PROVIDENCE
Hood River
Memorial Hospital

2019 Community Health Needs Assessment Executive Summary

Providence Hood River Memorial Hospital (Hood River, Oregon)

Understanding and Responding to Community Needs, Together

Improving the health of our communities is fundamental and a commitment rooted deeply in our heritage and purpose. As expressions of God's healing love, witnessed through the ministry of Jesus, our mission calls us to be steadfast in serving all with a special focus on our most poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets and opportunities. In the Columbia Gorge region, Providence Hood River Memorial Hospital (PHRMH) and 16 other regional community organizations, coordinated by the Columbia Gorge Health Council (CGHC) are learning and working together to improve the health and health care resources of Columbia Gorge residents. The collaborative brings together four hospitals, seven counties, three coordinated care organizations, and several social service agencies to produce a shared regional needs assessment.

PHRMH serves several counties in the Columbia River Gorge with its primary service area being the City of Hood River and greater Hood River County, Oregon. The facility is a 25-bed critical access hospital offering primary and specialty care, birth center with family suites, general surgery, radiology, diagnostic imaging, pathology and 24/7 emergency medicine. The surrounding six counties represented in the collaborative CHNA are primarily served by other area hospitals. The 2019 PHRMH CHNA was approved by the Service Area Advisory Council on November 20, 2019 and made publicly available on December 19, 2019.

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Our Starting Point: Gathering Community Health Data and Community Input

Through a mix-method approach using quantitative and qualitative data, the CHNA process utilized several sources of information to identify community needs. As part of the collaborative CHNA, public health data sources accessed for this report include the U.S. Census, Oregon and Washington Healthy Teen Survey, Oregon Health Authority (OHA) Immunization Program Data, and Hood River and Klickitat County Public Health, the Robert Wood Johnson County Health Rankings, the OHA 2018 Mental Health Survey, among others. An online and mailed Community Health Survey reached out to 2,500 residents in the Spring of 2019, using an address-based random-sampling of residents in the Columbia Gorge service area, yielding 373 responses. Another 448 surveys were hand-fielded at a variety of community events and locations throughout the survey period with the intent of accessing responses from specific populations at higher risk of disparities. Targeted populations for input included people with low incomes, as well as people with a variety of identities and experiences including older adults, young people, people who identify as LGBTQ+, Hispanic/Latinx people, people of color, recent immigrants, people experiencing homelessness, and rurally residing individuals. Some key findings:

- More than one in ten (11.5%) respondents and more than one in five (22.1%) low-income respondents currently lack stable housing or are worried about losing it soon. The affordable housing supply does not meet the demand among residents, particularly renters, resulting in housing insecurity, homelessness and stress among other health issues.
- 56.8% of survey respondents reported having been diagnosed with at least one chronic physical condition, and 29.7% report at least one chronic behavioral health condition with significantly higher impact on populations below 200% Federal Poverty Level (FPL).
- Behavioral health disparities exist by family income, with those at 200% or below FPL having significantly higher rates of depression and anxiety (39.1%). 1 in five (20.3%) reported particular concerns with social isolation.
- Nearly 6 in 10 (58.4%) survey respondents reported experiencing an unmet dental need in the last year, suggesting access to dental care may be a key challenge in the Columbia Gorge.

For more information, on the CHNA methods and process please see the full CHNA document beginning on page 15 available on the CGHC website, and attached to this report: http://cghealthcouncil.org/documents.

Identifying top health priorities, together

The requirements placed on hospitals, health departments and coordinated care organizations for the scope of a community health assessment do not fully overlap. To blend the information in a cohesive manner, we used the Robert Wood Johnson Foundation (RWJF) Culture of Health Action Framework to group similar content and themes. The Action Framework was adopted and adapted for the 2017

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Regional Community Health Improvement Plan (CHIP), providing continuity and further community alignment.

The data selected for inclusion in this assessment, including the design and content of the community health survey itself, is the result of a series of meetings, beginning with a gathering of the collaborative CHNA members in September of 2018. The Community Advisory Council of the Columbia Gorge Health Council served as the forum for the collaborative representatives, community members and other health and human services agencies to provide input and analysis in determining the 2019 CHNA health priorities.

Providence Hood River Memorial Hospital 2019 Priority Needs

The collaborative CHNA identified a wide spectrum of priority areas, some of which are most appropriately addressed by other partners. Considering PHRMC's unique capabilities, community partnerships, and potential areas of collaborative community impact, we are committed to addressing the following priority areas as aligned with the collaborative CHNA priority areas:

Priority #1: Social determinants of health resulting from poverty and inequity – focus areas in housing, transportation, and food security; includes coordination of supportive services.

Priority #2: Chronic health conditions – focus on prevention of obesity, diabetes, hypertension, and depression.

Priority #3: Community mental health/well-being and substance use disorders - focus on prevention (particularly for youth), culturally responsive care and health education, social isolation, and community building.

Priority #4: Access to health services – Focus on services navigation and coordination, culturally responsive care and oral health.

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that inevitably occur. A full accounting of data limitations can be found in the Appendix G of the Gorge Area 2019 Community Health Survey (http://cghealthcouncil.org/documents). The Community Health Improvement Plan (CHIP) development will consider the prioritized health needs identified through this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies.

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Measuring Our Success: Results from the 2016 CHNA and 2017-2019 CHIP

This report also evaluates the results from our most recent CHNA and CHIP. Identified priority needs from the 2016 CHNA included: access to care, behavioral health, chronic conditions and social determinants of health and well-being. PHRMH responded by making investments of direct funding, time, and resources to internal and external programs that were most likely to have an impact on the previously prioritized needs. This summary includes just a few highlights of our efforts across the Hood River County service area.

In addition, we invited written comments on the 2016 CHNA and 2017-2019 CHIP reports through website and published contact information, made widely available to the public. No written comments were received on the 2016 CHNA and 2017-2019 CHIP.

Priority Need	Program or Service Name	Results/Outcomes 2016-2019	Type of Support
Social Determinants of Health and Well-being	The Next Door and Immigration Counseling Service	Assists immigrants relocating in the Gorge. In 2018, this partnership helped 42 immigrants in the Hood River community obtain and maintain immigration status.	Grant
	Gorge Ecumenical Ministries/ Hood River County Government	Developed an ID card to enable vulnerable community members to access vital services, enhance public safety and increase the sense of belonging in the community. The goal is to enroll 5,000 people in the ID program over the next three years beginning in 2019.	Grant
	Mid-Columbia Economic Development District - Transportation Innovations Through Collective Impact Project	Brought stakeholders together to inventory current collective resources and to identify unmet transportation needs that prevent residents from accessing mental and public health services, healthy foods, and making social connections. Project outcomes	Grant

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		included stakeholder identification of prioritized projects and commitment to seeking funding for implementation of identified solutions.	
Access to Care	Hood River Family Medicine Residency Program	Four full-time primary care residents providing health care services at the local Federally Qualified Health Center.	Education
Chronic Conditions	North Central Public Health District	The Youth Fit 4 Life Program offered at Mid Valley Elementary School in Odell, OR with an estimated 150-200 student participants benefitting.	Grant
	Oregon Food Bank (OFB)	In 2017/2018 opened two school-based food pantries at local elementary schools. These pantries served 1,214 individuals (378 families) nearly 20,000 pounds of food. Family members shared that the fresh foods programs were unlike any previous food assistance.	Grant
	Gorge Grown Food Network – Veggie Rx Program	Provides fresh fruit and vegetables to 50 low income mothers and their families enrolled in the Hood River Health Department WIC program. Families receive $30 worth of produce/month per family member over the course of 15 months (9 months of pregnancy and 6 months postpartum). Education classes include cooking, gardening, exercise, and breast feeding.	Grant
	One Community Health (OCH)	Supported 12-week community-based health education courses in English and Spanish facilitated by Community Health Workers. “Steps to Wellness” empowers class participants to adopt	Grant

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		healthy lifestyle behaviors and prevent or manage chronic diseases.	
	Columbia Gorge Education Service District	Playworks Programs were incorporated into 10 elementary schools supporting learning and physical activity by providing safe, inclusive play opportunities during recess. In 2018, approximately 3,300 kids learned fun ways to stay active through the power of play.	Grant
Behavioral Health	The Next Door, Inc	Funded a collective impact specialist to secure grant funding for an Oregon Health Authority approved curriculum for mental health promotion in the Spanish-speaking immigrant community.	Grant & In-Kind

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COMMUNITY RESOURCES POTENTIALLY AVAILABLE TO ADDRESS THE SIGNIFICANT HEALTH NEEDS IDENTIFIED THROUGH THE CHNA

PHRMH cannot address the significant community health needs independently. Improving community health requires collaboration between community stakeholders and organizations. Below outlines a list of community resources potentially available to address identified community needs. This list is non-exhaustive and with likely changes in services and office locations over time, the information may need to be updated accordingly.

