	2019 Families w Children Under 18 CNAS (%)	2019 Assisted CNAS (%)	2019 Child CNAS (%)						
% with 3rd Grade Reading Proficiency	Data not comparable	56.8%	60.6%	NA	NA	NA	NA	NA	NA	44.8%	35%		2		1
% with 3rd Grade Math Proficiency	Data not comparable	57.9%	50.7%	NA	NA	NA	NA	NA	NA	45.4%	40%		6		1
Abuse/Neglect Victims per 1,000	11	9	28	NA	NA	NA	NA	NA	NA	13	9		31		5
% Children in Foster Care	0.6%	2.3%	1.2%	NA	NA	NA	NA	NA	NA	1.2%	No comparable data		17		3
% Foster Care Placement Stability	100%	71.3%	36.4%	NA	NA	NA	NA	NA	NA	62.3%	No comparable data		33		5
% Child Food Insecurity	No data	No data	24.4%	NA	NA	NA	NA	NA	NA	20%	18%		29	NA	5
%Homeless Students	No data	3.3%	2.5%	NA	NA	NA	NA	NA	NA	4%	No comparable data		8		1
%Referrals to Juvenile Justice per 1,000	13	25	17	NA	NA	NA	NA	NA	NA	14	24		20		3

Community Profile Detailed Charts

Detailed Charts Section 1: Community Profile

1a: Respondents by Zip Code. There were a total of 381 random community respondents, with most respondents living in zip codes 97828 (38%), 97846 (28%), and 97885 (16%).

1b: Respondents by Age. Residents ages 65-74 and 75-84 were the largest groups of respondents.

***1c: Respondents by Gender*.** 51% of respondents were female, 44% were male and 5% refused to answer.

1d: Respondents by Hispanic Ethnicity. In 2016, 89% of Wallowa County adults did not have Hispanic ethnicity, 8% refused to answer the questions, 2% did have Hispanic ethnicity, and 1% did not know.

1e: Respondents by Race. 86% of respondents are White, 8% refused to answer, and Asian or Pacific Islander, American Indian/Alaska Native, and Black respondents each made up 1% of the total.

1f: Annual Household Income. 32% of respondents refused to answer. Of those who did answer, the largest group was those with household incomes over $75k (9%), and the smallest was those with household incomes between 10k and 14k (1%).

1g: Highest Level of Education. The largest group of respondents was those with 1-3 years of college (32%), followed by those with just a high school diploma (25%) and those with a 4-year degree (24%).

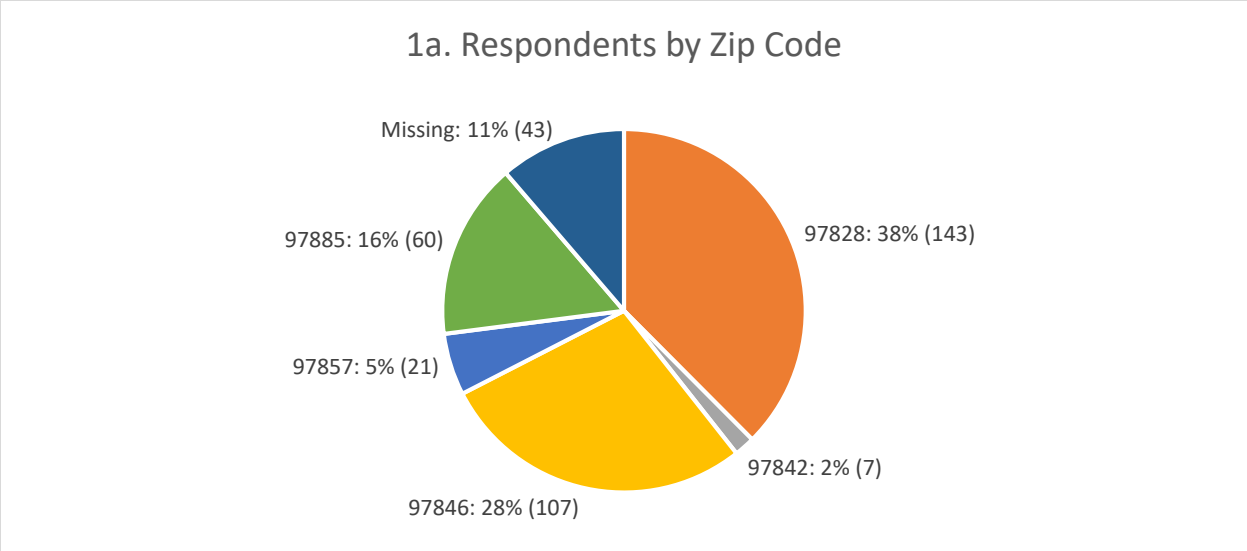
1h. Employment Type. 45% of respondents were retired, 26% of respondents were employed full time (including self-employment), 5% were part time/seasonal, and 3% were out of work and not seeking employment.

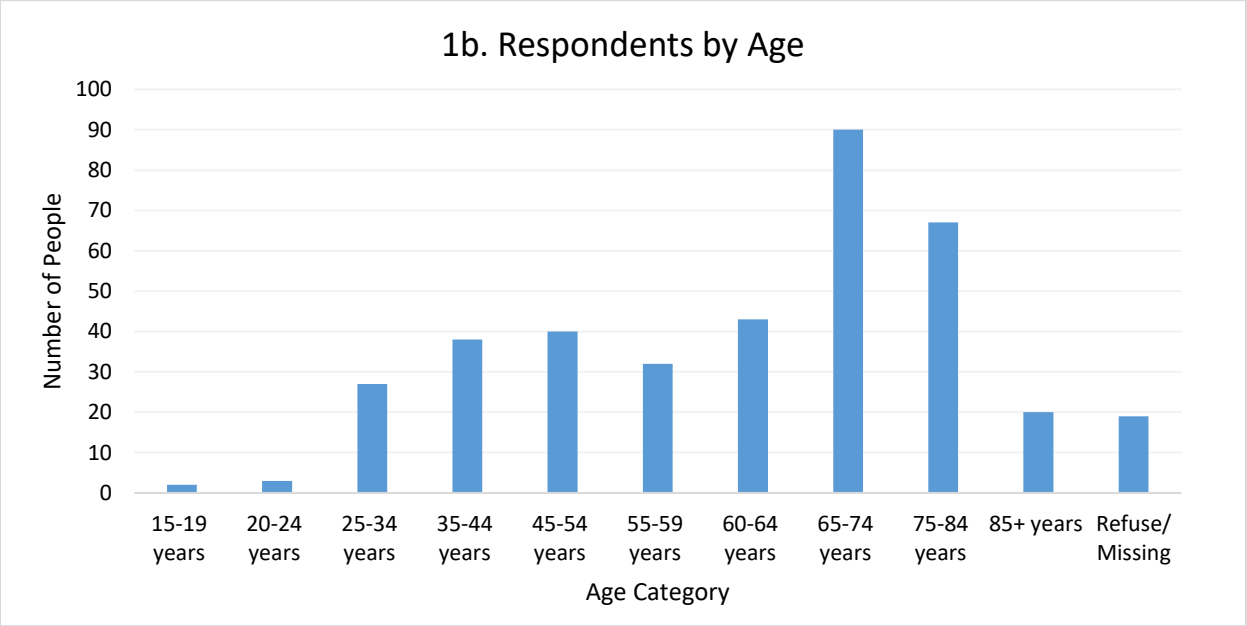
1i. Relationship Status. 59% of respondents were married, 12% of respondents were divorced, 11% were widowed, 6% were single, and 5% were part of an unmarried couple.

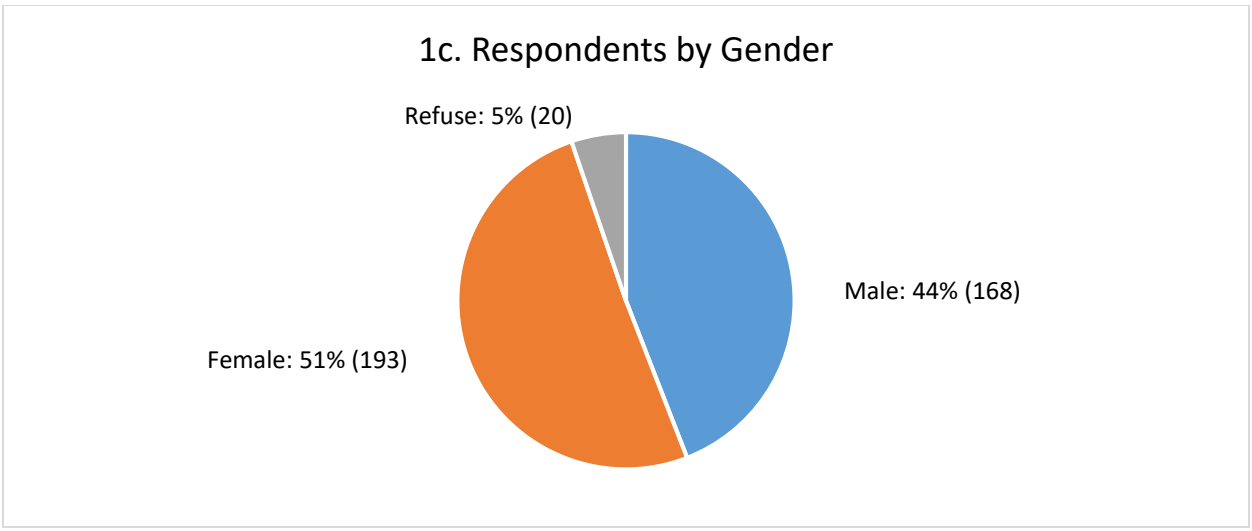
1j. Living Situation. 61% of respondents were homeowners, 14% were renters, 3% were residing in a free place to live, and less than 1% were homeless (1 respondent).

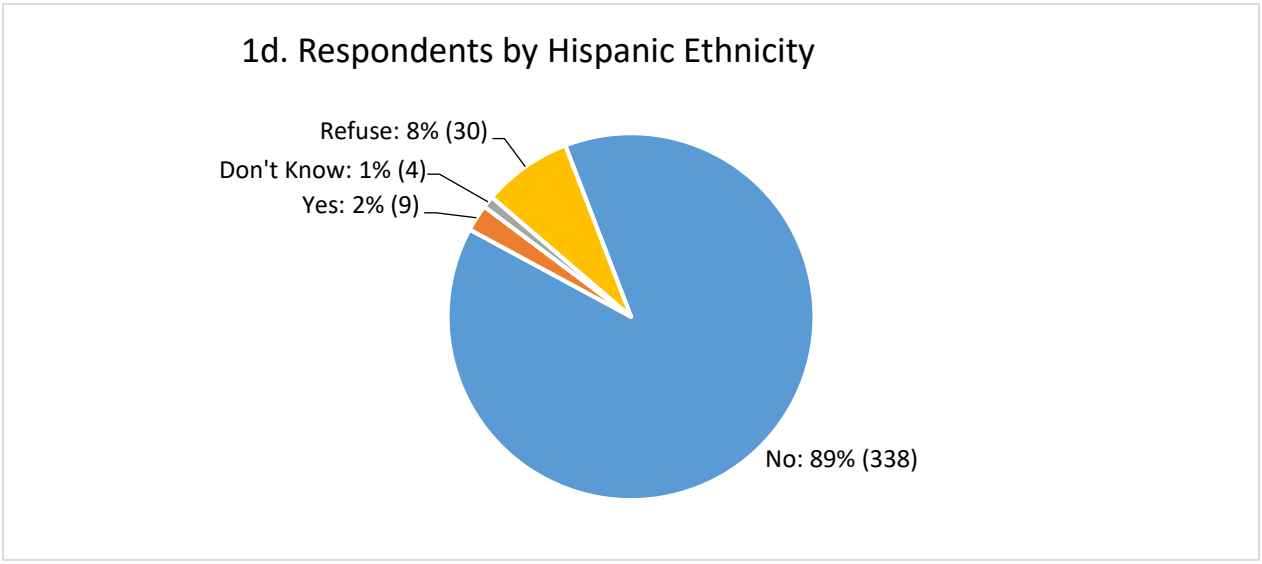
1k. Number of Adults (18+) Living in Household. The largest group of respondents lived in households with 2 adults (47%), the next largest was households with 1 adult (20%). The largest number of adults in a household was 11 (2 respondents).

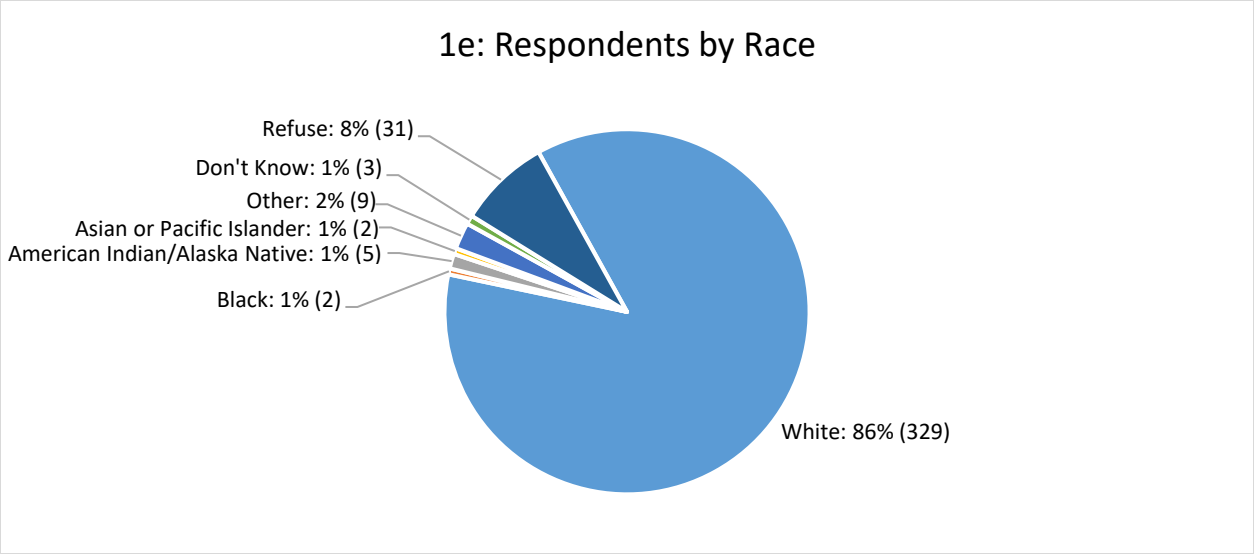
1l. Number of Children Living in Household. The largest group of respondents living with children lived in households with 2 children (7%), the next largest was households with 1 child (5%). 80% of respondents did not answer this question.

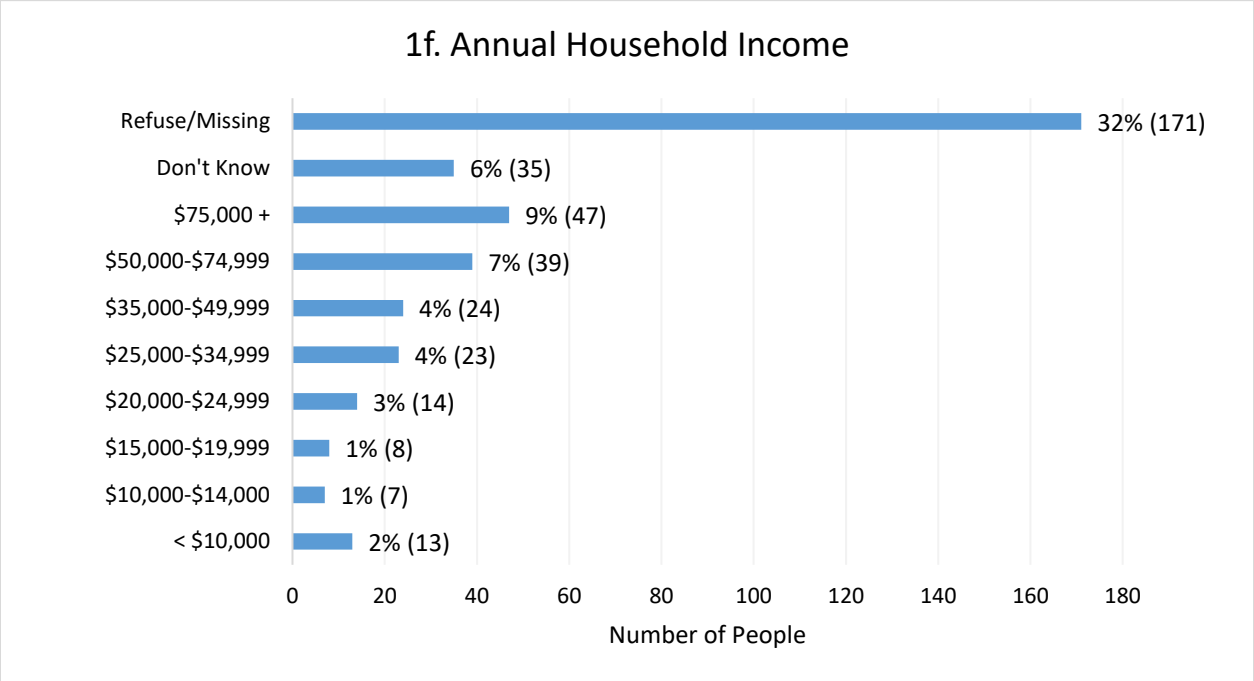

1a. Respondents by Zip Code
Missing: 11% (43)
97828: 38% (143)
97885: 16% (60)
97857: 5% (21)
97842: 2% (7)
97846: 28% (107)

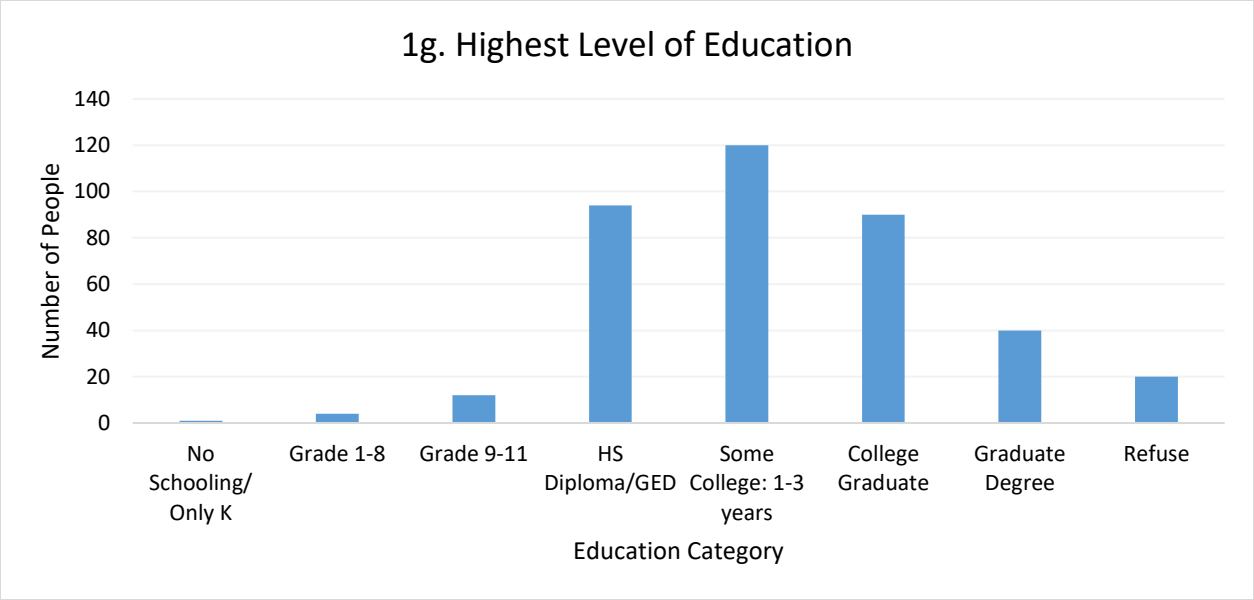

1b. Respondents by Age
Number of People
100
90
80
70
60
50
40
30
20
10
0
15-19 years
20-24 years
25-34 years
35-44 years
45-54 years
55-59 years
60-64 years
65-74 years
75-84 years
85+ years
Refuse/ Missing
Age Category

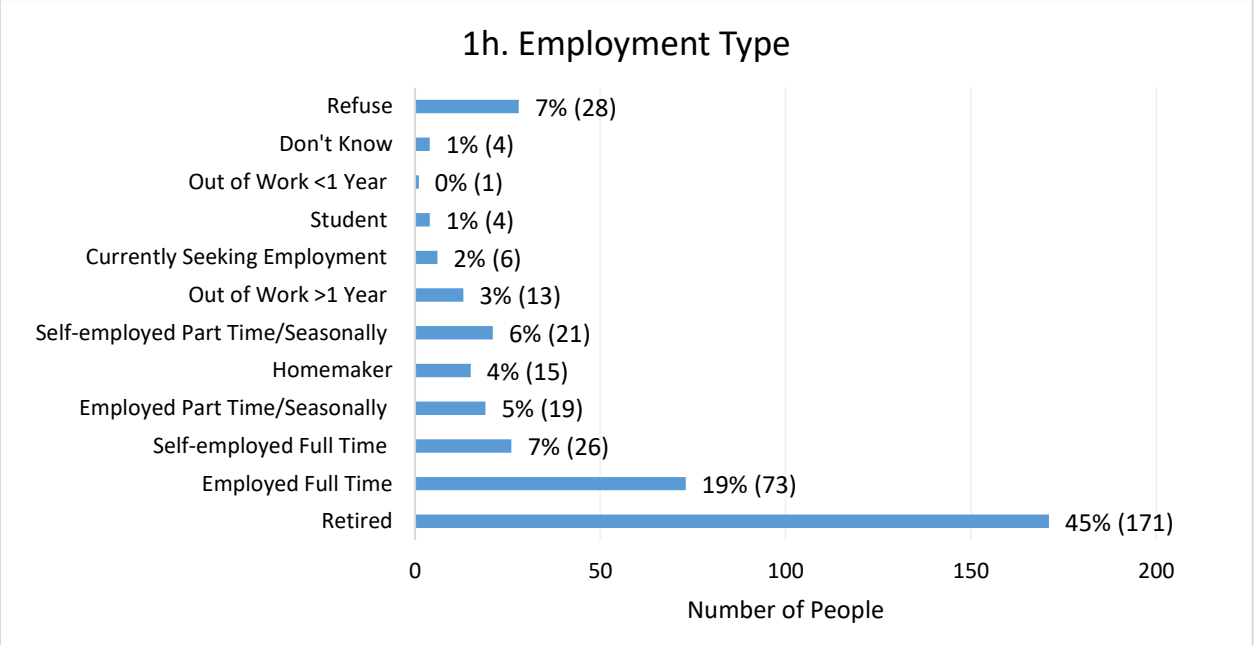

1c. Respondents by Gender
Refuse: 5% (20)
Male: 44% (168)
Female: 51% (193)

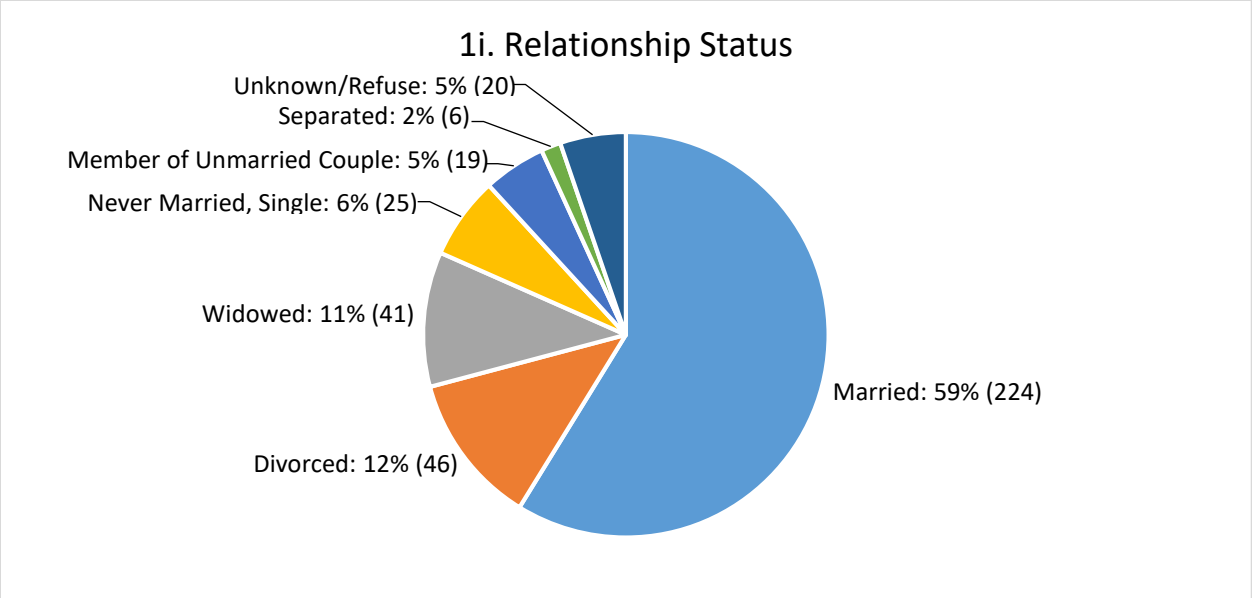

1d. Respondents by Hispanic Ethnicity
Refuse: 8% (30)
Don't Know: 1% (4)
Yes: 2% (9)
No: 89% (338)

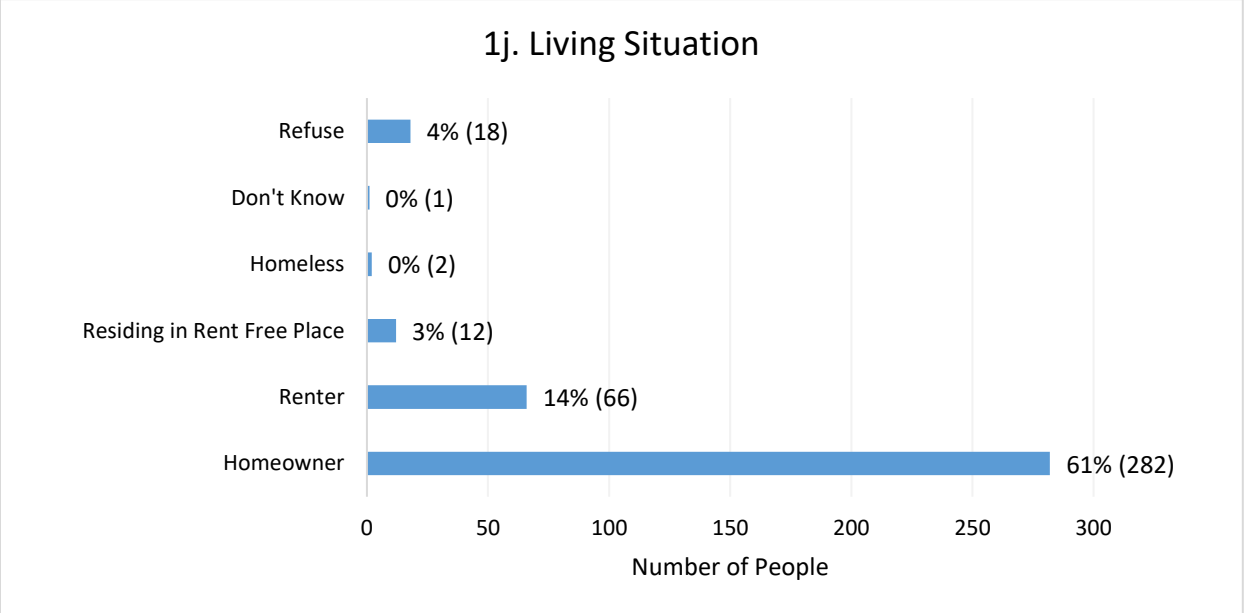

1e: Respondents by Race
Refuse: 8% (31)
Don't Know: 1% (3)
Other: 2% (9)
Asian or Pacific Islander: 1% (2)
American Indian/Alaska Native: 1% (5)
Black: 1% (2)
White: 86% (329)

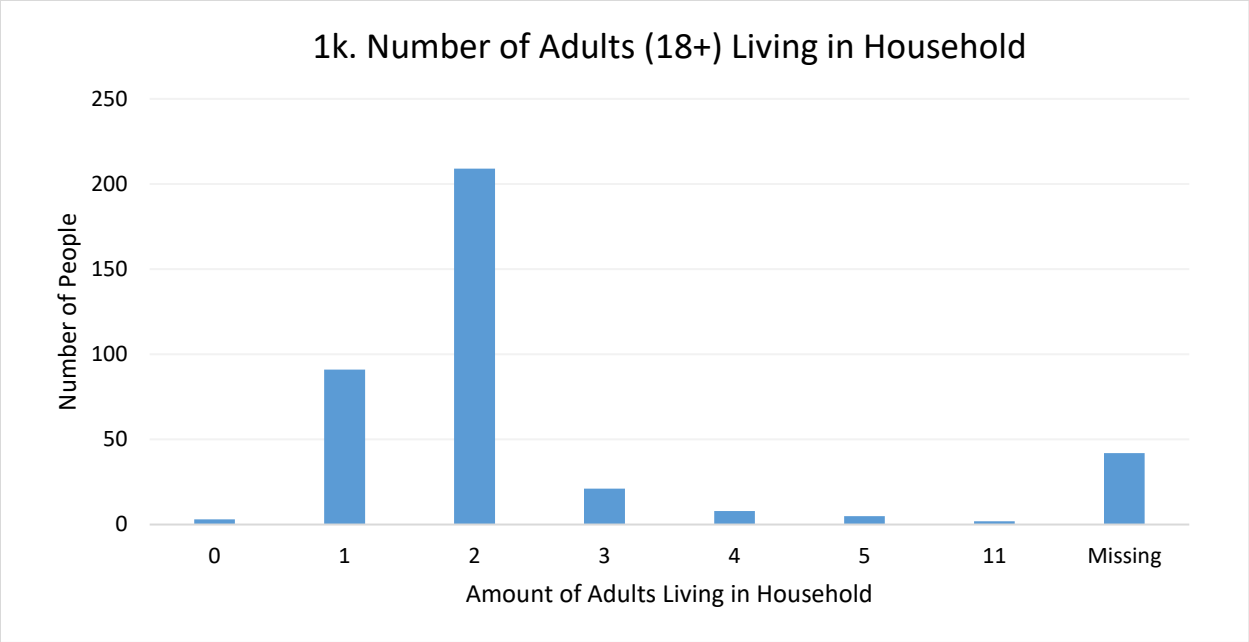

1f. Annual Household Income
Refuse/Missing
32% (171)
Don't Know
6% (35)
$75,000 +
9% (47)
$50,000-$74,999
7% (39)
$35,000-$49,999
4% (24)
$25,000-$34,999
4% (23)
$20,000-$24,999
3% (14)
$15,000-$19,999
1% (8)
$10,000-$14,000
1% (7)
< $10,000
2% (13)
0
20
40
60
80
100
120
140
160
180
Number of People

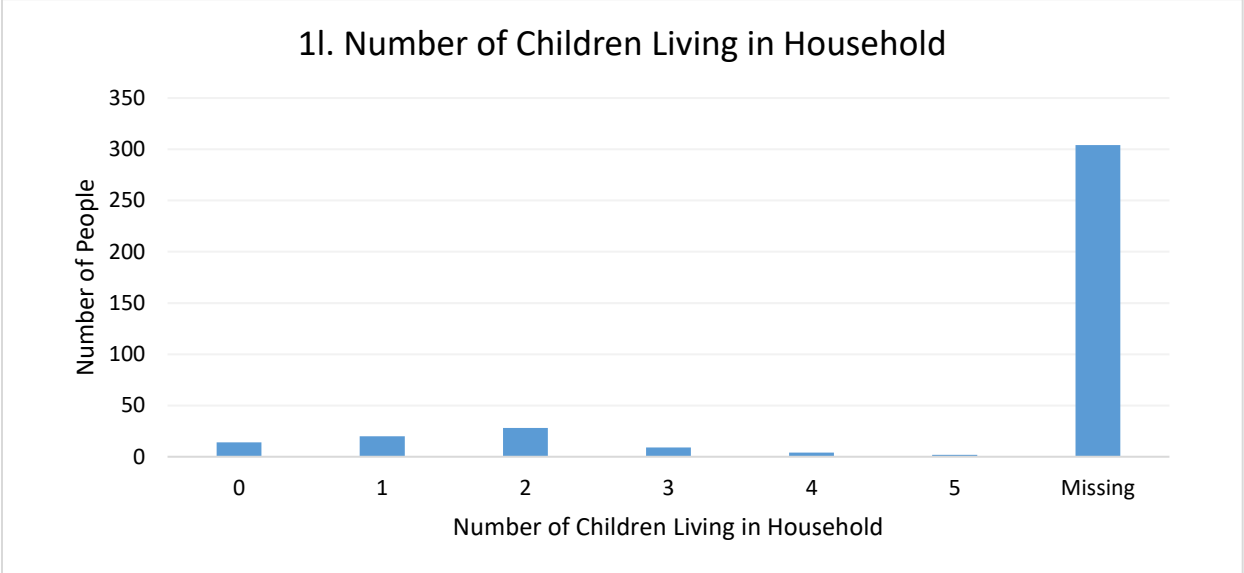

1g. Highest Level of Education
Number of People
140
120
100
80
60
40
20
0
No Schooling/ Only K
Grade 1-8
Grade 9-11
HS Diploma/GED
Some College: 1-3 years
College Graduate
Graduate Degree
Refuse
Education Category


1h. Employment Type
Refuse
Don't Know
Out of Work <1 Year
Student
Currently Seeking Employment
Out of Work >1 Year
Self-employed Part Time/Seasonally
Homemaker
Employed Part Time/Seasonally
Self-employed Full Time
Employed Full Time
Retired
7% (28)
1% (4)
0% (1)
1% (4)
2% (6)
3% (13)
6% (21)
4% (15)
5% (19)
7% (26)
19% (73)
45% (171)
0
50
100
150
200
Number of People


1i. Relationship Status
Unknown/Refuse: 5% (20)
Separated: 2% (6)
Member of Unmarried Couple: 5% (19)
Never Married, Single: 6% (25)
Widowed: 11% (41)
Divorced: 12% (46)
Married: 59% (224)


1j. Living Situation
Refuse
4% (18)
Don't Know
0% (1)
Homeless
0% (2)
Residing in Rent Free Place
3% (12)
Renter
14% (66)
Homeowner
61% (282)
0
50
100
150
200
250
300
Number of People


1k. Number of Adults (18+) Living in Household
250
200
150
100
50
0
Number of People
0
1
2
3
4
5
11
Missing
Amount of Adults Living in Household


1l. Number of Children Living in Household
350
300
250
200
150
100
50
0
Number of People
0
1
2
3
4
5
Missing
Number of Children Living in Household

Detailed Charts Section 2: Health Care Access

2a. Satisfaction with Healthcare Provider Communication. 55% of individuals reported being very satisfied with their communication with their health care provider, while 9% were very dissatisfied.

2b. Received Medical Care as Soon as Needed. In 2019, 28% of Wallowa County adults reported that they received medical care as soon as they thought they needed it. 47% of adults reported that they did not need medical care in the past 12 months.

2c. Received Dental Care as Soon as Needed. In 2019, 10% of Wallowa County adults reported that they received dental health care as soon as they thought they needed it. 69% of adults reported that they did not need dental care in the past 12 months.

2d. Received Mental Health Care as Soon as Needed. In 2019, 7% of Wallowa County adults reported that they received mental health care as soon as they thought they needed it. 75% of adults reported that they did not need mental health care in the last 12 months.

2e. Enough Time with Provider. When asked, "Within the past year, how often did your health care provider spend enough time with you?" 60% of adults responded Always, 27% of adults responded Usually, 5% of adults responded Sometimes, and 2% of adults responded Never.

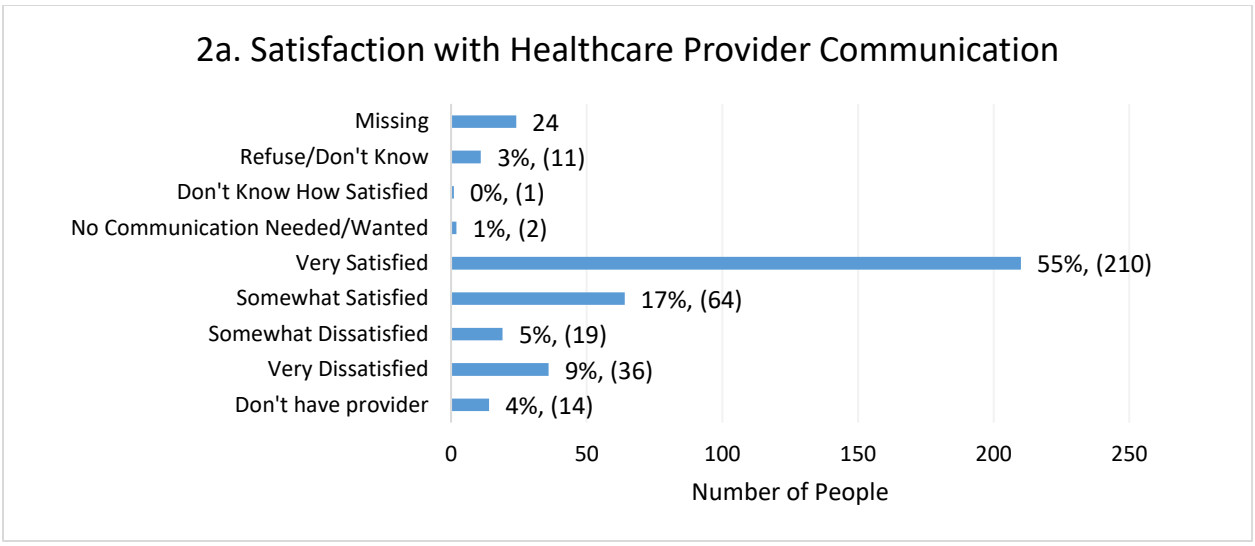
2f. Visited Dental Office for Any Reason.

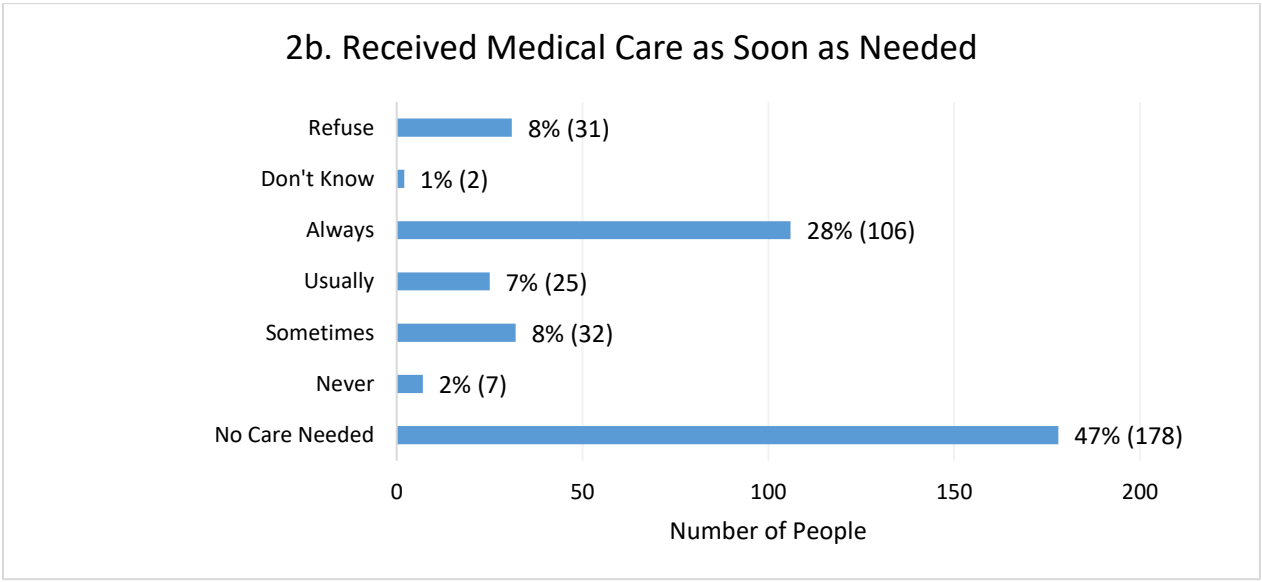
2g. Provider Sensitivity to Customs. When asked, "Is your provider sensitive to your family's values and customs?" 59% of adults responded Always, 22% of adults responded Usually, 3% of adults responded Sometimes, and 2% of adults responded Never.

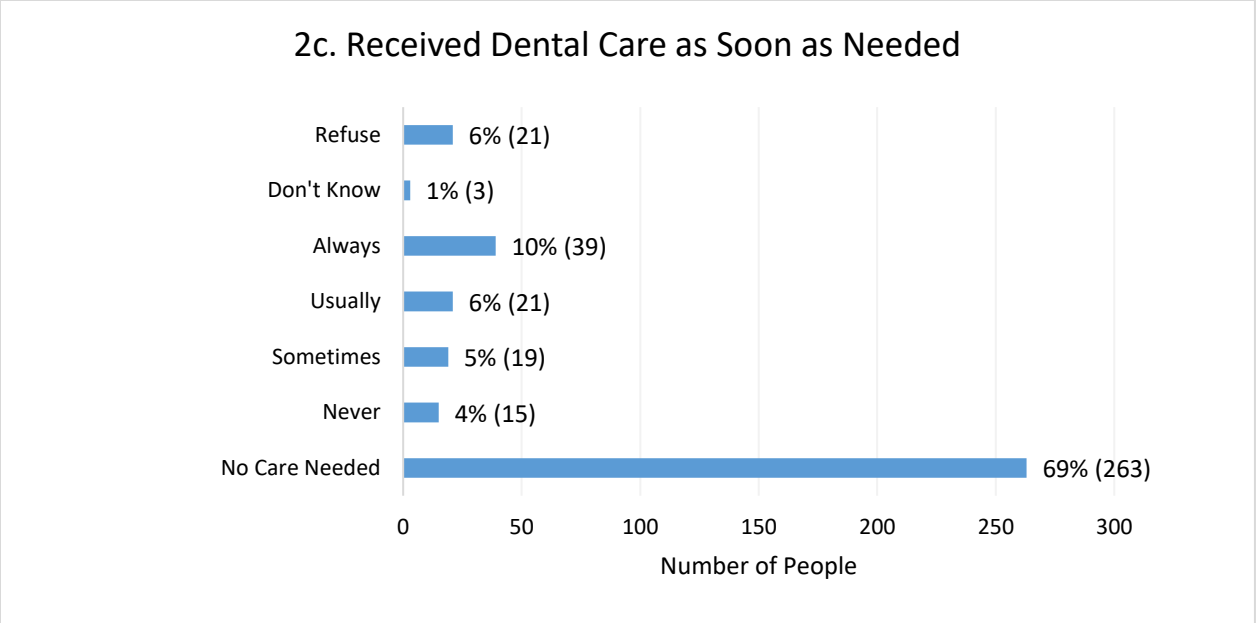
2h. Sought Care Outside County of Residence. In 2019, 55% of Wallowa County adults received care from outside of Wallowa County.