Organization Type	Organization or Program	Services offered	Address	Significant Health Need Addressed
Social Services	Gorge Ecumenical Ministries	Uniting diverse communities of faith through our common concerns and actions for justice, freedom, peace, and environmental care.	400 11th Street, Hood River, OR 97031	SDOH and wellbeing
Social Services	Gorge Grown Food Network	Building a resilient and inclusive regional food system that improves the health and well-being of our community	203 2nd St., Hood River, OR 97031	SDOH and wellbeing, Chronic Conditions
Social Services	The Next Door	The Next Door has over two dozen programs that support and empower people in our community	965 Tucker Rd Hood River, OR 97031	Access to care; SDOH and well-being, Chronic Conditions
Social Services	The Columbia Gorge Food Bank	Sources and receives donations from grocery stores, local orchards and farmers and food drives.	3610 Crates Way, The Dalles, OR 97058	SDOH and wellbeing, Chronic Conditions
Public Health	North Central Public Health District	The only three-county local health department in Oregon, serving Wasco,	419 E 7th #100, The Dalles, OR 97058	Chronic conditions

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		Sherman, & Gilliam Counties.		
Social Services	FISH Food Bank	To help alleviate hunger by distributing food regularly and on an emergency basis.	1130 Tucker Road, Hood River, OR 97031	SDOH and wellbeing, Chronic Conditions
Public Health	Hood River County Health Department	Serving Hood River County	1109 June St., Hood River, OR 97031	Chronic Conditions
Education	Columbia Gorge Education School District	Providing equitable, high quality, cost-effective and locally responsive educational services at a regional level.	400 East Scenic Drive, Suite 207, The Dalles, OR 97058	SDOH and wellbeing, Chronic Conditions
Education	Columbia Gorge Community College	Community college with two locations in the Gorge serving about 800 students, including health professions.	400 E. Scenic Drive, The Dalles, OR 97058	Access to care
Social Services, Healthcare	One Community Health	Federally-Qualified Health Center serving The Columbia River Gorge.	849 Pacific Ave., Hood River, OR 97031	Access to care

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2019 CHNA GOVERNANCE APPROVAL

The 2019 PHRMH CHNA was approved by the PHRMH's Service Area Advisory Council November 20, 2019 and made publicly available on December 19, 2019.

12/6/2019

Jeanie Vieira, RN — Date
Chief Executive, Columbia Gorge Service Area

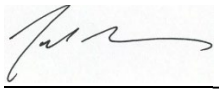
12/6/2019

Lisa Vance — Date
Chief Executive, Oregon Region

Joanne Warner

12/9/2019

Joanne Warner — Date
Chair, Oregon Community Ministry Board



12/11/2019

Joel Gilbertson — Date
Senior Vice President, Community Partnerships, Providence St. Joseph Health

CHNA/CHIP contact:

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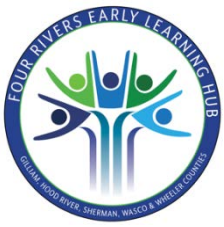
Request a copy free of charge or provide comments: communitybenefit@providence.org. View electronic copies of current and previous community health needs assessments: https://www.psjhealth.org/community-benefit/community-health-needs-assessments

Appendix 1. Columbia Gorge Regional Community Health Assessment 2019

Columbia Gorge Regional Community Health Assessment 2019



About the Region and the Community Health Assessment

The Columbia Gorge Region includes seven counties along the Columbia River. The region includes Hood River, Wasco, Sherman, Gilliam, and Wheeler counties in Oregon plus Skamania and Klickitat counties in Washington. Combined, these counties cover 10,284 square miles and are home to a population of approximately 84,000.

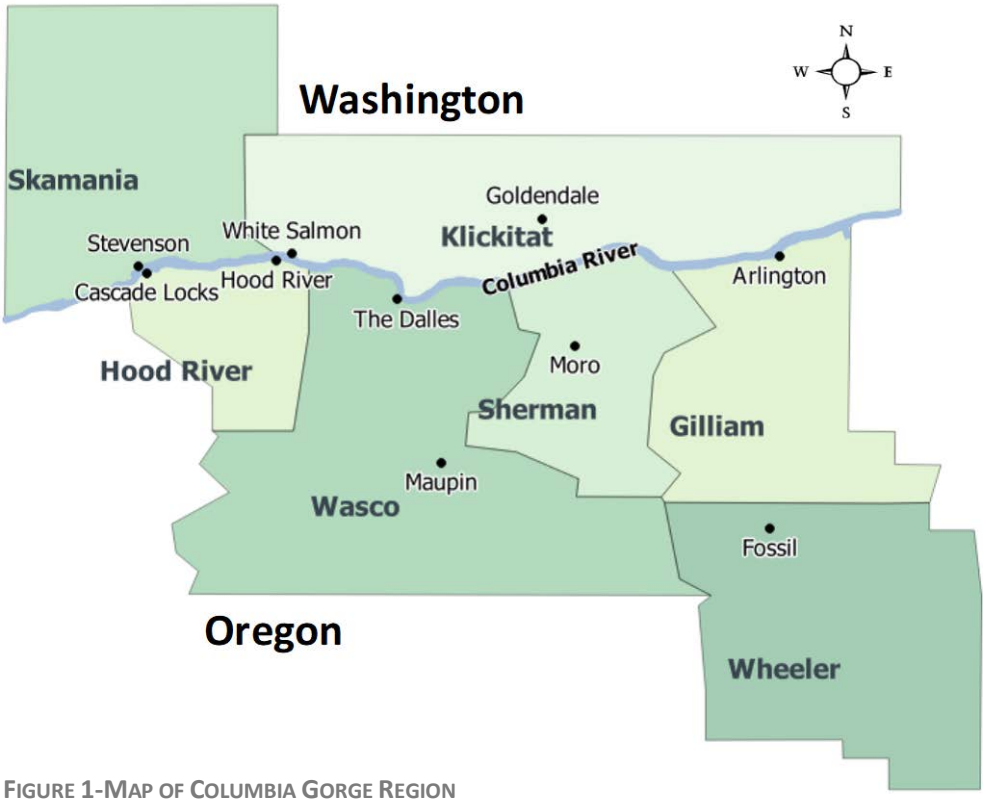


FIGURE 1-MAP OF COLUMBIA GORGE REGION

The Columbia Gorge Region is a mostly rural area with only a few towns that are larger than 1,000 people. Agriculture is a large industry in almost every county. Tourism, healthcare, forestry, and growing technology firms also drive the economy. Many of our industries rely on seasonal employment. Therefore, we experience a large influx of workers, especially migrant and seasonal farmworkers.

When gathering information for this Regional Community Health Assessment, we did best efforts to include similar information for all seven counties. Sometimes, information is only available for a subset of the population or we intentionally looked at a subset of the population. Whenever information is about a subset of the community, we clarified what portion of the population is included. Otherwise, the information is inclusive of all seven counties.

Because many of our local organizations are required to conduct a community health assessment, we chose to do this work collaboratively. The seventeen organizations highlighted on the cover page are part of the 2019 Regional Community Health Assessment cohort. More details about the cohort, the demographics and the organization of the content can be found starting on page 15.

Executive Summary

The Columbia Gorge Health Council and its partners are pleased to present the third collaborative regional Community Health Assessment (CHA) for the Columbia Gorge region. In the Columbia Gorge, we have taken the CCO model, infused in it our own local ideas and experiences, and created something unique that is both responsive to, and useful for, our community.

While every CCO is required to conduct its own CHA, the Gorge has put its own spin on the process. In our case, this CHA is built on collaboration. Led by the Columbia Gorge Health Council, the tri-annual CHA process starts with the 'Cohort' the 17 community partners who contributed funds and who have agreed to adopt the CHA as their organization's CHA. In addition, numerous community organizations listed on page 12 agreed to disseminate, administer and collect surveys from individual community members. These consumer surveys provide the backbone of data for the CHA.

Challenges

Health equity – or the lack thereof – is an issue that is difficult to identify through individual data points. We recognize that equity is a collection of conditions that cannot be 'solved' by a single action. It takes multiple, cross-sector, ongoing efforts to create true health equity. To this end, we, as a community, strive to include and elevate those voices of those who are impacted most by inequities and who historically have been most excluded from decision-making.

In the Gorge, we believe that each person is an expert in their own lived experience. We elevate and honor their voices by asking, listening and responding to those voices. In practice, this includes the Community Advisory Council (CAC) reviewing the survey questions, converting the surveys into plain language in addition to Spanish, and hand-fielding surveys to ensure responses from those people most affected by health inequities.