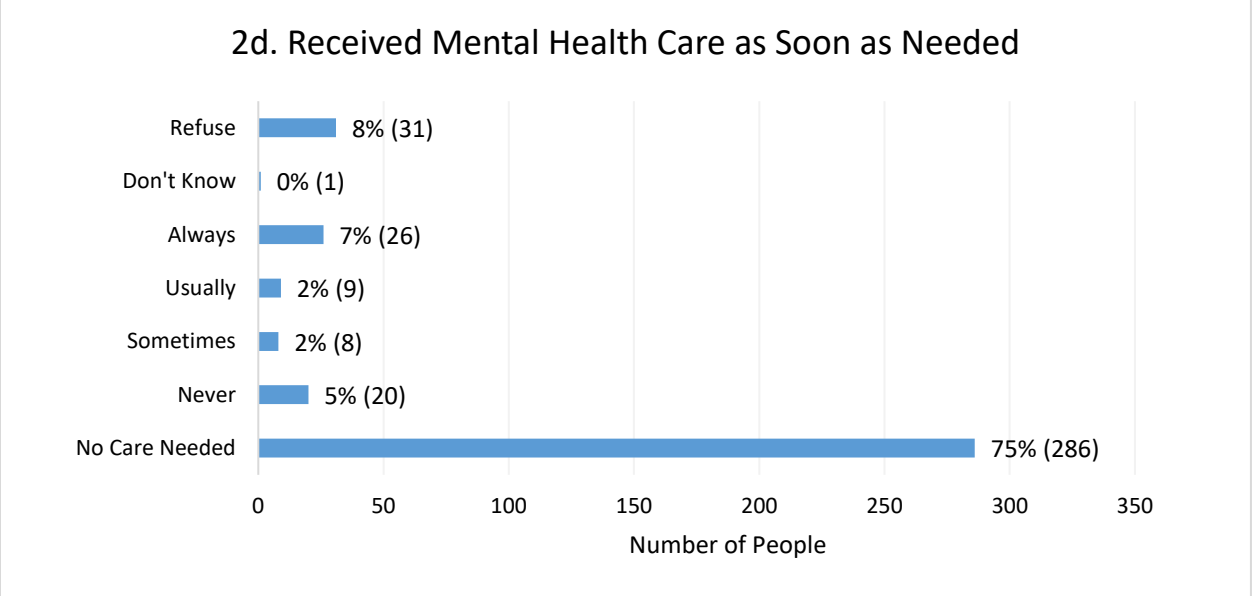
2i. Where Care was Sought. The most common place that was sought out for out of county care was Washington in which 23% of adults traveled to receive care. 10% of adults traveled to Union County and 6% of adults traveled to Idaho. (Graph 2W)

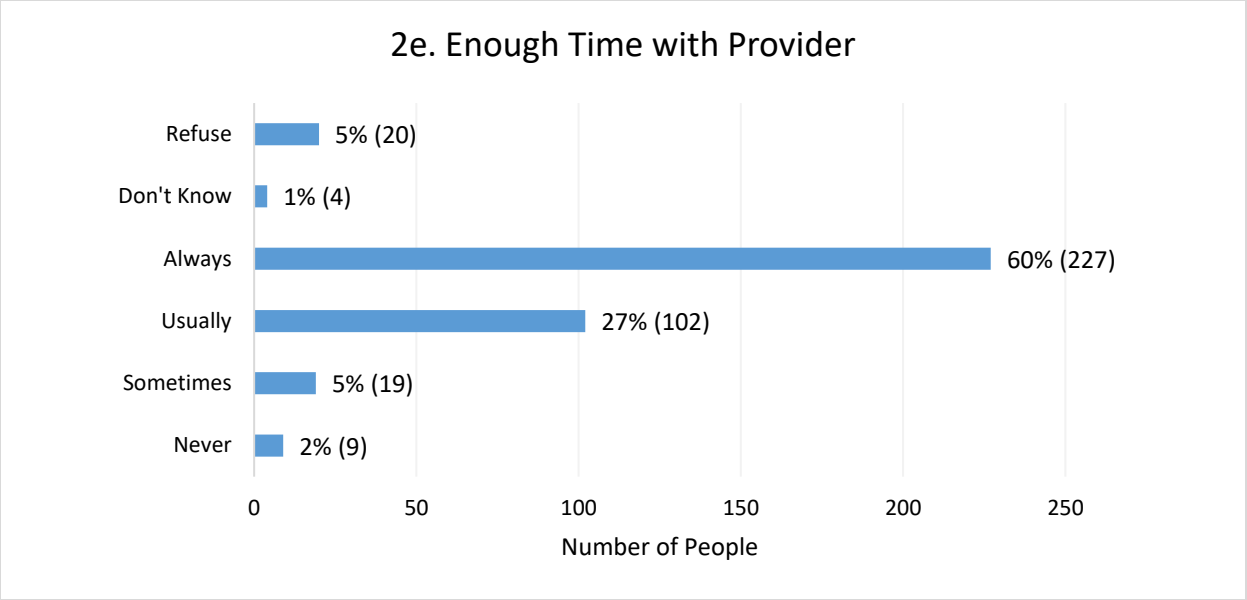
2j. Type of Care Sought Outside of County of Residence. In 2019, 72% of those who sought care outside of Wallowa County received Specialty Care, 7% received Primary Care, 5% received Care at an ER, and 5% had Another Hospital Stay.

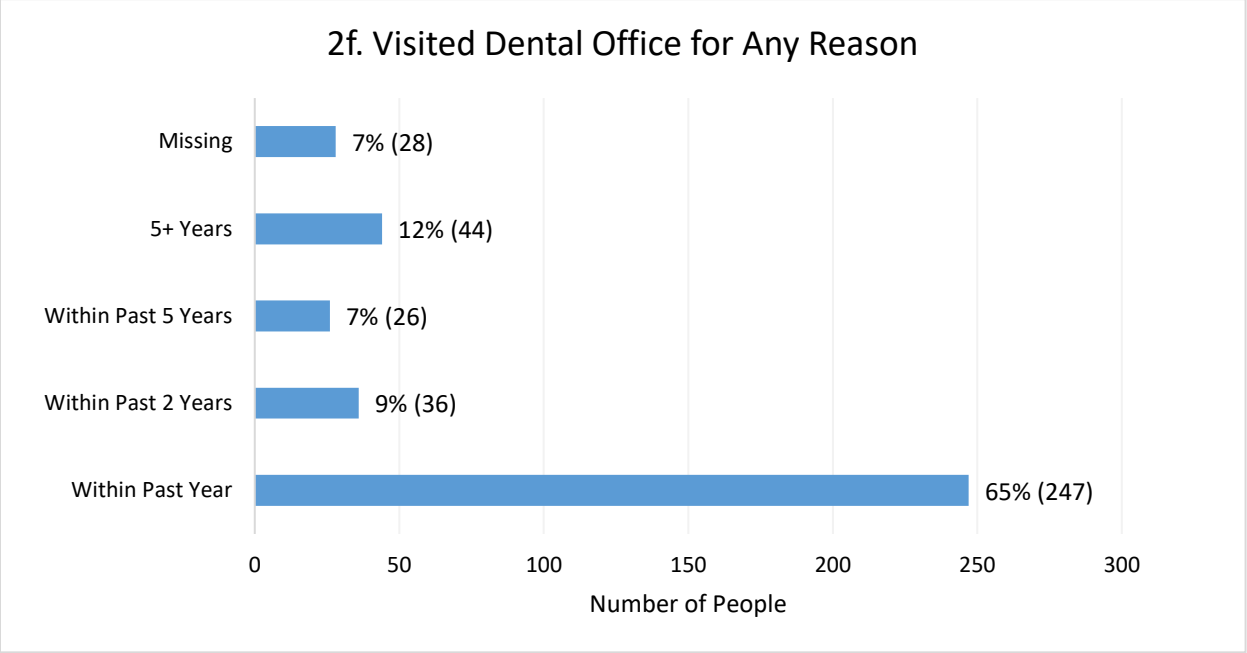

2a. Satisfaction with Healthcare Provider Communication
Missing
Refuse/Don't Know
Don't Know How Satisfied
No Communication Needed/Wanted
Very Satisfied
Somewhat Satisfied
Somewhat Dissatisfied
Very Dissatisfied
Don't have provider
24
3%, (11)
0%, (1)
1%, (2)
55%, (210)
17%, (64)
5%, (19)
9%, (36)
4%, (14)
0
50
100
150
200
250
Number of People

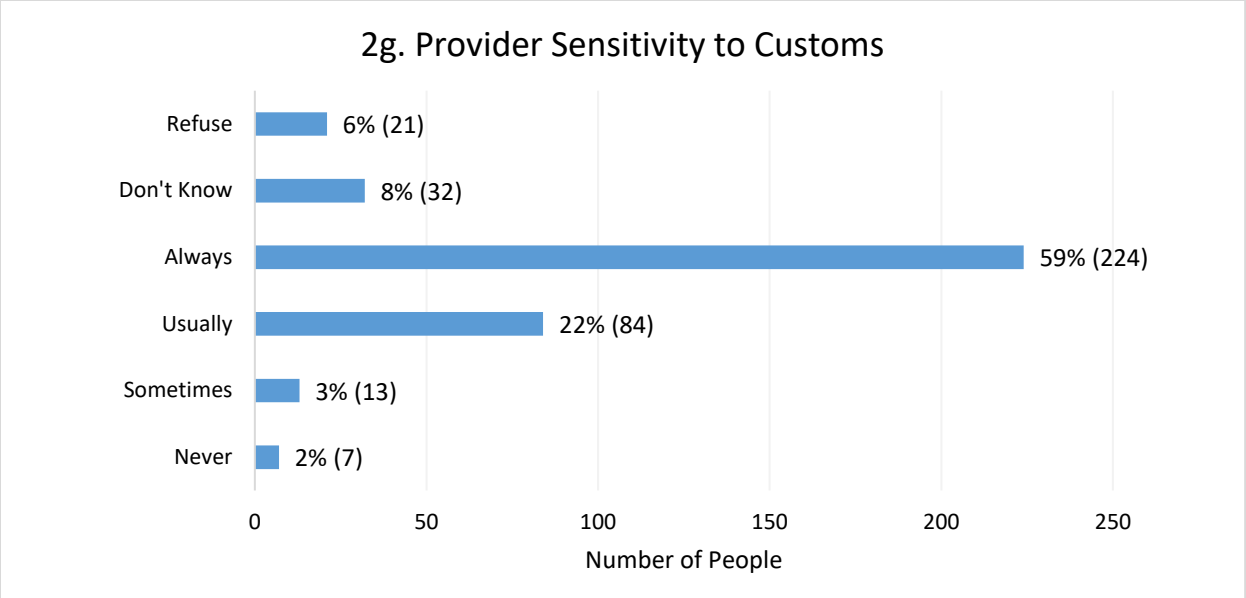

2b. Received Medical Care as Soon as Needed
Refuse
Don't Know
Always
Usually
Sometimes
Never
No Care Needed
8% (31)
1% (2)
28% (106)
7% (25)
8% (32)
2% (7)
47% (178)
0
50
100
150
200
Number of People

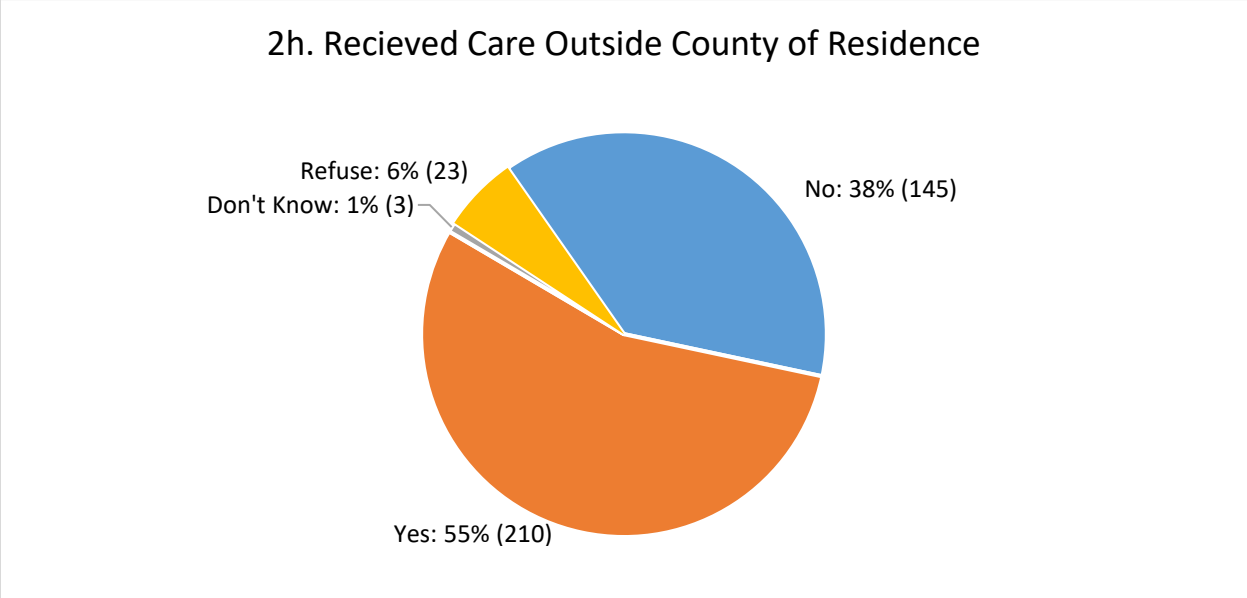

2c. Received Dental Care as Soon as Needed
Refuse
Don't Know
Always
Usually
Sometimes
Never
No Care Needed
6% (21)
1% (3)
10% (39)
6% (21)
5% (19)
4% (15)
69% (263)
0
50
100
150
200
250
300
Number of People

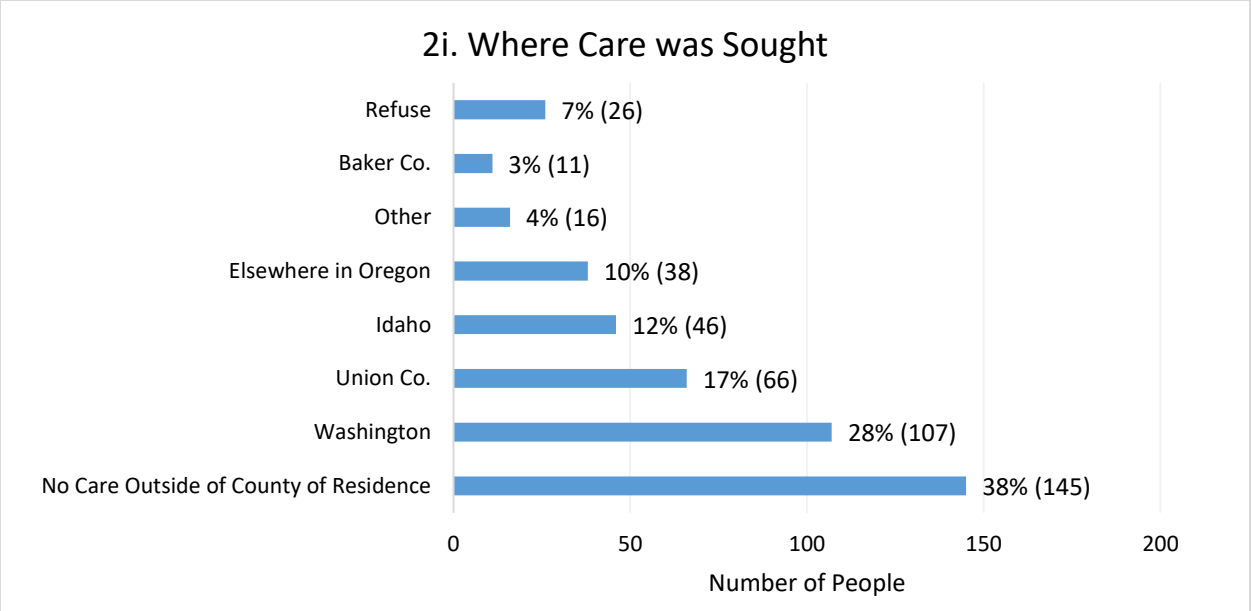

2d. Received Mental Health Care as Soon as Needed
Refuse
Don't Know
Always
Usually
Sometimes
Never
No Care Needed
8% (31)
0% (1)
7% (26)
2% (9)
2% (8)
5% (20)
75% (286)
0
50
100
150
200
250
300
350
Number of People

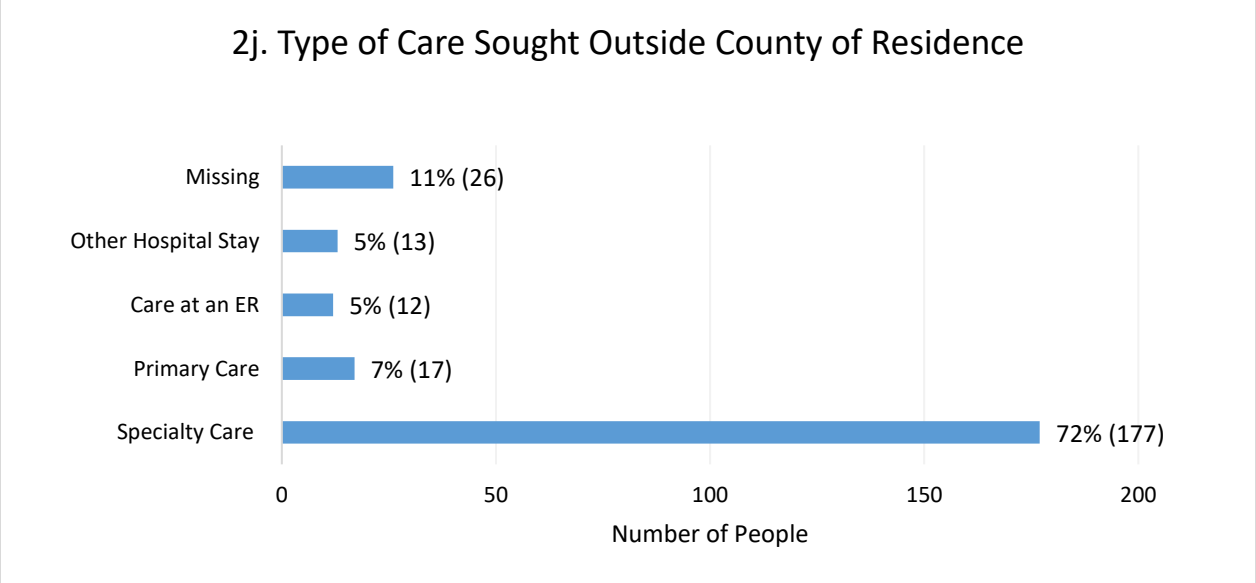

2e. Enough Time with Provider
Refuse
5% (20)
Don't Know
1% (4)
Always
60% (227)
Usually
27% (102)
Sometimes
5% (19)
Never
2% (9)
0
50
100
150
200
250
Number of People


2f. Visited Dental Office for Any Reason
Missing
7% (28)
5+ Years
12% (44)
Within Past 5 Years
7% (26)
Within Past 2 Years
9% (36)
Within Past Year
65% (247)
0
50
100
150
200
250
300
Number of People


2g. Provider Sensitivity to Customs
Refuse
6% (21)
Don't Know
8% (32)
Always
59% (224)
Usually
22% (84)
Sometimes
3% (13)
Never
2% (7)
0
50
100
150
200
250
Number of People


2h. Recieved Care Outside County of Residence
Refuse: 6% (23)
Don't Know: 1% (3)
No: 38% (145)
Yes: 55% (210)


2i. Where Care was Sought
Refuse
7% (26)
Baker Co.
3% (11)
Other
4% (16)
Elsewhere in Oregon
10% (38)
Idaho
12% (46)
Union Co.
17% (66)
Washington
28% (107)
No Care Outside of County of Residence
38% (145)
0
50
100
150
200
Number of People


2j. Type of Care Sought Outside County of Residence
Missing
11% (26)
Other Hospital Stay
5% (13)
Care at an ER
5% (12)
Primary Care
7% (17)
Specialty Care
72% (177)
0
50
100
150
200
Number of People

Detailed Charts Section 3: Heath Care Coverage

3a. Number of Respondents with Medical Coverage. 94% of respondents had medical insurance coverage.

3b. Number of Respondents with Mental Health Coverage. 49% of respondents had mental health insurance coverage.

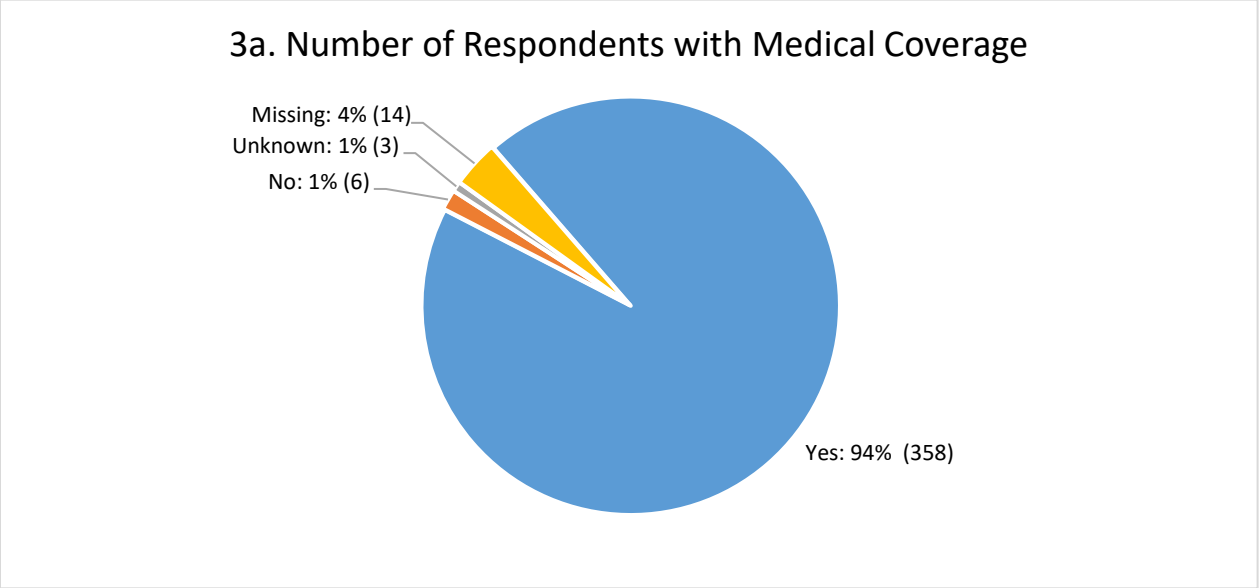
3c. Number of Respondents with Dental Coverage. 44% of respondents had medical insurance coverage.

3d. Number of Respondents with Vision Coverage. 40% of respondents had vision insurance coverage.

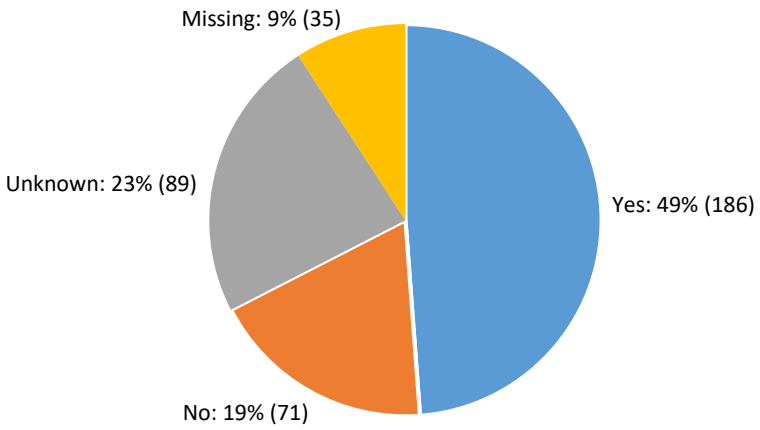
3e. Number of Respondents Uninsured. 4% of respondents were uninsured.

3f. Number of Respondents with Health Care Coverage, by Type. 358 of 381 respondents had medical coverage, while 152 respondents had vision coverage.

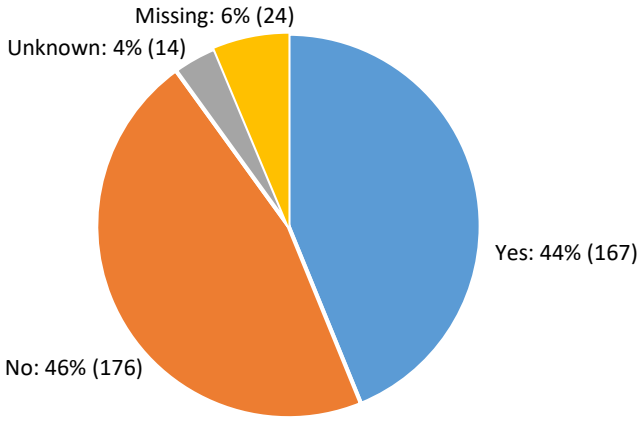
3g. Type of Insurance Coverage. 48% of respondents had Medicare, 10% had Oregon Health Plan, and 17% had Employer-sponsored health care.

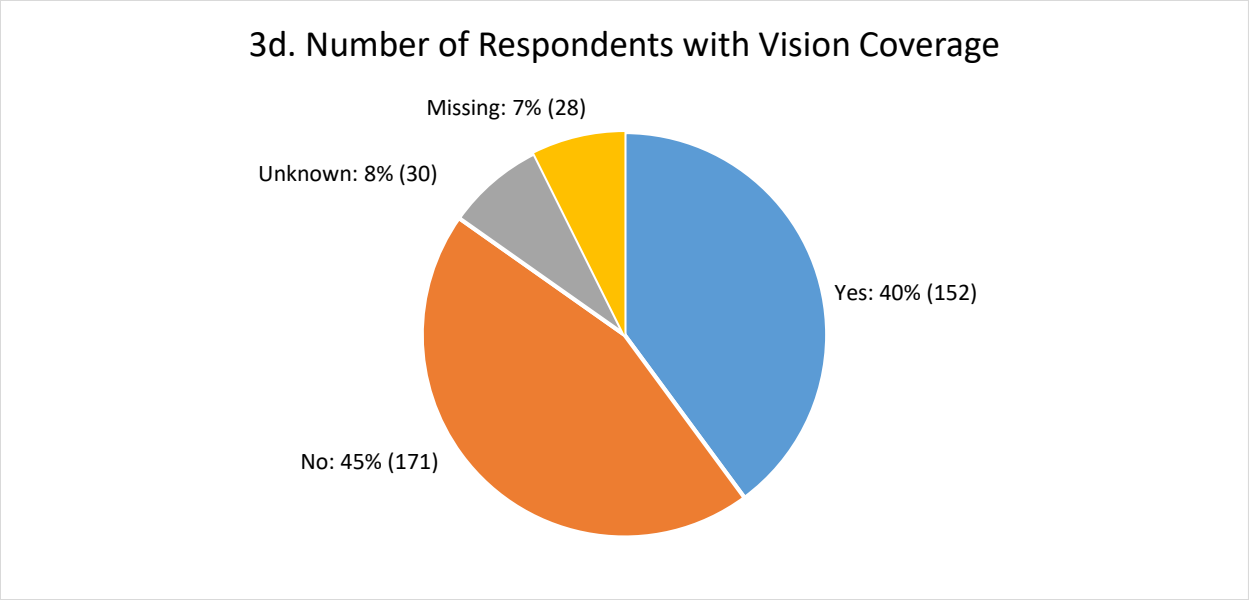


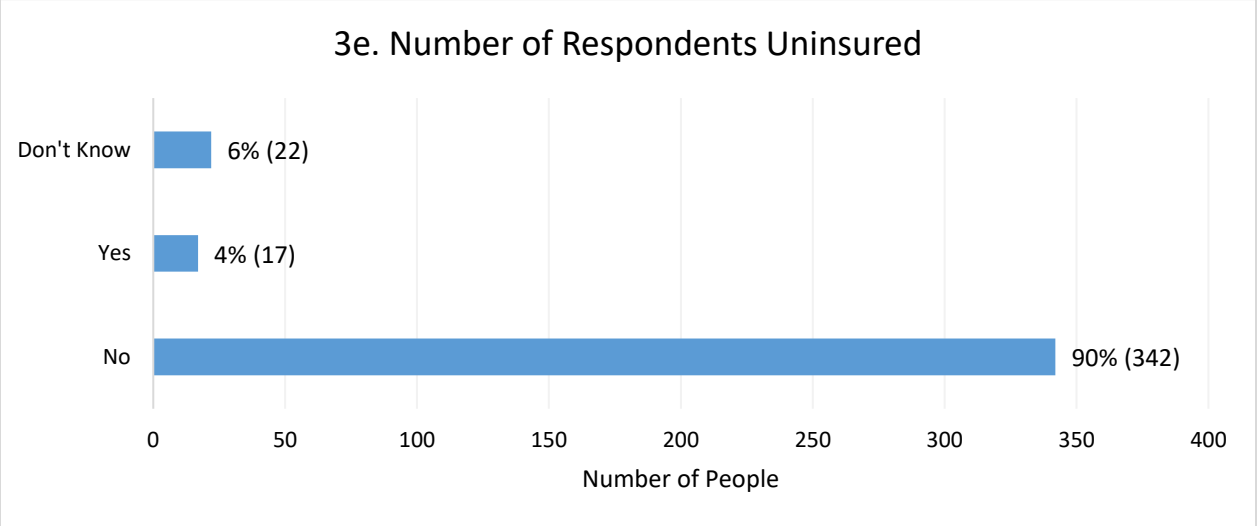
3b. Number of Respondents with Mental Health Coverage

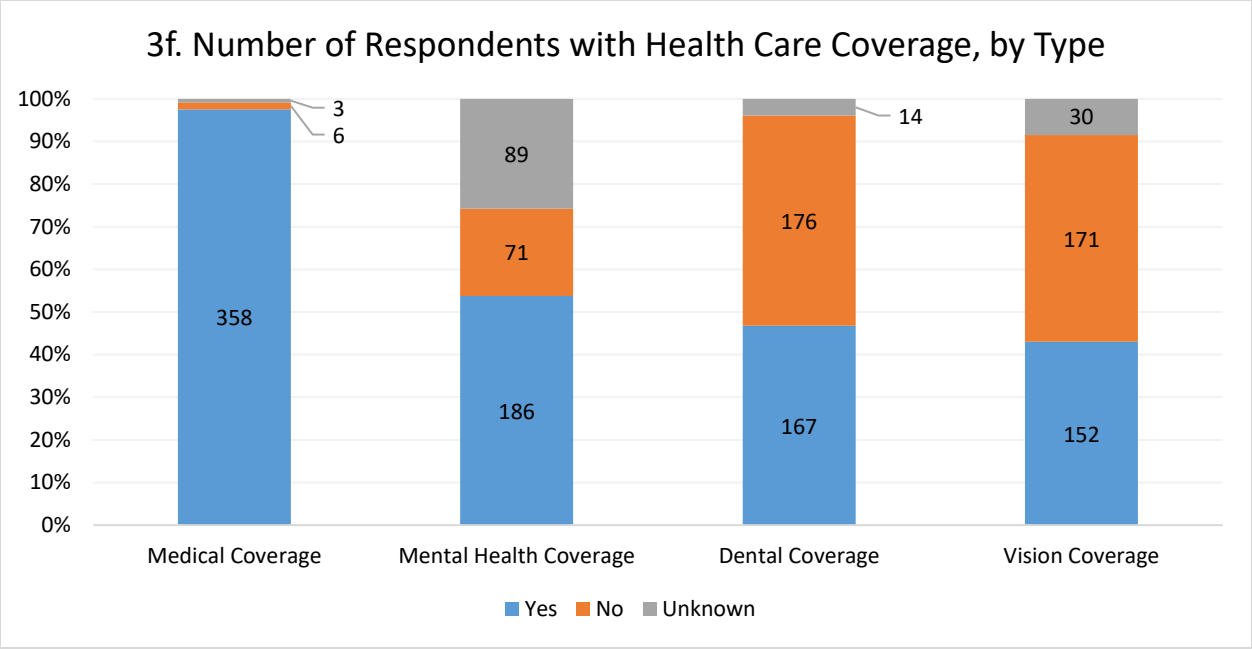


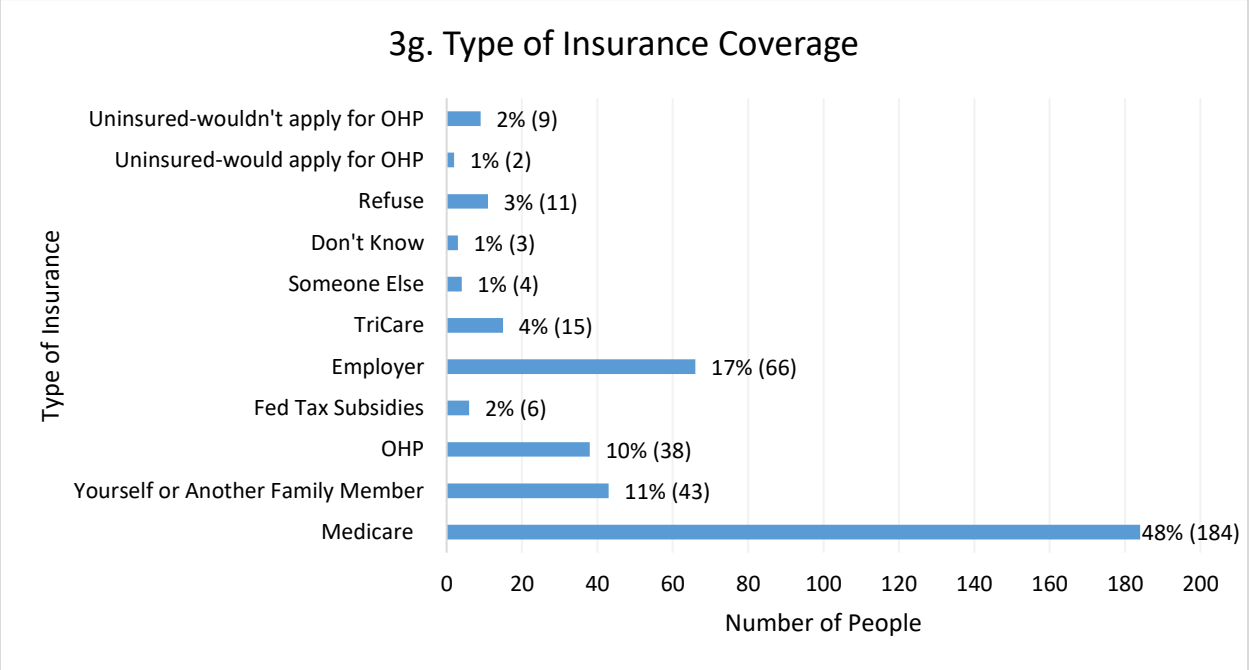
3c. Number of Respondents with Dental Coverage




3d. Number of Respondents with Vision Coverage
Missing: 7% (28)
Unknown: 8% (30)
Yes: 40% (152)
No: 45% (171)


3e. Number of Respondents Uninsured
Don't Know
6% (22)
Yes
4% (17)
No
90% (342)
0
50
100
150
200
250
300
350
400
Number of People


3f. Number of Respondents with Health Care Coverage, by Type
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3
6
358
89
71
186
176
167
14
30
171
152
Medical Coverage
Mental Health Coverage
Dental Coverage
Vision Coverage
Yes
No
Unknown


3g. Type of Insurance Coverage
Type of Insurance
Uninsured-wouldn't apply for OHP
2% (9)
Uninsured-would apply for OHP
1% (2)
Refuse
3% (11)
Don't Know
1% (3)
Someone Else
1% (4)
TriCare
4% (15)
Employer
17% (66)
Fed Tax Subsidies
2% (6)
OHP
10% (38)
Yourself or Another Family Member
11% (43)
Medicare
48% (184)
0
20
40
60
80
100
120
140
160
180
200
Number of People

Detailed Charts Section 4: Health Status

4a. I Have Been Told by a Doctor I Have… 19% of respondents reported they have been told by a doctor that they have cavities, 33% have high blood pressure, 18% have depression, 12% have asthma, and 8% have diabetes.

4b. Any Poor Mental Health Within the Past Month. 61% of respondents had no poor mental health days in the past month, and 21% of respondents reported at least one poor mental health day.

4c. Number of Poor Mental Health Days in the Past Month. 4% of respondents reported 2 poor mental health days per month, and 3% reported poor mental health days every day.

4d. Any Poor Dental Health Within the Past Month. 65% of respondents had no poor dental health days in the past month, and 8% of respondents reported at least one poor dental health day.

4e. Number of Poor Dental Health Days in the Past Month. 2% of respondents reported 5 poor dental health days per month, and 4% reported poor dental health days every day.

4f. Any Poor Physical Health Within the Past Month. 54% of respondents had no poor physical health days in the past month, and 29% of respondents reported at least one poor physical health day.

4g. Number of Poor Physical Health Days in the Past Month. 4% of respondents reported 10 poor physical health days per month, and 8% reported poor physical health days every day.

4h. Time Since Last Routine Doctor Visit. 1% of respondents reported never having a routine doctor visit. 73% of respondents had a routine doctor visit within the past year.

4i. Time Since Last Routine Dentist Checkup. 8% of respondents reported never having a routine dentist visit. 60% of respondents had a routine doctor visit within the past year.

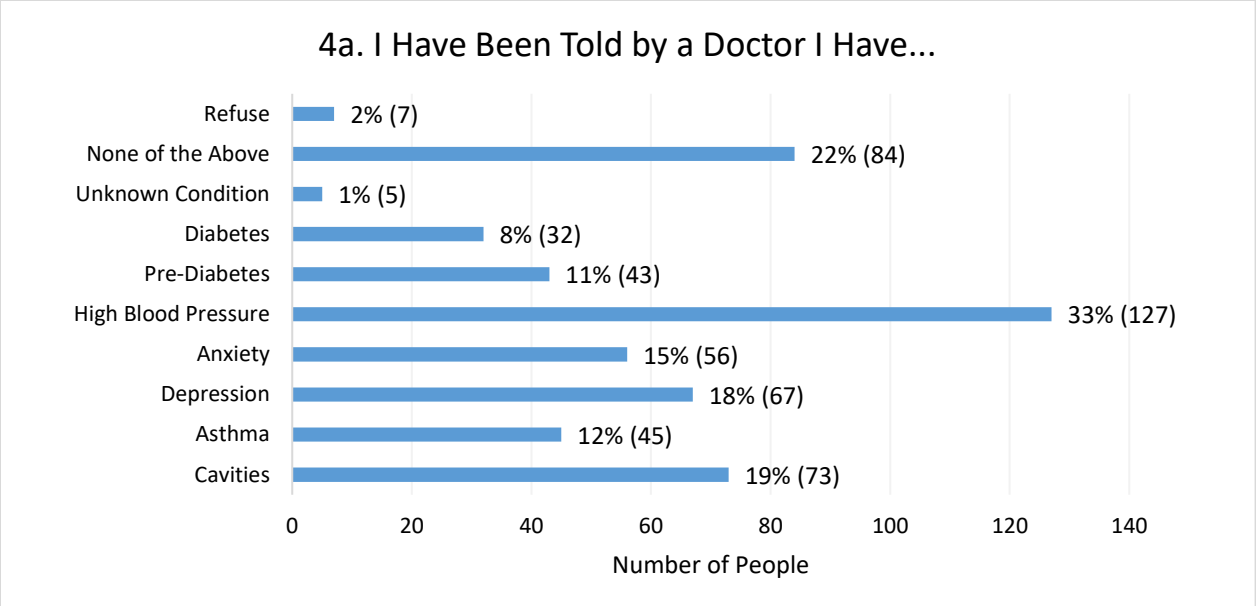
4j. Any Days of Poor Health that Limited Usual Activities. 65% of respondents had no poor health days that limited physical activity in the past month, and 21% of respondents reported at least one poor health day that limited usual activities.

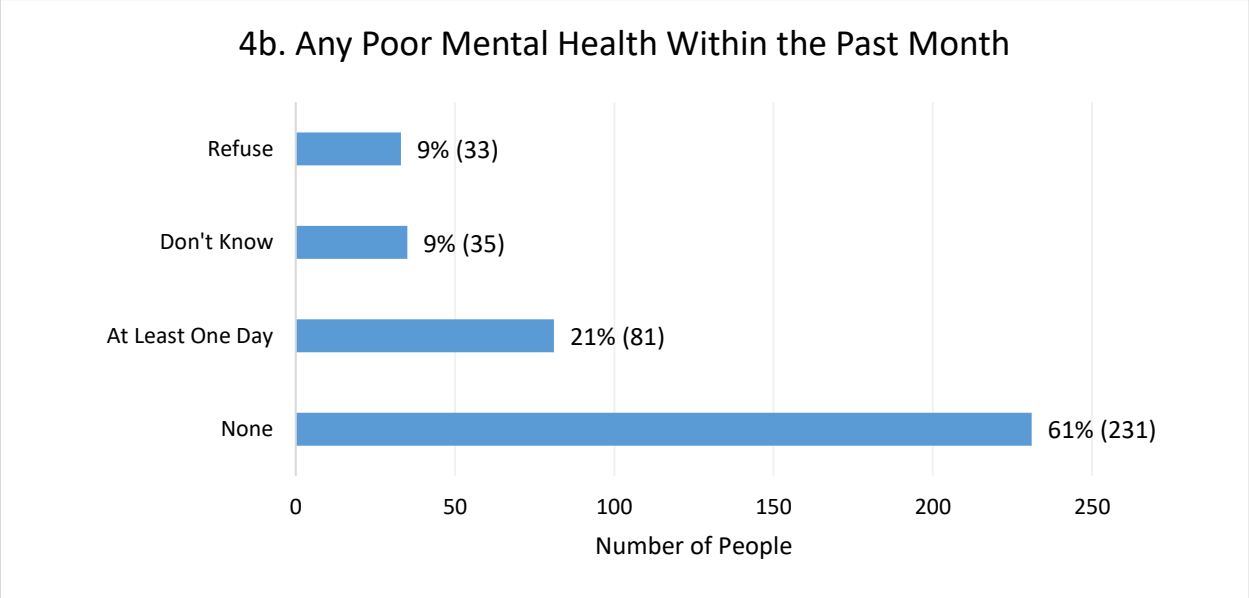
4k. Number of Days that Poor Health Limited Usual Activities. 3% of respondents reported 3 poor physical health days per month, and 6% reported poor health that limited activities every day.

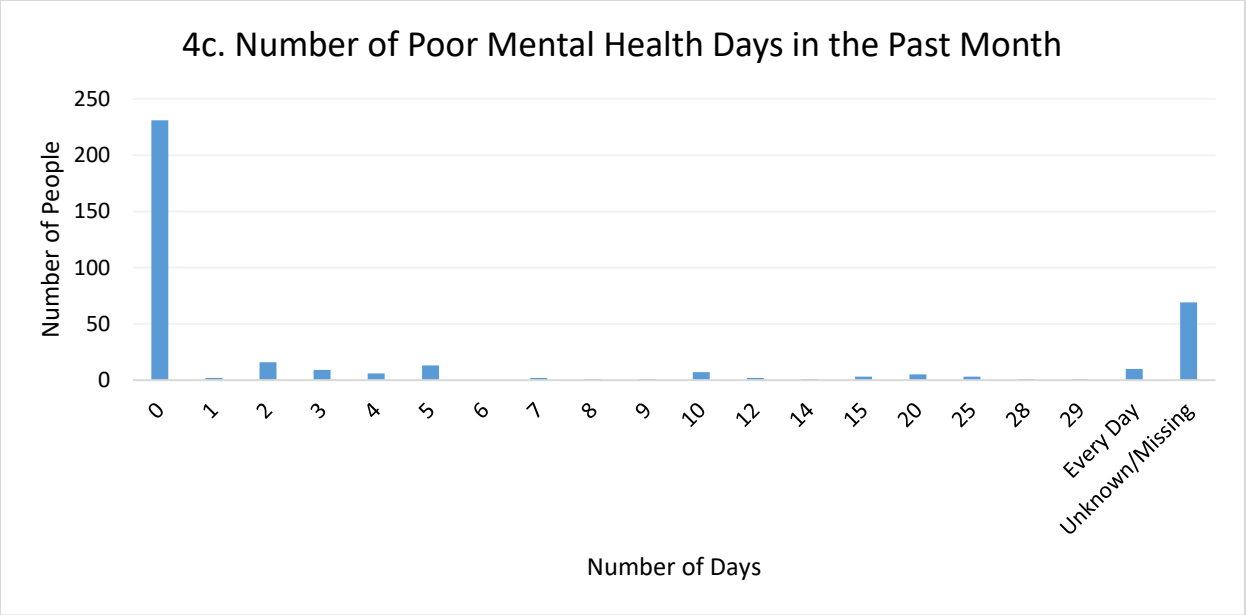
4l. Have You Exercised in the Past Month? 65% of respondents reported exercising in the past month, and 16% reported not exercising in the past month.

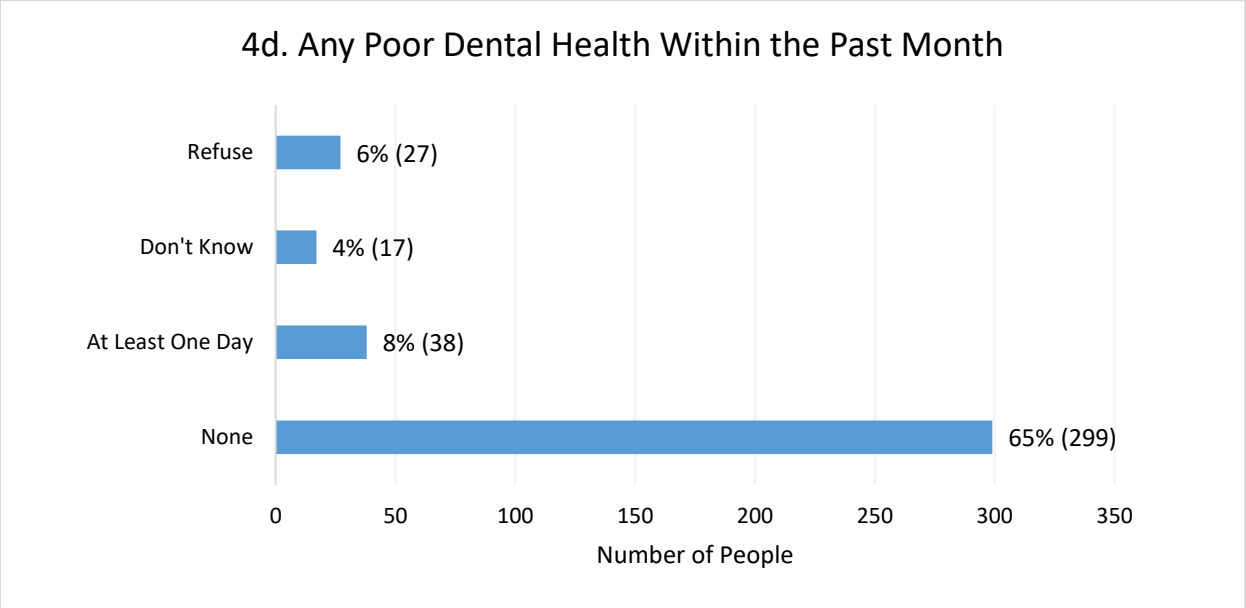
4m. Has Disabilities that Prevent Working. 19% of respondents reported having disabilities that prevent working. 70% reported not having disabilities that prevent working.

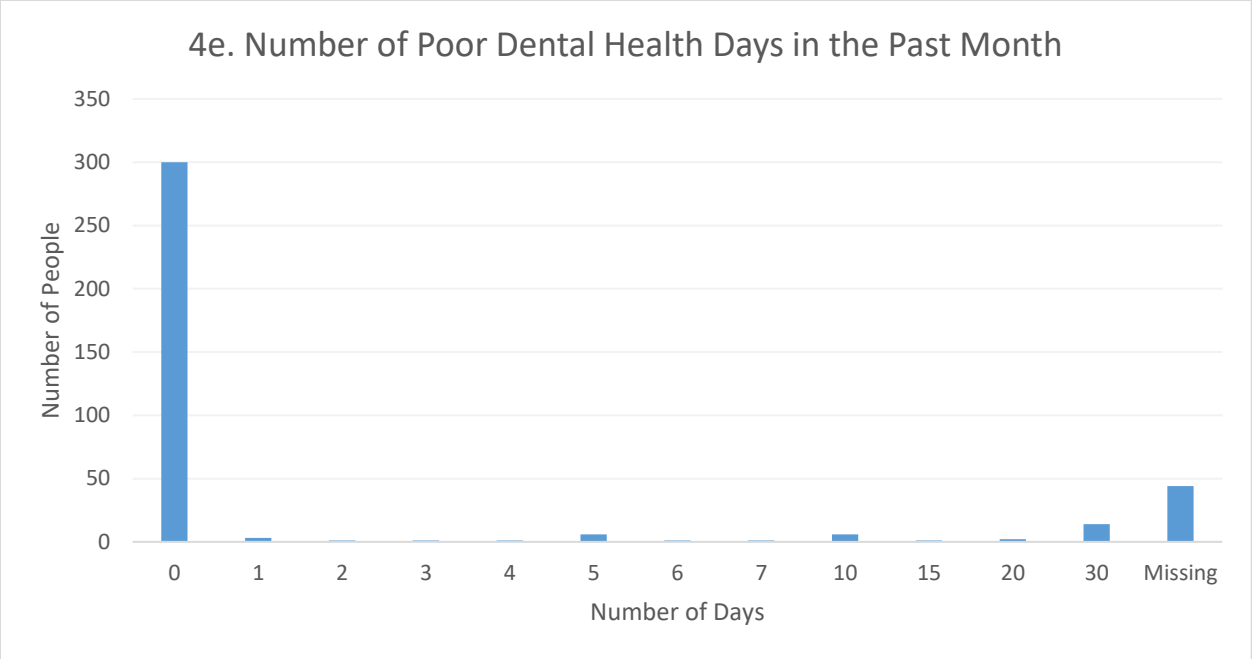
4n. Has Disabilities that Require Work Adjustments. 8% of respondents reported having disabilities that require work adjustments. 73% reported not having disabilities that require work adjustments.

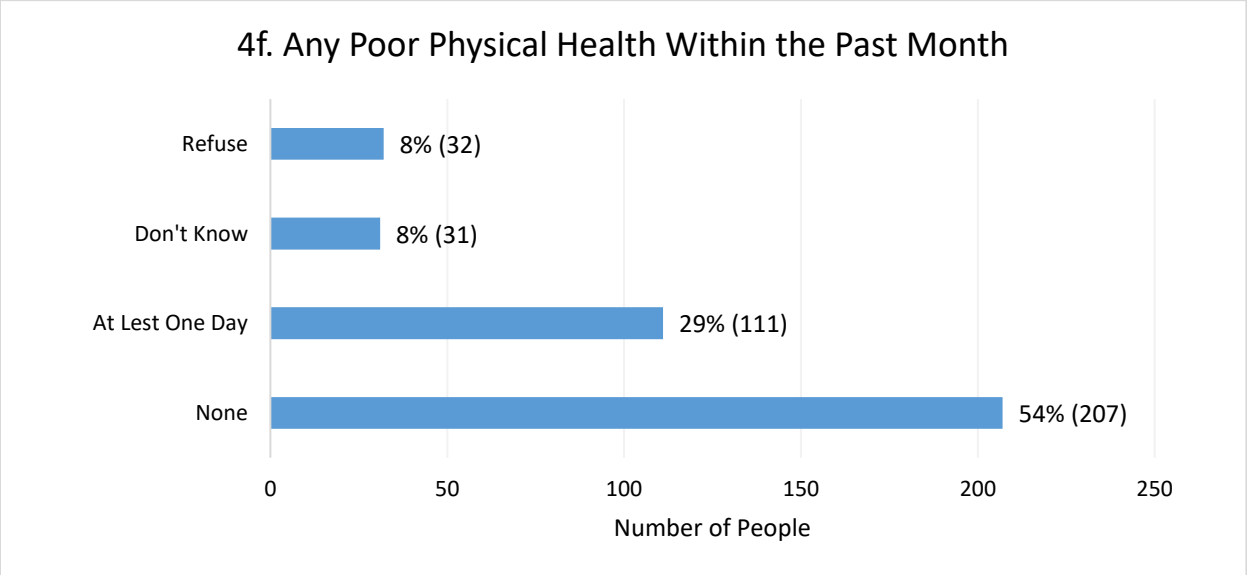

4a. I Have Been Told by a Doctor I Have...
Refuse
None of the Above
Unknown Condition
Diabetes
Pre-Diabetes
High Blood Pressure
Anxiety
Depression
Asthma
Cavities
2% (7)
22% (84)
1% (5)
8% (32)
11% (43)
33% (127)
15% (56)
18% (67)
12% (45)
19% (73)
0
20
40
60
80
100
120
140
Number of People

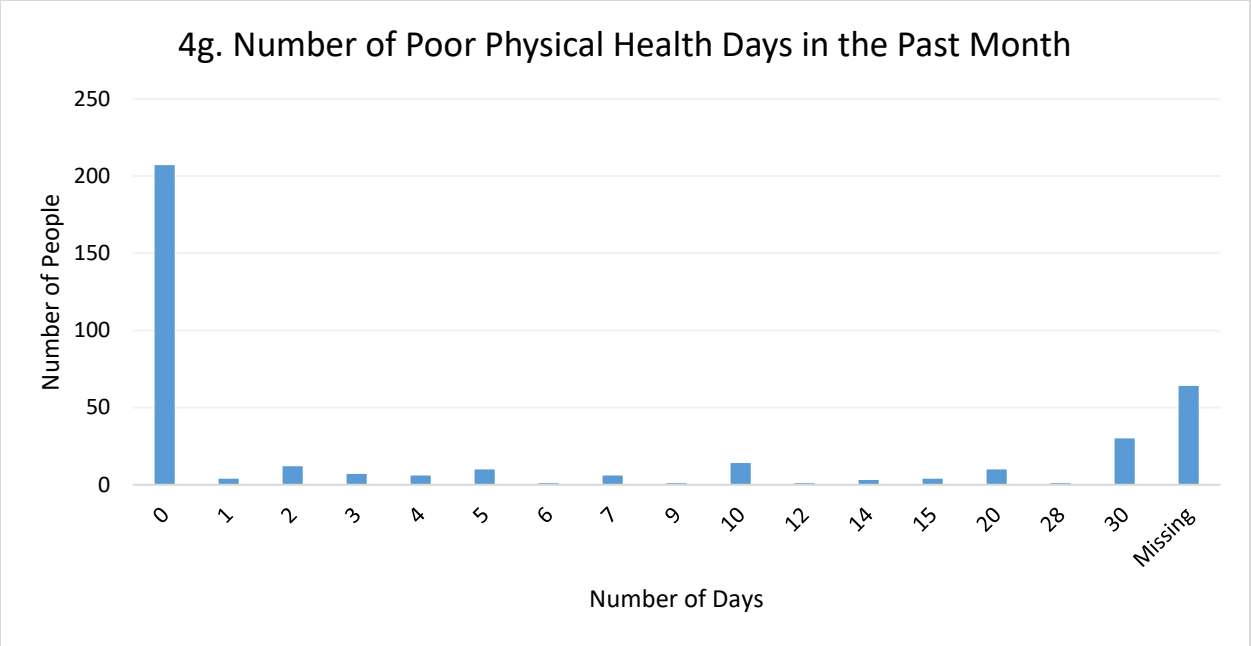

4b. Any Poor Mental Health Within the Past Month
Refuse
Don't Know
At Least One Day
None
9% (33)
9% (35)
21% (81)
61% (231)
0
50
100
150
200
250
Number of People

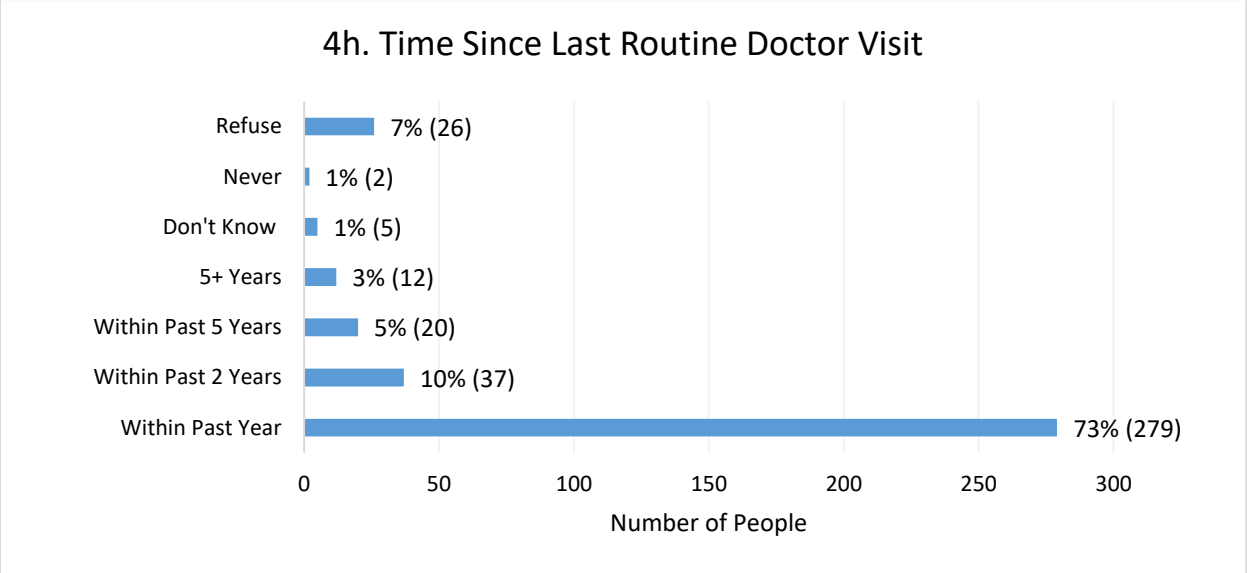

4c. Number of Poor Mental Health Days in the Past Month
Number of People
250
200
150
100
50
0
0
1
2
3
4
5
6
7
8
9
10
12
14
15
20
25
28
29
Every Day
Unknown/Missing
Number of Days

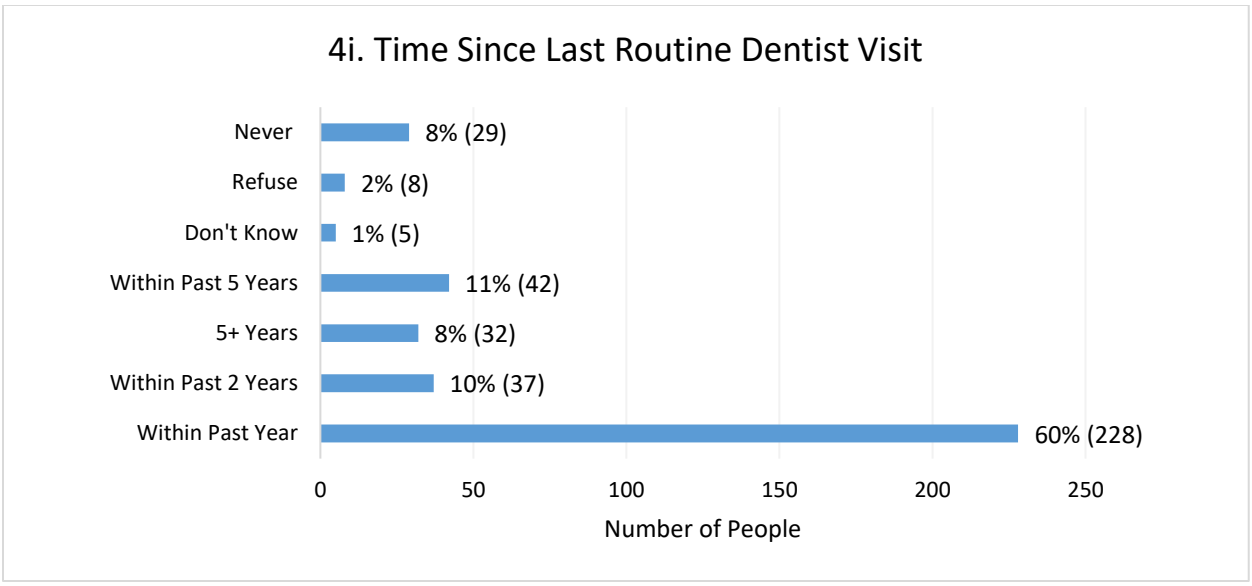

4d. Any Poor Dental Health Within the Past Month
Refuse
6% (27)
Don't Know
4% (17)
At Least One Day
8% (38)
None
65% (299)
0
50
100
150
200
250
300
350
Number of People

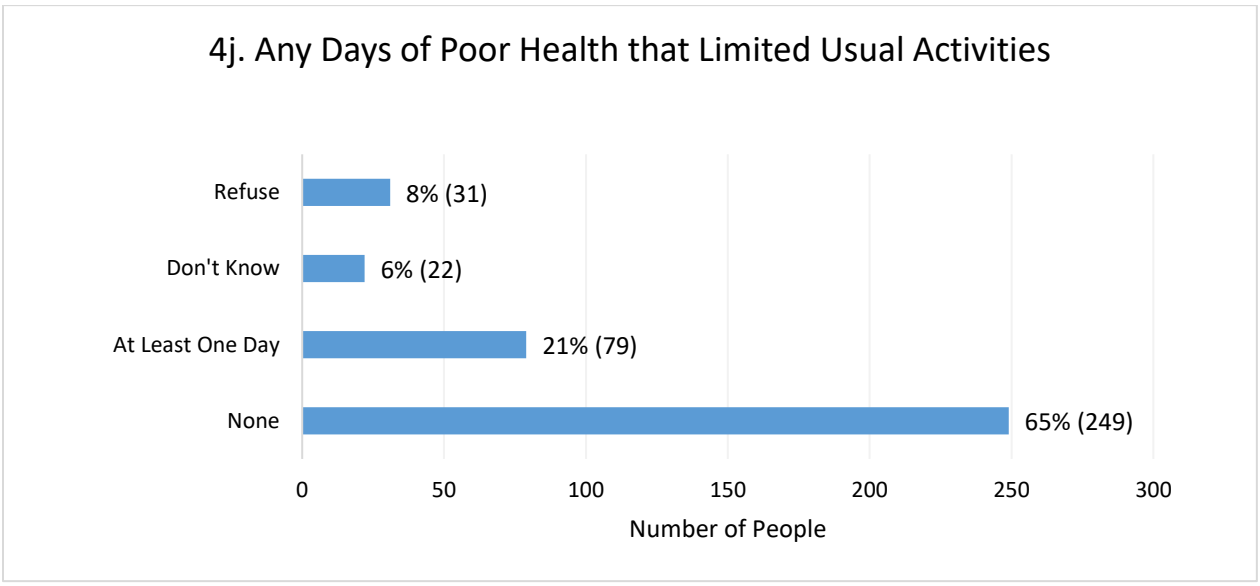

4e. Number of Poor Dental Health Days in the Past Month
350
300
250
200
150
100
50
0
Number of People
0
1
2
3
4
5
6
7
10
15
20
30
Missing
Number of Days

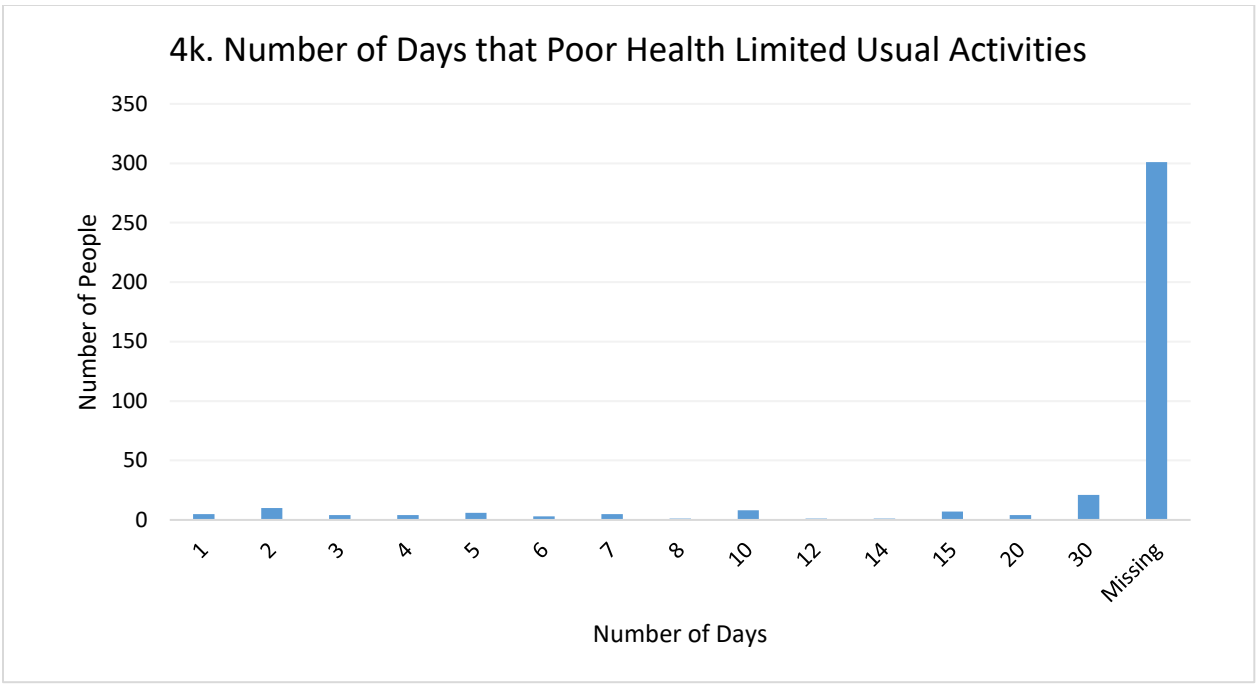

4f. Any Poor Physical Health Within the Past Month
Refuse
8% (32)
Don't Know
8% (31)
At Lest One Day
29% (111)
None
54% (207)
0
50
100
150
200
250
Number of People

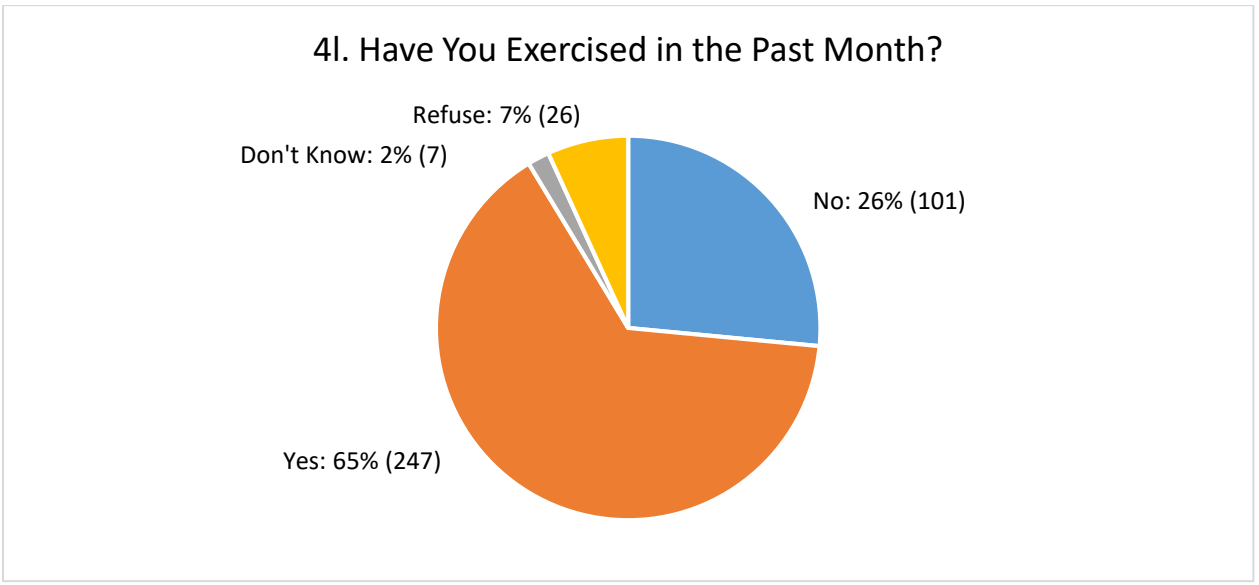

4g. Number of Poor Physical Health Days in the Past Month
250
200
150
100
50
0
Number of People
0
1
2
3
4
5
6
7
9
10
12
14
15
20
28
30
Missing
Number of Days

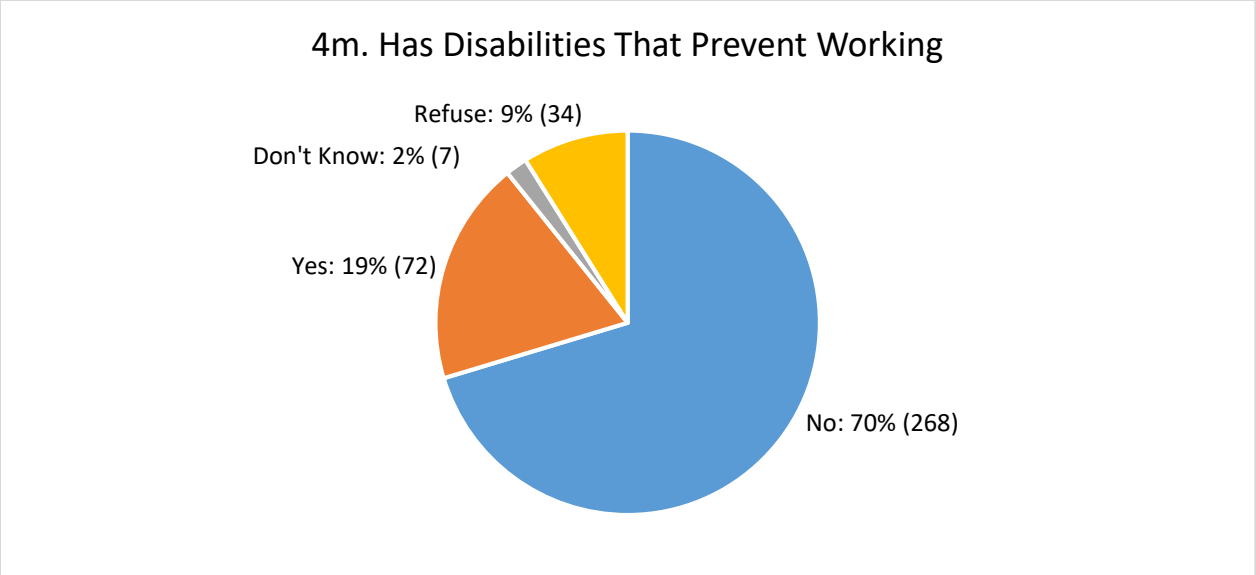

4h. Time Since Last Routine Doctor Visit
Refuse
7% (26)
Never
1% (2)
Don't Know
1% (5)
5+ Years
3% (12)
Within Past 5 Years
5% (20)
Within Past 2 Years
10% (37)
Within Past Year
73% (279)
0
50
100
150
200
250
300
Number of People

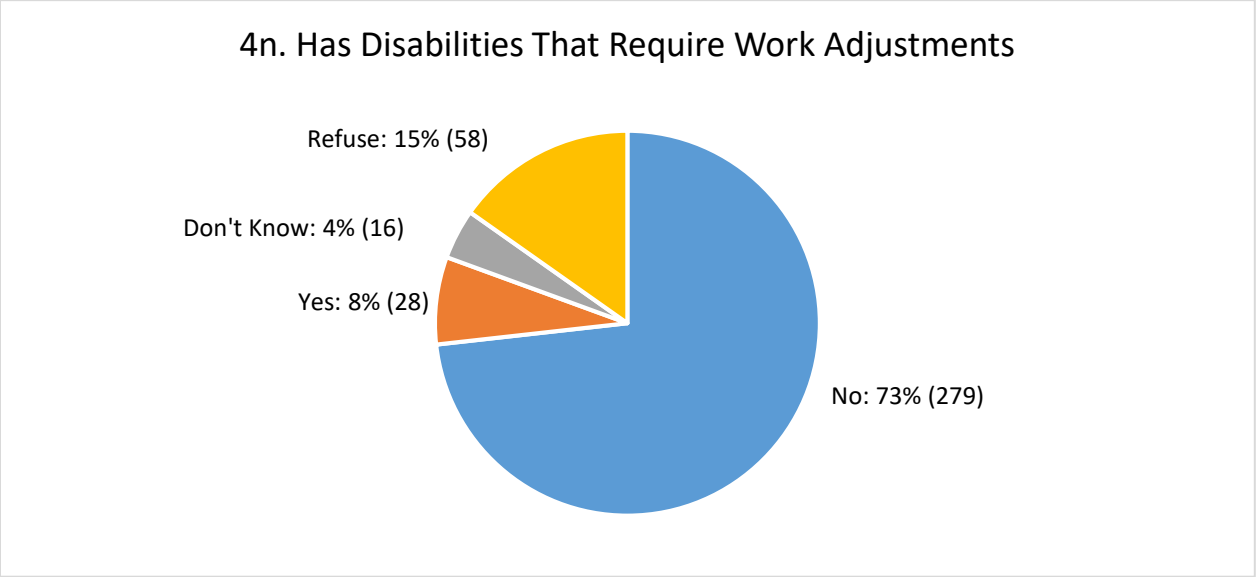

4i. Time Since Last Routine Dentist Visit
Never
8% (29)
Refuse
2% (8)
Don't Know
1% (5)
Within Past 5 Years
11% (42)
5+ Years
8% (32)
Within Past 2 Years
10% (37)
Within Past Year
60% (228)
0
50
100
150
200
250
Number of People


4j. Any Days of Poor Health that Limited Usual Activities
Refuse
8% (31)
Don't Know
6% (22)
At Least One Day
21% (79)
None
65% (249)
0
50
100
150
200
250
300
Number of People


4k. Number of Days that Poor Health Limited Usual Activities
Number of People
350
300
250
200
150
100
50
0
1
2
3
4
5
6
7
8
10
12
14
15
20
30
Missing
Number of Days


4l. Have You Exercised in the Past Month?
Refuse: 7% (26)
Don't Know: 2% (7)
No: 26% (101)
Yes: 65% (247)


4m. Has Disabilities That Prevent Working
Refuse: 9% (34)
Don't Know: 2% (7)
Yes: 19% (72)
No: 70% (268)


4n. Has Disabilities That Require Work Adjustments
Refuse: 15% (58)
Don't Know: 4% (16)
Yes: 8% (28)
No: 73% (279)

Detailed Charts Section 5: Social Circumstances

5a. Not Enough… Of the social circumstances summarized in this chart, more respondents reported that feeling stressed, anxious, or depressed was a problem than any other circumstance. The fewest respondents felt that help available for their own alcohol or drug use was a problem.

5b. Not Enough Money for Housing. A total of 13% of respondents reported that money for housing was a problem. 79% of respondents reported that money for housing was not a problem.

5c. Not Enough Money for Food. 13% of respondents reported that money for food was a problem. 79% of respondents reported that money for food was not a problem.

5d. Not Enough Money for Utilities. 15% of respondents reported that money for utilities was a problem. 79% of respondents reported that money for utilities was not a problem.

5e. Not Having Transportation. 5% of respondents reported that not having transportation was a problem. 85% of respondents reported that not having transportation was not a problem.

5f. Not Enough Money for Medical Insurance. 16% of respondents reported that money for utilities was a problem. 75% of respondents reported that money for utilities was not a problem.

5g. Not Enough Money for a Doctor. 18% of respondents reported that money for a doctor was a problem. 74% of respondents reported that money for a doctor was not a problem.

5h. Not Enough Money for Prescriptions. 11% of respondents reported that money for prescriptions was a problem. 79% of respondents reported that money for prescriptions was not a problem.

5i. Not Enough Money for a Dentist. 26% of respondents reported that money for a dentist was a problem. 64% of respondents reported that money for a dentist was not a problem.

5j. Problems with Being Homeless. 6% of respondents reported problems with being homeless. 81% of respondents reported that being homeless was not a problem.

5k. Feeling Stressed, Anxious, or Depressed. 40% of respondents reported feeling stressed, anxious, or depressed was a problem. 46% of respondents reported that feeling stressed, anxious, or depressed was not a problem.

5l. No Help for Stress, Anxiety, or Depression. 15% of respondents reported that having no help for stress, anxiety, or depression was a problem. 73% of respondents reported that having no help for these conditions was not a problem.

5m. Concern About Other's Alcohol or Drug Use. 18% of respondents reported that concern about others alcohol or drug use was a problem. 70% of respondents reported that having concern about other's alcohol or drug use was not a problem.

5n. No Help for Other's Alcohol or Drug Use. 9% of respondents reported that having no help for other's alcohol or drug use was a problem. 78% of respondents reported that having no help for other's alcohol or drug use was not a problem.

5o. Concern About Own Alcohol or Drug Use. 5% of respondents reported that concern about their own alcohol or drug use was a problem. 82% of respondents reported that having concern about their own alcohol or drug use was not a problem.

5p. No Help for Own Alcohol or Drug Use. 1% of respondents reported that having no help for their own alcohol or drug use was a problem. 87% of respondents reported that having no help for their own alcohol or drug use was not a problem.

5q. Unable to Read to Complete Job Applications. 4% of respondents reported that being unable to read to complete job applications was a problem. 85% of respondents reported that being unable to read to complete job applications was not a problem.

5r. Not Confident to Complete Medical Forms. 11% of respondents reported that not being confident to complete medical forms was a problem. 80% of respondents reported that that not being confident to complete medical forms was not a problem.

5s. Don't Comprehend Written Information. 11% of respondents reported that not comprehending written information was a problem. 78% of respondents reported that not comprehending written information was not a problem.

5t. No One to Talk About Work Problems. 8% of respondents reported that having no one to talk about work problems was a problem. 80% of respondents reported that having no one to talk about work problems was not a problem.

5u. No One to Talk About Personal Problems. 12% of respondents reported that having no one to talk about personal problems was a problem. 76% of respondents reported that having no one to talk about personal problems was not a problem.

5v. Feel Unsafe at Home (Verbal, Emotional, or Physical). 5% of respondents reported that feeling unsafe at home was a problem. 86% of respondents reported that feeling unsafe at home was not a problem.

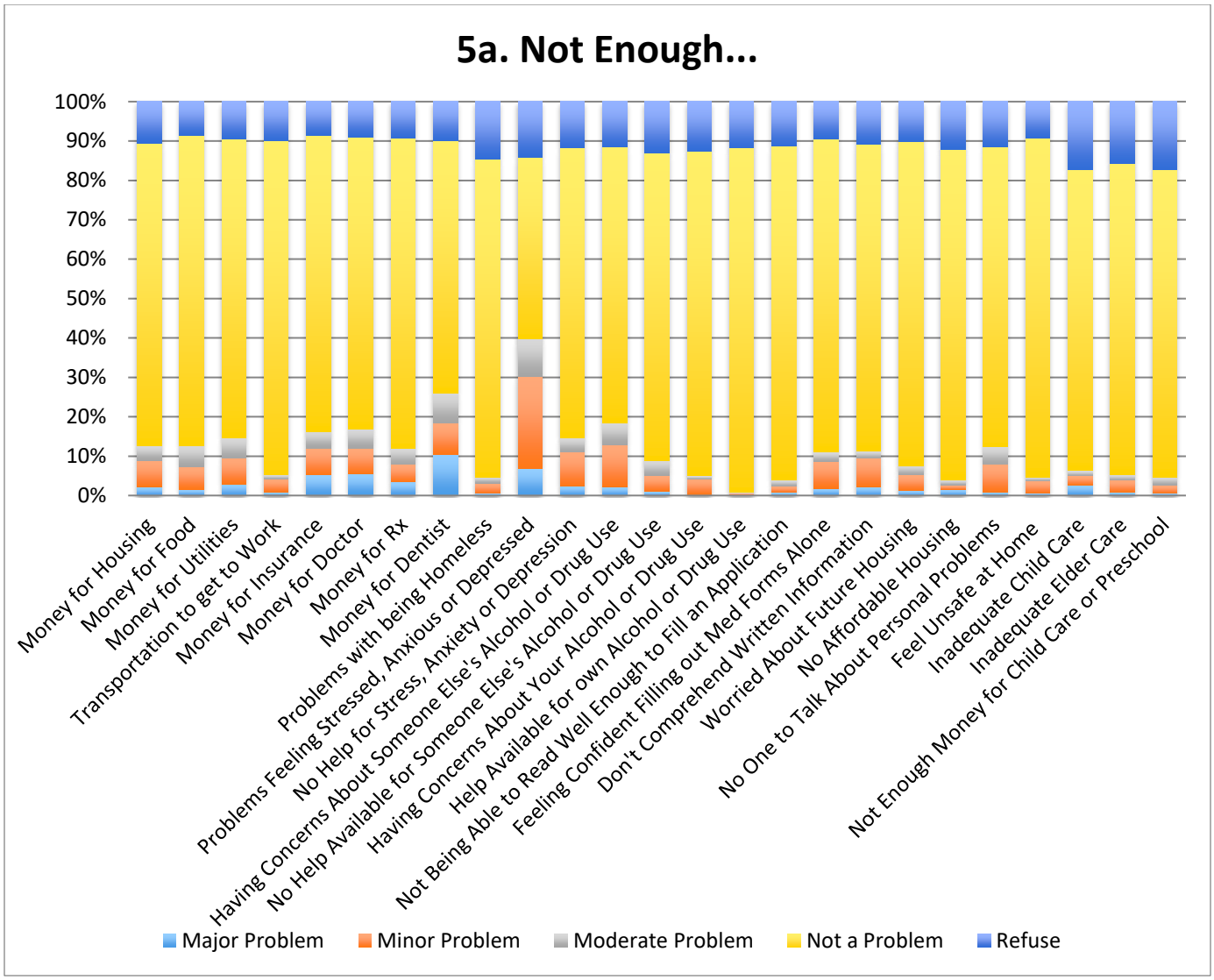
5w. Inadequate Child Care. 6% of respondents reported that having inadequate child care was a problem. 76% of respondents reported that having inadequate child care was not a problem.

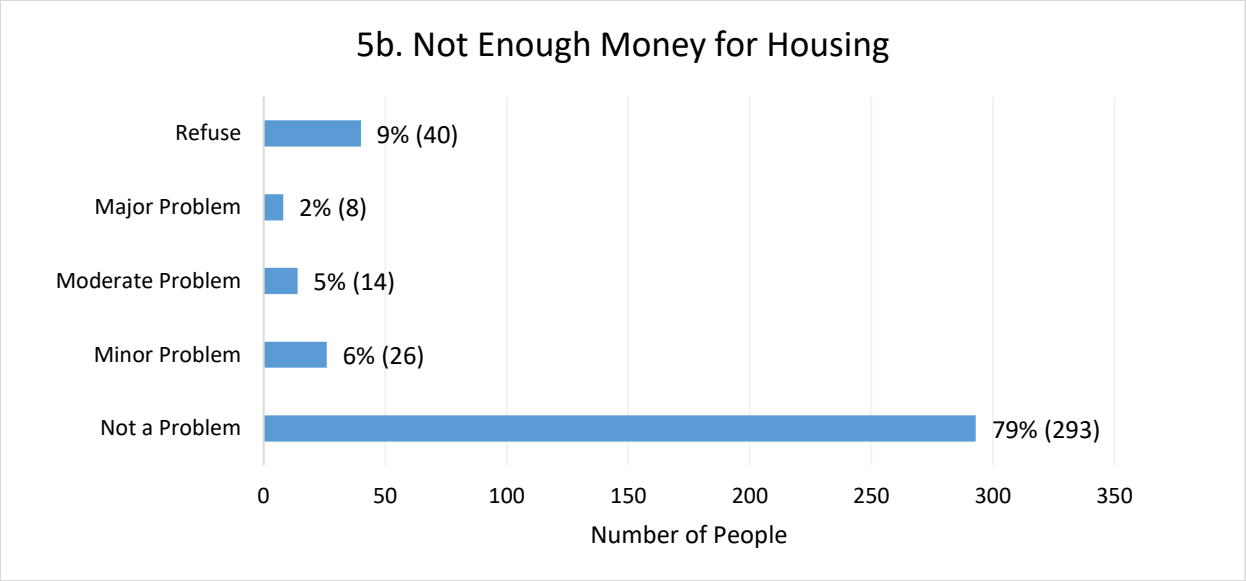
5x. Inadequate Elder Care. 5% of respondents reported that having inadequate elder care was a problem. 79% of respondents reported that having inadequate elder care was not a problem.