The 2019 CHA process has not been without challenges. Because this is our third CHA process, we have been able to identify issues that fall between the data. For example, we understand that the Federal Poverty Level (FPL) does not reflect true challenges and struggles for households in the Columbia Gorge due to the cost of housing (officially a designated housing burdened community). Thus, 2019 CHA uses 200% of the FPL to identify 'low-income', which we recognize is still inadequate to fully define income inequality.

In another example, while we received more survey responses from American Indian or Alaska Native community members as compared to 2016, the numbers are still small and make it difficult to assess the inequities faced by this segment of our community. This is a challenge the CHA Cohort and agency partners will address in the upcoming Community Health Improvement Plan (CHIP) process and in future versions of the CHA itself.

Moving Forward

Despite these challenges, the CHA/CHIP has become the foundation we use to build a healthier community. The CHA has helped this community develop a common understanding of its health needs while adopting a broad definition of health that includes food, housing, transportation, sense of community, and access, along with traditional physical, mental, and dental health. The next step in our

process is to hand this CHA over to our Community Advisory Council to create our third Community Health Improvement Plan (CHIP).

Using previous versions of the CHA/CHIP, community partners have created countless programs that address our broad health needs, and which have brought in more than $12 million in outside funding. The CHA and these collaborations were a significant reason the Columbia Gorge was awarded the Robert wood Johnson Foundation Culture of Health Prize in 2016.

It is our sincerest hope and belief that the 2019 CHA will continue to propel our community forward. We are confident that community providers of all types – healthcare, human service, social service, public health, prevention and promotion – will use this data to design and implement more new, innovative ideas to improve health and overall wellness in the Gorge. It is also our sincere hope that this CHA and the soon-to-come CHIP will spur more participation from individual community members, and more agency collaborations especially with education, business, and elected officials.

To those of you who already use this CHA we thank you. To those of you who don't yet use this CHA, please join us as we work to improve the health of both individuals and the entire community that is the Columbia Gorge.

The next eight pages highlights the key information from the detailed document.

A few notations for the Execuitve Summary information that follows.

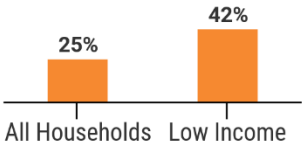
- Most data are rounded to the nearest percent for presentation purposes in the Executive Summary. Details can be found in the body of the document.
- Unless otherwise stated, data is either 2018 or 2019 information.
- When we use Oregon or Washington, we mean the 7 counties in our region. Oregon includes Gilliam, Hood River, Sherman, Wasco, and Wheeler counties. Washington includes Klickitat and Skamania counties.
- Five different surveys are referenced in this document. From the Consumer Health Survey, we use the following notations:
  - Adults are all responses from the Consumer Health Survey.
  - Parents are adults with one or more child ages 0-17 in the household.
  - Parents of children ages 0-5 have infants or toddlers in the household.
  - Caregivers are adults who are performing caregiving services for another adult.
  - Diverse Communities are Adults who self-reported their race or ethnicity as any combination of Latino or Hispanic, American Indian or Alaska Native, Asian or Asian American, Black or African American and Other.
  - Low Income households are defined as <200% Federal Poverty Level (FPL) or $24,120 per year for single adults and $49,200 per year for a family of 4.
  - Medicaid means the Adult completing the survey has Medicaid as their health insurance including those who have both Medicaid and Medicare.
- Students means responses from the Student Wellness Survey or Healthy Teen Survey.

Sense of Community

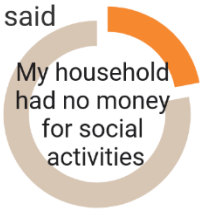
People with **social** and **family supports**, a sense of **security** and **belonging** have better physical and mental health and are more likely to thrive.

Social Supports means - people feel loved, wanted and have someone to help in times of need.

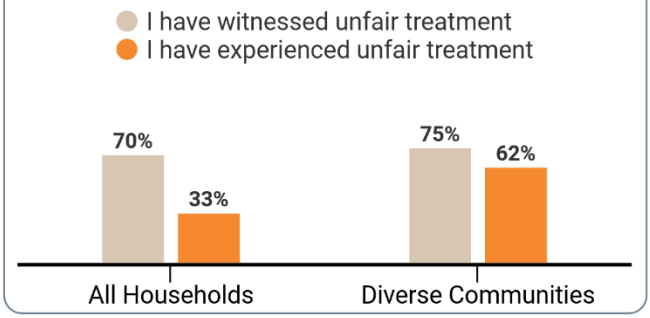
% of Adults who did not have enough social supports:



22% of Adults said



Belonging means - all people are treated fairly. This includes all races, ethnicities, genders, and sexual orientations.



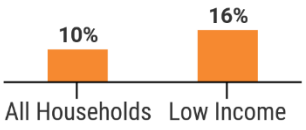
Family Supports means - people can meet the needs of their family from young children to aging parents.

34% of Parents said

50% of Caregivers said

Security means - people feel safe in their neighborhoods and trust their neighbors.

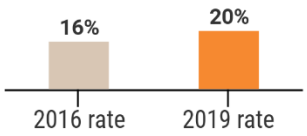
% of Adults who do not feel safe:



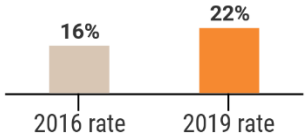
82% of Adults said

Traumatic events cause physical, emotional, spiritual or psychological harm. People with trauma can feel threatened, anxious or frightened and can have long term chronic health conditions.

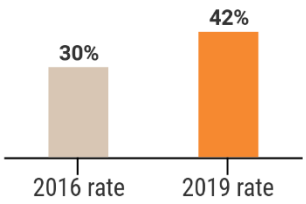
% of Adults who said I was made to do something sexual that I did not want to do:



% of Adults who said I was physically hurt or threatened by an intimate partner:



% of Adults who said I witnessed or experienced violence:

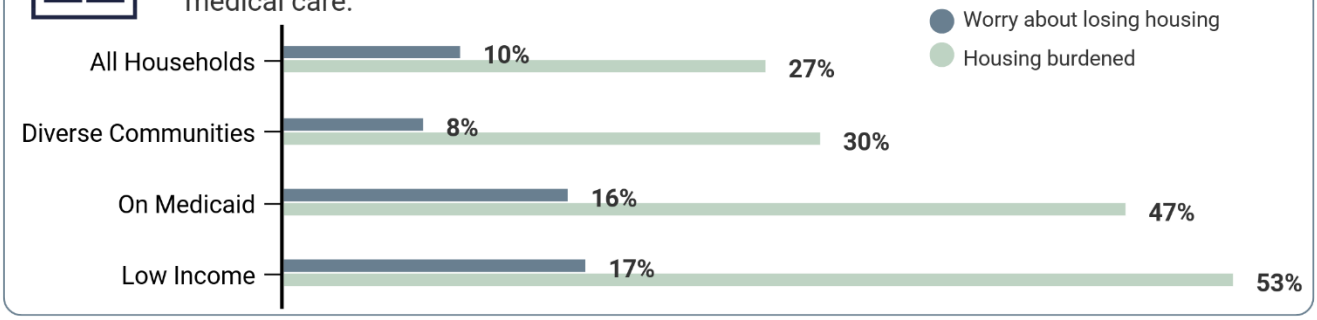


Find details starting at Sense of Community on page 19 and Early Education on page 32 of the **Columbia Gorge Regional Community Health Assessment 2019** at cghealthcouncil.org. Data sources: R2, R3.

Built Environment, Part 1

This means the places where we live, learn, work, and play. It includes **basic needs** like **housing** that is affordable and appropriate, **healthy foods** and mobility and **transportation.**

Housing burden means people are spending 50% or more of their income on housing. So, they may struggle paying for other basic needs like food, clothing, transportation, and medical care.

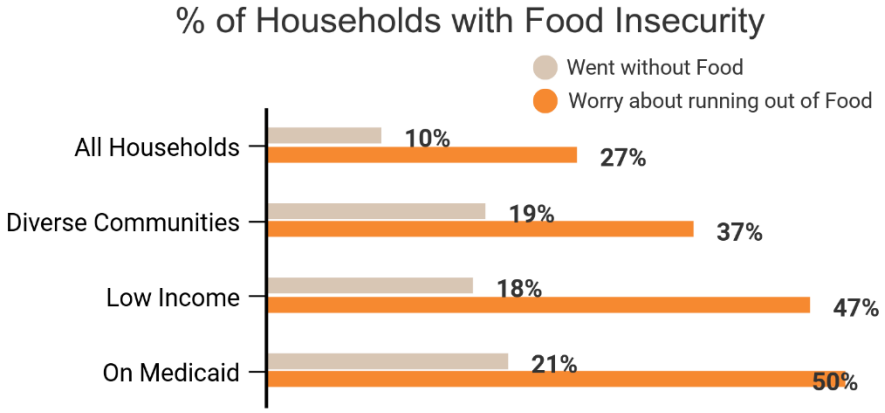


The Dalles High School **cafeteria** has **seating** for **10% of the students**.