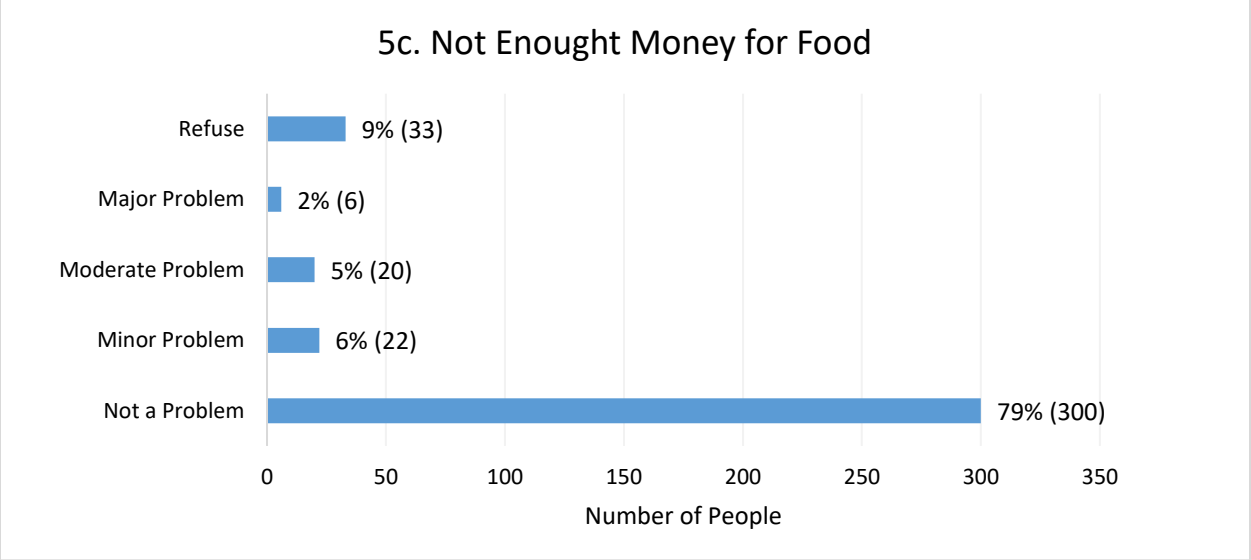
5y. Not Enough Money for Child Care or Preschool. 5% of respondents reported that not having enough money for child care or preschool was a problem. 78% of respondents reported that not having enough money for child care or preschool was not a problem.

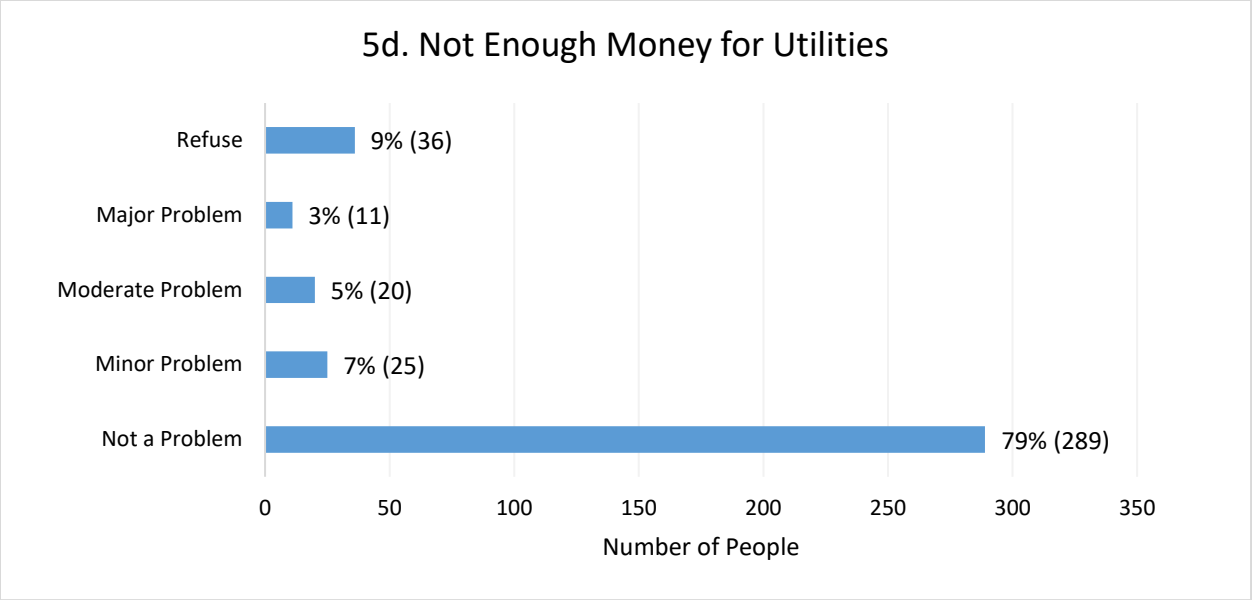
5z. Worry About Future Housing. 8% of respondents reported that worry about future housing was a problem. 82% of respondents reported that worry about future housing was not a problem.

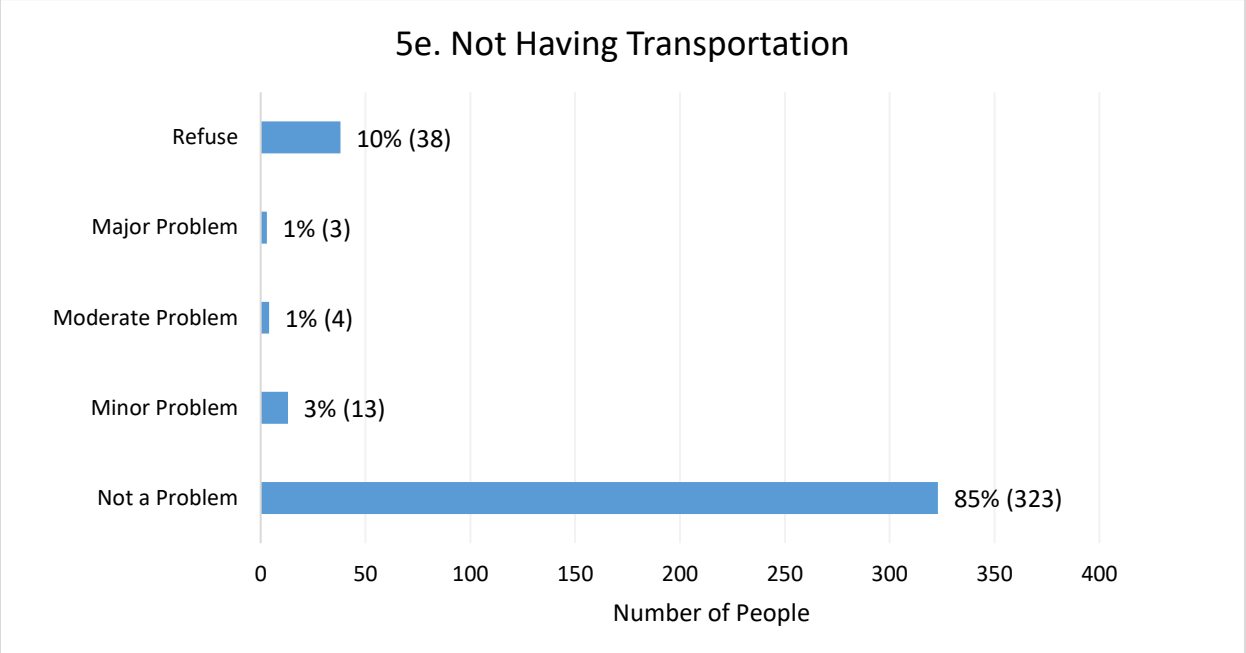
5aa. No Affordable Housing. 4% of respondents reported that no affordable housing was a problem. 84% of respondents reported that no affordable housing was not a problem.

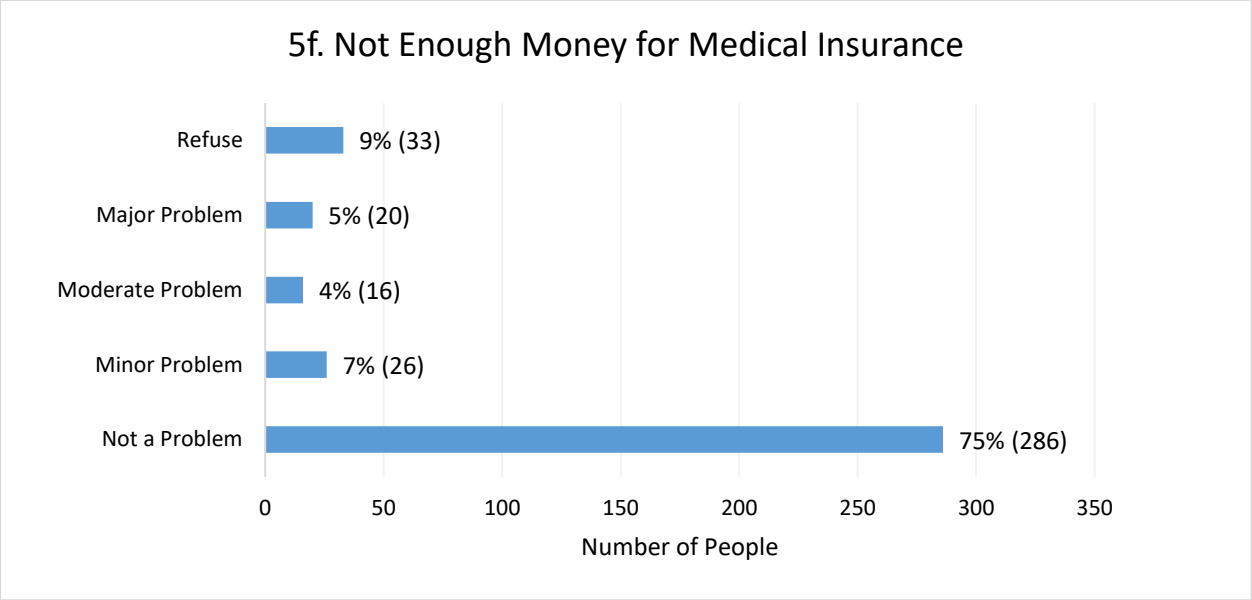

5a. Not Enough...
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Money for Housing
Money for Food
Money for Utilities
Transportation to get to Work
Money for Insurance
Money for Doctor
Money for Rx
Money for Dentist
Problems with being Homeless
Problems Feeling Stressed, Anxious or Depressed
No Help for Stress, Anxiety or Depression
Having Concerns About Someone Else's Alcohol or Drug Use
No Help Available for Someone Else's Alcohol or Drug Use
Having Concerns About Your Alcohol or Drug Use
Help Available for own Alcohol or Drug Use
Not Being Able to Read Well Enough to Fill an Application
Feeling Confident Filling out Med Forms Alone
Don't Comprehend Written Information
Worried About Future Housing
No Affordable Housing
No One to Talk About Personal Problems
Feel Unsafe at Home
Inadequate Child Care
Inadequate Elder Care
Not Enough Money for Child Care or Preschool
Major Problem
Minor Problem
Moderate Problem
Not a Problem
Refuse

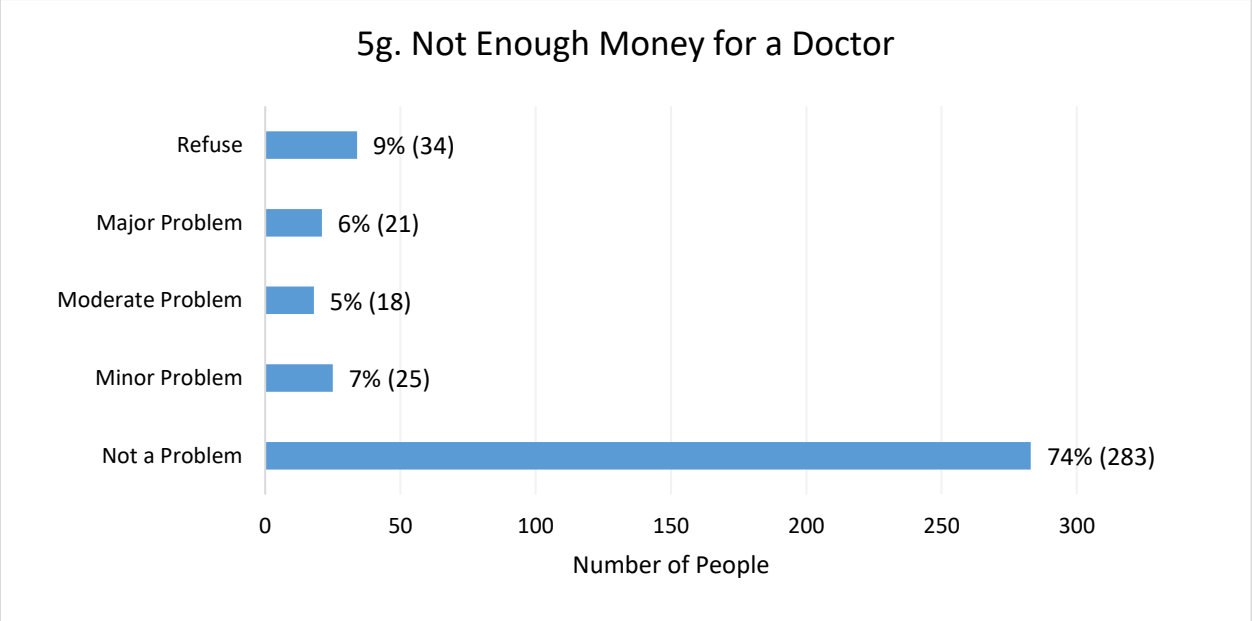

5b. Not Enough Money for Housing
Refuse
9% (40)
Major Problem
2% (8)
Moderate Problem
5% (14)
Minor Problem
6% (26)
Not a Problem
79% (293)
0
50
100
150
200
250
300
350
Number of People

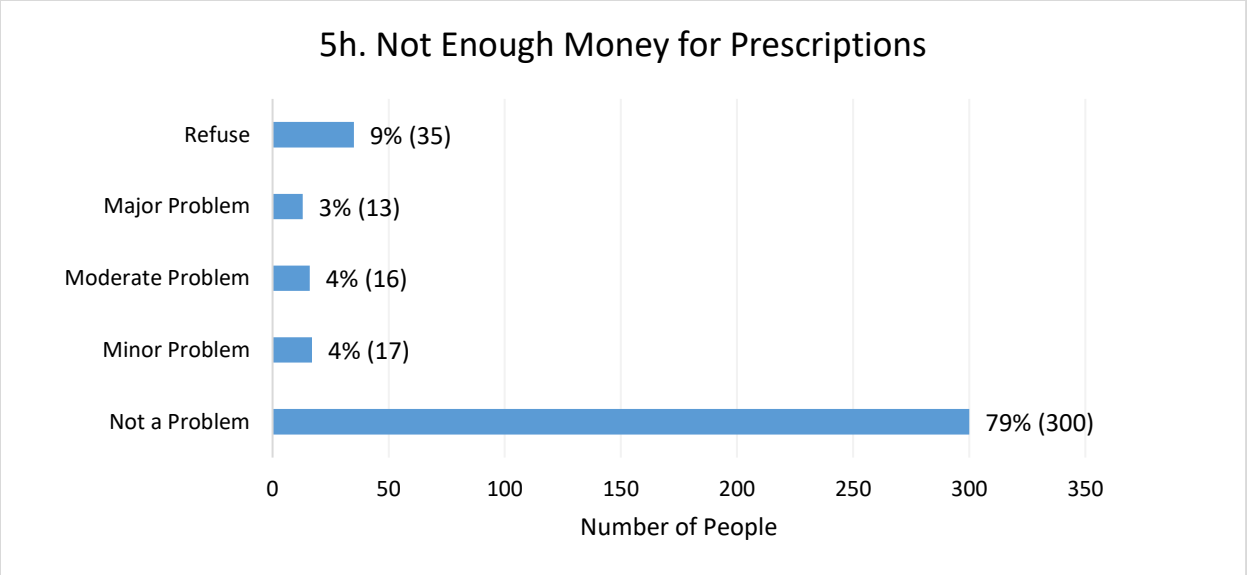

5c. Not Enought Money for Food
Refuse
9% (33)
Major Problem
2% (6)
Moderate Problem
5% (20)
Minor Problem
6% (22)
Not a Problem
79% (300)
0
50
100
150
200
250
300
350
Number of People

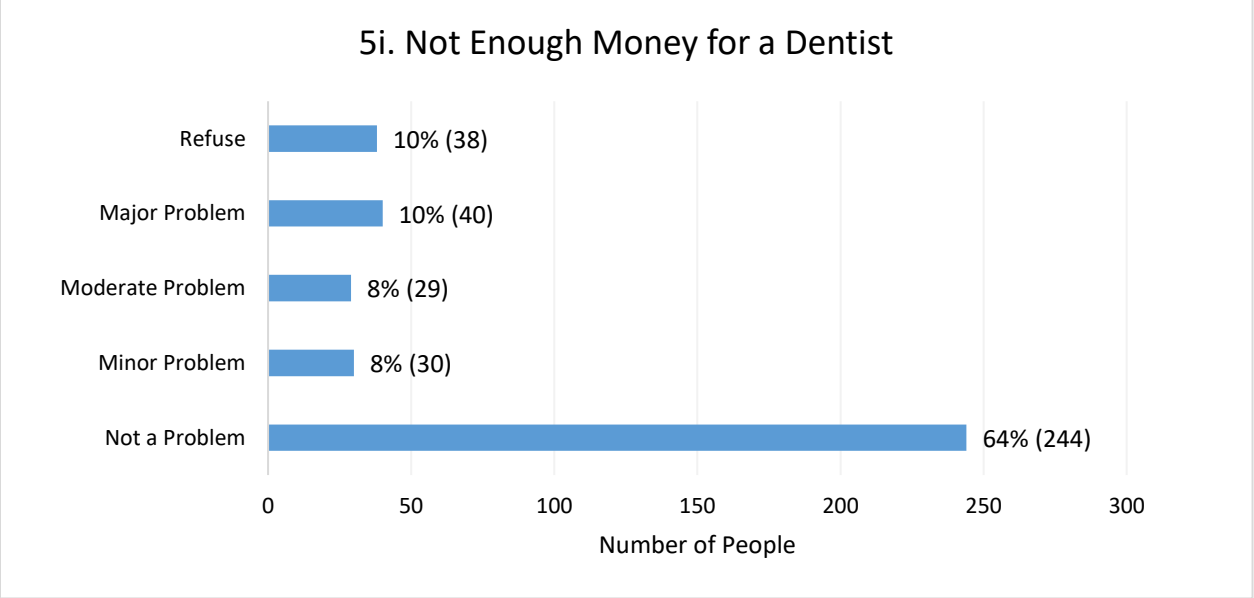

5d. Not Enough Money for Utilities
Refuse
9% (36)
Major Problem
3% (11)
Moderate Problem
5% (20)
Minor Problem
7% (25)
Not a Problem
79% (289)
0
50
100
150
200
250
300
350
Number of People

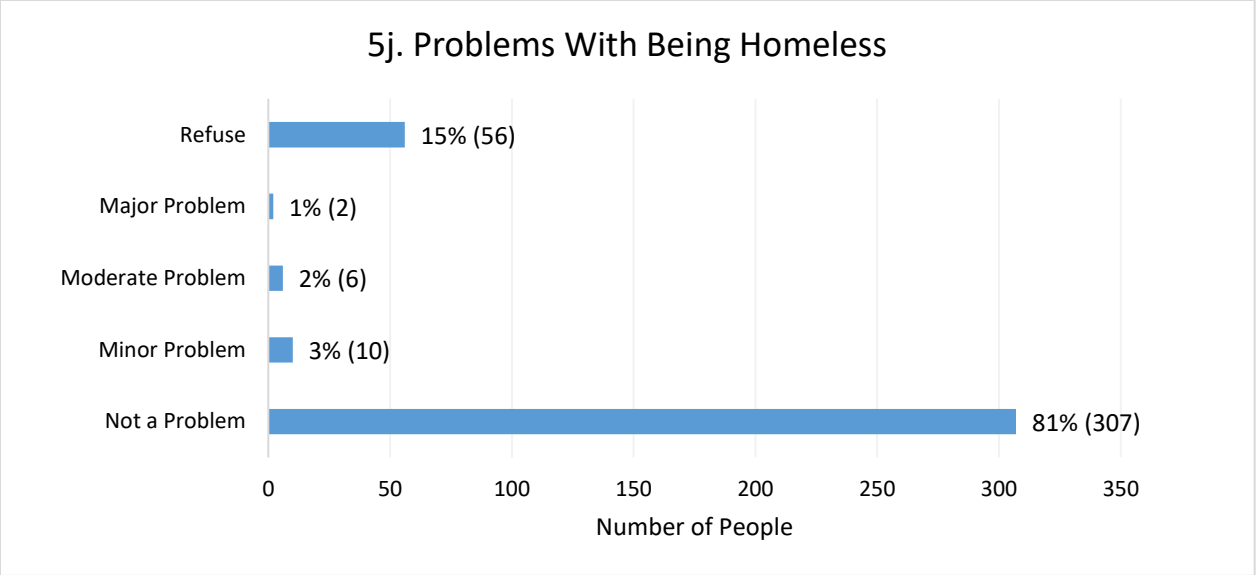

5e. Not Having Transportation
Refuse
10% (38)
Major Problem
1% (3)
Moderate Problem
1% (4)
Minor Problem
3% (13)
Not a Problem
85% (323)
0
50
100
150
200
250
300
350
400
Number of People

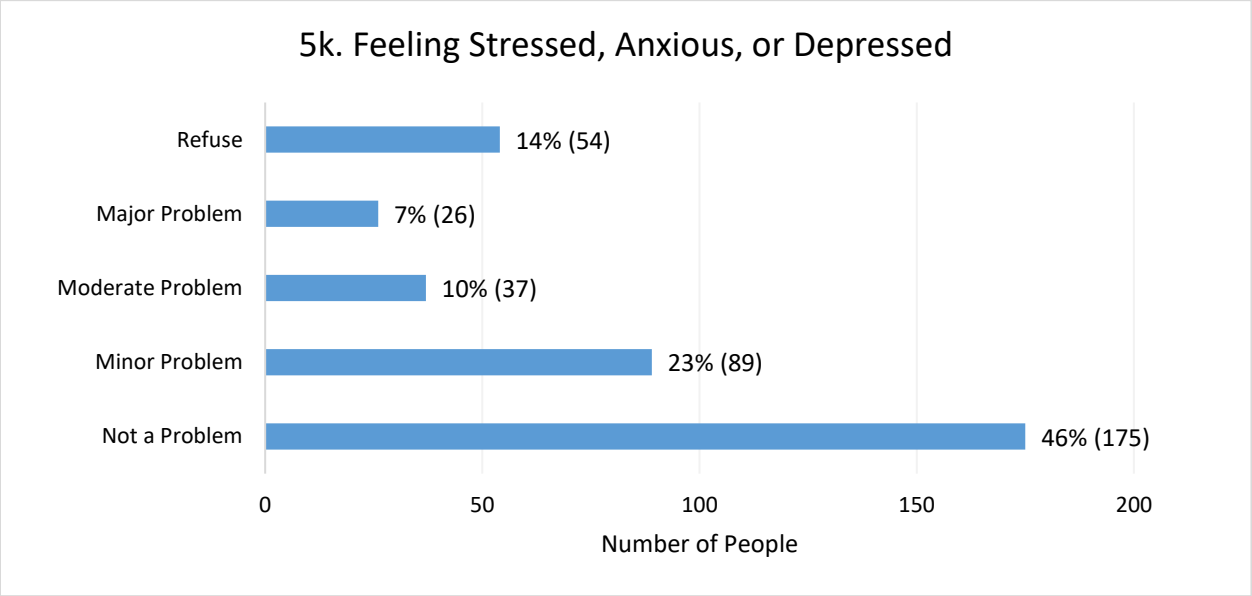

5f. Not Enough Money for Medical Insurance
Refuse
9% (33)
Major Problem
5% (20)
Moderate Problem
4% (16)
Minor Problem
7% (26)
Not a Problem
75% (286)
0
50
100
150
200
250
300
350
Number of People

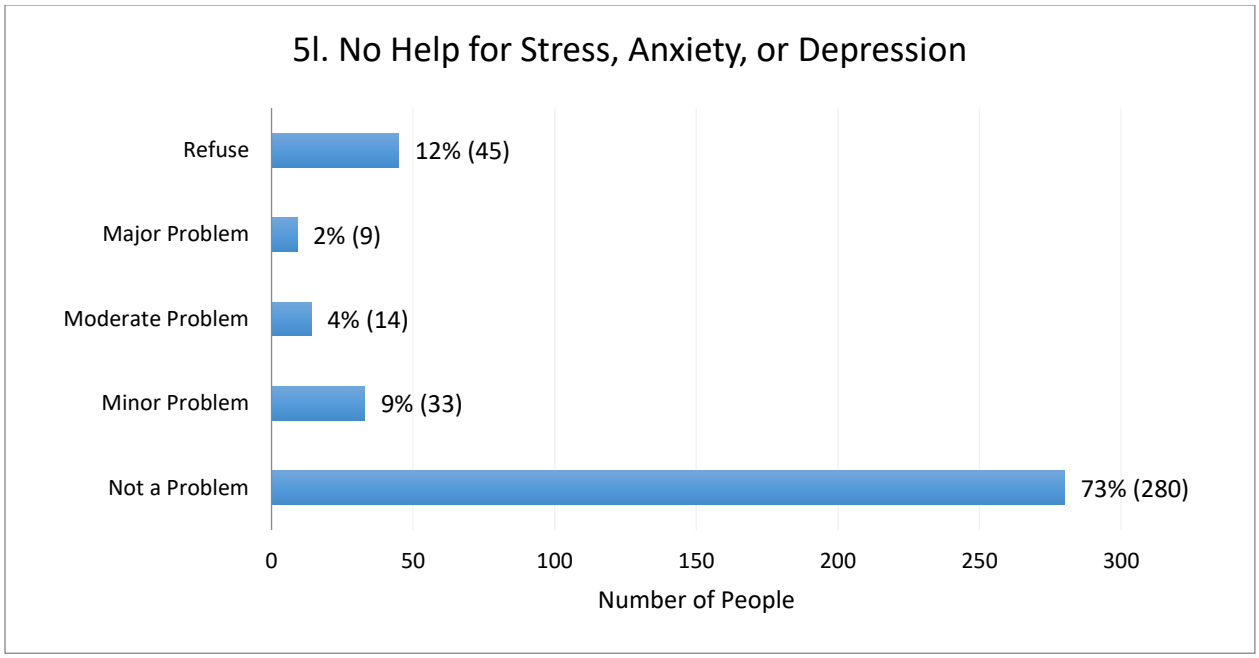

5g. Not Enough Money for a Doctor
Refuse
9% (34)
Major Problem
6% (21)
Moderate Problem
5% (18)
Minor Problem
7% (25)
Not a Problem
74% (283)
0
50
100
150
200
250
300
Number of People

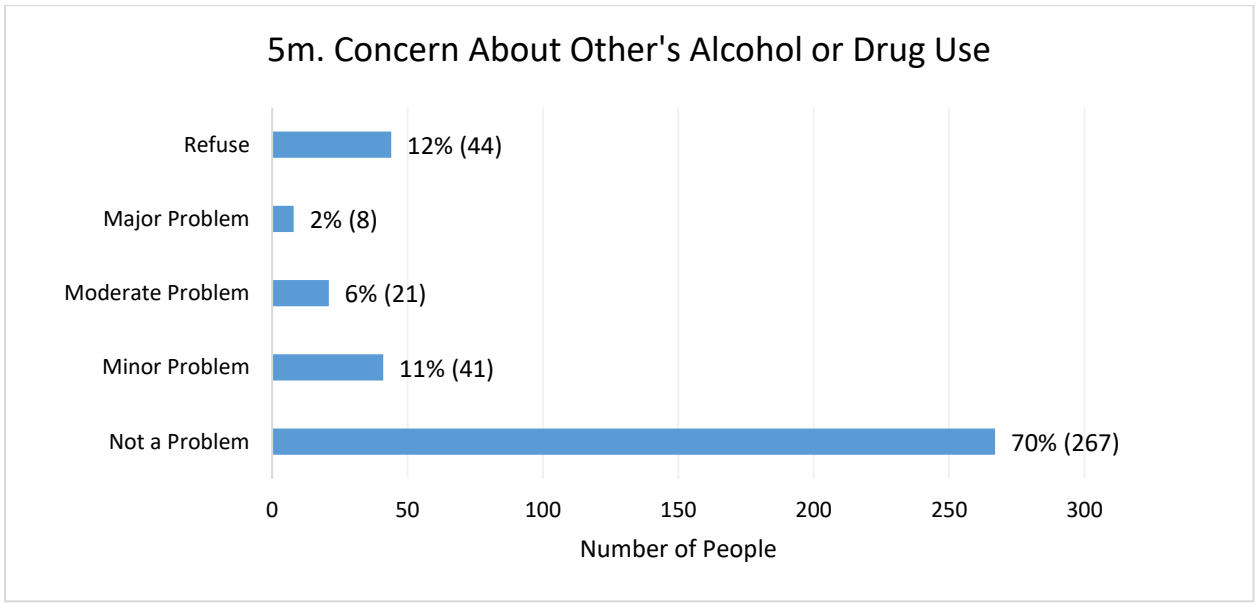

5h. Not Enough Money for Prescriptions
Refuse
9% (35)
Major Problem
3% (13)
Moderate Problem
4% (16)
Minor Problem
4% (17)
Not a Problem
79% (300)
0
50
100
150
200
250
300
350
Number of People

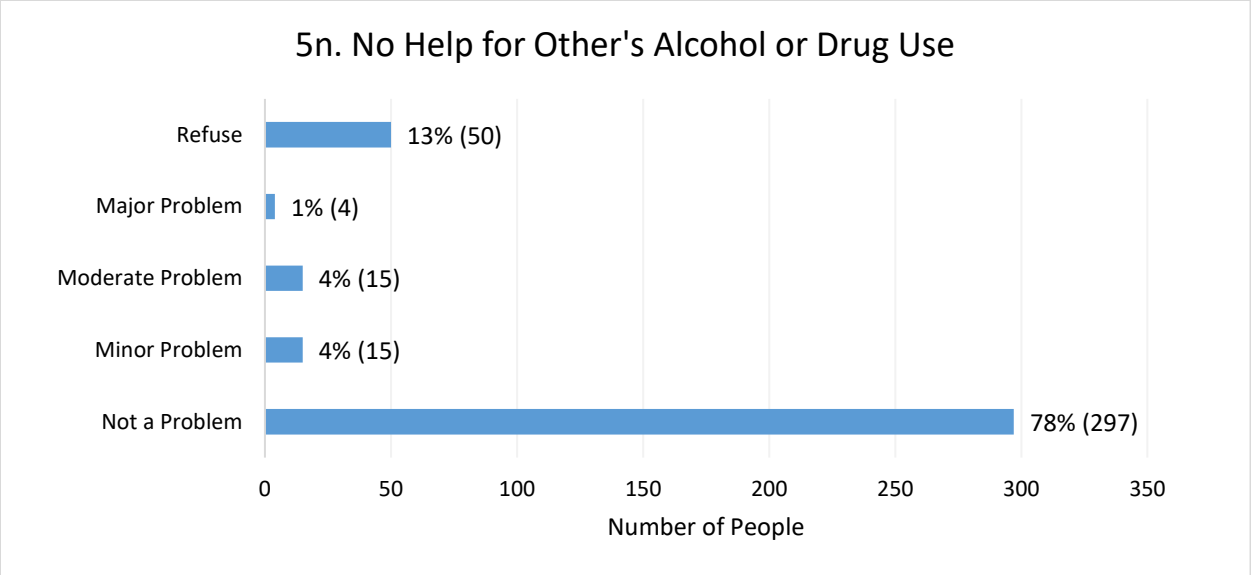

5i. Not Enough Money for a Dentist
Refuse
10% (38)
Major Problem
10% (40)
Moderate Problem
8% (29)
Minor Problem
8% (30)
Not a Problem
64% (244)
0
50
100
150
200
250
300
Number of People

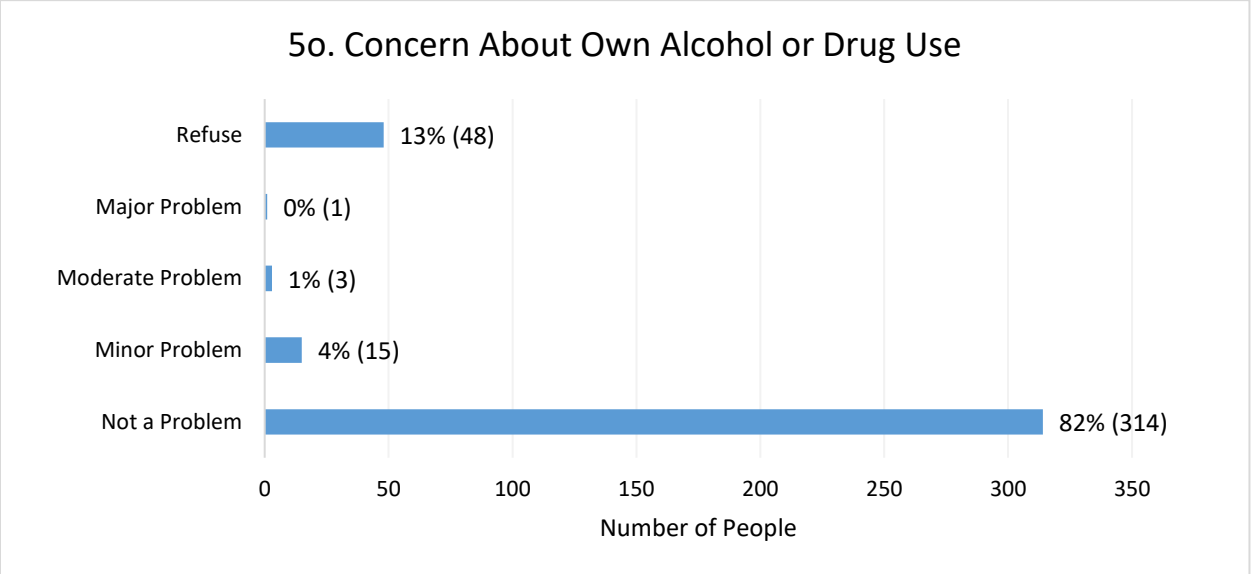

5j. Problems With Being Homeless
Refuse
15% (56)
Major Problem
1% (2)
Moderate Problem
2% (6)
Minor Problem
3% (10)
Not a Problem
81% (307)
0
50
100
150
200
250
300
350
Number of People

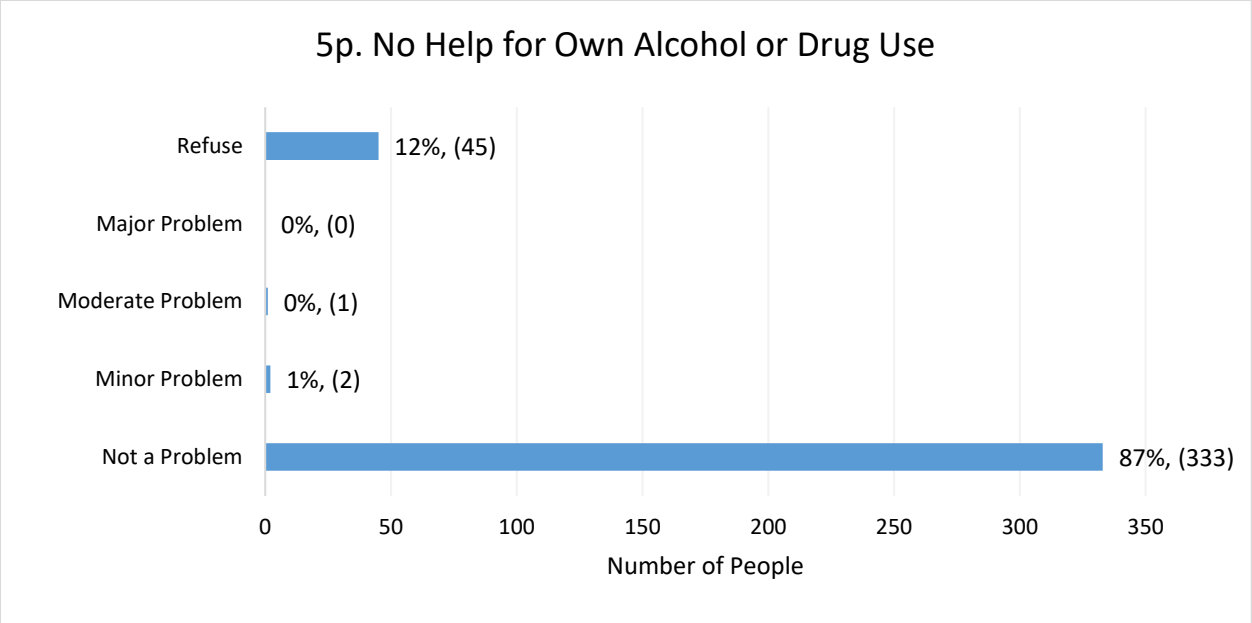

5k. Feeling Stressed, Anxious, or Depressed
Refuse
14% (54)
Major Problem
7% (26)
Moderate Problem
10% (37)
Minor Problem
23% (89)
Not a Problem
46% (175)
0
50
100
150
200
Number of People

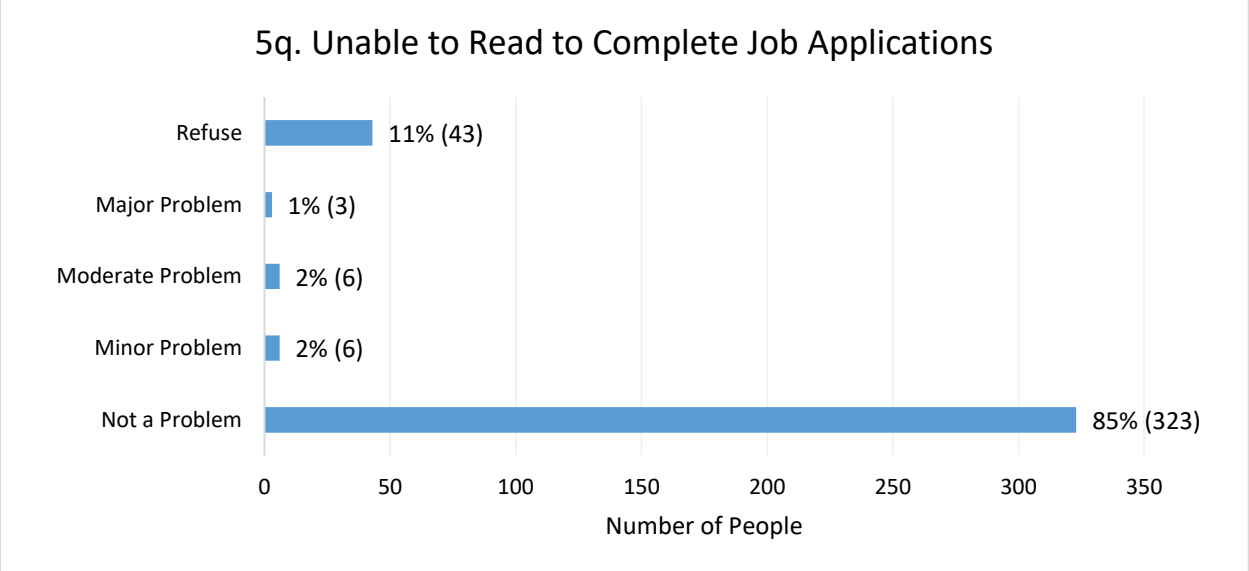

5l. No Help for Stress, Anxiety, or Depression
Refuse
12% (45)
Major Problem
2% (9)
Moderate Problem
4% (14)
Minor Problem
9% (33)
Not a Problem
73% (280)
0
50
100
150
200
250
300
Number of People

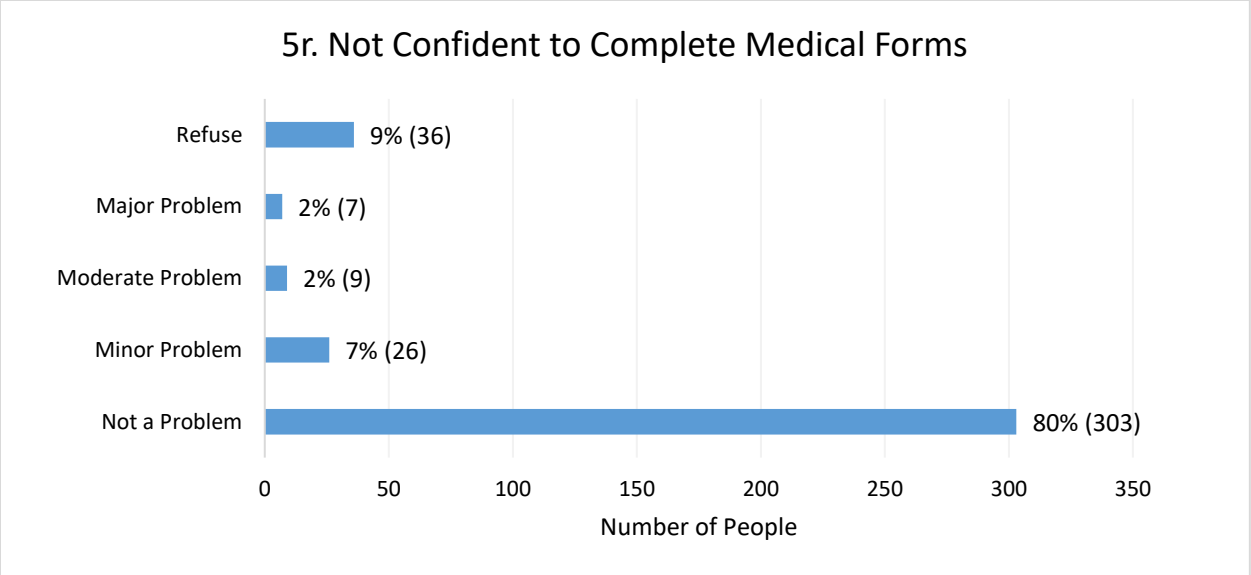

5m. Concern About Other's Alcohol or Drug Use
Refuse
12% (44)
Major Problem
2% (8)
Moderate Problem
6% (21)
Minor Problem
11% (41)
Not a Problem
70% (267)
0
50
100
150
200
250
300
Number of People

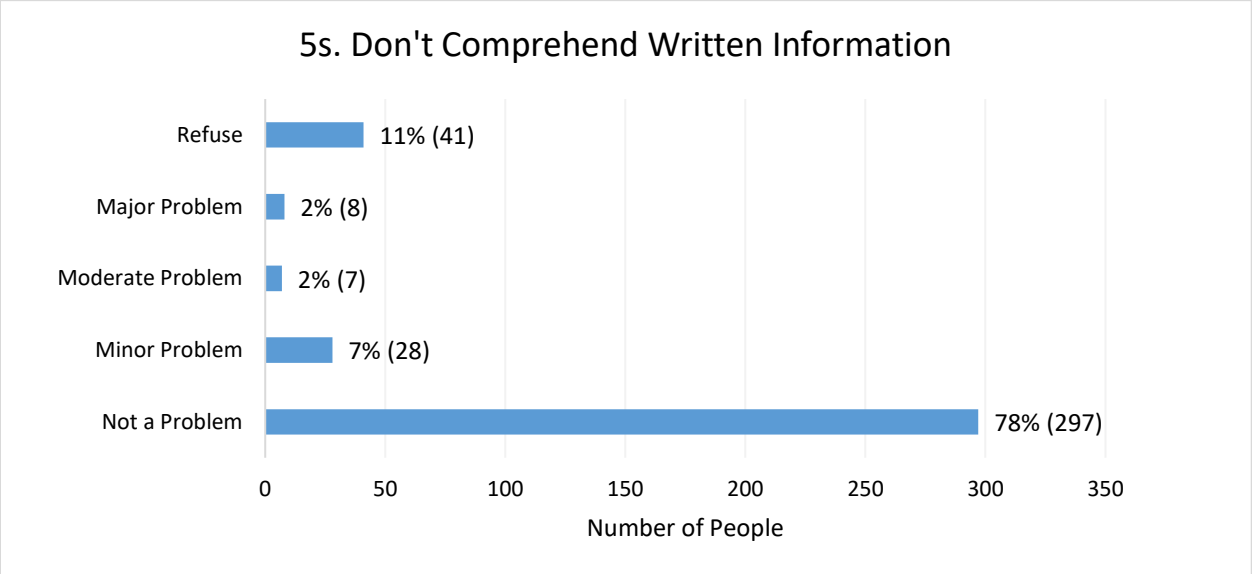

5n. No Help for Other's Alcohol or Drug Use
Refuse
13% (50)
Major Problem
1% (4)
Moderate Problem
4% (15)
Minor Problem
4% (15)
Not a Problem
78% (297)
0
50
100
150
200
250
300
350
Number of People

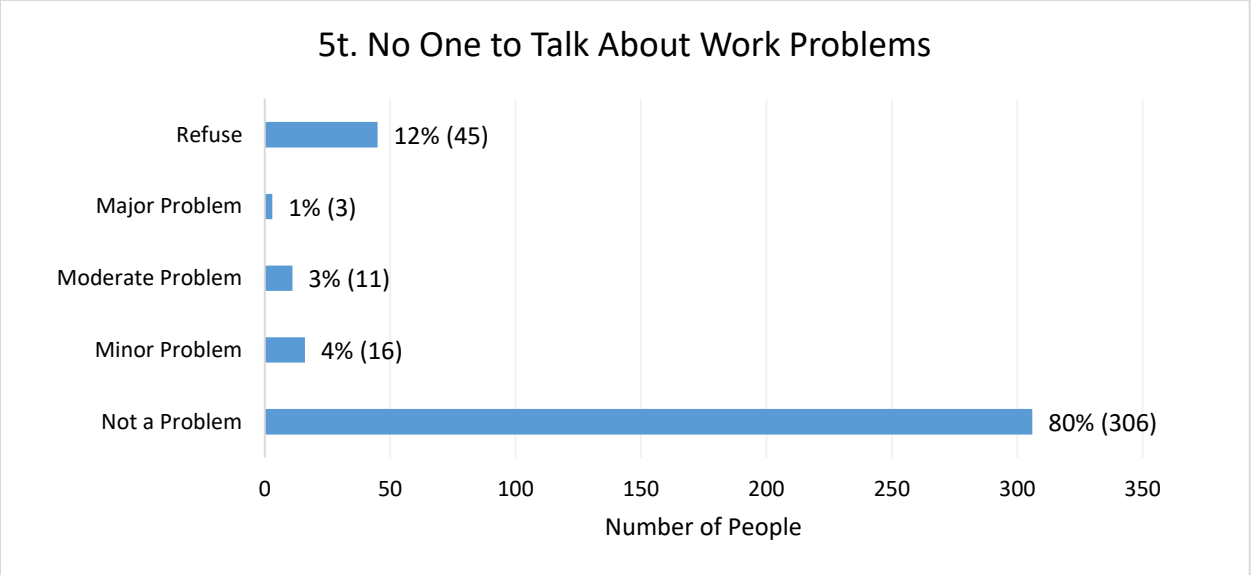

5o. Concern About Own Alcohol or Drug Use
Refuse
13% (48)
Major Problem
0% (1)
Moderate Problem
1% (3)
Minor Problem
4% (15)
Not a Problem
82% (314)
0
50
100
150
200
250
300
350
Number of People

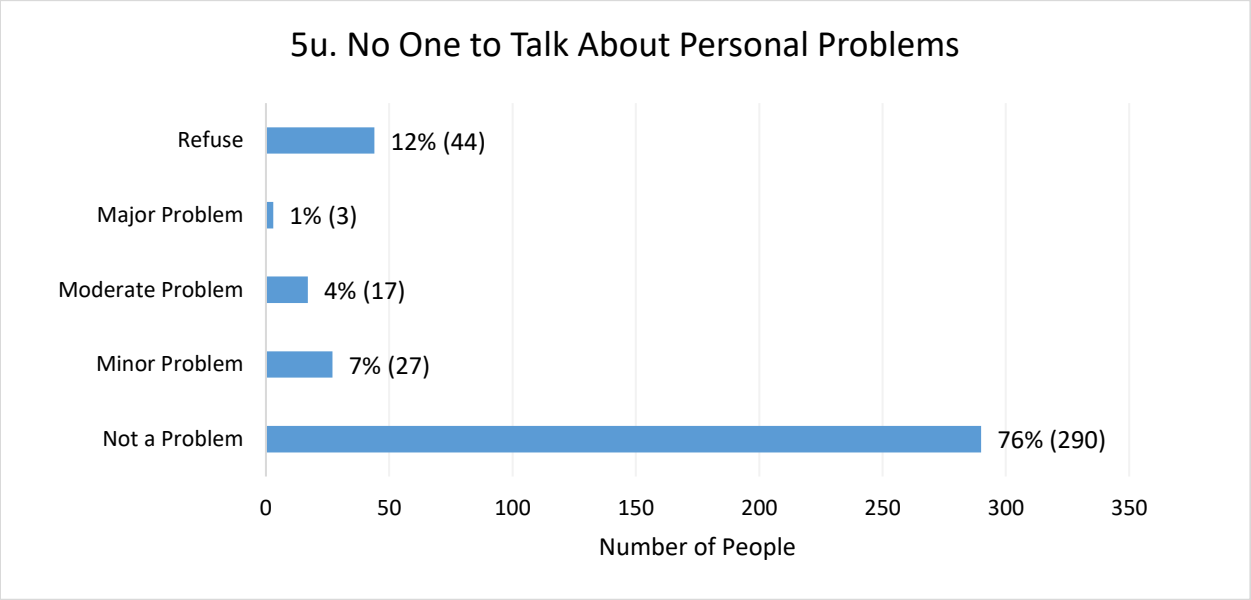

5p. No Help for Own Alcohol or Drug Use
Refuse
Major Problem
Moderate Problem
Minor Problem
Not a Problem
12%, (45)
0%, (0)
0%, (1)
1%, (2)
87%, (333)
0
50
100
150
200
250
300
350
Number of People

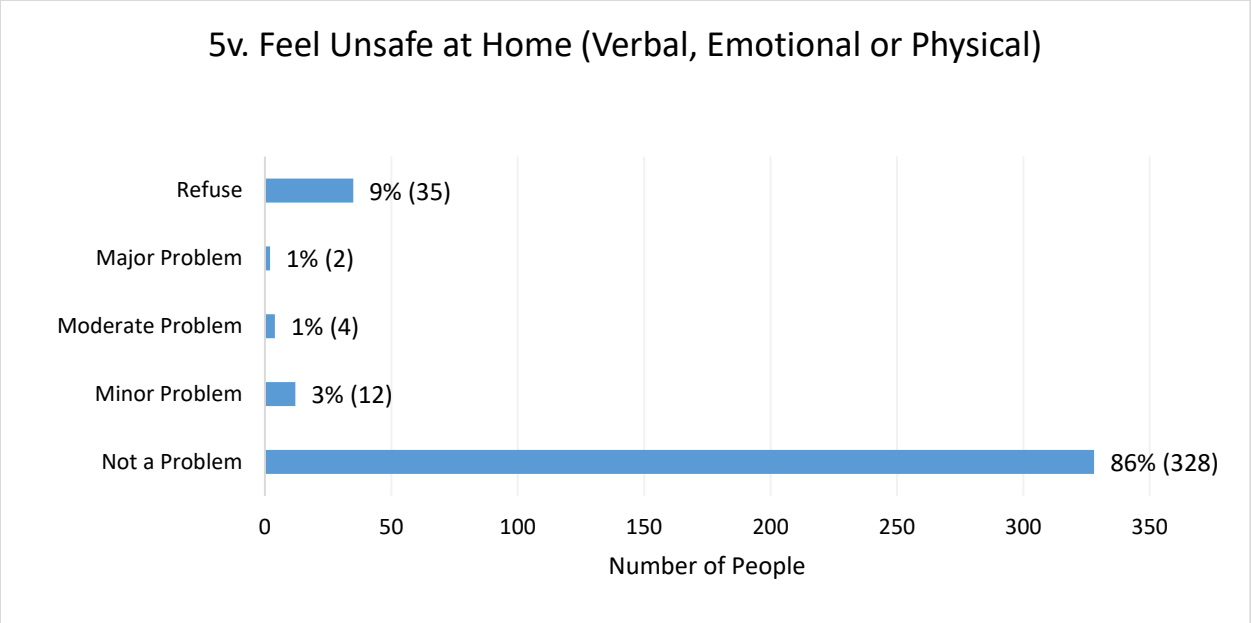

5q. Unable to Read to Complete Job Applications
Refuse
Major Problem
Moderate Problem
Minor Problem
Not a Problem
11% (43)
1% (3)
2% (6)
2% (6)
85% (323)
0
50
100
150
200
250
300
350
Number of People

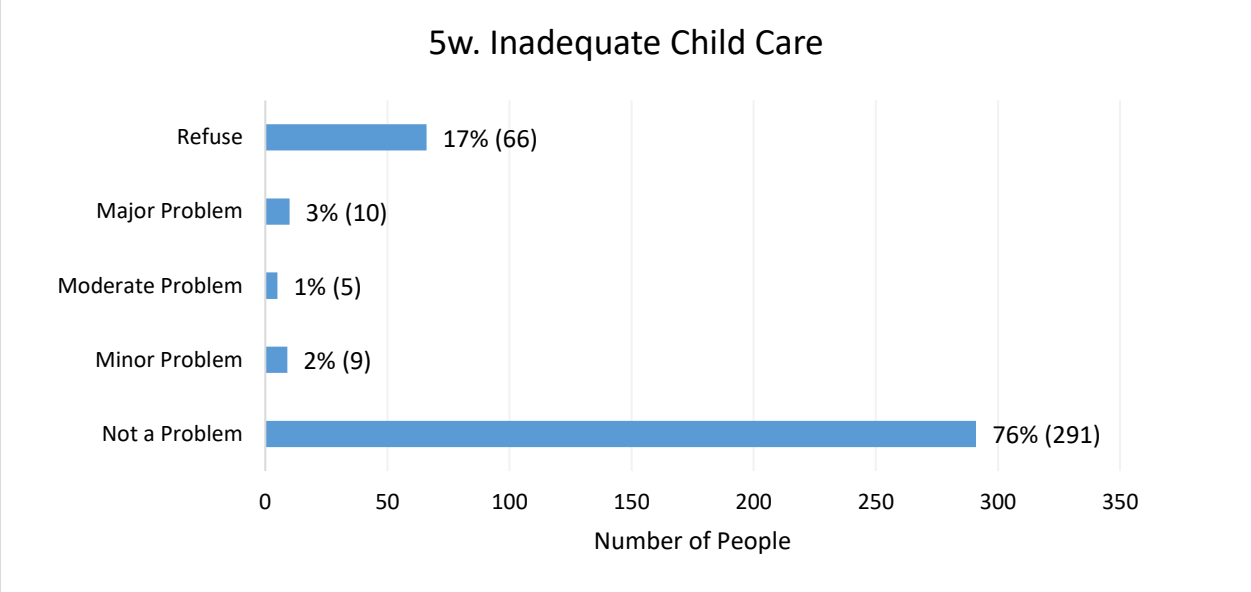

5r. Not Confident to Complete Medical Forms
Refuse
9% (36)
Major Problem
2% (7)
Moderate Problem
2% (9)
Minor Problem
7% (26)
Not a Problem
80% (303)
0
50
100
150
200
250
300
350
Number of People

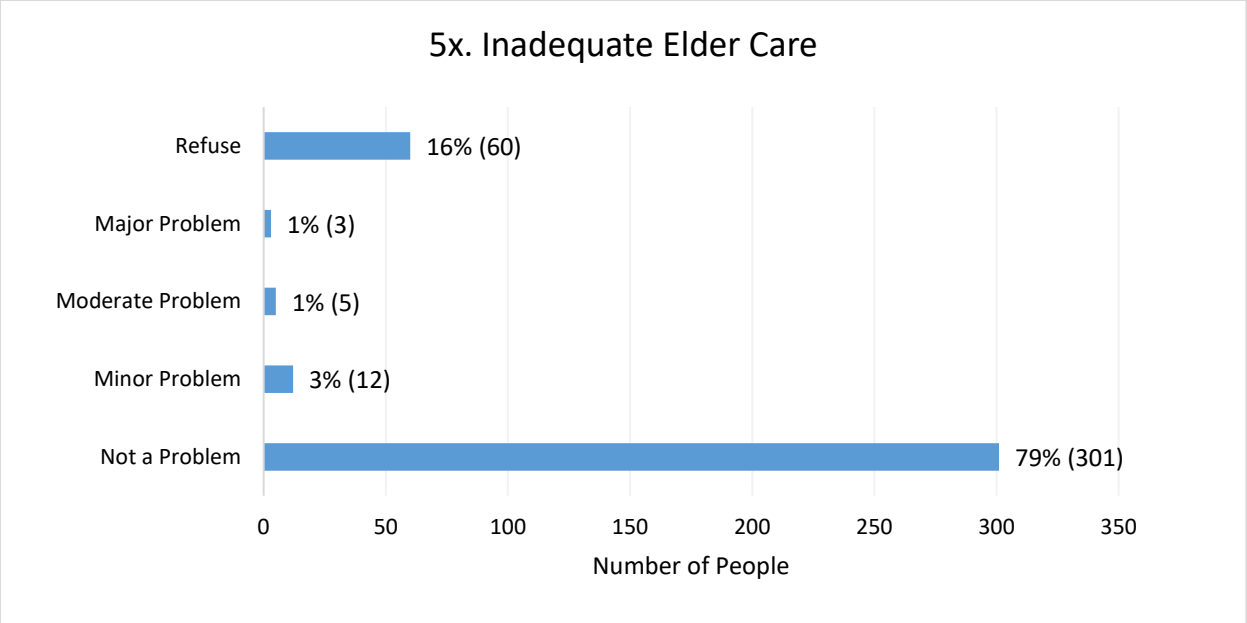

5s. Don't Comprehend Written Information
Refuse
11% (41)
Major Problem
2% (8)
Moderate Problem
2% (7)
Minor Problem
7% (28)
Not a Problem
78% (297)
0
50
100
150
200
250
300
350
Number of People

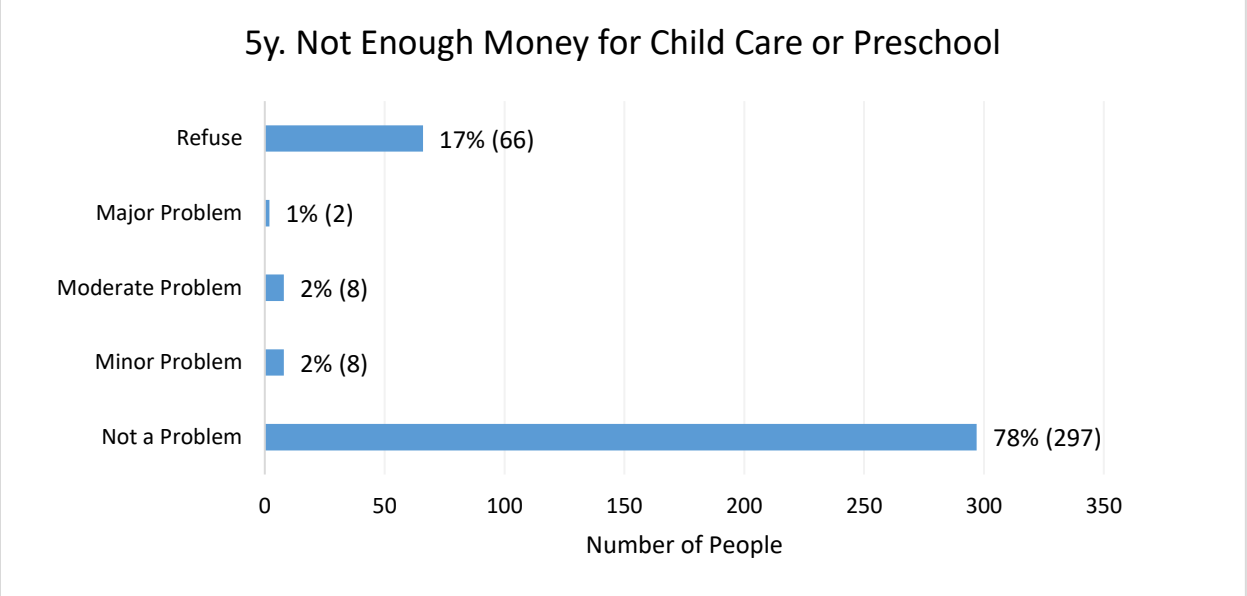

5t. No One to Talk About Work Problems
Refuse
Major Problem
Moderate Problem
Minor Problem
Not a Problem
12% (45)
1% (3)
3% (11)
4% (16)
80% (306)
0
50
100
150
200
250
300
350
Number of People

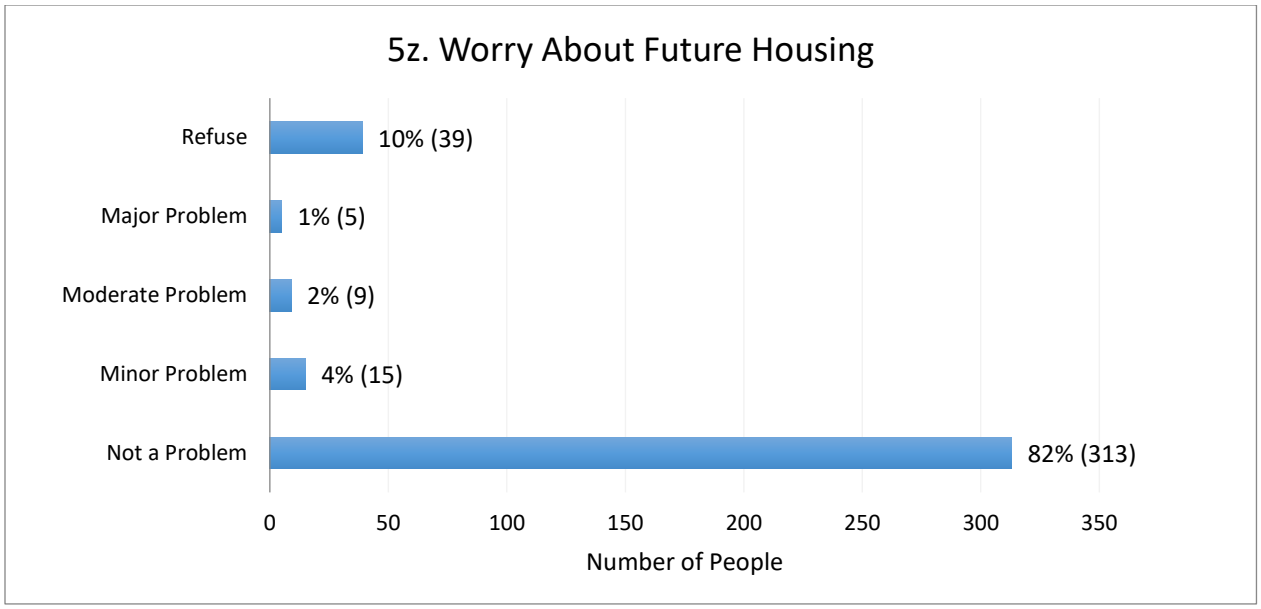

5u. No One to Talk About Personal Problems
Refuse
Major Problem
Moderate Problem
Minor Problem
Not a Problem
12% (44)
1% (3)
4% (17)
7% (27)
76% (290)
0
50
100
150
200
250
300
350
Number of People

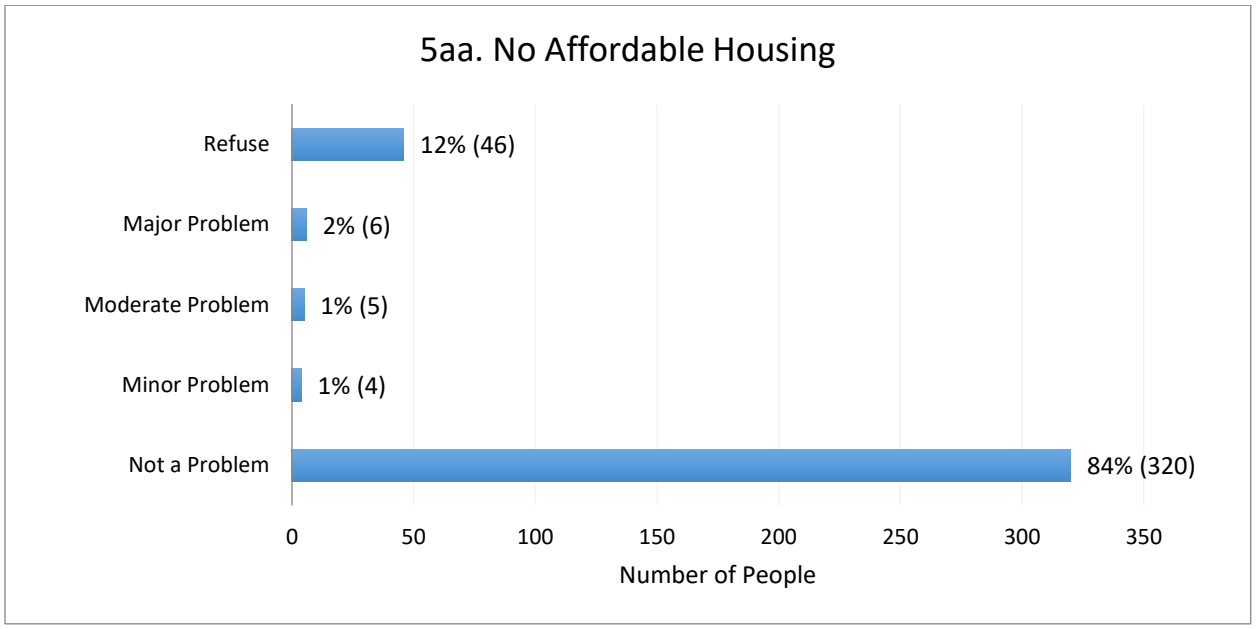

5v. Feel Unsafe at Home (Verbal, Emotional or Physical)
Refuse
9% (35)
Major Problem
1% (2)
Moderate Problem
1% (4)
Minor Problem
3% (12)
Not a Problem
86% (328)
0
50
100
150
200
250
300
350
Number of People


5w. Inadequate Child Care
Refuse
17% (66)
Major Problem
3% (10)
Moderate Problem
1% (5)
Minor Problem
2% (9)
Not a Problem
76% (291)
0
50
100
150
200
250
300
350
Number of People


5x. Inadequate Elder Care
Refuse
16% (60)
Major Problem
1% (3)
Moderate Problem
1% (5)
Minor Problem
3% (12)
Not a Problem
79% (301)
0
50
100
150
200
250
300
350
Number of People


5y. Not Enough Money for Child Care or Preschool
Refuse
17% (66)
Major Problem
1% (2)
Moderate Problem
2% (8)
Minor Problem
2% (8)
Not a Problem
78% (297)
0
50
100
150
200
250
300
350
Number of People


5z. Worry About Future Housing
Refuse
10% (39)
Major Problem
1% (5)
Moderate Problem
2% (9)
Minor Problem
4% (15)
Not a Problem
82% (313)
0
50
100
150
200
250
300
350
Number of People


5aa. No Affordable Housing
Refuse
12% (46)
Major Problem
2% (6)
Moderate Problem
1% (5)
Minor Problem
1% (4)
Not a Problem
84% (320)
0
50
100
150
200
250
300
350
Number of People

Detailed Charts Section 6: Social Needs

6a. Wanted Services. Of the needs summarized in this chart, more respondents reported that they needed more affordable places to buy food than any other service. The fewest respondents felt that they needed more parenting education and support.

6b. Parenting Education and Support. 55% of respondents felt that parenting education and support services were fine as is. 5% of respondents wanted more of these services, and 12% felt that they needed less of these services.

6c. Affordable Place to Exercise. 50% of respondents felt that affordable places to exercise were fine as is. 26% of respondents wanted more of these services, and 7% felt that they needed less of these services.

6d. Affordable Place to Exercise. 43% of respondents felt that affordable places to buy healthy food were fine as is. 37% of respondents wanted more of these services, and 4% felt that they needed less of these services.

6e. Connection with Social Activities. 59% of respondents felt that connections with social activities were fine as is. 22% of respondents wanted more of these services, and 4% felt that they needed less of these services.

6f. Family Connection. 64% of respondents felt that their access to family connections were fine as is. 17% of respondents wanted more of these services, and 3% felt that they needed less of these services.

6f. Sense of Meaning and Purpose. 64% of respondents felt that their access to a sense of meaning and purpose was fine as is. 16% of respondents wanted more of these services, and 4% felt that they needed less of these services.

6h. Opportunities to Develop Spiritual Life. 60% of respondents felt that opportunities to develop spiritual life were fine as is. 10% of respondents wanted more of these services, and 5% felt that they needed less of these services.

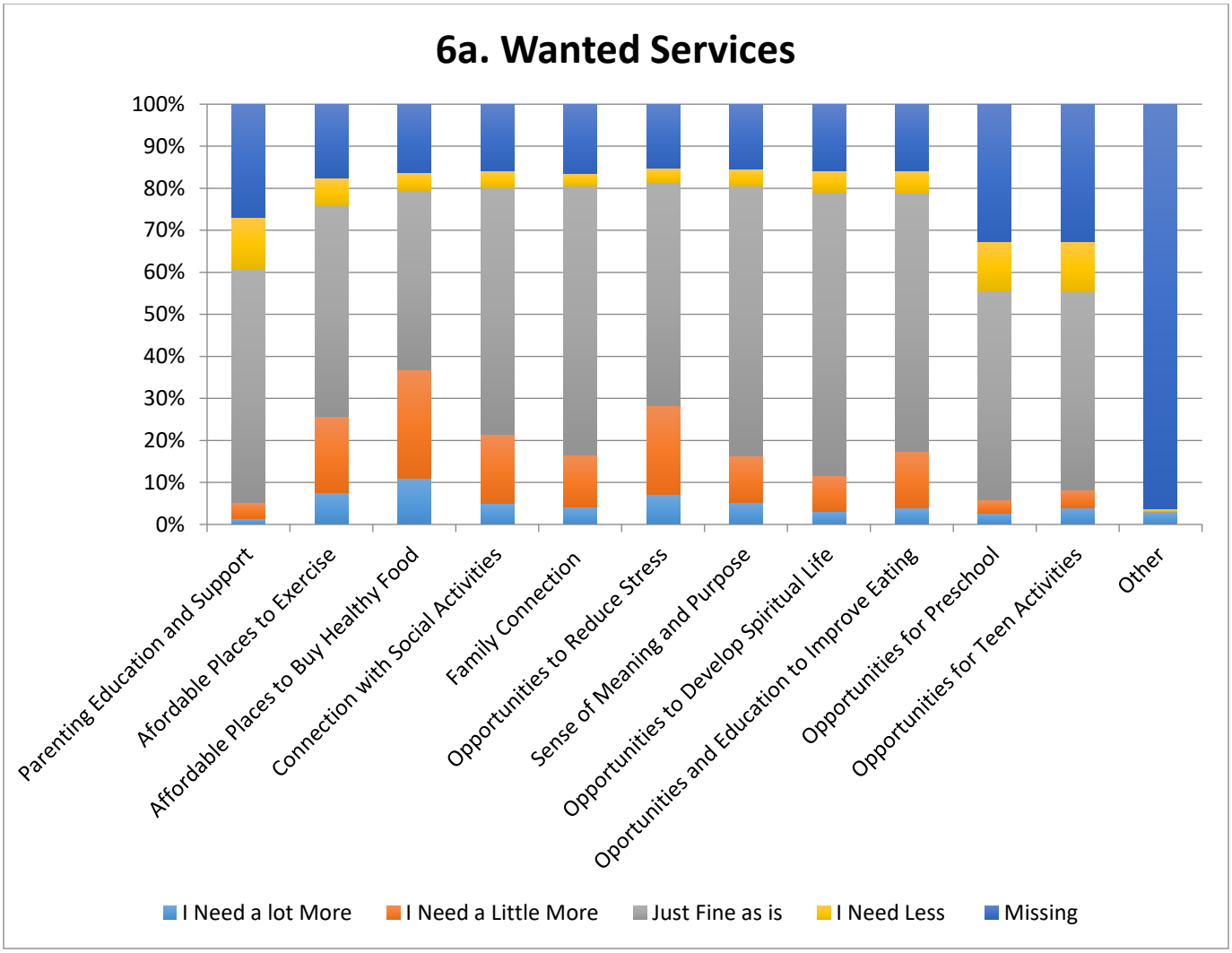
6i. Opportunities to Reduce Stress. 53% of respondents felt that opportunities to reduce stress were fine as is. 28% of respondents wanted more of these services, and 3% felt that they needed less of these services.

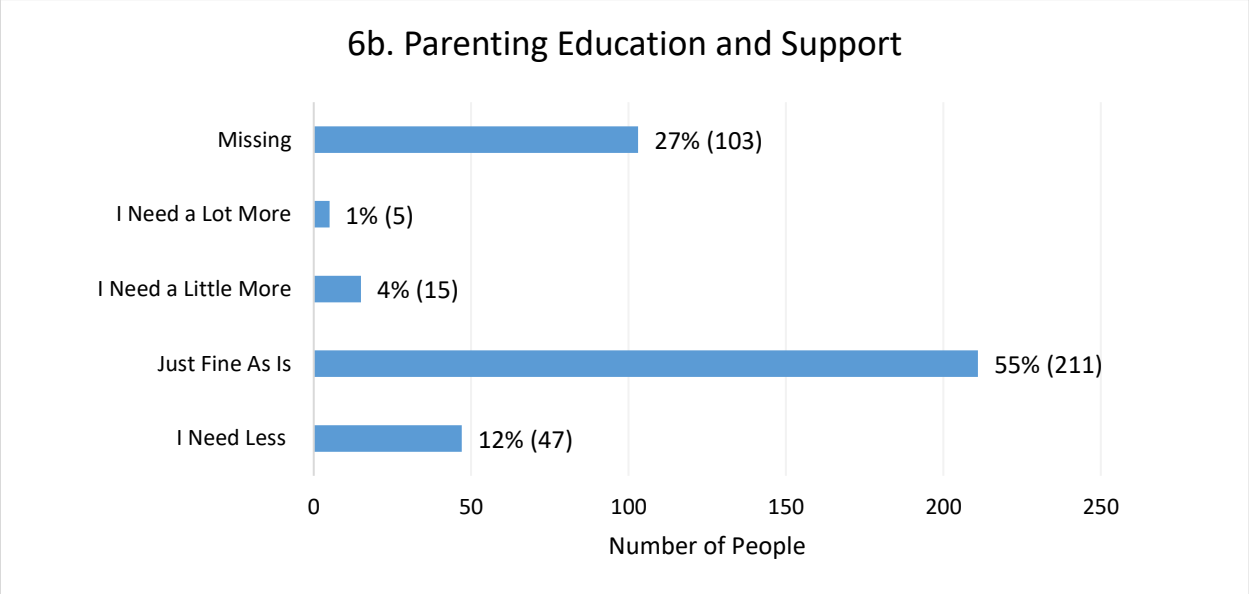
6h. Opportunities and Education to Improve Eating. 61% of respondents felt that opportunities and education to improve eating were fine as is. 17% of respondents wanted more of these services, and 6% felt that they needed less of these services.

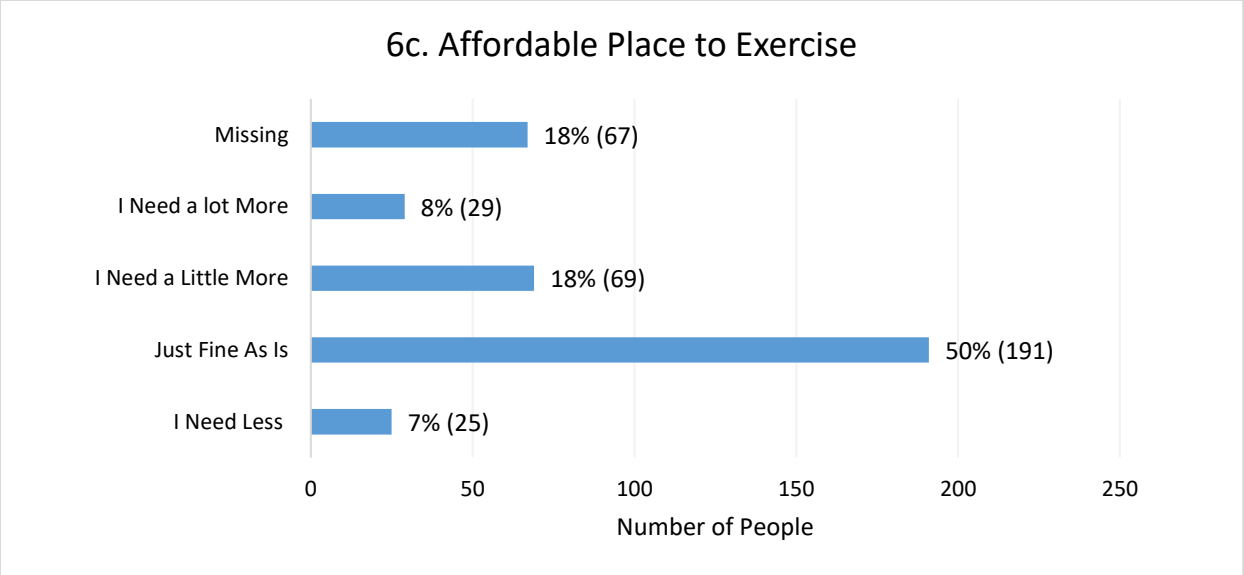
6h. Opportunities for Preschool. 50% of respondents felt that opportunities for preschool were fine as is. 6% of respondents wanted more of these services, and 12% felt that they needed less of these services.

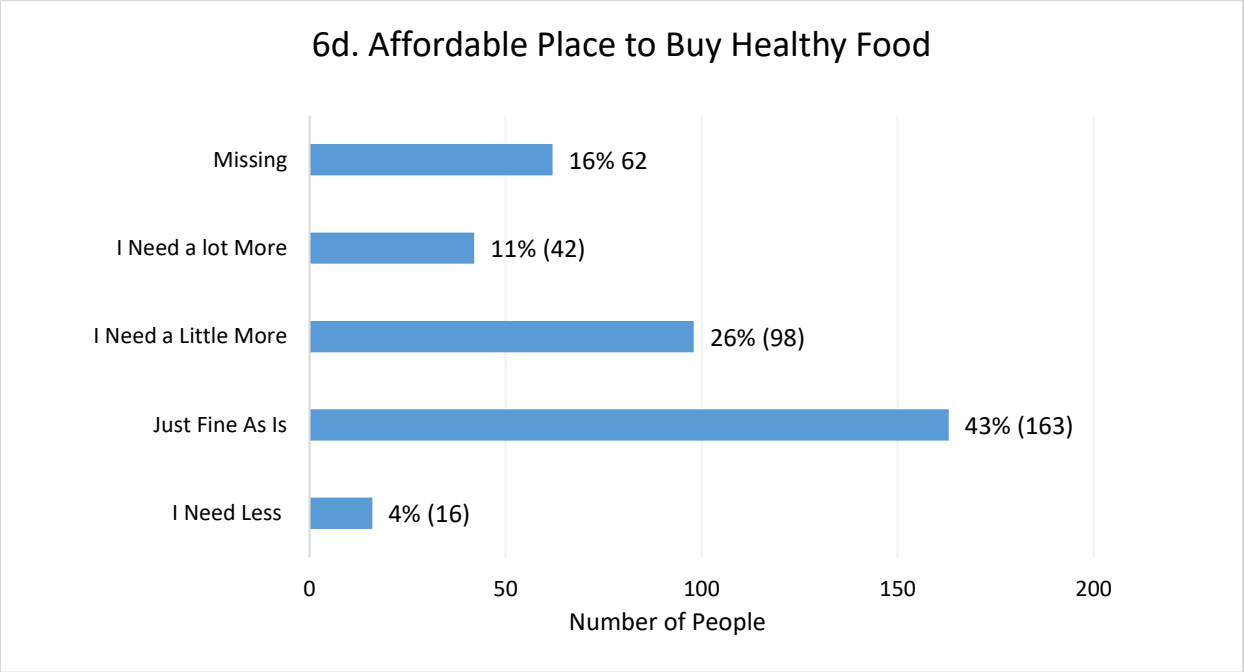
6l. Opportunities for Teen Activities. 47% of respondents felt that opportunities for teen activities were fine as is. 8% of respondents wanted more of these services, and 12% felt that they needed less of these services.

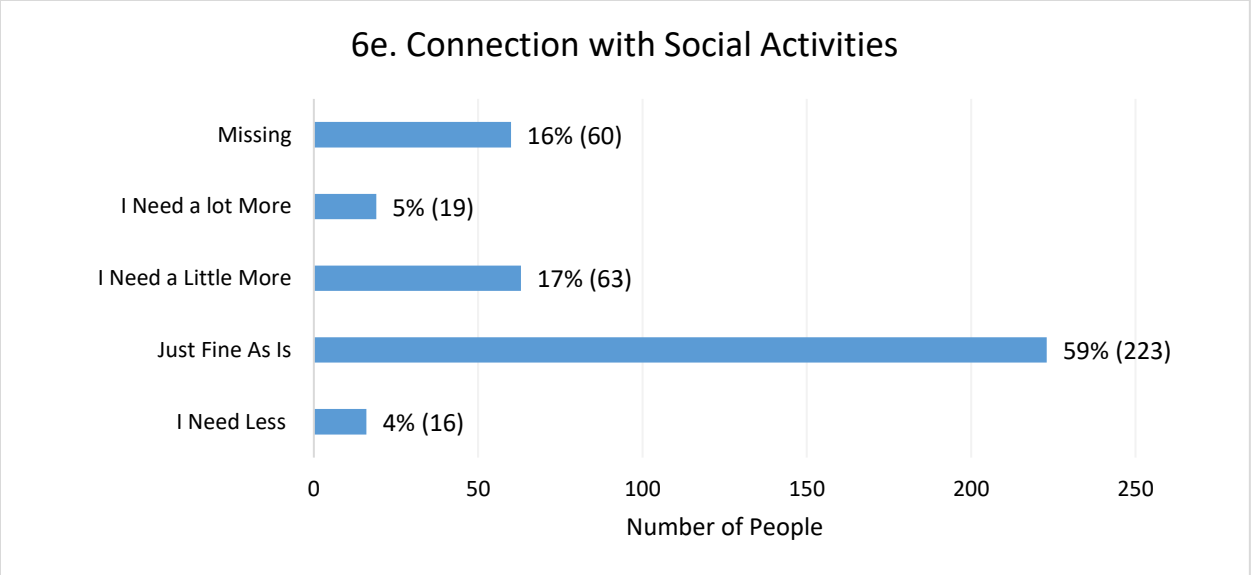
6h. Other Activities. The majority of respondents (96%) did not answer this question. 3% said that they needed more of this service, and 1% said that they needed less of this service.