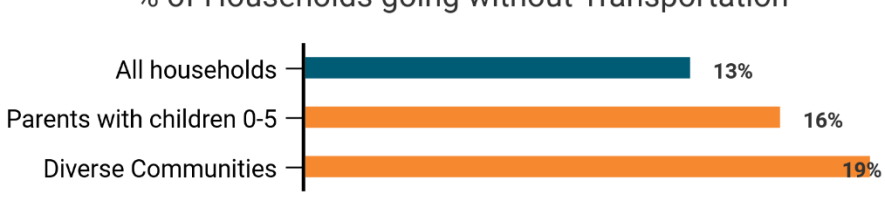
55% of Households said they had 2 or more servings of fruit per day.

64% of Households said they had 2 or more servings of veggies per day.

Food insecurity means people worry about running out of food or they went without food.



Transportation barriers means people go without transportation when they really need it or go without basic needs like healthcare and food due to transportation or distance. Transportation is the highest unmet need.



Find details starting at Built Environment on page 24 of the **Columbia Gorge Regional Community Health Assessment 2019** at cghealthcouncil.org. Data sources: R3, R5, R15, R24

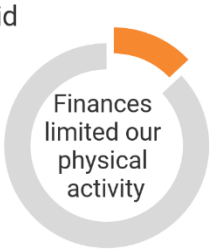
Built Environment, Part 2

This also includes all people having the chance to be **physically active** and **youth being safe**. To make the best of our built environment, we all need to **feel safe** in our neighborhoods, parks, and schools.

Physical Activity

79% of the community

13% of Households said

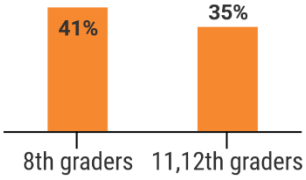


10% of Households said

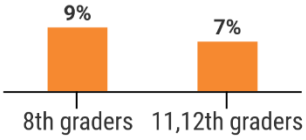
Youth Safety

82% of Adults said other adults watched out for children and kept them safe.

% of Students who said they were bullied going to or at school:



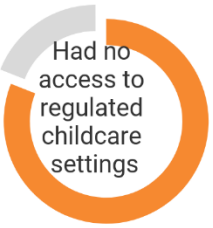
% of Students who said they missed school due to feeling unsafe:



Basic Needs

25% of Households said

81% of 0 to 24 month Infants and Toddlers



6% of Households said

Inequity:

- 25% of all Households went without 1 or more basic needs like housing, food, transportation or childcare.
- Low Income Households and Caregivers go without more basic needs.

37% of Low Income Households said

31% of Caregivers said

Find details starting at Built Environment on page 24 of the **Columbia Gorge Regional Community Health Assessment 2019** at cghealthcouncil.org. Data sources: R3, R5, R14, R17, R32

Youth Health

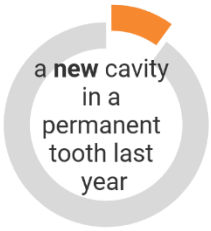
Healthy children lead to healthy adults and a healthy community. Health in the early years can impact quality of life for years to come.

Physical, mental and oral health of youth:

83% of Oregon Teens said we had

72% of Oregon Teens said we had

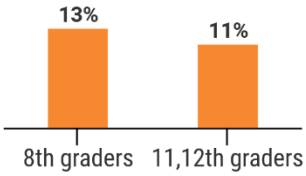
10% of 8 to 9 year olds had



38% of 11th and 12th graders had

5% of Parents said a healthcare provider told them

% of Students who reported they have attempted suicide:



% of 11th and 12th graders reporting they had used these in the last 30 days:

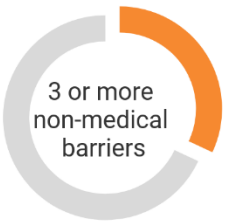
68% of Adults said "I know of at least one local resource where I could refer someone who is at risk for suicide."

Inequity:

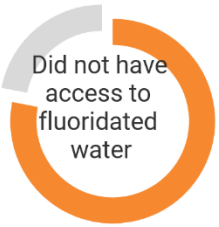
- Youth on Medicaid have higher rates of chronic health conditions and non-medical barriers like poverty or foster care.
- Most youth have no access to fluoridated water.

24% of Youth on Medicaid had

32% of Youth on Medicaid had



78% of all Youth



Find details starting at Measuring Results of Healthcare on page 37 of the **Columbia Gorge Regional Community Health Assessment 2019** at cghealthcouncil.org. Data sources: R1, R3, R4, R6, R7, R10, R14, R17, R19

Youth Healthcare Access

This means all children got the healthcare services they needed and they received preventive services like vaccines.

2-year olds: 72% in Oregon and **39% in Washington** had their needed vaccines.

Oregon

Washington

13 to 17 year olds: 51% in Oregon and **17% in Washington** had their needed vaccines.

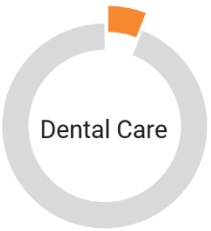
Oregon

Washington

Parents were asked if their child or children got all the healthcare they needed.

5% of Parents said my **child** did not get needed

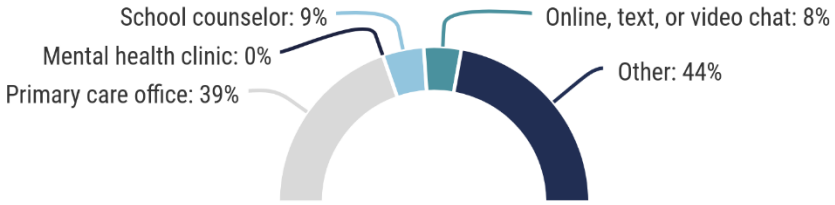
6% of Parents said my **child** did not get needed



16% of Parents said my **child** did not get needed

25% of Parents said my **child** did not get needed

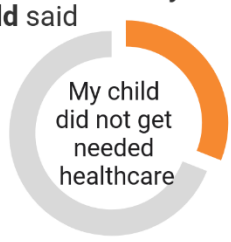
Where Parents reported their child got mental health services:



Inequity:

- Young children went without needed healthcare.
- School-based services were not available to all teens.

31% of Parents with children 0 to 5 years old said



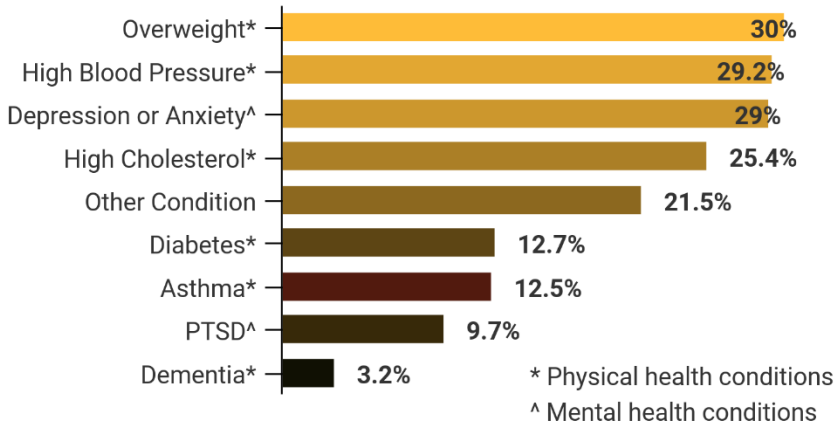
66% of High School Students did not have access to a school-based health center.

Find details starting at Youth Healthcare Access on page 34 of the **Columbia Gorge Regional Community Health Assessment 2019** at cghealthcouncil.org. Data sources: R1, R3, R4, R10, R17, R20

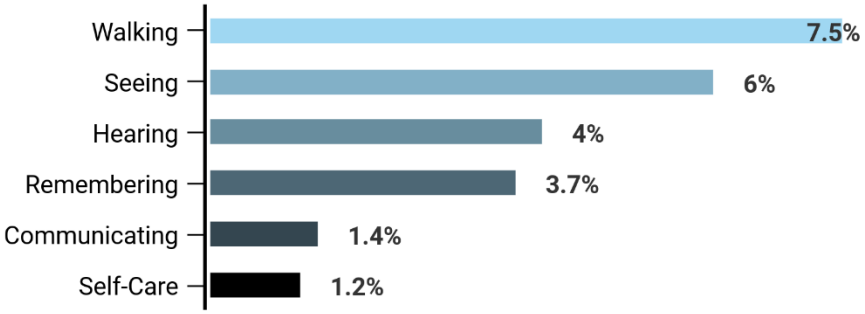
Adult Health

Health affects how well adults can learn and earn income. People with chronic conditions or other illnesses that are managed can thrive and be healthy.