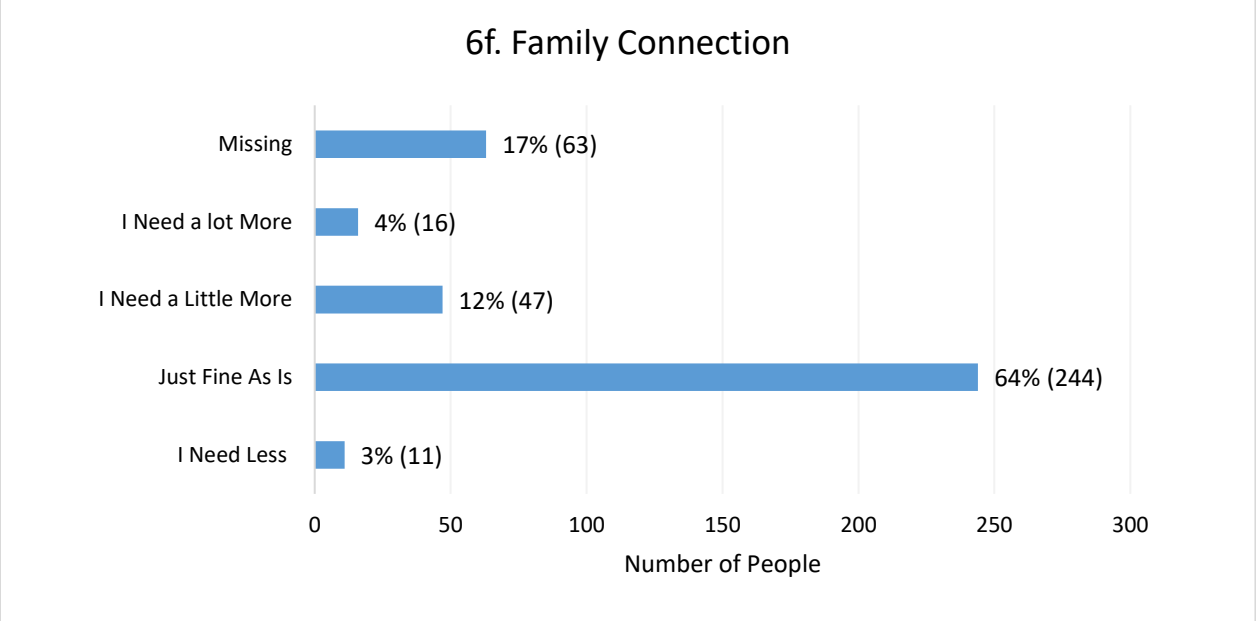

6a. Wanted Services
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Parenting Education and Support
Afordable Places to Exercise
Affordable Places to Buy Healthy Food
Connection with Social Activities
Family Connection
Opportunities to Reduce Stress
Sense of Meaning and Purpose
Opportunities to Develop Spiritual Life
Oportunities and Education to Improve Eating
Opportunities for Preschool
Opportunities for Teen Activities
Other
I Need a lot More
I Need a Little More
Just Fine as is
I Need Less
Missing

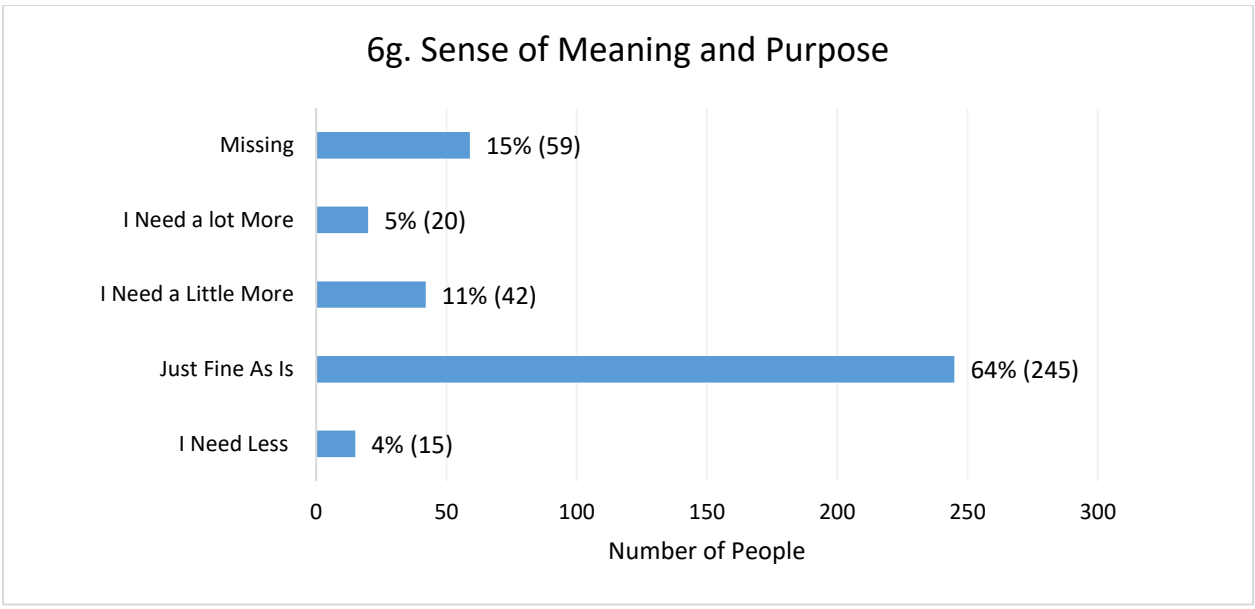

6b. Parenting Education and Support
Missing
27% (103)
I Need a Lot More
1% (5)
I Need a Little More
4% (15)
Just Fine As Is
55% (211)
I Need Less
12% (47)
0
50
100
150
200
250
Number of People

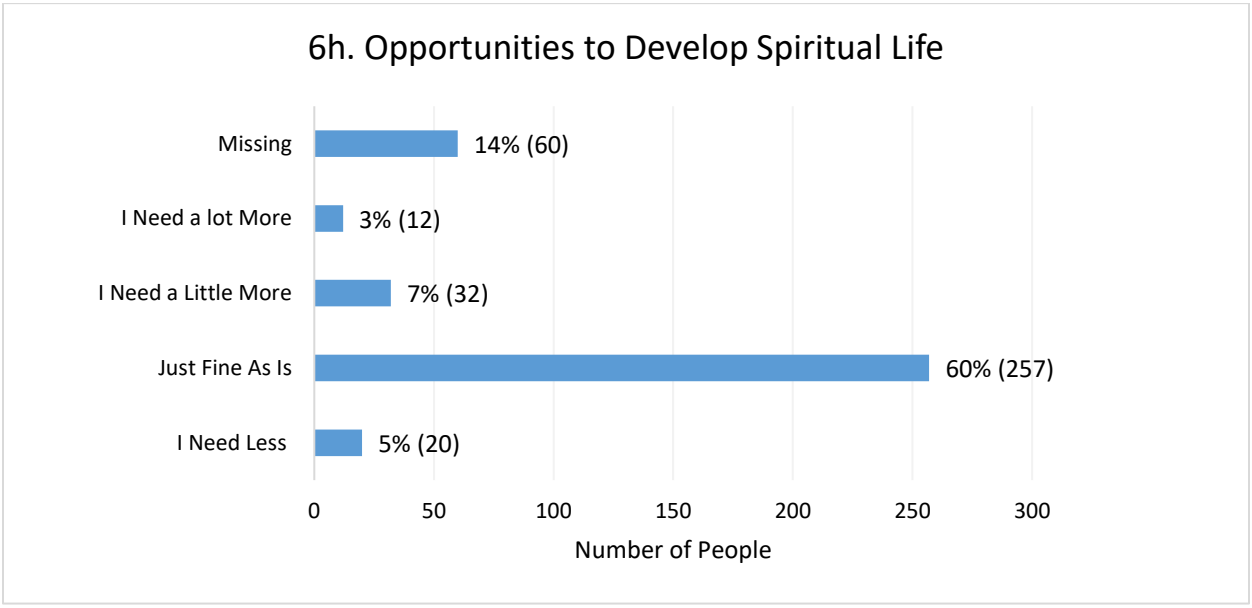

6c. Affordable Place to Exercise
Missing
I Need a lot More
I Need a Little More
Just Fine As Is
I Need Less
18% (67)
8% (29)
18% (69)
50% (191)
7% (25)
0
50
100
150
200
250
Number of People

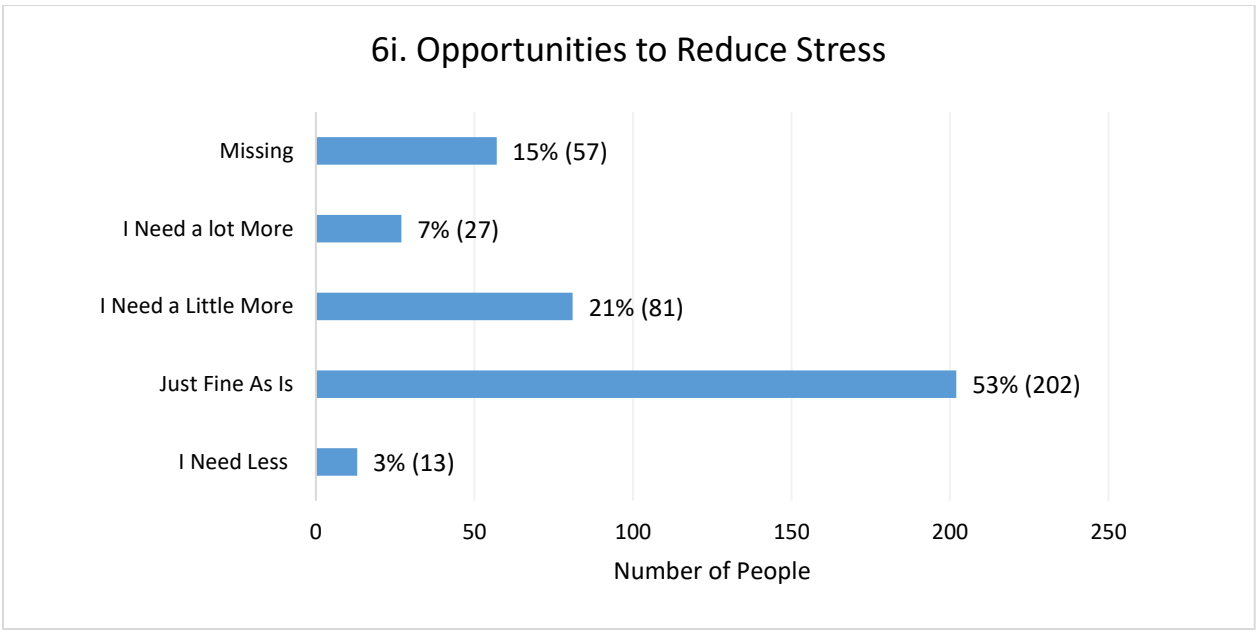

6d. Affordable Place to Buy Healthy Food
Missing
I Need a lot More
I Need a Little More
Just Fine As Is
I Need Less
16% 62
11% (42)
26% (98)
43% (163)
4% (16)
0
50
100
150
200
Number of People

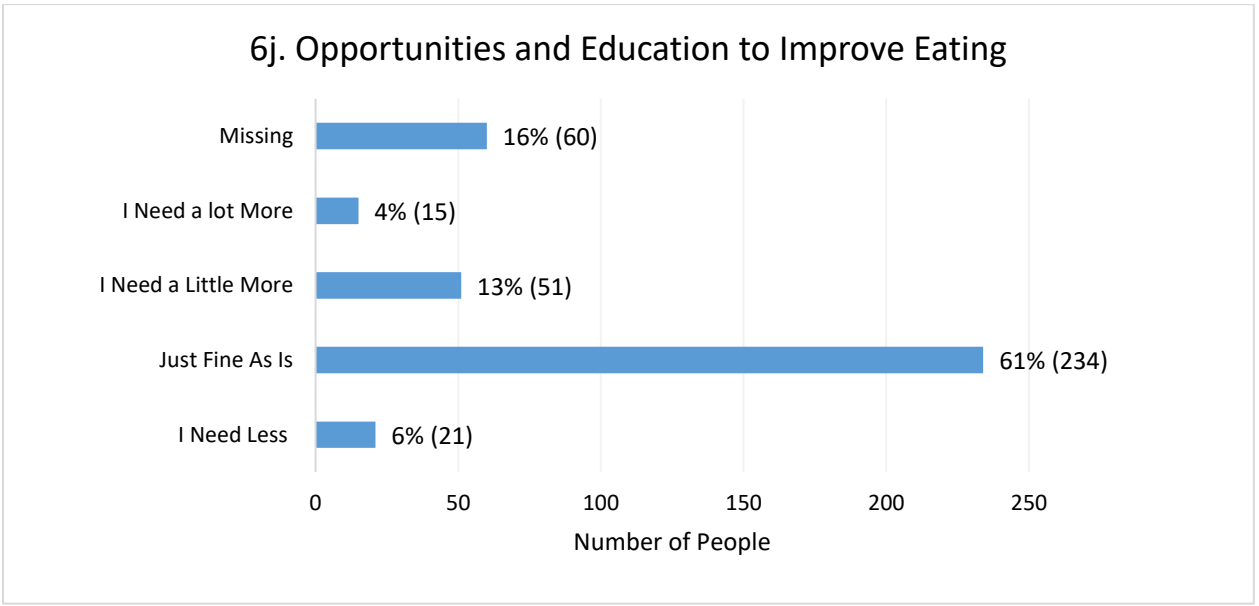

6e. Connection with Social Activities
Missing
16% (60)
I Need a lot More
5% (19)
I Need a Little More
17% (63)
Just Fine As Is
59% (223)
I Need Less
4% (16)
0
50
100
150
200
250
Number of People

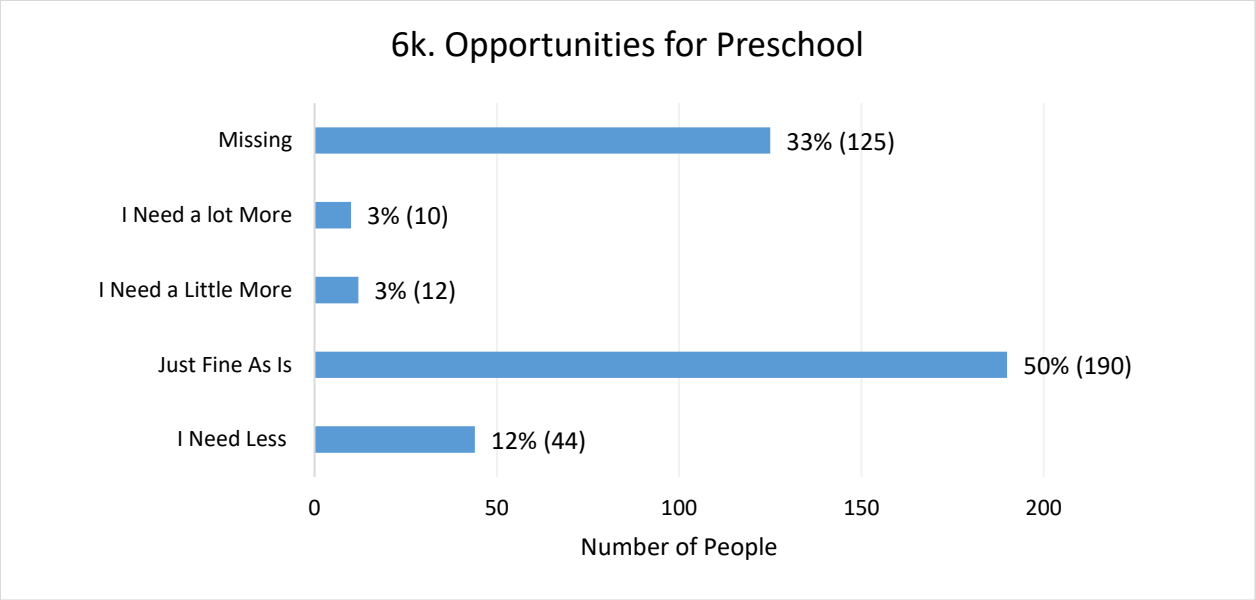

6f. Family Connection
Missing
17% (63)
I Need a lot More
4% (16)
I Need a Little More
12% (47)
Just Fine As Is
64% (244)
I Need Less
3% (11)
0
50
100
150
200
250
300
Number of People

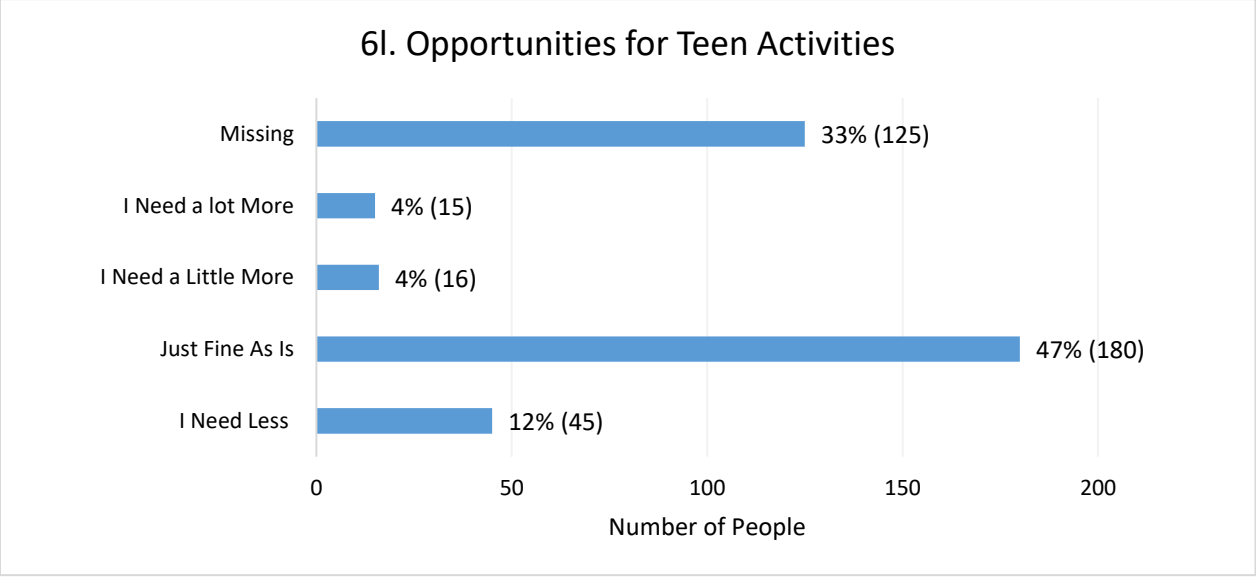

6g. Sense of Meaning and Purpose
Missing
15% (59)
I Need a lot More
5% (20)
I Need a Little More
11% (42)
Just Fine As Is
64% (245)
I Need Less
4% (15)
0
50
100
150
200
250
300
Number of People

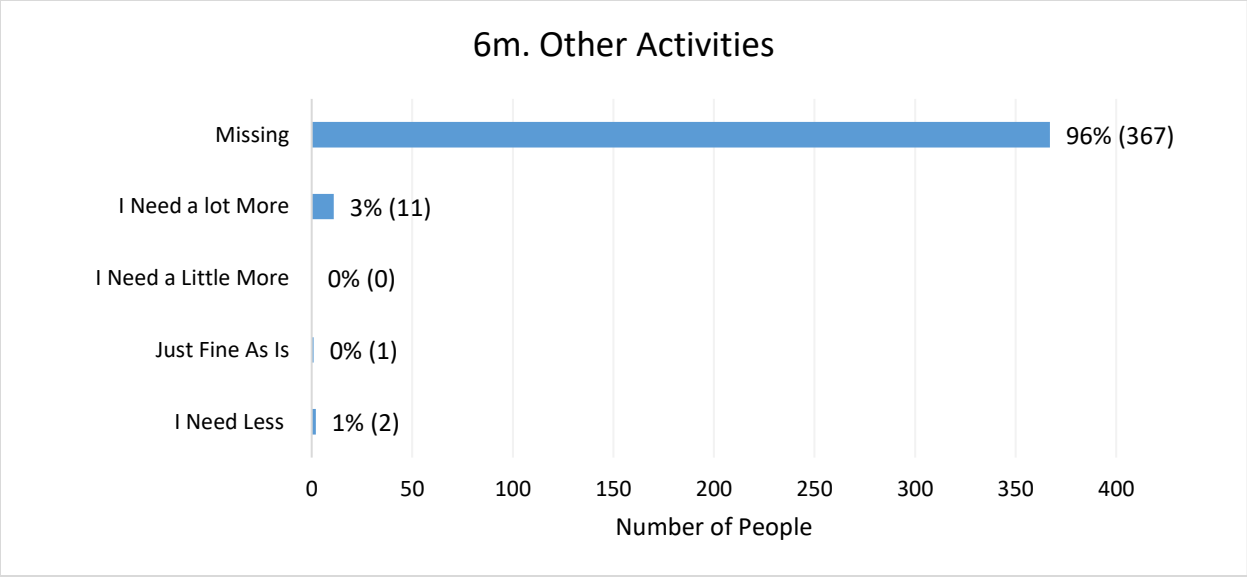

6h. Opportunities to Develop Spiritual Life
Missing
14% (60)
I Need a lot More
3% (12)
I Need a Little More
7% (32)
Just Fine As Is
60% (257)
I Need Less
5% (20)
0
50
100
150
200
250
300
Number of People


6i. Opportunities to Reduce Stress
Missing
15% (57)
I Need a lot More
7% (27)
I Need a Little More
21% (81)
Just Fine As Is
53% (202)
I Need Less
3% (13)
0
50
100
150
200
250
Number of People


6j. Opportunities and Education to Improve Eating
Missing
16% (60)
I Need a lot More
4% (15)
I Need a Little More
13% (51)
Just Fine As Is
61% (234)
I Need Less
6% (21)
0
50
100
150
200
250
Number of People


6k. Opportunities for Preschool
Missing
I Need a lot More
I Need a Little More
Just Fine As Is
I Need Less
33% (125)
3% (10)
3% (12)
50% (190)
12% (44)
0
50
100
150
200
Number of People


6l. Opportunities for Teen Activities
Missing
I Need a lot More
I Need a Little More
Just Fine As Is
I Need Less
33% (125)
4% (15)
4% (16)
47% (180)
12% (45)
0
50
100
150
200
Number of People


6m. Other Activities
Missing
I Need a lot More
I Need a Little More
Just Fine As Is
I Need Less
96% (367)
3% (11)
0% (0)
0% (1)
1% (2)
0
50
100
150
200
250
300
350
400
Number of People

Detailed Charts Section 7: Children's Health Survey

7a. Child has a Primary Care Provider. Of households with children, 90% had a primary care provider for children. 2% did not have a primary care provider for children.

7b. Children's Insurance Type – Most Children are Insured. Of households in which most children were insured, 30% had a employer-sponsored health insurance for children, 29 % had Oregon Health Plan for children, 16% of households were primarily self-pay, and 5% had Medicare for children.

7c. Children's Insurance Type – Some Children are Insured. The majority of respondents (98%) did not answer this question. 2% reported that some children had employer-sponsored health insurance.

7d. OHP Eligibility – No Children Have Insurance. The majority of respondents (92%) did not answer this question. 4% reported that children were eligible for Oregon Health Plan, and 4% reported that of children were not eligible for Oregon Health Plan.

7e. Have Any Children Been Uninsured in the Past Year? 78% of households with children reported that no children were uninsured in the past year. No households responded that children had been uninsured in the last year.

7f. Child's Doctor Spent Enough Time. 52% of households with children reported that their child's doctor always spent enough time with them, 32% reported that the doctor usually spent enough time with them, and 8% reported that the doctor sometimes spent enough time with them.

7g. Child's Doctor is Sensitive to Customs. 62% of households with children reported that their child's doctor is always sensitive to their customs, 19% reported that the doctor usually is usually sensitive to customs, and 6% reported that the doctor is sometimes sensitive to customs.

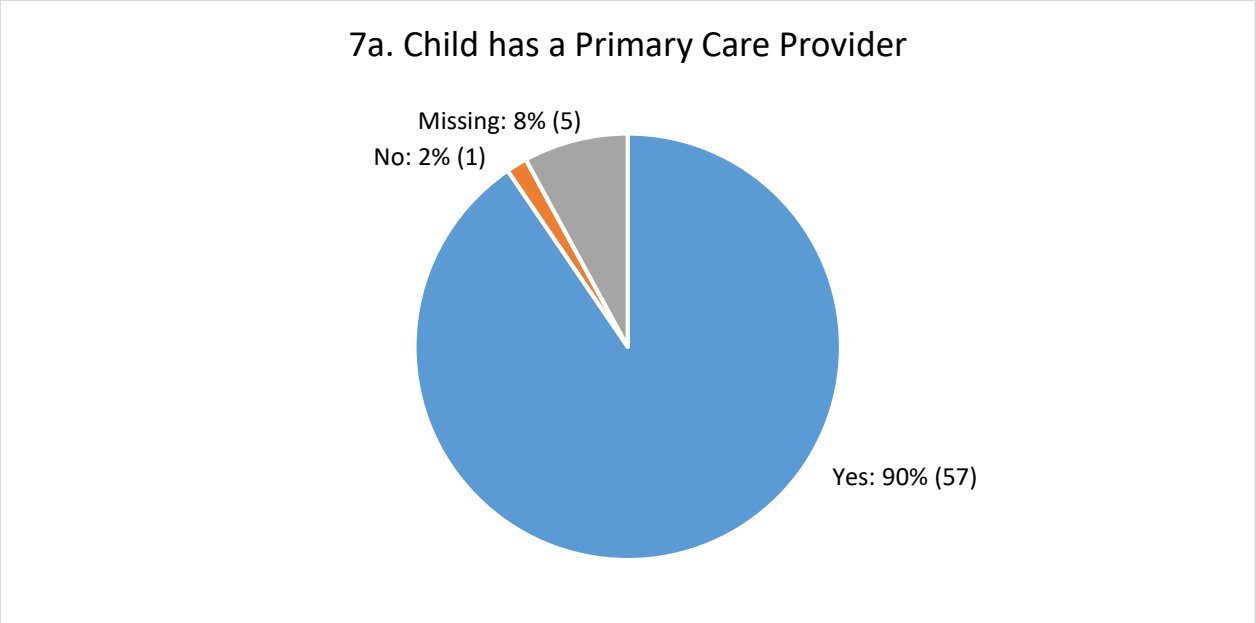
7h. Children's Health Conditions. 59% of households with children reported that their child did not have any of the listed conditions, 13% reported that a child had cavities, 10% reported that a child had Anxiety, 10% reported that a child had ADHD, and 6% reported that a child had Depression, 3% reported that a child had Asthma, and 2% reported that a child had Pre-Diabetes.

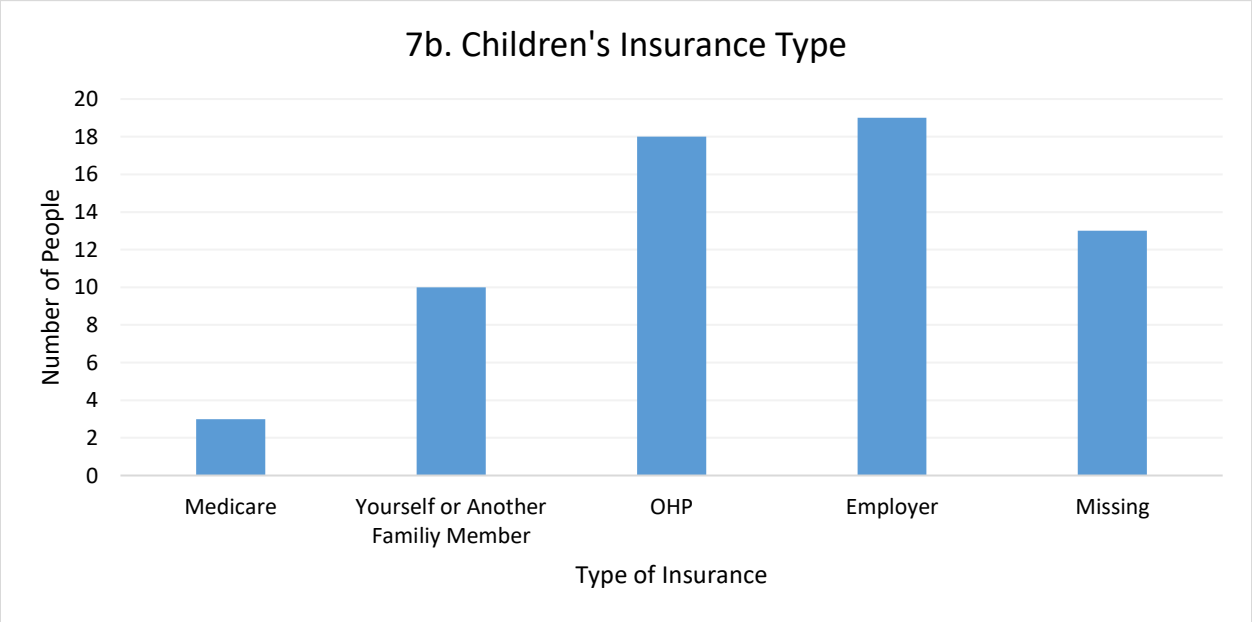
7h. Children's Health Conditions. 59% of households with children reported that their child did not have any of the listed conditions, 13% reported that a child had cavities, 10% reported that a child had Anxiety, 10% reported that a child had ADHD, and 6% reported that a child had Depression, 3% reported that a child had Asthma, and 2% reported that a child had Pre-Diabetes.

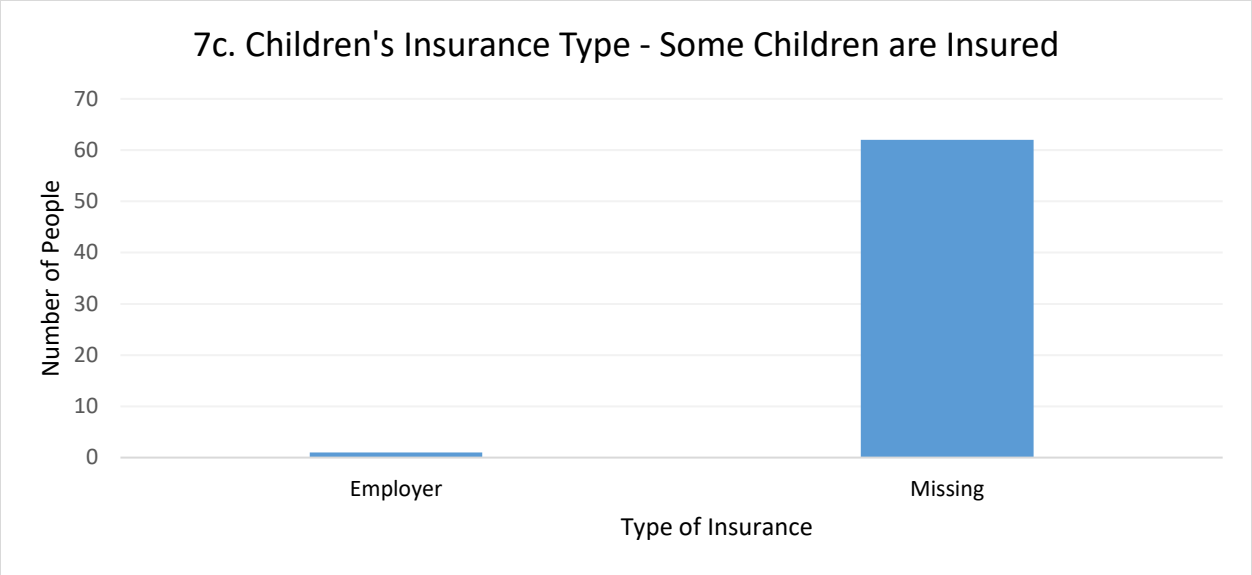
7i. Child with a Physical Condition Got Care as Soon as They Needed It. 25% of households with children reported that their child always got care when needed for a physical condition, 6% reported that their child usually did, 8% that their child sometimes did, and none that their child never did. 43% reported that their child did not need care for a physical health condition in the past year.

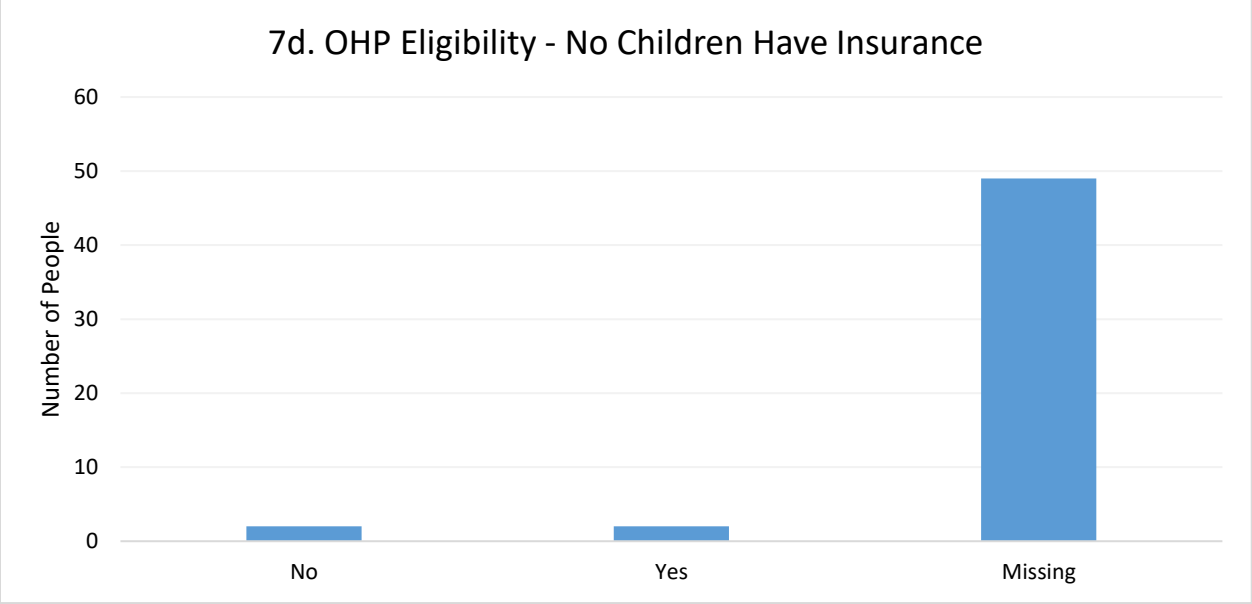
7j. Child with a Dental Condition Got Care as Soon as They Needed It. 11% of households with children reported that their child always got care when needed for a dental condition, 2% reported that their child usually did, 11% that their child sometimes did, and none that their child never did. 67% reported that their child did not need care for a dental health condition in the past year.

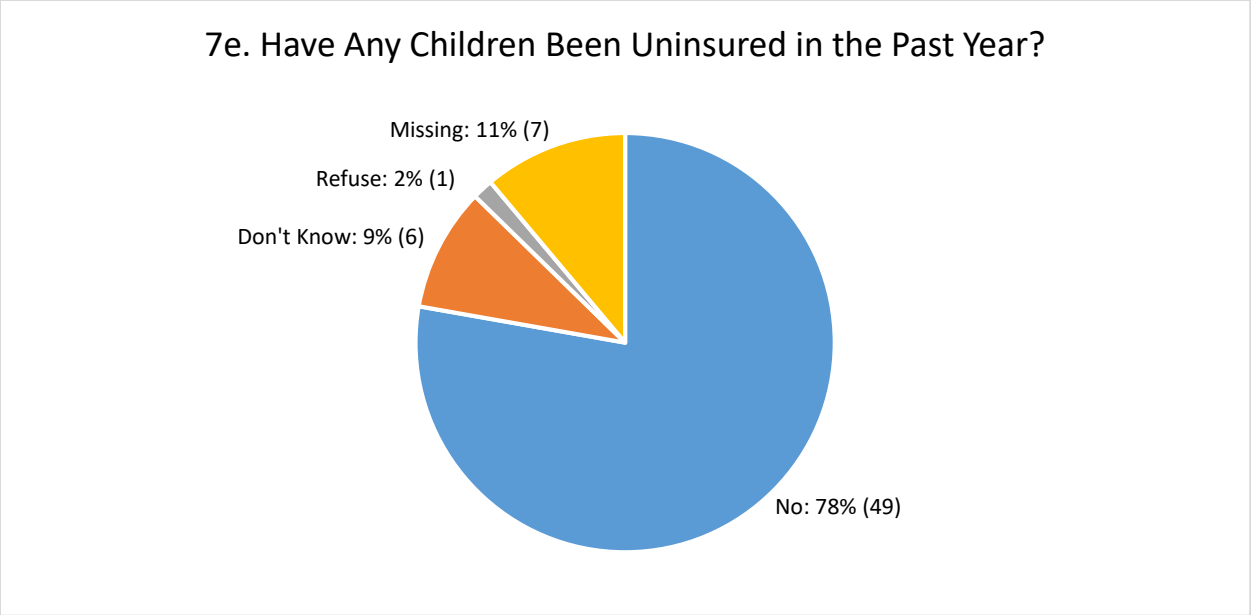
7j. Child with a Mental Health Condition Got Care as Soon as They Needed It. 3% of households with children reported that their child always got care when needed for a mental health condition, 5% reported that their child usually did, 10% that their child sometimes did, and 2% reported that their child never did. 70% reported that their child did not need care for a mental health condition in the past year.

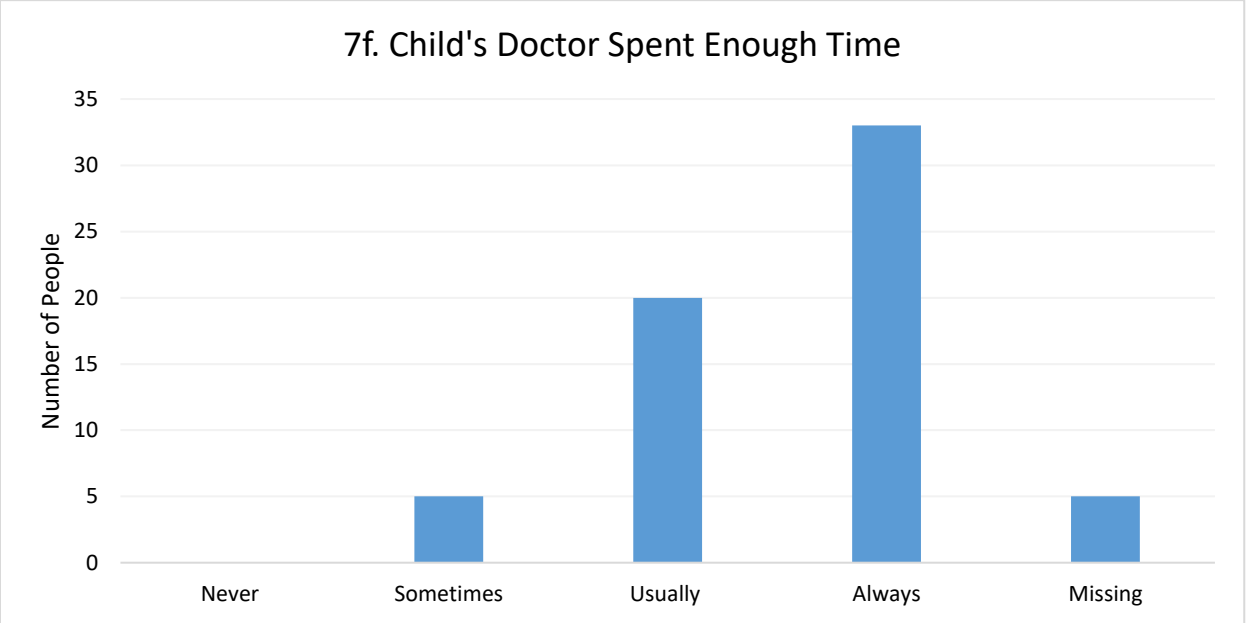

7a. Child has a Primary Care Provider
Missing: 8% (5)
No: 2% (1)
Yes: 90% (57)

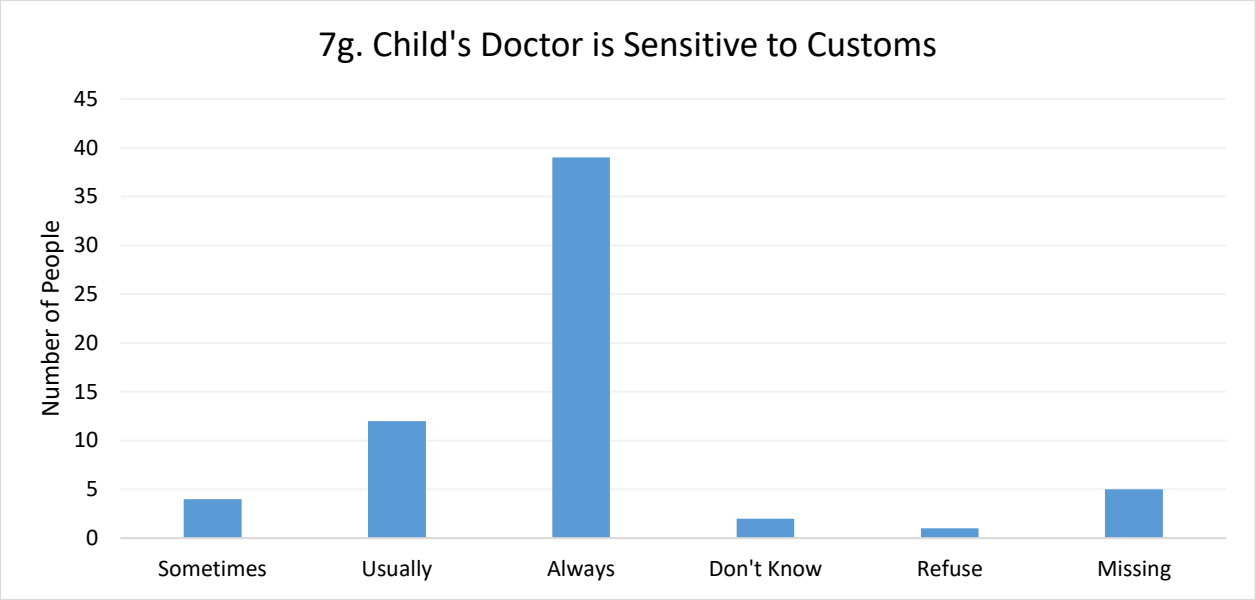

7b. Children's Insurance Type
Number of People
20
18
16
14
12
10
8
6
4
2
0
Medicare
Yourself or Another Familiy Member
OHP
Employer
Missing
Type of Insurance

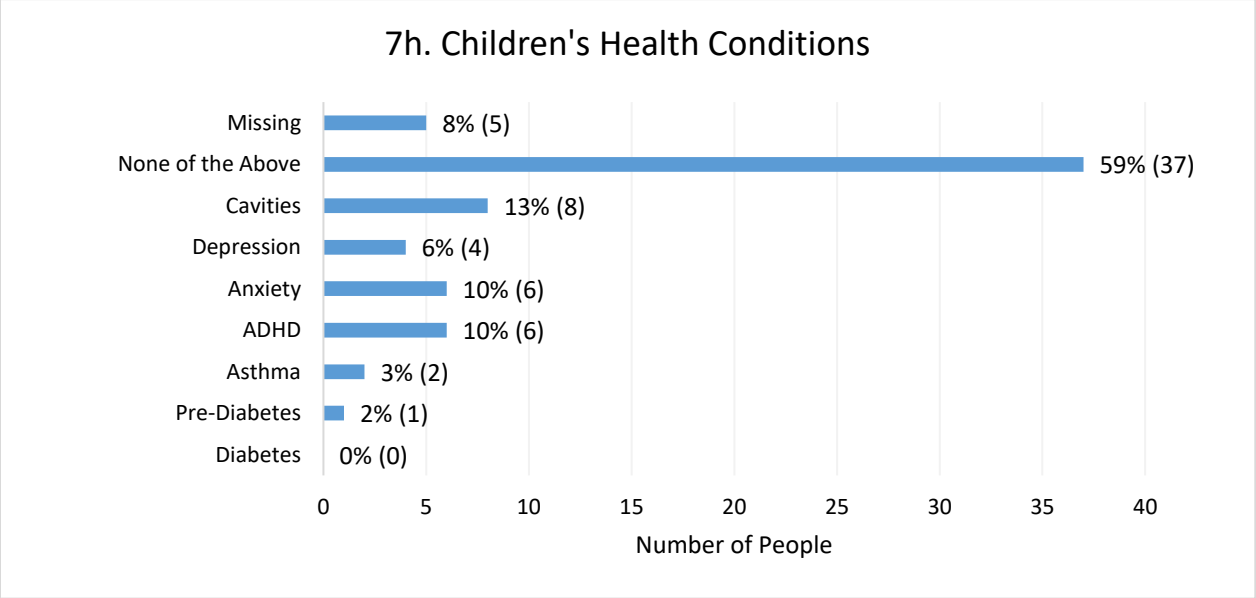

7c. Children's Insurance Type - Some Children are Insured
70
60
50
40
30
20
10
0
Number of People
Employer
Missing
Type of Insurance

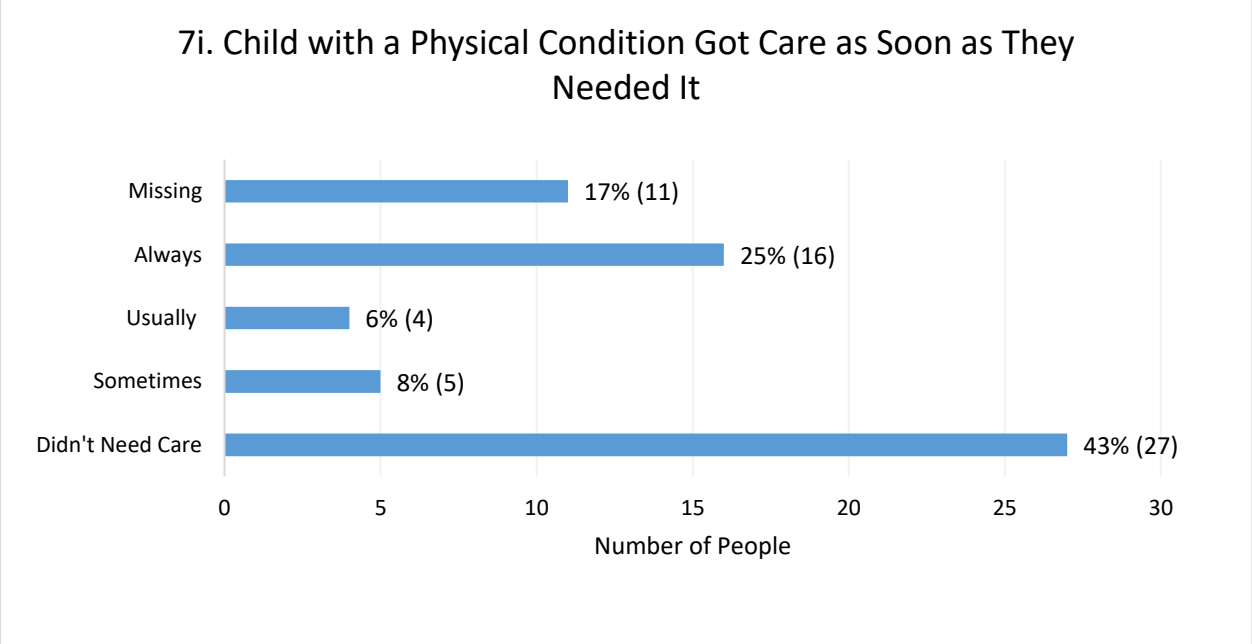

7d. OHP Eligibility - No Children Have Insurance
60
50
40
30
20
10
0
Number of People
No
Yes
Missing

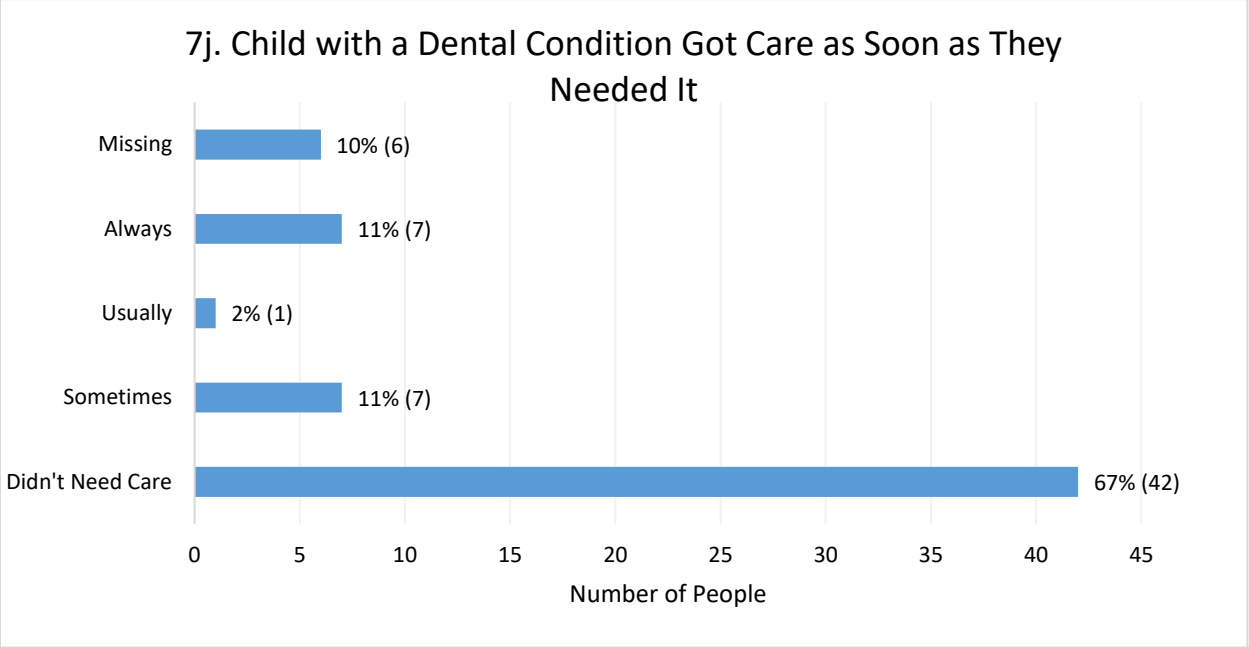

7e. Have Any Children Been Uninsured in the Past Year?
Missing: 11% (7)
Refuse: 2% (1)
Don't Know: 9% (6)
No: 78% (49)

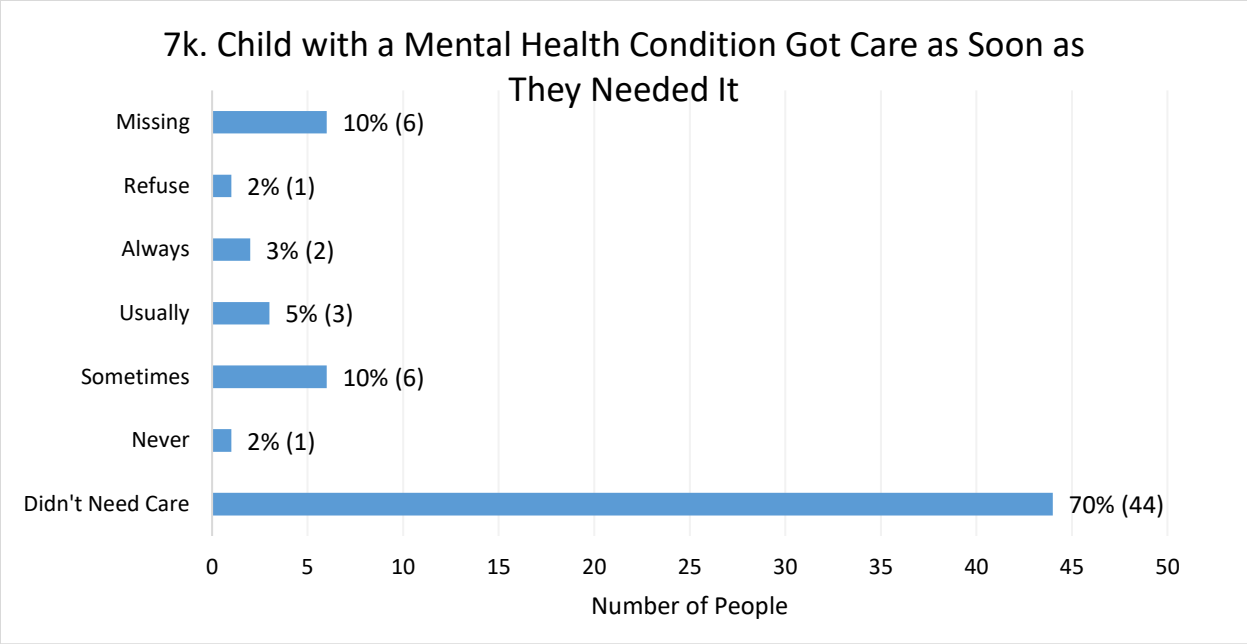

7f. Child's Doctor Spent Enough Time
Number of People
35
30
25
20
15
10
5
0
Never
Sometimes
Usually
Always
Missing


7g. Child's Doctor is Sensitive to Customs
Number of People
45
40
35
30
25
20
15
10
5
0
Sometimes
Usually
Always
Don't Know
Refuse
Missing


7h. Children's Health Conditions
Missing
None of the Above
Cavities
Depression
Anxiety
ADHD
Asthma
Pre-Diabetes
Diabetes
8% (5)
59% (37)
13% (8)
6% (4)
10% (6)
10% (6)
3% (2)
2% (1)
0% (0)
0
5
10
15
20
25
30
35
40
Number of People


7i. Child with a Physical Condition Got Care as Soon as They Needed It
Missing
Always
Usually
Sometimes
Didn't Need Care
17% (11)
25% (16)
6% (4)
8% (5)
43% (27)
0
5
10
15
20
25
30
Number of People


7j. Child with a Dental Condition Got Care as Soon as They Needed It
Missing
Always
Usually
Sometimes
Didn't Need Care
10% (6)
11% (7)
2% (1)
11% (7)
67% (42)
0
5
10
15
20
25
30
35
40
45
Number of People


7k. Child with a Mental Health Condition Got Care as Soon as They Needed It
Missing
10% (6)
Refuse
2% (1)
Always
3% (2)
Usually
5% (3)
Sometimes
10% (6)
Never
2% (1)
Didn't Need Care
70% (44)
0
5
10
15
20
25
30
35
40
45
50
Number of People

Specialty Care Access Outside of Wallowa County

112 people answered that they sought specialty care outside the county in the prior 12 months. 111 people wrote in the types of specialty care for which they left the county. Those 111 people noted referrals for 193 different types of health issues

Types of Specialty Care for Which Respondents Left the County	# of Respondents per Specialty Type
Cardiologist	23
Ophthalmologist	21
Orthopedist	20
Neurologist	16
Dentist	12
Dermatologist	12
Oncologist	8
Endocrinologist	7
Urologist	7
Gastroenterologist	7
Optometrist	7
Otorhinolaryngology	7
Gynecologist/Women's Health	5
Rheumatologist	5
Radiologist	5
Podiatrist	4
Audiologist	4
Surgeon	4
Pulmonologist	3
Orthodontics	3
General Practitioners	2
Nephrologist	2
Back Specialist	1
Pediatrician	1
Internal Medicine	1
Physical Therapist	1
Sleep Specialist	1
Alternative Medicine Practitioners	1
Emergency Care Physician	1
Wound Care	1
Sports medicine	1
total	**193**

Care Integration Assessment Report

I. Introduction:

The purpose of the integration of care assessment is to assess the efforts to provide comprehensive services in the same location, optimally in a team setting, throughout strategic initiatives identified in the community health assessment (CHA) process. Specifically, questions should be addressed such as "How does this initiative bring oral health, mental health, and physical health services together to more effectively address the identified problem?" and "What are the barriers and opportunities identified to improve the integration of services across the initiative? The Care Integration Assessment provides critical information to the planning process in order to maximize the effectiveness of cross-sector community projects and programs.

Evidence for improved outcomes using integrated care models has been demonstrated across the country and the world.[1] Improving community health requires addressing the social determinants of health and improving the delivery systems designed to address health care needs. The Care Integration Assessment engages participants in brainstorming activities directed at identifying where integration exists in the community delivery systems, where gaps may be, and what resources would be necessary to assure initiatives have oral, physical, and mental health, as well as substance use treatment, readily available for community members.

The Care Integration Assessment looks at integration across 9 different sectors. It identifies areas where integration is already occurring, what are assessed to be the areas of greatest need, and which areas would bring the greatest benefit from integration.

II. Data Collection Methods:

a. *Design*: The Northeast Oregon Network used a methodology published by the Oregon Health Authority Transformation Center. It was originally intended as a structure for Coordained Care Organization to use in order to meet new legislative requirements that to address integration of care. Given that Wallowa County partners have long been focusing on care integration, it made since to conduct the assessment as a part of this needs assessment process. The primary consultant to this assessment was also the co-developer of the tool for the Oregon Health Authority and was experienced in its process.

b. *Procedure*: A wide variety of individuals and organization were invited to attend a four-hour session in April of 2019 to participate in a structured qualitative data collection effort to assess integration of care. Participants were first invited to share integration highs and lows. Participants were then split into pairs and spent roughly 5-10 minutes on each of the sectors completing a grid that identified by sector what other sectors this area was integrated with, where the opportunities for

[1] Essential Hospitals Institute. Integrated Health Care: Literature Review. May 2013. http://essentialhospitals.org/wp-content/uploads/2013/12/Integrated-Health-Care-Literature-Review-Webpost-8-22-13-CB.pdf Accessed 5/23/18.

integration were, what barriers existed to integration, and what resources would be needed to start integration. All pairs brainstormed this data for all the sectors. Finally, each participant completed an integration grid that gave a priority ranking to areas where integration was most needed, and areas where it would be most beneficial.

c. *Limitations:* The primary limitation of the assessment is that only eight organizations/sectors were represented. These eight organizations are generally already highly integrated. Those that are less integrated, such as the school district, vision providers, complementary and alternative care providers, and faith based social service providers were not present. These likely represented areas where integration is not occurring as much but could be beneficial.

III. Data Summary:

Eleven individuals from eight different organizations attended and completed the integration assessment. The grid below summarizes the results. Areas highlighted in red, with a number of 5 or 6, indicate the areas of highest need. The grid assess both areas of greatest need, and areas of greatest benefit. The one area where there was convergence between areas of greatest need and of greatest benefit was in the area of physical health care and health food access. Other areas of convergence are less clear. See the appendix for a report out by sector of the current status of integration, the areas needed for integration, the barriers to integration, and the resources needed to encourage integration. This qualitative data will be of great interest to those creating action plans focusing on integration.

**Note: Thanks to Elizabeth Powers for her input on the formatting and data presentation of the grid.

Wallowa County Integration Assessment	Housing	Food	Education	Income	Oral Health	Physical Health	Mental Health	Substance Use Tx	Public Health	Areas of Greatest NEED
Housing		6	5	5	6	5	3	4	5	Housing
Food	4		3	4	5	5	5	5	4	Food
Education	2	5		6	4	6	4	6	5	Education
Income	3	5	2		5	4	4	5	5	Income
Oral Health	1	4	4	3		3	3	4	5	Oral Health
Physical Health	2	5	3	3	6		1	3	4	Physical Health
Mental Health	4	4	6	4	4	6		2	5	Mental Health
Substance Use Tx	5	1	3	3	3	6	5		3	Substance Use Tx
Public Health	1	1	4	2	4	4	2	4		Public Health
Areas of Greatest BENEFIT	Housing	Food	Education	Income	Oral Health	Physical Health	Mental Health	Substance Use Tx	Public Health	

Scale: 6 = highest, 1 = lowest

Participating Entities:

- o Building Healthly Families
- o Local Community Advisory Council (LCAC)
- o Northeast Oregon Network (NEON)
- o Olive Branch Family Health
- o Veterans Administration (VA)
- o Wallowa Memorial Hospital
- o Wallowa Valley Center for Wellness
- o Winding Waters Clinic

(11 individual responses)

Appendix: Secondary Data Source Survey

Population	2010 Assessment Data	2016 Assessment Data	Current Assessment Data	County Rank	Oregon	U.S.	Year current data was collected
Population (2014)	6828	6893	7081		4,190,713	327167434	2018
% change from prior assessment		-2.70%	2.29%		3.60%	3.30%	
Age: (Median)	50.3	51.9 years	52.7		39.2	37.8	2013-2017
Under 5 years	4.30%	5.00%	4.50%		5.80%	6.20%	2013-2017
5-19 years [Persons under 5 years, percent 2014]	16.50%	5.30%	14.40%		18.10%	19.5%	2013-2017
20-44 years [Persons under 18 years, percent 2014]	20.90%	20.60%	22.40%		33.60%	33.40%	2013-2017
45-64 years	35.60%	34.50%	31.40%		26.30%	26.10%	2013-2017
[Age 65 and over]	22.70%	24.00%	27.30%		16.40%	14.90%	2013-2017
Sex: (Female)	49.60%	51.10%	51.90%		50.47%	50.77%	2013-2017
(Male)	50.40%	48.90%	48.10%		49.53%	49.23%	2013-2017
Race/Ethnicity	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
One race	98.70%	97.60%	96.78%		95.2%	96.90%	2013-2017
White alone		93.90%	93.44%		80.4%	61.46%	2013-2017
White	95.70%	98.10%	95.59%		89.20%	73.00%	2013-2017
Black or African American		0.60%	0.22%		2%	14.52%	2013-2017
American Indian and Alaska Native		1.40%	0.19%		1.18%	0.82%	2013-2017
Asian		0.70%	0.28%		4.34%	5.35%	2013-2017
Native Hawaiian and Other Pacific Islander		0.80%	10.00%		0.40%	0.17%	2013-2017
Some other race	1.40%	0.70%	0.41%		3.16%	4.84%	2013-2017
Two or more races	1.30%	2.40%	3.22%		4.80%	3.14%	2013-2017
Hispanic or Latino (of any race)	2.30%	2.80%	2.71%		13.30%	17.60%	2013-2017

Marital Status	2010 Assessment Data	2016 Assessment Data	Current Assessment Data	County Rank	Oregon	U.S.	Year current data was collected
Now Married, except separated (male)	64.50%	55.90%	61.50%		50.70%	49.90%	2013-2017
Now Married, except separated (female)	62.30%	51.80%	57.00%		48.50%	46.60%	2013-2017
Households by type	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Housing Units		4075	4158		1733041	135393564	2013-2017
Married Couple	56.50%	48.30%	51.30%		48.50%	48.40%	2013-2017
Male/No spouse	2.10%	2.40%	3.60%		4.40%	4.80%	2013-2017
Female/No spouse	5.80%	10.90%	7.70%		10.30%	12.70%	2013-2017
Non-family	35.50%	38.50%	37.40%		36.70%	34.10%	2013-2017
Persons/Household	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Avg. Household Size	2.13%	2.25	2.15		2.5	2.63	2013-2017
Avg. Family Size	2.66%	2.70	2.70		3.05	3.24	2013-2017
Household Income	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Median Household income	$41,382	$41,994	$44,877		$56,119	$57,652	2013-2017
Median Family	$50,876	$41,522	$60,606		$69,031	$70,850	2013-2017
Per capita income	$24,887	$23,996	$26,898		$30,410	$31,770	2013-2017
Vehicles/Household	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
No vehicle	3.40%	0.70%	0.60%		3.30%	4.40%	2013-2017
1 vehicle	14.60%	17.10%	14.10%		21.20%	20.90%	2013-2017
2 vehicles	30.50%	39.30%	39.00%		41.30%	41.20%	2013-2017
3 or more vehicles	51.50%	42.20%	46.20%		34.20%	33.50%	2013-2017

Social Security Beneficiaries	2010 Assessment Data	2016 Assessment Data	Current Assessment Data	County Rank	Oregon	U.S.	Year current data was collected
With Social Security	39.20%	44.50%	17.91%		22.49%	22.86%	2013-2017
Mean Social Security Income	$14,514	$17,402	$16,894		$19,136	$18,778	2013-2017
Health Coverage	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Insurance Coverage of the Total Population 2013-2017							
Employer		CNAS	42%		53%	55%	2013-2017
Non-Group (Individual)		CNAS	27%		16%	13%	2013-2017
Medicaid		CNAS	22.8		22%	20%	2013-2017
Medicare		CNAS	28.9		18%	17%	2013-2017
Total Number of Medicare Beneficiaries		2038	1955		722,064	52,445,202	2013-2017
Percent of Medicare Beneficiaries		29.6%	27.7%		18.1%	16.6%	
Uninsured Children, regional	15.90%	8.80%	4.80%	29	3.30%	5%	2018, 2017 U.S.
Uninsured	19%	9.00%	8.00%		9%	10.50%	2017
Dental Insurance		44% CNAS	43.8% CNAS		74%	77%	2016
Poverty	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
All Families below poverty level	14.00%	13.40%	13.70%		14.90%	14.60%	2013-2017, 2017
Single/female head of household	25.10%	26.8%	40.9%		28.90%	28.80%	2013-2017
Households With Related Children under 18	36.50%	20.30%	20.90%		15.90%	16.70%	2013-2017
Individuals Over 65	9.60%	6.40%	9.10%		8.20%	9.30%	2013-2017
Married couple families	6.40%	6.50%	5.30%		5.20%	5.30%	2013-2017
All People	10.70%	6,807	14%		15%	15%	2013-2017
Childhood Poverty (ages 0-17)		26.30%	22.50%	20	17.20%	17.50%	2018, 2017 U.S.
Adult Illiteracy	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Adult Health Literacy	ND	85.5%, self-reported CNAS	88.7%, self-reported CNAS		no data	12% proficient	2019, 1993

Homelessness	2010 Assessment Data	2016 Assessment Data	Current Assessment Data	County Rank	Oregon	U.S.	Year current data was collected
Homeless sometime during year	ND	4.3% self-reported CNAS	4.7% self-reported CNAS, .11 2017 Point time Count		0.35%	0.17%	2017-2018
Unemployment	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Unemployment rate (seasonally adjusted)	13.40%	10.2%	6.4%		4.4%	3.8%	Jul-05
Occupation Sectors	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Civilian employed population 16 years and over	-	2990	3034	-	1,885,983	150,599,165	2013-2017
Management, professional, and related occupations	37.70%	37.30%	34.46%		38.12%	37.44%	2013-2017
Service Occupations	16.50%	19.33%	17.93%		18.25%	17.97%	2013-2017
Sales and office occupations	17.80%	21.27%	23.20%		22.92%	25.53%	2013-2017
Production, transportation, and material moving occupations	12%	9.40%	10.74%		11.82%	12.17%	2013-2017
Agriculture, forestry, fishing and hunting, and mining	14.80%	12.67%	13.74%		3.27%	1.30%	2013-2017
Construction	9.40%	6.15%	10.78%		6%	6.35%	2013-2017
Manufacturing	8.60%	4.80%	5.89%		5.79%	5.89%	2013-2017
Wholesale Trade	1.20%	0.86%	7.90%		2.92%	2.68%	2013-2017
Retail Trade	9.60%	12.47%	9.85%		11.86%	11.40%	2013-2017
Transportation and warehousing, and utilities	3.40%	4%	3%		2.27%	5.10%	2013-2017
Information	1.00%	1.23%	0.59%		1.86%	2.11%	2013-2017
Finance and insurance, and real estate and rental and leasing	5.00%	3.17%	6.13%		5.69%	6.58%	2013-2017
Professional, scientific, and management, and administrative and waste management services	6.00%	5.91%	6.82%		10.77%	11.29%	2013-2017

Educational services, and health care and social assistance	20.80%	24%	24%		22.90%	23.10%	2013-2017
Arts, entertainment, and recreation, and accommodation and food services	7.50%	1.90%	7.22%		9.82%	9.69%	2013-2017
Other Services, except public administration	7.00%	5%	5%		4.77%	4.90%	2013-2017
Public administration	5.70%	5.91%	6.66%		4.53%	467.00%	2013-2017
Government Workers	20.50%	19.90%	18.39%		13.60%	13.80%	2013-2017
Self-employed	15.90%	16.10%	23.73%		11.81%	9.65%	2013-2017
Housing By Type	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Total Occupied	77.30%	4086	3126		1571631	118825921	2013-2017
Owner-occupied units		2122	2123		969453	75833135	2013-2017
With a mortgage	53.40%	52.10%	49.18%		66.81%	63.54%	2013-2017
Without a mortgage	46.60%	47.90%	50.82%		33.19%	36.46%	2013-2017
Renter-occupied	25.80%	29.70%	32.09%		38.32%	37.18%	2013-2017
Owner-occupied	74.20%	70.30%	67.91%		61.72%	63.81%	2013-2017
Median Gross Rent	$635	$1,221	$676		$988	$982	2013-2017
Vacant housing units	22.70%	26.10%	33.01%		10.27%	13.94%	2013-2017
Mobile homes	16.40%	15.70%	17.60%		8.30%	5.70%	2013-2017
Education Attainment	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
(population age 25+)	5079.00%	5,259	5,390		2,797,953.00	216271644	2013-2017
Less than High School Diploma		6.9%	7.1%		9.80%	12.6%	2013-2017
High school graduate or equivalency	92.10%	33.70%	30.50%		23.40%	27.3%	2013-2017
Some college, no degree		24.90%	26.90%		25.80%	20.8%	2013-2017
Associates Degree		9.40%	9.70%		8.70%	8.3%	2013-2017
Bachelor's Degree +	22.70%	14.60%	16.10%		20.10%	19.1%	2013-2017
Graduate or professional degree		10.50%	9.60%		12.20%	11.8%	2013-2017

Language Spoken at Home	2010 Assessment Data	2016 Assessment Data	Current Assessment Data	County Rank	Oregon	U.S.	Year current data was collected
English Only	94.90%	95.90%	96.50%		84.80%	78.70%	2013-2017
Other than English	5.10%	4.10%	3.50%		15.20%	21.30%	2013-2017
Spanish	3.00%	2%	2%		9.00%	13%	2013-2017
Other Languages		0%	2%		6.20%	8.10%	2013-2017
Foreign Born	2.70%	2%	no current data, sample size too small		9.80%	1.34%	2013-2017
Alcohol Past Month	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Female Alcohol Use	56%	77%	no data		no data	no data	2016
Female Binge Drinking	9%	43.00%	no data		11.90%	no data	2016
Female Heavy Use	5%	18.00%	no data		7.70%	no data	2016
Male Alcohol Use	62%	75%	no data		no data	no data	2016
Male Binge Drinking	34%	29%	no data		21.70%	no data	2016
Male Heavy Use	16%	no data	no data		7.60%	no data	2016
Alcohol Use, 8th Grade	33%	no data	no data		10.30%	no data	2017
Binge Drinking, 8th Grade	13%	no data	no data		4.60%	no data	2017
Alcohol Use, 11th Grade	57%	no data	no data		26.90%	29.80%	2017
Binge Drinking, 11th Grade	44%	no data	no data		14.10%	13.50%	2017
Drinking and Driving 11th Grade	11%	no data	no data		2.10%	10.00%	2017
Binge Drinking (male and female)	no data	no data	19.20%		18.30%	17.40%	2014-2017, 2017
Heavy Drinking (male and female)	no data	no data	14.00%		7.70%	6.30%	2014-2017, 2017
% Self-Reported Drinking and Driving At Least Once Last 30 Days	no data	no data	no data		3.80%	3.90%	2016
Alcohol	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Rate of death from Motor Vehicle Crashes per 100,000	19	23	21		10.5	11.4	2011-2017, 2017

Percent of motor vehicle fatalities that are alcohol-involved		44.0%	56.0%		31.0%	28%	2013-2017, 2016
Morbidity Percent w/ Alcohol dependence or abuse in the past year	7%	6.5%	Data soure no longer available				
Drugs	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Rate of Death from Drug-induced causes (all ages)	8%	15%	no data		no data	no data	
Morbidity Percent of Person w/ Drug or Dependence or Abuse	3%	2.2%	no data		no data	no data	
Percent of Adults with Marijuana Use Within the Past 30 Days Age Adjusted			13.40%		17.60%	30% crude rate	2014-2017, 2017
Adults Percent of Persons who used Marijuana or Hashish in the past 30 days, 18-25 years old	19%	23%	no data		no data	22.10%	2017
Percent of Persons who used Marijuana or Hashish in the past 30 days, 26 or older	5%	5%	no data		no data	7.90%	2017
Percent of Persons who used illicit Drugs other than marijuana in the past 30 days, 18-25	8%	10%	no data		no data	no data	
Percent of Persons who used illicit Drugs other than marijuana in the past 30 days, 26 or older	2%	4%	no data		no data	no data	
Percent of youth who used marijuana one or more times in the past 30 days, 8th grade	4%	no data	no data		7%	5.60%	2017
Percent of youth who used marijuana one or more times in the past 30 days, 11th grade		no data	no data		21%	22.20%	2017

Percent of youth who used illicit Drugs other than marijuana in the past 30 days, 8th grade		no data	no data		no data	6.10%	2018
Percent of youth who used illicit Drugs other than marijuana in the past 30 days, 11th grade		no data	no data		no data	12.40%	2018
Percent of youth who used Prescription drugs to get high in the past 30 days, 8th grade		no data	no data		5%	no comparable data	2017
Percent of youth who used Prescription drugs to get high in the past 30 days, 11th grade	22%	no data	no data		7%	no comparable data	2017
Opioid Risky Prescribing >90 MED Individuals per 1,000 Residents from a Single Source	no data	11.11	4.88		4.48	no comparable data	2019 quarter 1
Drug overdose hospitalizations per 100,000	no data	no data	0.00		22.79	no comparable data	2019 quarter 1
Drug Overdose Deaths per 100,000	no data	0.00	0.00		6.60	21.70	2015-2017, 2017
Mental Health	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Percent of youth who attempted Suicide in the past year, 8th grade	7%	no data	no data		4.50%	no reliable national data	2017
Percent of youth who attempted Suicide in the past year, 11th grade	6%	no data	no data		3.60%	7.4% all high school	2017
Percent of adults with depression	no data	20.80%	16.90%		25.60%	20.5% crude rate	2014-2017, 2017
Rate of Domestic Disturbance Offenses per 10,000 population (all ages)	4%	20%	no data		no data	no data	NA
Mental Health Youth	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**

Percent of Youth who had a depressive episode in the past year, 8th grade	6%	no data	no data		30%	no data	2017
Percent of Youth who had a depressive episode in the past year, 11th grade	22%	no data	no data		32%	no data	2017
12-month Prevalence of Major Depressive Episode amend U.S. Adolescents	no data	no data	no data		no data	6.10%	2018
Youth Suicide Attempts 11th grade	no data	no data	no data		7%	14.46 per 100,000 age 15-24	2017
Immunizations	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Immunizations (Adult Influenza 65 and over, FFS Medicare Enrollees)	66.50%	47%	31%		40.00%	59.6%, 2017-2018	2016 data most recent, from, 2019 County Health Rankings. No Oregon data
Immunizations (Adult Pneumonia 65 and over)	no data	no data	no data		80.90%	74.70%	2017
Immunizations (Adult Overall-1 dose Flu)	no data	37%	no data		37.00%	37.10%	2017-2018
Immunizations Two Year Old Fully Immunized (4:3:1:3:3:1:4)	77.8	59.00%	69.00%		69%	73.2%, 2017	2018
Immunizations Sexually Transmitted Diseases and HIV Deaths	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
STDS: Chlamydia Rate per 100,000		205.5	181-265		433	497.3	2016
STDS: Gonorrhea Rate per 100,000		6.2	<=16		108	145.8	2016
STDS: Syphilis Reported Cases		0.0	0.0		8.1	8.7	2016
Sexually Transmitted Infections per 100,000			189.6		432.5	no data	2016
Vital Statistics	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**

Total Births	51	64	62		45,102	3,855,500	2013-2017, 2017 US
Birth Rate per 1,000	7.2	8.1	8.85		11.2	11.8	2013-2017, 2017
Total Deaths	74	84	85		34160	2,596,993	2013-2017, 2017
Death Rate per 100,000 (non age adjusted)	1069.38	1221.2	1186.6		834.6	863.8	2013-2017, 2017
Death Rate per 100,000 (age adjusetd)	726	811.8	825.2		853.6	731.9	2013-2017, 2017
Teen Pregnancy Rate per 1,000 (All Ages 15-19, aggregate)	11.5	15	28.9		49.2	18.8	2013-2017, 2017
Prenatal Care starting in first trimester as a percent of births	78%	77.20%	78.90%		81.00%	77.3	2018, 2017
Inadequate Pre Natal care as a percentage of births	9%	3.50%	3.54%		6%	6%	2013-2017, 2017
Tobacco Use During Pregnancy as a percentage of births	6.60%	15.80%	13.60%		9.50%	6.90%	2016,, 2017
Low birthweight rate per 1,000 births	64.40	52.6	51.4		64.7	81	2013-2017, 2017
Marriages	35	61	76		28,041	2,236,496	2017
Divorces	9	18	19		14,009	787250	2016
Death Rates due to selected causes, in descending order, per 100,000 population	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Total Crude Death Rate per	1069.8	1221.2	1186.6		834.6	850.0	2013-2017, 2017
Total Death Rate Age Adjusted	729.3	811.8	825.2		853.6	731.9	2015-2017, 2017
Cancer Death Rate Age Adjusted	166.6 crude	283.6 crude	136.2		160.9	152.5	2011-2017, 2017
Heart Disease Death Rate Age Adjusted	179.3 crude	283.6 crude	159.6		133.3	165.0	2011-2017, 2017
CLRD Death Rate Age Adjusted	31 crude	60.8 crude	27.4		41.4	40.9	2011-2017, 2017
Cerebrovascular Disease Death Rate Age Adjusted	65.5 crude	75.2 crude	30.3		38.1	37.6	2011-2017, 2017
Unintended Injuries Death Rate Age Adjusted	43.3 crude	75.2 crude	63.4		42.1	45.6	2011-2017, 2017

Alzheimer's diseases/dementia Crude Death Rate	14.5 crude	14.5 crude	8.3		37.9	31.0 age adjusted	2013-2017, 2017
Diabetes Crude Death Rate	11.1	37.6	25.0		27.6	21.5 age adjusted	2013-2017, 2017
Suicide	20.2 crude	28.9 crude	27.9		17.7	14.0	2011-2017, 2017
Alcohol Induced Death Rate Age Adjusted	20.2 crude	17.4 crude	41.7		38.2	no corresponding category	2013-16
Flu and Pneumonia Crude Rate	196.5	17.4	30.6		11.5	14.3	2013-2017, 2017
Premature Death Years of Potential Life Lost	5111.00	7500.00	7100.00		6000.00	7432.00	2015-2017, 2016
Age-adjusted prevalence of selected chronic conditions among adults	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Arthritis age adjusted	12%	12.40%	23.40%		24.20%	22.70%	2014-2017, 2013-2015
Asthma Age Adjusted	7%	13.60%	6.20%		11.00%	7.90%	2014-2017, 2017
Heart Attack Age Adjusted	2%	4.60%	no data		3.60%	4.20%	2014-2017, 2017
Coronary Heart Disease Age Adjusted	4%	no data	1.90%		3.40%	3.90%	2014-2017, 2017
Stroke Age Adjusted	4%	ND	no data		2.70%	3.00%	2014-2017, 2017
Diabetes Age Adjusted	4%	9.20%	5.10%		8.60%	11%	2014-2017, 2017
High Blood Pressure Age Adjusted	25%	51.60%	22.00%		26.70%	32.20%	2014-2017, 2017
High Blood Cholesterol Age Adjusted	20.00%	68.00%	19.70%		28.30%	33.00%	2014-2017, 2017
One or More Chronic Diseases Age Adjusted	no data	46.00%	50.00%		53.50%	60.00%	
Age-adjusted for Prevalence of Modifiable Chronic Disease Risk Factors and for Preventive Health Screening among Adults	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
% of adults who currently smoke cigarettes	10%	8.60%	14.40%		17.60%	14%	2014-2017, 2017
% Using E-Cigarettes Crude Rate	no measure	no measure	no data		4.30%	5%	2017
Smokeless tobacco use		11.70%	no data		4.30%	3.40%	2014-2017, 2016

% of adults classified as obese	20%	22.20%	16.40%		28.60%	31.30%	2014-2017, 2015-2016
% of adults who consumed at least 5 servings of fruits and vegetables per day	26%	10.20%	no longer a BRFSS measure		no longer a BRFSS measure	no longer a BRFSS measure	
% of adults who received medical advice to reduce salt intake	no measure	no data	18.30%		14.80%	no data	2014-2017
% of adults who consumed seven or more sodas per week	no measure	no data	28.10%		13.20%	no data	2014-2017
% with no physical activity outside of work within the past month	no measure	no measure	20.90%		17.90%	no data	2014-2017
% who meet CDC guidelines for both aerobic and muscle strengthening activities	no measure	no measure	22.50%		22.70%	20.3% crude rate	2014-2017, 2017
% With Insufficient Sleep	no data	29.00%	28.00%		31.00%	27% Top U.S. Performers	2016
% with presence of one or more risk factors for chronic disease	no measure	no measure	60.60%		74.40%	no data	2014-2017
% who had their cholesterol checked within past 5 years (≥ 18 years old)	58%	86.50%	75.70%		77.20%	85.9% crude rate	2014-17
Current on Colorectal Cancer Screening	56%	no data	68.90%		68.70%	67.7% crude rate	2014-17, 2016
Blood sugar test within past three years		no data	54.10%		64.80%	no data	2014-17
% who had mammogram within past 2 years (Women≥40 years old) crude rate	61%	no data	no data		73.70%	77.60%	2016
% who had a Pap test within past 3 years (Women≥years old) crude rate	85%	no data	no data		78.80%	79.80%	2016
Modifiable Risk Factors for Chronic Disease Among 11th graders	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
% at risk of overweight	23%	no data	no data		15.20%	16.50%	2017

% who consumed at least 5 servings of fruits and vegetables per day	15%	no data	no data		18.80%	no data	2017
% who had breakfast every day	28%	no data	no data		32.30%	32.80%	2017
% who drank at least 3 glasses of milk per day	10%	no data	no data		8.20%	no data	2017
% who drank at least 7 sodas per week	33%	no data	no data		10.90%	17.90%	2017
% who participated in PE activity 5 days a week		no data	no data		20.00%	24.30%	2017
% who were online more than 3 hours per day	18%	no data	no data		46.80%	42%	2017
Modifiable Risk Factors for Chronic Disease Among 8th graders	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
% overweight or obese	14%	no data	no data		25.70%	no data	2017
% who consumed at least 5 servings of fruits and vegetables per day	15%	no data	no data		25.10%	no data	2017
% who had breakfast every day	54%	no data	no data		41.30%	no data	2017
% who drank at least 3 glasses of milk per day	30%	no data	no data		12.80%	no data	2017
% who drank at least 7 sodas per week	24%	no data	no data		9.20%	no data	2017
% who participated in PE activity	2%	no data	no data		55.90%	no data	2017
% who watched TV more than 2 hours daily	32%	no data	no data		39.90%	no data	2017
Food and Physical Activity Environment	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Access to Exercise Opportunities	no data	65.00%	57%		88%	91% top U.S. Performers	2018
Food Environment Index (lower number indicates poorer performance)		6.8	7.00		7.6	8.6 top U.S. Performers	2018
Food Insecurity	no data	15.00%	15.00%		13.00%	11.80%	2016
Limited Access to Healthy Foods	no data	10.00%	10.00%		5.00%	2% top U.S. Performers	2016

Physical Environment	2010 Assessment Data	2016 Assessment Data	Current Assessment Data	County Rank	Oregon	U.S.	Year current data was collected
Air pollution-particulate matter	8	10	6.7		7.9	6.1 (US top performers	2014
Drinking water violations	no data	Yes	Yes		no data	no data	2017
Severe housing problems	no data	17%	17.00%		20%	9% Top U.S. Performer	2011-2015
Driving alone to work	no data	65%	70.00%		71%	72% Top U.S. Performer	2013-2017
Long commute-driving alone	no data	16%	13.00%		28%	15% Top U.S. Performer	2013-2017
Homeownership	no data		68.00%		62%	80% Top U.S. Performer	2013-2017
Severe Housing Cost Burden	no data	17.00%	16.00%		17.00%	15.20%	2013-2017, 2017
Social & Economic Factors	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Children in poverty	21%	26%	20.00%		17%	20%	2017
Income inequality		4.70	4.70		4.60	3.7 Top U.S. Performer	2013-2017
Children in single-parent households	24%	34%	37.00%		30%	20% Top U.S. Performers	2013-2017
Number of Social associations per 10,000		19	20.20		10.36	21.9 Top U.S. Performer	2016
Number of Violent crimes per 100,000	79	28	0		249	63 Top U.S. Performer	2014-2016
Injury deaths	no data	115	125		72	57 Top U.S. Performer	2013-2017
Children Eligible for Free and Reduced Lunch	30%	38%	44%		51%	32% Top U.S. Performers	2016-2017
Residential Segregation-nonwhite/white: Index, higher values indicate greater segregation	no data	no data	29		33	15 Top U.S. Performers	2013-2017
Clinical Care	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Uninsured	no data	11%	6%		9%	10.50%	2013-2017
Primary care physicians	867:1	911:1	1019:01:00		1207:01:00	1030 to 1 Top U.S. Performer	2014-2017
Dentists	no data	3407:1	1740 to 1		1270 to 1	1280 to 1 Top U.S. Performer	2016

Mental health providers	no data	852:1	500 to 1		230 to 1	330 to 1 Top U.S. Performer	2016
Preventable hospital stays per 1,000	17.3	17.9	20.8		8.5	no comparable data	2015-2017
Diabetic monitoring	88%	81%	90%		86%	91% top U.S. Performers	2018
% of FFS Medicare Population with Flu Vaccination	no data	29%	31%		40%	52% Top U.S. Performers	2016
Health Behaviors	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Adult smoking	10%	13%	15%		16%	14.00%	2018
Adult obesity Age Adjusted	27%	25%	16.40%		28.60%	39.80%	2014-2017, 2015-2016
No physical activity outside of work in the last month.	21%	20%	20.90%		17.90%	26.6% 2017	2018
% of Driving Deaths that are Alcohol-impaired driving deaths	no data	40%	56.00%		31.00%	13% Top U.S. Performer	2018
Health Outcomes	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Poor or fair health	14%	13%	14%		16%	17.6% crude rate	2016, 2017
Poor physical health days	4.4	3.1	3.70		3.80	4.00	2016, 2017
Poor mental health days	2.2	1.5	4.10		4.50	3.90	2016, 2017
Life Expectancy	no data	no data	79.5		79.6	78.6	2016, 2017
Frequent Physical Distress	no data	no data	11.00%		11.00%	12.00%	2016, 2017
Frequent Mental Distress	no data	no data	12.00%		14.00%	12.00%	2016, 2017
Children	**2010 Assessment Data**	**2016 Assessment Data**	**Current Assessment Data**	**County Rank**	**Oregon**	**U.S.**	**Year current data was collected**
Early Education Enrollment (% of 3/4 yr. olds in preschool)	Data not comparable	43.70%	43.00%	15	44.20%	48.00%	2018, 2015-2017
3rd Grade Math Proficiency	80.90%	57.90%	50.70%	6	45.40%	40.00%	2018, 2017
3rd Grade English Language Arts Proficiency	94.10%	56.80%	60.60%	2	44.80%	35.00%	2018, 2017
Abuse and Neglect Victims per 1,000 age 0-17	11	9	28	31	13	9	2018, 2017

Children in Foster Care	0.60%	2.30%	1.20%	17	1.20%	no comparable data	2018
Foster Care Aging Out	No data	No data	0.00%	1	9.00%	No comparable data	2018
Foster Care Placement Stability	100.00%	71.30%	36.40%	33	62.30%	No comparable data	2018
Child Food Insecurity	No data		24.40%	29	20.00%	18.00%	2018, 2016
Homeless Students	No data	3.30%	2.50%	8	4.00%	No comparable data	2018
Referrals to Juvenile Justice per 1,000 age 0-17	13	25	17	20	14	24	2018, 2016
Employment Related Day Care	No comparable data	122	9	NA		No comparable data	2018

APPENDIX: Integration of Care Assessment OHA Guidelines

Community Health Improvement Planning for Integrated Care

Guidelines to Meet HB 2675 Requirements

Authors Rick Kincade, MD and Lisa Ladendorff, LCSW

Background and Context:

During the 2017 Legislative Session, House Bill 2675 was passed. This bill amended ORS 414.627 that relates to Community Health Improvement Plan requirements that Coordinated Care Organizations must meet. Specifically, the bill stated that the Community Health Improvement Plan shall include a plan and a strategy for integrating physical, behavioral and oral health care services and may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
(b) Health policy;
(c) System design;
(d) Outcome and quality improvement;
(e) Integration of service delivery; and
(f) Workforce development.