Adults said the most common health conditions they had are:



% of Adults reporting **A LOT of difficulty** with these:

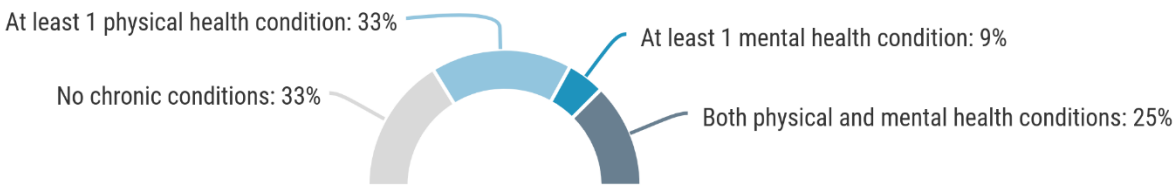


84% of Adults said

13% of Adults said

56% of Adult tobacco users said

% of Adults reporting some type of a chronic condition:



Find details starting at Adult Health on page 37 of the **Columbia Gorge Regional Community Health Assessment 2019** at cghealthcouncil.org. Data sources: R3

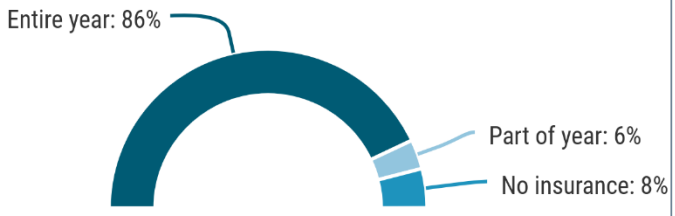
Adult Healthcare Access

This means adults got the healthcare services they needed. The health of adults also has a direct impact on the health of their children and the children they care for.

Flu shots for Adults: 29% in Oregon and **15% in Washington** had flu shots in 2018.

Oregon Washington

% of Adults with medical insurance:



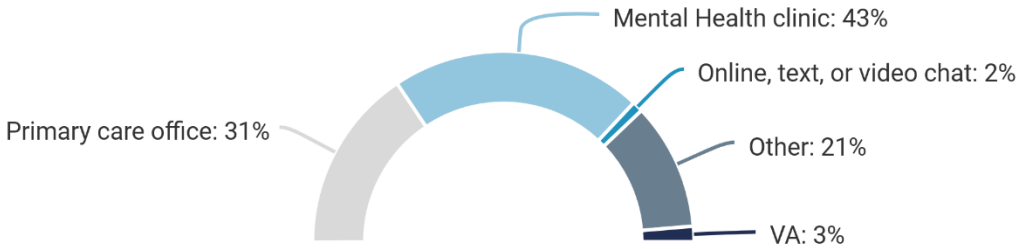
Adults were asked if they got all the healthcare they needed.

9% of Adults said we did not get needed

30% of Adults said we did not get needed

24% of Adults said we did not get needed

Where Adults got Mental Health Services:



Inequity:

- Parents of young children went without insurance at higher rates.
- Without insurance, adults were not getting the care they need.
- Transportation was a barrier too.

16% of Parents of children 0 to 5 said

47% of Adults without Health Insurance said

8% of **Households**

Find details starting at Adult Healthcare Access on page 34 of the **Columbia Gorge Regional Community Health Assessment 2019** at cghealthcouncil.org. Data sources: R3, R5

Acknowledgments

Completing a regional community health assessment is a community effort and is dependent on the support of many people and organizations. The Community Advisory Council, or CAC, oversees all stages of the Community Health Assessment and is the final decision-maker for the Community Health Assessment. The CAC forum includes many CAC agencies who helped with survey distribution and general data collection.

Advantage Dental Services, LLC
Aging in the Gorge Alliance
Aging and People with Disabilities (APD)
Area Agency on Aging (AAA)
Blue Zones Project
Bridges to Health
Columbia Gorge Family Medicine
Columbia Gorge Food Bank
Columbia Gorge Health Council
Department of Human Services – Self Sufficiency
Deschutes Rim Health Clinic
Down Manor
Eastern Oregon CCO
FISH Food Bank
Four Rivers Early Learning Hub
GOBHI
Gorge Grown
HAVEN From Domestic & Sexual Violence
Helping Hands Against Violence Inc.
Hood River County Health Department
Hood River County Prevention
Hood River School District
Hood River Shelter Services
Klickitat County Health Department
Klickitat Valley Health
Lindsay Miller Consulting
Mid-Columbia Economic Development District (MCEDD)
Mid-Columbia Housing Authority
MCMC Hospital
MCMC Internal Medicine
MCMC Visiting Nurses/Transition Team
Meals on Wheels, HRV Adult Center
Meals on Wheels, Wasco County
Mid-Columbia Center for Living
Mid-Columbia Senior Center, The Dalles
Next Door, Inc
North Central Public Health District
OHSU
One Community Health
OSU Extension
Pacific Source Community Solutions
Providence CORE
Providence Hood River Family Medicine
Providence Hood River Internal Medicine
Providence Hood River Memorial Hospital
Reliance eHealth Collaborative
Skamania County Health Department
Skyline Hospital
Southwest Accountable Communities of Health
Strong Women
The Next Door
Mid-Columbia Health Equity Advocates (MCHEA)
United Way of the Columbia Gorge
Youth Empowerment Shelter
YOUTHTHINK

Table of Contents

Introduction

In 2013, twelve different organizations in the Columbia Gorge Region formed a cohort to create an integrated Columbia Gorge Regional Community Health Assessment. This 2019 version represents the third iteration of our collaborative work with seventeen organizations as part of the cohort and represented on the cover page. The full list of organizations and the year each joined is noted below.

Columbia Gorge Health Council (2013)
Hood River County Health Department (2013)
Klickitat County Health Department (2013)
Klickitat Valley Health (2013)
Mid-Columbia Center for Living (2013)
Mid-Columbia Medical Center (2013)
North Central Public Health District (2013)
One Community Health (2013)
Pacific Source Community Solutions (2013)
Providence Hood River Memorial Hospital (2013)
Skamania County Health Department (2013)
Skyline Hospital (2013)

Four Rivers Early Learning Hub (2016)
United Way (2016)

Advantage Dental Services, LLC (2019)
Eastern Oregon CCO (2019)
Southwest Accountable Communities of Health (2019)

We once again looked at both social and economic conditions in addition to key healthcare information in the region. By doing so we were able to recognize the most important issues that face our population. Our Principles of Collaboration remained the same and outline our mutual intention:

- A collaborative approach to the Community Health Survey (CHA) and the Community Health Improvement Plan (CHIP) is better for our region, yielding more accurate and more actionable products, as community providers agree on the needs within our region and communities and as we align our abilities to address those needs together.
- A collaborative approach to the CHA and CHIP will maximize collective resources available for improving health in the region.
- A collaborative approach to the CHA and CHIP must be truly collaborative, requiring commitments of cash or in-kind resources from all participants who would use it to satisfy a regulatory requirement.

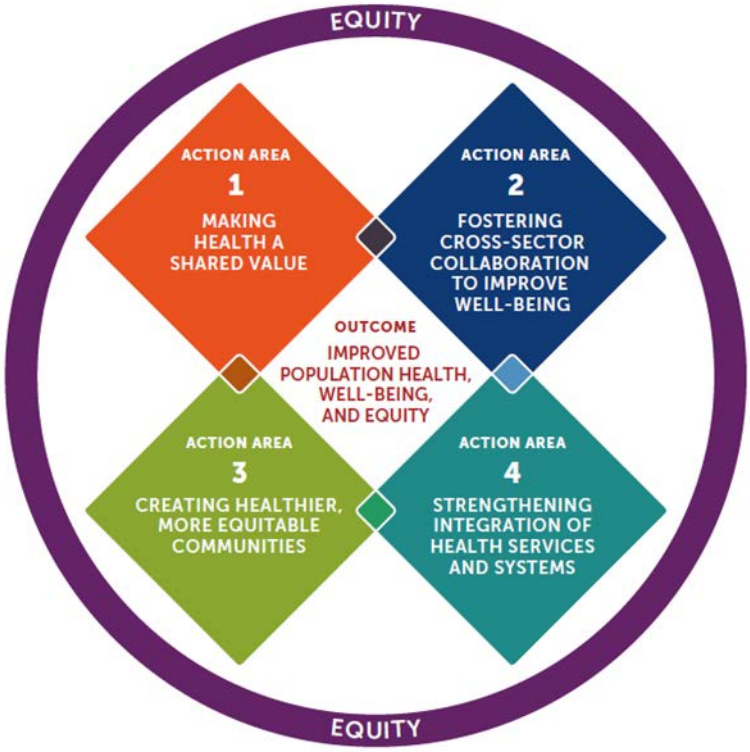
The rest of this document illustrates our collaborative effort and our shared recognition of the greatest needs in the Columbia Gorge Region.