The target audience for these guidelines are Coordinated Care Organizations and their Community Advisory Councils. The guidelines are intended to provide concepts, processes, tools, examples and resources to aid communities in developing meaningful and achievable goals and objectives that increase integration efforts across multiple sectors in a community. In addition to these guidelines, a recorded webinar is available for further training and instruction on their use. *(webinar link)*

The clinical and social value of integration has been clearly demonstrated in multiple health centers across the country. Bringing multi-disciplinary care to clinical environments has been most powerfully documented in the Patient Centered Primary Care Home programs, which has been a cornerstone of the OHA's primary care strategy. The introduction of dental care within the CCO delivery system has been deliberate, understanding the strong link between oral health and overall health outcomes. Integration of oral health services has been challenging in many communities, but has great potential for improving community health when implemented effectively.

The ultimate goal of integration is improved patient outcomes, improved patient experience, improved provider experience as well as a reduction of total cost of care. The financial impact of care integration has been demonstrated with increased efficiency, improved preventive services and more effective collaborative care plans. House Bill 2675 calls for collaborative community-based initiatives to purposefully integrate key services within the delivery system and ultimately within the programs addressing the social determinants of health.

Recommended Approach:

This guideline recommends the following approaches to add integration elements to the CCO Community Health Improvement plan:

1. Identify potential areas for integration and available resources using the MAPP Assessment model as a base and adding a 5th Care Integration Assessment to the current four MAPP Assessments.
    - The Care Integration Assessment will consist of a planning and preparation phase, a brainstorming phase, and an identification of resources and opportunities phase.
    - Two grids are provided to aid in the assessment process:
        i. General community grid that identifies areas of existing integration, areas of potential integration, and areas where integration is not possible or desirable.
        ii. Grid intended for oral health, primary care and behavioral health, that identifies areas of integration by level of integration (coordinated, co-located and fully integrated)

2. Create plans and strategies for implementing priority areas utilizing 10 domains of integration adapted from an AHRQ Behavioral Health Primary Care Integration Model. This will help you organize thinking about possible areas for integration initiatives and activities.
    - Two planning grids are provided to assist CHP planning groups in taking priority areas identified in the assessment and creating logical, meaningful and achievable goals and objectives for the plan.
        i. A domain assessment grid that allows the team to assess current efforts in the desired areas of integration by domain, as well as brainstorm possible next step goals.
        ii. A feasibility assessment grid for each potential goal/objective idea from the brainstorm that assesses for partnerships, readiness, and resources for each goal.

3. Utilize tool kits and examples provided in the appendices to operationalize the integration assessment and improvement planning processes. These resources consist of sample work plans, facilitator guides, sample assessment report and health improvement plan goals, and a reference list of toolkits covering a variety of sectors of integration.

Integration Assessment Process for CCO CHA:

Supplemental Care Integration Assessment – Overview

The OHA's CCO Care Integration Assessment, based off the MAPP Forces of Change Assessment, allows communities to assess the efforts to provide comprehensive services in the same location, optimally in a team setting, throughout strategic initiatives identified in the community health assessment (CHA) process. Specifically, questions should be addressed such as "How does this initiative bring oral health, mental health, and physical health services together to more effectively address the identified problem?" and "What are the barriers and opportunities identified to improve the integration of services across the initiative? The Care Integration Assessment provides critical information to the planning process in order to maximize the effectiveness of cross-sector community projects and programs.

Evidence for improved outcomes using integrated care models has been demonstrated across the country and the world.[23] Improving community health requires addressing the social determinants of health and improving the delivery systems designed to address health care needs. The Care Integration Assessment engages participants in brainstorming activities directed at identifying where integration exists in the community delivery systems, where gaps may be, and what resources would be necessary to assure initiatives have oral, physical, and mental health, as well as substance use treatment, readily available for community members.

This integration assessment tool is specifically designed to support Coordinated Care Organizations in identifying opportunities for integration. It is intended to be led and supported by the Community Advisory Councils with assistance from CCO staff.

[2] Essential Hospitlas Institute. Integrated Health Care: Literature Review. May 2013. http://essentialhospitals.org/wp-content/uploads/2013/12/Integrated-Health-Care-Literature-Review-Webpost-8-22-13-CB.pdf Accessed 5/23/18.

[3] McKinsety&Company. The evidence for integrated care. March 2015. https://www.mckinsey.com/~/media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/The%20evidence%20for%20integrated%20care/The%20evidence%20for%20integrated%20care.ashx Accessed 5/23/18.

How to Conduct the Care Integration Assessment:

Step 1 – Planning and preparation

- During this step a small planning team (hosted by the CCO's Community Advisory Council) prepares for one or more brainstorming sessions by identifying key leaders and content experts within the community, care providers, dates, locations, and facilitation. A communication plan should be developed to support this process. The planning team will oversee the process and collection of information.

Step 2 – Convening a brainstorming session to identify integration opportunities

- Next, the identified leaders will gather for the brainstorming activity. This will be a facilitated discussion in which participants share ideas, and identify integration gaps, required resources or reorganization of care delivery systems to maximize integration opportunities.

Step 3 – Identifying opportunities and resources necessary to improve integration as a means of reaching each strategic goal

- Once the list of opportunities and barriers are identified, the team will catalog possible community partners and funding streams for potential venues of community interaction. This information will be collated and passed on to the CHA steering committee, in the form of a report, for consideration as the MAPP process unfolds.

Care Integration Brainstorming Worksheet

The following worksheet is designed for the care integration assessment committee members to use in their preparation for a brainstorming session.

What is Care Integration?

Care integration is the purposeful presence or coordination of services maximally supporting a person or family at each opportunity for interaction with social and health systems.

Types of Integration:

- Coordinated: Care provided in separate locations and systems, focuses on communication.
- Co-located: Care provided in the same location but separate systems, focuses on physical proximity.
- Fully integrated: Care provided in the same location and system, focuses on practice change.

What areas or categories are included?

Consider integration of supporting systems, including the following:

1. Social Determinants of Health:
   - Social Services
     - Housing supports
     - Food services
     - Legal services
     - Transportation
   - Education
     - Primary
     - Secondary
     - Workforce planning
   - Income generation
     - Job skills training
     - Community development and planning

2. Health Care Systems:
   - Oral health
   - Physical health
   - Mental health[4]
   - Substance use treatment

[4] While the term behavioral health is sometimes used to refer to combined mental health and substance use treatment, in other settings is it used to refer to interventions focused on lifestyle behavior change. We have chosen to use the distinct terms of mental health and substance use treatment in order to be clear about what is constituted by these services, but also because in many communities, these services are not yet provided in an integrated setting.

- Public health

What are the opportunities for integration?

Think about the points of contact with individuals and families that could influence their health outcomes and well-being.

1. What are the points of contact?
2. What gaps in services could have been addressed, if available?
3. What systems of care would need to interact to improve efficiency in care delivery?
4. Where is care integration most effectively occurring today?
5. What are the current barriers to more effective integration?
6. Were there areas in the previous CHA/CHP in which integration improved outcomes? Could these be leveraged in the next CHP?
7. What opportunities or resources could be available during the next CHP cycle which could improve the chance of meaningful integration?

CARE INTEGRATION ASSESSMENT EXERCISES:

Community Integration Planning Grid:

The purpose of this planning grid is to identify the level of integration existing today, or with the potential to become integrated in the three years of the CHP planning cycle. For example, looking at housing environments, as you move across the horizontal axis, consider whether food security services, education services, and income development services are integrated into housing. This tool helps communities to identify opportunities for increasing the level of integration in those environments with targeted initiatives using community collaborative arrangements between service providers.

Strategic Area	Housing Services	Food Security	Education	Income	Oral Health	Physical Health	Mental Health	Substance Use Treatment	Public Health
Housing	X								
Food		X							
Education			X						
Income				X					
Oral Health					X				
Physical Health						X			
Mental Health							X		
Substance Use Treatment								X	
Public Health									X

Scoring Integration in the community:

1. *** Areas of existing integration
2. ### Value of potential integration
3. NA Areas where integration is not appropriate or possible

Focused CCO Services Integration Evaluation Grid:

Understanding that the CCO's have primary responsibility for coordination of Medicaid services in their communities, this evaluation grid is intended to be used at the plan level, but could also be applied at the organizational or provider association level to assess the degree of integration of these core services within care environments. Studies have demonstrated increasing value of integration (improved outcomes and lower total cost of care) as an entity moves from coordinated to being fully integrated. The goal of this assessment is to highlight areas of integration opportunity and develop plans for intentional service integration.

Level of Integration:

1. CC = Coordinated Care
2. CLC = Co-located Care
3. FIC = Fully Integrated Care

Services	Primary Care	Oral Health	Mental Health	Substance Use Treatment
Primary Care	X			
Oral Health		X		
Mental Health			X	
Substance Use Treatment				X

Understanding that different clinics have varying levels of integration, CCOs may wish to quantitate the percentage of patients served by Primary Care Provider (PCP) at each level of integration across the domains of oral health, mental health, and substance use treatment. Areas of significant gaps in higher levels of integration could be assisted in expanding integration with coordinated initiatives, alternative payment models, and grant based projects. This focused evaluation grid is meant to highlight programmatic opportunities within the compensated services of CCO's. Optimally, the desire to expand the impact of CCO's in their communities may lead their CHIP to mirror the Community's CHIP to include the broader discussion and plan including the social determinants of health.

Appendix: Integration Of Care Assessment Qualitative Data Results

Best Examples of Integration

- NEON-BHF-DHS/ Connecting students to medical care
- Early Head start, Integrating food security, Dental into daily classroom. Also Integrate parent ED and home visiting
- Community Health workers
- Watershed festival
- Direct scheduling of transportation to any appointment from mental health
- Partnering with the VA for focus groups on health improvement ideas and service provision
- Relationship with community connections, DHS, *DYS*, Law enforcement, courts, BHF, PC clinics, *WMH*
- DHF- Food Bank, SNAP, Food Banks, Fresh alliance
- K-readiness at the clinic, AsQ's provided, immediate follow up with ideas
- Community connection
- Drug Court
- Prevention work with BHF, WVCW- school, *court*, Girls C. Boy C. Character strong, Juvenile Dept. in all schools, ENT, JO, WAL, AH Ed.
- DHS
- VA choice, call schedule care for our veterans, work through referrals available "close" care for our veterans for vision, dental, etc.
- Prenatal care/ Home visiting, all prenatal receive an in clinic visit and warm hand off if needed
- Churches
- NEON- Hillock Ins. Health Ins. Medicare
- Staff on community boards, chamber, WVCW, WWMC, city council
- WVSL
- Education, Head Start, great services, getting our young members in a positive start and supportive to families.
- Behavior health professional in medical clinics
- RN at STOP/SART
- Group rounds, team based care across multiple types of supportive services
- Focus childcare network
- MDT
- Joseph Clinic, medical/ dental/ BH/ Pharmacy
- BH with Primary care
- WVNC
- Cradle to career
- Health fest
- WVCW counselors in the schools
- Direct Scheduling of patients to the pain clinic at primary care appointments

Best Opportunities for Integration

- Medical/ Pharmacy, Insurance Coverage
- Integrated professional development
- Schools with children, needing IEP's/ OT services etc.
- Middle class connection to programs and opportunities
- Just above poverty population, affordable housing, food security, insurance
- Housing- funds, refunds, resources
- Caregivers- agencies/ organizations, offering caregiver support, training, home visits etc.
- School counselors, lots of progress but still a need
- Teen work force, teen activities beyond norm, young adult, young parents
- Working poor, housing health
- Housing, transitional housing
- Substance use DX populations
- Senior meals/ community connection
- Existing but could expand, food services to families at risk, elderly
- Pre-K education/ High quality affordable childcare
- Childcare Providers/ offering expanding what early Head Start does for screenings to all providers in community
- Trauma Ed./ prevention in community
- Speech therapy schools, clinics, hospital
- School based health care
- Seniors and Palliative care
- Crisis situations
- Prevention/ outreach, speak series, wellness walks, diet/ nutrition around social detriments of health
- "Tele" opportunities
- Changing "built" environment to support health and wellness (engaging government in health)
- In home care
- Exercise/ movement in social environment
- Social SVCS, Health care, SVCS, Directory
- Childcare

Mental Health

1. *Areas of Integration*	2. *Opportunities for Integration*
Supported employment, Dual diagnose (SUD/ Mental or physical/ mental) Health coaching Bidirectional integration NEON, CFW, providers, law enforcement DHS, Community Connections, Courts, 24/7 crisis Safe Harbors in Schools Mental Health first aid	All PCP have mental health counselors or more, Co- location 4 days of school counselors in all school programs, hospital inpatient care Self-help/ education as route for pts to seek care (not "medicalized") LCAC CCO 2.0 Psych support workers
3. *Barriers to Integration*	4. *Resources Needed for Integration*
Stigma Current locations Staffing (been improving) Language/ communication between PCP and mental health workers Regulations/ Diff provider requirements from Px health Siloed funding, documentation complexity/ different standards, sets up siloed care/ competition It is difficult for patients that aren't Medicaid to get good mental health care in our county. This also needs to be integrated with physical heath Resources Lack of inpatient acute	Modernization of mental health (state level) Education to access tele health beyond location site treatment Regulation deconstruction at state Medicaid and federal CMS letters More school counselor F.T.E

Oral Health

1. *Areas of Integration*	2. *Opportunities for Integration*
School screenings by WWC and advantage "college" students OSHU and WWC First Tooth (? Repeat/ expand trainings?) NEON oral education- CHW training LCAC Increases dental services/ providers	Coordinating with local dentist who is the primary dentist (PCD) for patients at PCP info? State Law and dental student screening? LCAC Training all PCPs in dental blocks Targeting to opiate Rx Dental Van? VA- visits/ care Access to care for working poor School screenings in non- traditional programs Network of Care
3. *Barriers to Integration*	4. *Resources Needed for Integration*
Interest in coordination Fear of care Funding- specifically Medicare/ elderly and disabled Restorative care not paid for/ not affordable Senior oral health care Silo in funding Orthodontic out of the community VA not included Income levels vs. cost of care Limited Insurance coverage	Point person/ champion to bring people together Donation fund- raise funds in community to cover non-funded care Dental buy in to coverage Coverage barriers to use of plans and providers

Physical health

1. *Areas of Integration*	2. *Opportunities for Integration*
Co- Locations OCH in/ EPIC providence- Hospital TWC, WICW All clinic facilities have co-locations LCAC- providers ref. CM's to health-gym/yoga All PCP clinics together at med staff Group visits- high blood pressure, Diabetes Telehealth	Infrastructure Cross referrals, direct scheduling? At either PCP mental health, etc. Public indoor pool Increased vision providers Network of care LCAC VA Involvement to what is available Where patients present, i.e. SUD Tele-health (specialist coverage) CCO 2.0 School based health
3. *Barriers to Integration*	4. *Resources Needed for Integration*
Sharing patients' comfort If patients aren't Medicaid it's difficult for them to get mental health with our current county healthcare, this paired with physical health should be integrated Risky un-insured rate Regulations Space designed for integrated care and patient centered care Lack of confidentiality Access (include pharmacy) after hours/ weekends Prior auth quagmire Facilities affordable Walking paths Ropes courses	Coordinated extended hours among clinics so that community- wide hours Training providers to communicate coordination to patients Community buy in- partners funding- access Liability OSU buy in

Substance Use treatment

1. *Areas of Integration*	2. *Opportunities for Integration*
Prevention in the schools, teen screens, student wellness survey MAT protocol at WW, spread to all substances Drug Court Green relationship with L.E	Age specific treatment, substance specific treatment, awareness of consequences Coordinated education/ prevention wellness talks/ activities or social engagement Network of care School- youth School administration allowing for more coordination programs and education Education and standardized protocols for providers
3. *Barriers to Integration*	4. *Resources Needed for Integration*
Stigma Lack of inpatient SUD beds Confidentiality Limited resources School buy-in Social perception That it's ok to drink "Culture change" Parental awareness, acceptance, not a moral issue Community buy in Siloed funding Community awareness How to get integrated programs paid for	More person power Education/ normalizing Creating "dual Dx" treatment program- uniform requirement documentation Private health coverage doesn't cover treatment (Medicaid only) More funding or less siloed funding that pays for all the peripheral services that are not "billable"

Poverty/ Income

1. *Areas of Integration*	2. *Opportunities for Integration*
EHS/ Head Start- Income- based early education ERDC- employment related daycare (DHS program) Food programs: Free reduced lunch, summer lunch Some org are helping with food/ housing/ transportation Support employment WR programming	Social security benefits- services and support Supported employment for everyone Car seats Living wage jobs with workforce employers, supported employment Cost of living Community funding for SDOH that all agencies can access Resort prices for locals
3. *Barriers to Integration*	4. *Resources Needed for Integration*
Stigma Cost of food/ housing and transportation (Gas) being at the end of the road 100-200%, 300%, FPL/ Working poor Firm cut off rather than gradual Front desk catch of need, Schools, CPs, CHW Going from Medicaid- working poor La Grande services- Employment/ unemployment- social security Lack of support for economic growth Lack of education around SS benefits and employment	Safe, clean and affordable housing Government advocacy, state, feds, local Engaging local government Economic development

Housing services

1. *Areas of Integration*	2. *Opportunities for Integration*
Needed: more professional housing- mid level More low to mid income housing Youth housing Safe harbors Domestic Violence grant program- DHS program	All business across all sections partnering to brainstorm ideas on growing this market Single person units Multi-generational housing Housing collaborative (a la Union County) Little to no oversight of landlords
3. *Barriers to Integration*	4. *Resources Needed for Integration*
Money! Space! Construction workforce shortage! Stigma - NIMBY Disregard for housing laws Tiny house – zoning laws * Complicated Dev. Requirements Non-Hud-VASH USDA funding available/Pendleton to apply Community education/buy-in	Time to dedicate to meeting & identifying all people who are interested Local govt buy in * $ - time to write the fed/state grants Union HMUC assist Funding – community buy-in/support

Public Health

1. *Areas of Integration*	2. *Opportunities for Integration*
Disaster response Stop-gap measures for loss of health department	←RH Services are available ←Testing the HD used to do Multi-disciplinary community education WC Network of care Sanitation/health insp (restaurants, homes, business, pool) Smoking cessation/education – working w businesses WIC w home visitors & home visit How do you get 3 core PH functions to be stronger?
3. *Barriers to Integration*	4. *Resources Needed for Integration*
No public health dept $ needed Govt support needed Education about services No location for services not tied to a provider Fracture by the closure of the HD Poor communication re: where services are offered No anonymous space/system	More government (county) support Alert sense Point person/agency Space dedicated 21+ for smoking/tobacco use WIC funding level Advocate with the state for better PH partnership

Education

1. *Areas of Integration*	2. *Opportunities for Education*
Head Start Shared MH services ESD - + BHF Juv. Dept WVCW Jo Chart School vocational track Wallowa Elementary Special Education Shared prof. develop, ACES, Trauma informed Care PLTs	Long-term community led planning for a school-based health ctr. Including educators & parents of all classes from ground level ↑MH resources Family life education resources Vo-reh Colleges 0- schools Job fairs- ↑awareness of future opportunities Aligned calendars Network of care
3. *Barriers to Integration*	4. *Resources Needed for Integration*
No education resource location for beyond school (after hours) Parent buy-in/openness to integration offerings (those who don't need services are closing doors for those who do) * 3 different school system administrations * 4 plus alt ed Home school * 7th day 3 city schools + Troy/Imnaha Parents not engaged/overwhelmed or not sure where to find the resources too much info to track/radar ↓resources & support Mandated legislation	1 school with stronger education base Funding Community buy in Community knowledge Personnel shortage Cultivate inclusive culture Better networking (or on calendar) w/ ESD/superintendent – group office hours

APPENDIX: Community Member Survey 2019

Thank you for agreeing to take part in this short health information survey. The purpose of the survey is to gather information about the health of Wallowa County residents, so Wallowa County Providers and Community Leaders can design programs to better serve resident's health needs. Building Healthy Families, Northeast Oregon Network, Wallowa Memorial Hospital, Wallowa Valley Center for Wellness, Winding Waters Medical Clinic, and the Wallowa County Local Advisory Committee to the Eastern Oregon Coordinated Care Organization have joined together to develop and deliver this survey.

We will not ask for your name, address, or other personal information that might identify you. You do not have to answer any question you don't want to, and you can end the survey at any time. Any information you give will be confidential.

Please answer by checking the box and/or line next to the most appropriate answer (☑) and write in your answer where asked. When the survey is finished, please mail it back in the self-addressed stamped envelope included with the survey.

FIRST, PLEASE TELL US WHERE YOU CURRENTLY LIVE.

1. What zip code do you *currently* live in?

- ☐ ___ ___ ___ ___ ___ *[please write here]*
- ☐ Don't know

PART 1: PLEASE ANSWER A FEW QUESTIONS ABOUT YOUR CURRENT ACCESS TO HEALTH CARE.

2. Do you currently have any kind of *health care coverage*, including employer or individual health insurance, or government plans such as Medicare or Medicaid?

- ☐ **YES** → *Please tell us which of the following pays the MOST of the costs for your health insurance plan:*
  - ___ Medicare
  - ___ Yourself or another family member
  - ___ Medicaid or Oregon Health Plan (OHP)
  - ___Federal Tax Subsidies
  - ___ Employer
  - ___ Military (TriCare)
  - ___ Someone Else
  - ___ Don't know
  - ___ I do not want to give this information
- ☐ **NO (I am uninsured)** → *Please tell us if you were eligible for the Oregon Health Plan, or a subsidized Qualified Health Plan, would you apply to be enrolled?*
  - ___ YES
  - ___ **NO**→ *Please tell us why not? [write in the box below]*

Write Here

- ☐ Don't know if I have health insurance

3. If you currently have health care coverage, please check the box for each type of coverage listed below:

Medical Coverage
- ☐ Yes
- ☐ No
- ☐ I don't know

Mental Health Coverage
- ☐ Yes
- ☐ No
- ☐ I don't know

Dental Coverage
- ☐ Yes
- ☐ No
- ☐ I don't know

Vision Coverage
- ☐ Yes
- ☐ No
- ☐ I don't know

4. Have you been *uninsured* at any time in the past 12 months?

- ☐ **YES** → *Please tell us, is there anything other than cost that has prevented you from seeking medical coverage? [write in the box below]*

Write Here

- ☐ No
- ☐ Don't know
- ☐ I do not want to give this information

5. **In the past 12 months, did you have an injury, illness or condition that needed care right away in a clinic, emergency room or doctor's office?**
   - ☐ **YES** → *Please tell us, when you needed care right away, how often did you get care as soon as you thought you needed it?*
     - ___ Never
     - ___ Sometimes
     - ___ Usually
     - ___ Always
   - ☐ No
   - ☐ Don't know
   - ☐ I do not want to give this information

6. **In the past 12 months, did you have a dental health problem (bad tooth, pain, bleeding or infection) requiring care in a dentist's office, doctor's office, or emergency room?**
   - ☐ **YES** → *Please tell us, when you needed care right away, how often did you get care as soon as you thought you needed it?*
     - ___ Never
     - ___ Sometimes
     - ___ Usually
     - ___ Always
   - ☐ No
   - ☐ Don't know
   - ☐ I do not want to give this information

7. **In the past 12 months, did you have a stressful life event or mental health problem that needed care in a counselor's office, doctor's office or emergency room?**
   - ☐ **YES** → *Please tell us, when you needed mental health care, how often did you get care as soon as you thought you needed it?*
     - ___ Never
     - ___ Sometimes
     - ___ Usually
     - ___ Always
   - ☐ No
   - ☐ Don't know
   - ☐ I do not want to give this information

A personal doctor or healthcare provider is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt.

8. **Do you have a personal doctor or healthcare provider?**
   - ☐ **YES**→ *Please tell us, overall, are you very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied with the communication between you and your personal doctor or healthcare provider?*
     - ___ Very Dissatisfied
     - ___ Somewhat Dissatisfied
     - ___ Somewhat Satisfied
     - ___ Very Satisfied
     - ___ No communication needed or wanted
     - ___ Don't know
     - ___ I do not want to give this information
   - ☐ No
   - ☐ Don't know
   - ☐ I do not want to give this information

9. **During the past 12 months, how often did your doctors and other health care providers spend enough time with you (during your office visit)?**
   - ☐ Never
   - ☐ Sometimes
   - ☐ Usually
   - ☐ Always
   - ☐ Don't Know
   - ☐ Refuse

10. **When you are seen by doctors or other health care providers, how often are they sensitive to your family's values and customs?**
    - ☐ Never
    - ☐ Sometimes
    - ☐ Usually
    - ☐ Always
    - ☐ Don't Know
    - ☐ Refuse

11. **How long has it been since you last visited a dentist or dental clinic for any reason? Include visits to dental specialists, such as orthodontists.**
    - ☐ Within the past year (anytime less than 12 months ago)

- ☐ Within the past 2 years (1 year but less than 2 years ago)
- ☐ Within the past 5 years (2 years but less than 5 years ago)
- ☐ 5 or more years ago

12. In the past 12 months, did you or any members of your household seek medical care outside of your county of residence?

- ☐ **YES→** *Please tell us, did you travel to any of the locations listed below? [check all that apply]*
  ___ Baker County, OR
  ___ Union County, OR
  ___ Elsewhere in Oregon
  ___ Idaho
  ___ Washington
  ___ Other. Please specify: _____

  Please tell us, what kind of care did you travel outside of your county of residence to receive?
  ___ Care at an emergency room
  ___ Other hospital stay
  ___ Primary Care *(example: personal doctor)*
  ___ Specialty Care *(doctors that focus on one area of the body like a surgeon or heart doctor). → Please tell us what types of specialty care doctors you traveled to see. [write in the box below]*

Write Here

- ☐ No
- ☐ Don't know
- ☐ I do not want to give this information

NEXT PAGE →

PART 2: PLEASE READ EACH CIRCUMSTANCE BELOW AND TELL US HOW MUCH OF A PROBLEM IT HAS BEEN IN YOUR HOUSEHOLD IN THE PAST 12 MONTHS. PUT A CHECK IN THE BOX TO TELL US YOUR CHOICE.

Circumstance	Not a problem	Minor Problem	Moderate Problem	Major Problem	I don't want to give this information
EXAMPLE: The weather today.			✓		
Not having enough money to pay for housing.					
Not having enough money for food.					
Not having enough money to pay the utility bills.					
Trouble getting to work, to school or to get medical care because you didn't have transportation.					
Not having enough money to pay for, or get medical insurance.					
Not having enough money to pay for a doctor.					
Not having enough money to purchase prescriptions.					
Not having enough money to pay for a dentist.					
Problems with being homeless.					
Feeling stressed, anxious or depressed.					
Not being able to get help when you felt stressed, anxious or depressed.					
Having concerns about someone else's alcohol or drug use.					
Not being able to get help for someone else's alcohol or drug use concern.					
Having concerns about your alcohol or drug use.					
Not being able to get help for your alcohol or drug use concerns.					
Not being able to read well enough to fill out an application (like for a job).					
Feeling confident filling out medical forms by yourself.					
Problems learning about medical conditions because written material was hard to understand.					
Not being able to talk to someone about problems at work or with my housework.					
Not being able to talk to someone about my personal or family problems.					

Circumstance	Not a problem	Minor Problem	Moderate Problem	Major Problem	I don't want to give this information
Not feeling safe in my house from verbal, emotional or physical abuse.					
Not being able to get child care when I need it.					
Not being able to get elder adult care when I need it.					
Not being able to afford child care or preschool.					
I have a place to live today, but am worried about losing it in the future.					
I have the money for housing, but the type of housing I can afford is not available.					

PART 3: PLEASE READ EACH ITEM BELOW AND TELL US HOW MUCH OF IT YOU MIGHT LIKE TO SEE MORE OF IN YOUR LIFE IN THE NEXT 12 MONTHS. PUT A CHECK IN THE BOX TO TELL US YOUR CHOICE.

Service	I Need Less	Just Fine As It Is	I Need a Little More	I Need A Lot More
EXAMPLE: Swimming Pools			✓	
Parenting education and support.				
No or low cost places to exercise.				
Places to buy healthy and low cost food.				
Connection with social activities, such as more time to spend with my friends or in community activities.				
Connection with family members.				
Opportunities to reduce stress in my life.				
Sense of meaning and purpose about my life.				
Opportunities to develop my spiritual life and share it with others.				
Opportunities for education and support on improving my eating.				
Opportunities for preschool for my child.				
Opportunities for teenage activities for my child.				
Other: Please Write In				

PART 4: PLEASE TELL US ABOUT YOUR HEALTH STATUS. YOUR RESPONSES WILL ASSIST THE COMMUNITY IN GETTING THE RESOURCES WE NEED TO CARE FOR NORTHEAST OREGON RESIDENTS.

13. Have you ever been told by a doctor that you have…? *(check all that apply)*

- ☐ Type II Diabetes
- ☐ Pre-Diabetes
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Mental Health Issues such as:
  - ___ Anxiety
  - ___ Depression
- ☐ Dental Issues such as:
  - ___ Cavities
- ☐ None of the above
- ☐ Don't Know
- ☐ I do not want to give this information

14. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

- ☐ ___= Number of days *[write in the blank]*
- ☐ None
- ☐ Don't Know
- ☐ I do not want to give this information

15. Now thinking about your dental health, which includes tooth pain or infection, for how many days during the past 30 days was your dental health not good?

- ☐ ___= Number of days *[write in the blank]*
- ☐ None
- ☐ Don't Know
- ☐ I do not want to give this information

16. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

- ☐ ___= Number of days *[write in the blank]*
- ☐ None
- ☐ Don't Know
- ☐ I do not want to give this information

17. About how long has it been since you last visited a doctor for a routine checkup? A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition.

- ☐ Within past year (anytime less than 12 months ago)
- ☐ Within past 2 years (more than 1 year but less than 2 years ago)
- ☐ Within past 5 years (more than 2 years but less than 5 years ago)
- ☐ 5 or more years ago
- ☐ Don't know
- ☐ Never
- ☐ I do not want to give this information

18. About how long has it been since you last visited a dentist for a routine checkup? A routine checkup is a teeth cleaning, x-rays, and exam by a dentist.

- ☐ Within past year (anytime less than 12 months ago)
- ☐ Within past 2 years (more than 1 year but less than 2 years ago)
- ☐ Within past 5 years (more than 2 years but less than 5 years ago)
- ☐ 5 or more years ago
- ☐ Don't know
- ☐ Never
- ☐ I do not want to give this information

19. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation?

- ☐ ___= Number of days *[write in blank]*
- ☐ None
- ☐ Don't Know
- ☐ I do not want to give this information

20. During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ I do not want to give this information

21. Do you have any disabilities that prevent you from working for paid employment?

- ☐ Yes
- ☐ No
- ☐ Don't know

- ☐ I do not want to give this information

22. Do you have any disabilities that require adjustments for you to work for paid employment?
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ I do not want to give this information

PART 5: PLEASE TELL US SOME GENERAL INFORMATION ABOUT YOURSELF.

23. What is your age?
- ☐ 15 to 19 years
- ☐ 20 to 24 years
- ☐ 25 to 34 years
- ☐ 35 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 59 years
- ☐ 60 to 64 years
- ☐ 65 to 74 years
- ☐ 75 to 84 years
- ☐ 85 years and over
- ☐ Don't Know
- ☐ I do not want to provide this information

24. Are you male or female?
- ☐ Male
- ☐ Female
- ☐ I do not want to give this information

25. Are you of Hispanic, Latino or Spanish origin?
- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ I do not want to provide this information

26. What is your race?
- ☐ White
- ☐ Black
- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Other. *Please specify:* _____
- ☐ Don't know
- ☐ I do not want to give this information

27. Are you… (relationship status)
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Never Married, or Single
- ☐ A member of an unmarried couple
- ☐ Don't know
- ☐ I do not want to give this information

28. What is the highest grade, year of school, or degree you completed?
- ☐ Never attended school or only attended kindergarten
- ☐ Grades 1 through 8 (Elementary or Middle School)
- ☐ Grades 9 through 11 (Some high school)
- ☐ Grades 12 or GED (High school graduate)
- ☐ College 1 year to 3 years (Some college)
- ☐ College 4 years or more (College graduate)
- ☐ Graduate school (Graduate degree)
- ☐ Don't know
- ☐ I do not want to give this information

29. Are you… [*PLEASE CHECK ALL THAT APPLY]*
- ☐ Employed for wages full time
- ☐ Employed for wages part time or seasonally
- ☐ Self-employed full time
- ☐ Self-employed part time or seasonally
- ☐ Out of work for more than one year
- ☐ Out of work for less than one year
- ☐ Currently seeking employment
- ☐ A homemaker
- ☐ A student
- ☐ Retired
- ☐ Don't Know
- ☐ I do not want to give this information

Please tell us about your current housing situation.

30. Are you…?
- ☐ A Renter
- ☐ A Homeowner
- ☐ Living in a residence in which I do not pay rent
- ☐ Homeless
- ☐ Don't Know
- ☐ I don't want to give this information

31. What is your annual household income from all sources?
- ☐ _____ per year [*write amount]*
- ☐ Don't know
- ☐ I don't want to give this information

32. How many adults ages 18 years or older live in your household (including yourself)?
- ☐ _____ *[write number]*
- ☐ Don't know
- ☐ I don't want to give this information

33. How many children less than 18 years of age live in your household?

- ☐ _____ *[write number]* → *Please complete the Section: Children on the next page.*
- ☐ Don't know
- ☐ I don't want to give this information

PARENTS AND GUARDIANS, PLEASE COMPLETE THE LAST PAGES →

THANK YOU FOR YOUR TIME. YOUR RESPONSES ARE VERY IMPORTANT TO UNDERSTANDING THE HEALTH OF WALLOWA COUNTY.

SURVEY RESULTS WILL BE AVAILABLE ON THE NORTHEAST OREGON NETWORK WEBSITE WWW.NEONOREGON.ORG IN JUNE, 2019.

IF YOU ARE NOT THE PARENT OR GUARDIAN OF ANY CHILDREN UNDER THE AGE OF 18 YEARS IN YOUR HOUSEHOLD, WE HAVE NO FURTHER QUESTIONS FOR YOU.

PLEASE RETURN THE COMPLETED QUESTIONNAIRE TO THE NORTHEAST OREGON NETWORK IN THE SELF-ADDRESSED STAMPED ENVELOPE PROVIDED WITH THE SURVEY.

SUPPLEMENTAL SECTION ON CHILDREN: IF YOU ARE A PARENT OR GUARDIAN OF ANY CHILDREN UNDER 18 YEARS OF AGE IN YOUR HOUSEHOLD, PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. **Do your children have a personal doctor or health care provider?**
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
   - ☐ I don't want to give this information

2. **Do your children have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare?**

   ☐ **YES**, **ALL OF MY CHILDREN ARE INSURED→** *Please tell us which of the following pays the MOST of the costs for your children's health insurance plan:*
   ___ Medicare
   ___ Yourself or another family member
   ___ Medicaid or Oregon Health Plan (OHP)
   ___ Employer
   ___ Military (TriCare)
   ___ Someone Else
   ___ Don't know
   ___ I do not want to give this information

   ☐ **YES**, **SOME OF MY CHILDREN ARE INSURED→** *Please tell us which of the following pays the MOST of the costs for your children's health insurance plan:*
   ___ Medicare
   ___ Yourself or another family member
   ___ Medicaid or Oregon Health Plan (OHP)
   ___ Employer
   ___ Military (TriCare)
   ___ Someone Else
   ___ Don't know
   ___ I do not want to give this information

   ☐ **NO, NONE OF MY CHILDREN ARE INSURED)** → *Please tell us If your children were eligible for the Oregon Health Plan or a subsidized Qualified Health Plan, would you apply to be enrolled?*
   ___ YES
   ___ **NO→** *Please tell us why not?*
   [write in the box below]

Write Here

   - ☐ Don't know if my children have health insurance
   - ☐ I do not want to give this information

3. **Have any of your children been uninsured at any time in the past 12 months?**

   ☐ **YES** → *Please tell us, is there anything other than cost that has prevented you from seeking medical care for your children? [write in the box below]*

Write Here

- ☐ No
- ☐ Don't know
- ☐ I do not want to give this information

4. **During the past 12 months, how often did your children's doctors and other health care providers spend enough time with your children (during their office visit)?**
   - ☐ Never
   - ☐ Sometimes
   - ☐ Usually
   - ☐ Always
   - ☐ Don't Know
   - ☐ Refuse

5. **When your children are seen by doctors or other health care providers, how often are they sensitive to your family's values and customs?**
   - ☐ Never
   - ☐ Sometimes
   - ☐ Usually
   - ☐ Always
   - ☐ Don't Know
   - ☐ Refuse

6. **Have you ever been told by a doctor that any of your children have…?** ***(check all that apply)***
   - ☐ Type II Diabetes
   - ☐ Pre-Diabetes
   - ☐ Asthma
   - ☐ Mental Health Issues such as:
     - ___ ADHD
     - ___ Anxiety
     - ___ Depression
   - ☐ Dental Issues such as:
     - ___ Cavities
   - ☐ None of the above
   - ☐ Don't know
   - ☐ I don't want to give this information

7. **In the past 12 months, did any of your children have an injury, illness or condition that needed care right away in a clinic, emergency room or doctor's office?**
   - ☐ **YES** → *Please tell us, when your children needed care right away, how often did they get care as soon as you thought they needed it?*
     - ___ Never
     - ___ Sometimes
     - ___ Usually
     - ___ Always
   - ☐ No

- ☐ Don't know
- ☐ I do not want to give this information

8. **In the past 12 months, did any of your children have a dental health problem (bad tooth, pain, bleeding or infection) requiring care in a dentist's office, doctor's office, or emergency room?**
   - ☐ **YES** → *Please tell us, when your children needed care right away, how often did they get care as soon as you thought they needed it?*
     ___ Never
     ___ Sometimes
     ___ Usually
     ___ Always
   - ☐ No
   - ☐ Don't know
   - ☐ I do not want to give this information

9. **In the past 12 months, did any of your children have a stressful life event or mental health problem that needed care in a counselor's office, doctor's office or emergency room?**
   - ☐ **YES** → *Please tell us, when your children needed mental health care, how often did they get care as soon as you thought they needed it?*
     ___ Never
     ___ Sometimes
     ___ Usually
     ___ Always
   - ☐ No
   - ☐ Don't know
   - ☐ I do not want to give this information

END OF SURVEY. THANK YOU!