How we organized the information

The requirements placed on hospitals, health departments and coordinated care organizations for the scope of a community health assessment do not fully overlap. To blend the information in a cohesive manner, we used the Robert Wood Johnson Foundation (RWJF) Culture of Health Action Framework to group similar content and themes. The Action Framework was adopted and adapted for the 2017 Regional Community Health Improvement Plan (CHIP). Using the Action Framework for the 2019 Regional Community Health Assessment provided continuity and further community alignment.

The Culture of Health Action Framework provides a shared language and a shared measurement system - both of which are cornerstones of the Collective Impact work to create a healthy community. The Action Framework includes three core elements:

- *Action Areas*: high-level objectives which can improve population health, well-being and equity;
- *Drivers*: activities or systemic factors that are critical to achieving better health; and,
- *Measures*: specific social, economic and policy data points that can help track progress over time.



The Action Framework is informed by rigorous research on the multiple factors which affect health. It recognizes there are many ways to build a Culture of Health and provides numerous entry points for all types of organizations and communities to get involved.

For more information about the RWJF Action Framework visit this link: http://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html

The 2017 Community Health Improvement Plan (CHIP) focused on 3 Drivers within the Action Areas:

- Driver 1.2: Sense of Community as part of Action Area 1: Making Health a Shared Value
- Driver 3.1: Built Environment/Physical Conditions as part of Action Area 3: Creating Healthier, More Equitable Communities
- Driver 4.1: Access as part of Action Area 4: Strengthening Integration of Health Services and Systems

The Community Health Assessment Development

The development of the Community Health Assessment involved all seventeen cohort representatives and the Community Advisory Council (CAC). The CAC includes Medicaid consumers and more than 30 different local non-profits, healthcare, and government agencies. Determining the content of the CHA was completed through four separate meetings with the CAC and additional working sessions with cohort members. The scope of the 2019 Regional Community Health Assessment included all three of the 2017 CHIP topic areas plus additional areas as needed by cohort members for regulatory requirements. See Appendix B – List of the local, state and national requirements for Community Health Assessments for details.

The resulting data was reviewed by the CAC in three additional meetings and another four community sessions were held to gather feedback and determine the topics and scope in the executive summary.

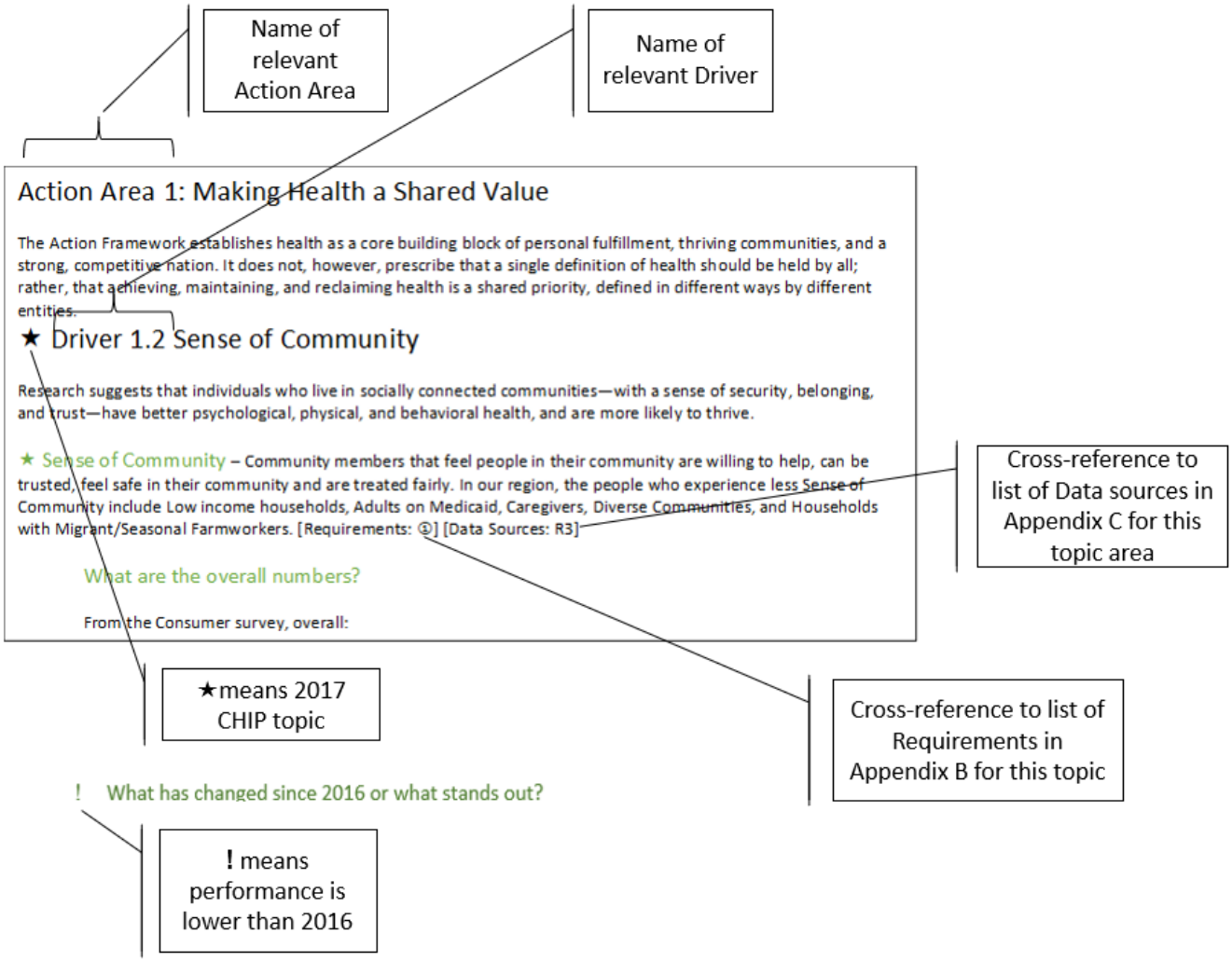
The term "survey data" is used throughout the document. Survey data refers to a consumer health survey conducted in the region in the summer of 2019. A reference to all copies of the survey is in Appendix F – References to the Consumer Health Survey. Details on the methods for the survey can be found in Appendix G – Consumer Survey Methods.

Demographics of the region

The current population of the Columbia Gorge Region is 88,432. Wasco and Skamania counties have seen an increase in population since 2016 while the remaining counties have similar or slight decreases in population. The Hispanic population has grown in almost every county. The region is also represented by relatively small populations of Blacks, American Indians, and Asian or Pacific Islanders. (Source: County Health Rankings 2019)

		Oregon					**Washington**	
		Gilliam	Hood River	Sherman	Wasco	Wheeler	Klickitat	Skamania
	Total Population	1855	23377	1758	26437	1357	21811	11837
Ethnicity	Hispanic Population	116	7315	125	4856	76	2688	716
	Non-Hispanic Population	1739	16062	1633	21581	1281	19123	11121
Race	White	1764	22232	1665	24491	1263	20568	11153
	African American	5	96	4	144	3	97	63
	American Indian / Alaskan Native	27	300	51	1020	28	561	222
	Asian	16	377	9	325	13	186	120
	Pacific Islander/ Hawaiian	10	58	1	215	3	41	24
	Other	33	314	28	242	47	358	255

How to read the detailed document



Action Area 1: Making Health a Shared Value

The Action Framework establishes health as a core building block of personal fulfillment, thriving communities, and a strong, competitive nation. It does not, however, prescribe that a single definition of health should be held by all; rather, that achieving, maintaining, and reclaiming health is a shared priority, defined in different ways by different entities.

★ Driver 1.2 Sense of Community

Research suggests that individuals who live in socially connected communities—with a sense of security, belonging, and trust—have better psychological, physical, and behavioral health, and are more likely to thrive.

★ Sense of Community – Community members that feel people in their community are willing to help, can be trusted, feel safe in their community and are treated fairly. In our region, the people who experience less Sense of Community include Low income households, Adults on Medicaid, Caregivers, Diverse Communities, and Households with Migrant/Seasonal Farmworkers. [Requirements: ①] [Data Sources: R3]

What are the overall numbers?

From the Consumer survey, overall:

- 33% have been treated unfairly and 70% have witnessed others being treated unfairly.
- 18% don't trust their neighbors
- 10% don't feel safe in their neighborhood
- 18% feel adults don't keep children safe and out of trouble
- 20% said they were made to do something sexual that they did not want to do
- 22% said they were physically hurt or threatened by an intimate partner
- 42% said they have witnessed or experienced violence

! What has changed since 2016 or what stands out?

Unfair treatment of others happens frequently and is observed by many

- 62% of Diverse Communities experience unfair treatment
- 16% of Low Income feel unsafe

Rates of people reporting violence have increased. The numbers below are 2016 rates followed by 2019 rates.

- Made to do something sexual that you did not want to do: from 15.7% to 20%
- Physically hurt or threatened by an intimate partner: from 16.2% to 22.3%
- Witnessed or experienced violence: from 30.4% to 41.8%

★ Social Support - Community members indicating they have adequate social support from partner, family, and friends. In our region, the people who experience fewer social supports include Low income households and Adults on Medicaid. [Requirements: ①] [Data Sources: R2, R3]

What are the overall numbers?

From the Consumer survey overall, the Social Support Indicators show social support challenges are worse than those reported in 2016, with about 20% reporting poor social support for most domains. Low Income, Medicare, Medicaid and Uninsured were most likely to report low social support.

- 26% do not have someone to make them feel loved or wanted (21% 2016)
- 27% do not have someone to give them good advice (22% 2016)
- 31% do not have someone to relax with (29% 2016)
- 31% do not have someone to talk to about problems (26% 2016)
- 32% do not have someone to help if they were confined to a bed (29% 2016)
- 42% of Low Income have no social supports
- 37% of Adults on Medicaid feel they lack social support

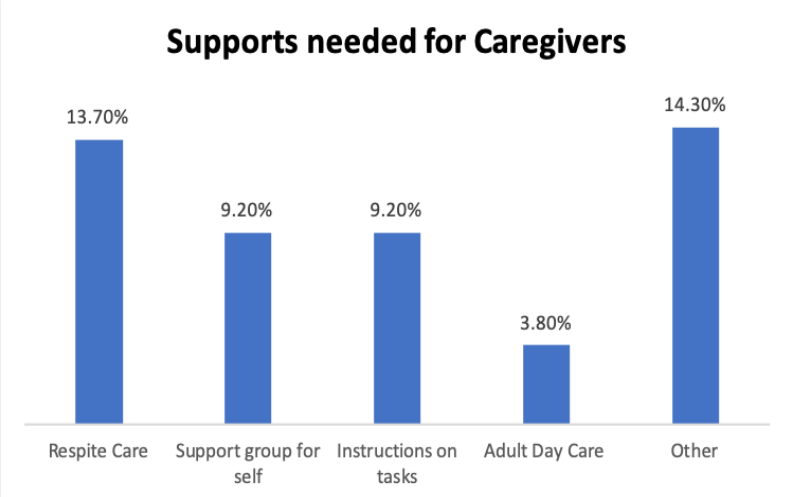
Blue Zone data from The Dalles shows overall well-being holding steady from 2017 to 2019:

- Well-Being Index Steady 0.3%
- Purpose Decrease 0.7%
- Social Decreasing 1.1%
- Financial Increased 4.2%
- Community Increased 2.7%
- Physical Decreased 1.4%

28% increase in agreement that Blue Zones Project has had a positive impact on their community. 2% (2017) to 30% (2019)

Caregiver:

- 16% of Adults are Caregivers to an older adult and 50% of Caregivers have adequate support.
- Respite care is identified as highest need.



! What has changed since 2016 or what stands out?

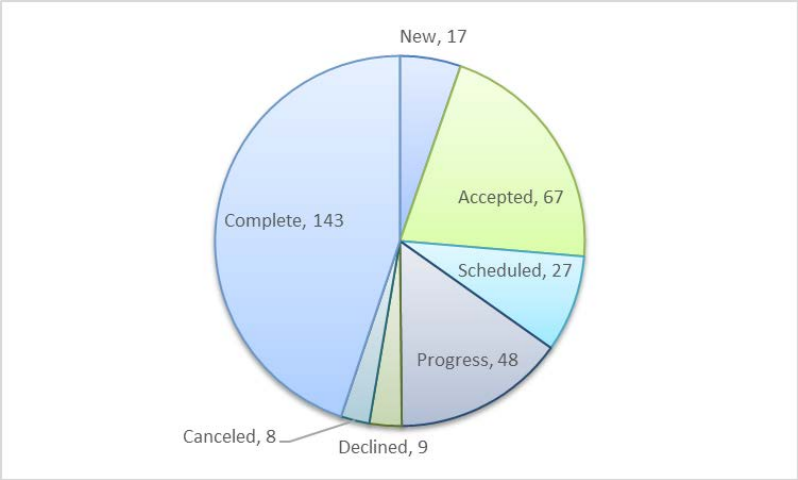
All social support indicators from the consumer survey are worse than 2016, see details above.

★ Effective referrals – the social service and healthcare community frequently and effectively refer clients to each other's services to meet the health needs of clients and their families. [Requirements: ① ② ③ ④] [Data Sources: R26]

What are the overall numbers?

The Columbia Gorge region uses a regional Health Information Exchange capability from Reliance eHealth Collaborative which includes a closed-loop eReferral system. Currently, there are 58 unique organizations using the eReferral platform.

Approximately 94% of eReferrals are accepted and acted on with less than 6% overall having been Cancelled or Declined. The eReferral platform allows for overall performance analytics and supports progress reporting.



A user of the eReferral system is DHS Child Welfare. They use the system to send referrals to Mid-Columbia Center for Living for the mandatory Child and Adolescent Needs and Strengths (CANS) documentation that is required within 60 days for all children taken into custody.

Action Area 2: Fostering Cross-sector Collaboration to Improve Well-being

Health means much more than simply not being sick. This Action Area places focus on collaborations that include sectors typically viewed as "outside" of health care and demonstrates how these cross-sector collaborations can play an essential role. Hospitals, health systems, and medical professionals continue to make important strides in collaborating, but the health care sector cannot bear sole responsibility for improving health. We must break down silos that separate improving health from the work of education, business, transportation, community development, and other historically "non-health" sectors that form an integral piece of the health puzzle. We also must ensure that organizations representing traditionally vulnerable communities are actively included in dialogue and decision-making.

Driver 2.1 Number and Quality of Partnerships

Research indicates that building relationships among partners is the most challenging aspect of creating change, and that leadership is particularly important for cross-sector synergy. Other key factors include establishing a history of collaboration between organizations, ensuring participants have the resources they need, and building a sense of shared accountability.

Local health organizational collaboration - Community health assessments, community health improvement plans, and coalitions are established to increase impact across all health sectors [Requirements: ③④⑤⑥⑦⑨] [Data Sources: R3]

What are the overall numbers?

Fifteen (15) unique organizations contribute financially to a shared regional Community Health Assessment including seven counties, two states, four public health departments, three

accountable care organizations, one early learning hub, United Way, and one Dental Care Organization.
Community Advisory Council includes nine (9) additional organizations engaged in the Community Health Assessment effort representing domains including housing, food, transportation, aging, and prevention.
More than 50% of Consumer Surveys are hand-fielded to reach under-served populations. 45% of hand-fielded surveys reached Diverse Communities.

What's changed since 2016?

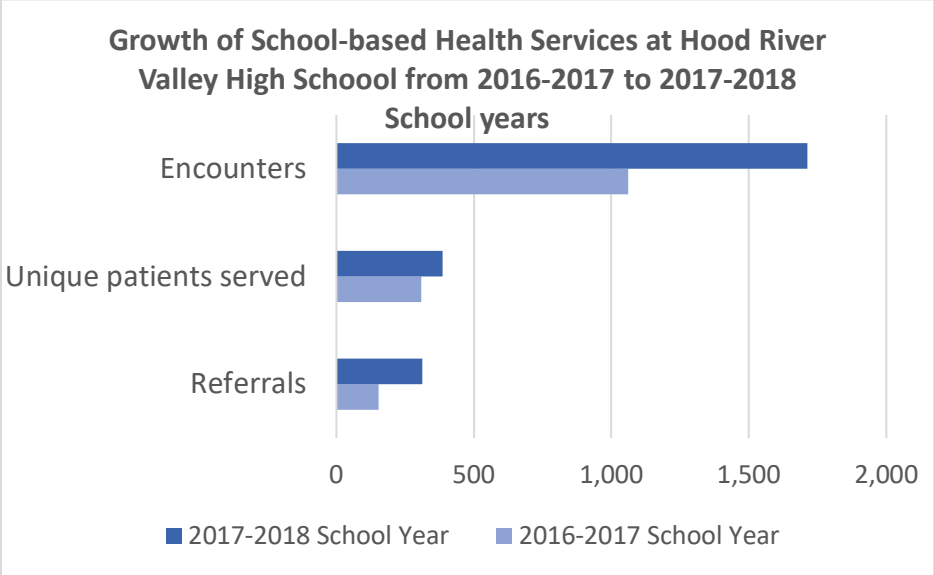
The 2019 cohort for the Community Health Assessment added Advantage Dental Services, LLC, Eastern Oregon CCO (EOCCO) and Southwest Accountable Communities of Health (SWACH).

Opportunities to improve health for youth at schools – the breadth and depth of school-based health centers and school-based healthcare services. [Requirements: ④] [Data Sources: R10]

What are the overall numbers?

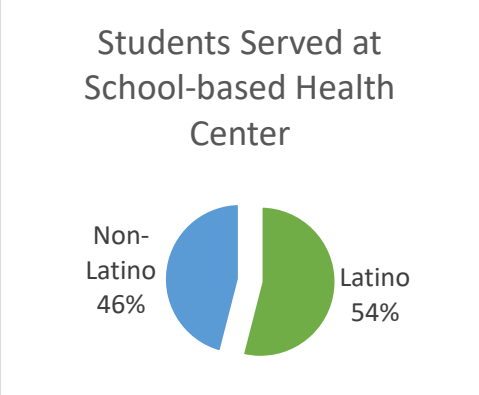
Hood River Valley High School has the only school-based health center (SBHC) in the Gorge Region. The SBHC is operated by One Community Health (OCH) who provides medical, dental and behavioral health services. 33% of the Hood River Valley student population is served onsite at the SBHC.

On average, students receiving care had 4.4 visits per students which is higher than state and national averages. The average number of behavioral health visits was 3.7 visits per student.



Top Primary Diagnoses are:

- Mental health including substance use
- Family planning
- Acute physical health concerns



Students served were 54% Latino and 46% Non-Latino

What's changed since 2016 or what stands out?

20% increase in students served and 62% increase in encounters between 2016-2017 school year an 2017-2018 school year.

No new School-based Health Centers established in 3 years.

Unmet mental health needs of teens suggest that more mental health services are needed at student-based health centers.

Driver 2.2 Investment in Cross-Sector Collaborations

In addition to measuring the quality and quantity of cross-sector collaborations, it is important to track investments that support these partnerships.

Allocations for health investments related to nutrition and indoor and outdoor physical activity

Means breaking down silos that separate improving health from the day-to-day work of businesses, schools, and other community institutions. These and other historically "non-health" sectors recognize their important contributions to well-being, aligning resources and policies accordingly. Public and private sectors work together to support population health and well-being. [Requirements:] [Data Sources: R11, R12, R9, R18, R10]

What are the overall numbers?

Providence supports Healthier Kids, Together - promoting increased activity and improved nutrition for Oregon's children. Providence Hood River Memorial Hospital partnered with the Oregon Food Bank to support a school-based food pantry that will provide more the 39,000 pounds of food and serve as many as 4,500 families. Additional partnerships focus on physical activity during recess at 10 Gorge elementary schools, an after-school physical activity program at Mid Valley elementary school, voucher for free fresh veggies for mothers with the WIC benefit and their family members and investments infrastructure in three local parks.

Skyline Hospital's community health initiatives include employing one FTE who teaches cooking classes for youth, serves as a healthcare representative on coalitions and boards, promotes safe physical activity and offers cooking demonstrations at the local foodbanks. Additionally, Skyline has purchased bicycle helmets for youth, coordinated classes and trainings with physicians and other experts, and offered discount fitness programs for patients with barriers to this service. The total value of the Community Health Program between 2017 and 2019 was approximately $210,000.

Mid-Columbia Medical Center has recognized childhood obesity is known to disproportionately affect children of lower socio-economic status. In response to the county's 26% children in poverty rate (compared to 23% statewide), MCMC has formed a workgroup specific to the creation of a pediatric obesity clinic in which to monitor and address patient obesity rates.

As part of MCMC's mission to spread health and wellness throughout the community, they provide free athletic training services to 8 local middle and high schools at an annual cost of over $365,000. Their free services include injury prevention, triage, rehabilitation and concussion care. Their 5 full time staff dedicate their entire workload to keeping student athletes at these schools safe and healthy through the year-round sports season.

Columbia Gorge Health Council community program funding of $517,900 for:

- Food Access for All - the Food Security Coalition working to build resilient, local food system and improve equitable access to nutritious food in the Gorge. Amount awarded: $176,300
- Imagination Yoga - Teaching yoga to second graders in Wasco and HR counties. Addressing childhood inactivity, distractibility, anxiety and bullying. Amount awarded: $25,000

- Power of Play - Playworks® designed to leverage the power of safe, fun and healthy play at school in ten elementary schools in HR and Wasco counties. Amount awarded: $246,600
- Summer Swim RX - Provided swim passes for the local pool to low income youth in The Dalles and Hood River. Amount awarded: $50,000
- Mighty Mouth Campaign - Consumer communication that healthy nutrition is good for your teeth. Amount awarded: $20,000

One Community Health continues to offer the SALUD program to our patients and will offer the PASOS program in 2019/2020. The Steps Forward/Pasos Adelante curriculum focuses on healthy food choices and preparation, chronic disease risk, community health, and participant advocacy.

Action Area 3: Creating Healthier, More Equitable Communities

The goal of this Action Area is to encourage communities to fulfill their greatest health potential by improving the environment in which residents live, learn, work, and play. While we have made strides in creating healthier environments, we must ensure that community settings support overall well-being and extend to upstream influences of health including early childhood education.

★ Driver 3.1 Built Environment/Physical Conditions

The built environment—or the physical space in which we live, learn, work, and play—is key to a community's well-being. For example, sidewalks in good condition and active transport routes, such as bicycle lanes, are features of the physical environment that may provide greater access to exercise and healthy food options. However, to take advantage of these opportunities, it's essential that we feel safe in our neighborhoods, parks, and schools.

★ Housing affordability and appropriateness

– There is strong evidence characterizing housing's relationship to health. Housing stability, quality, safety, and affordability all affect health outcomes. Access to stable housing is particularly challenging for those living with mental illness even with supports. In the Gorge region, the people who experience higher levels of housing insecurity include Families with young children, Low income households, Adults on Medicaid, Adults on Medicare and Caregivers. [Requirements: ①⑩] [Data Sources: R3, R5, R24, R30]

What are the overall numbers?

From the Consumer Survey, households are 'Housing burdened' or paying more than 50% of their income on housing at the following rates

- 27% of households
- 30% of Diverse Communities
- 53% of Low-Income households
- 53% of Uninsured
- 47% of Medicaid/Dual Eligible

County Health rankings list:

- 14% a total of 4247 households in the Gorge seven counties that have a severe housing cost burden, this reflects the mailed community health survey responses
- 17% have severe housing problems – Severe housing problems defined as at least one of the following issues: overcrowding, high housing costs, lack of kitchen facilities or plumbing facilities

In addition, the following other details were noted in the Consumer Survey:

- 10.3% of respondents have housing of their own but are worried about losing it
  - 12.1% of Parents with young children are worried about losing their housing
- 6.8% of respondents could be considered to have insecure or unstable housing
  - 0.3% staying in a hotel
  - 4.7% with friends or family
  - 1.8% shelter, car, or on the street
- 9% went without utilities
- 11.1% of respondents reported living with their adult children
  - 23.5% of Diverse Communities reported living with their adult children
- 5.4% of respondents reported living with my parents or partner's parents
  - 9.8% of Diverse Communities reported living with their parents or partner's parents

Mid-Columbia Housing Authority reports

- 99% occupancy rate within their own supported housing properties
- 60% housing voucher utilization

Mid-Columbia Center for Living and Mid-Columbia Housing Authority partner in the Housing Access Support Program (HAS) which is a tenant-based rental assistance program specifically for individuals who are very low or low income, have serious mental illness and who have at least one eligible criterion. The program covers up to $900/month per person, but rent cannot exceed the Fair Market Rent for that county. The individual would pay no more than 30% of their income on rent. As of November 2019, HAS program has:

- 17 clients housed
- 14 needing housing
  - 9 clients actively looking for housing with the HAS team
  - 3 clients on wait list which will be working with the HAS team in the future
  - 2 clients pending completion of paperwork

The consistent theme is the lack of affordable housing to serve community members overall and HAS program participants.

! What's changed since 2016 or what stands out?

Since 2016, the number surveyed who were worried about their housing and those that did not have stable housing stayed the same - 25% worried losing housing and 7% went without housing.

The number who are housing burdened is worse than 2016 and more people are going without utilities.

Housing affordability continues to get worse and the supply of affordable housing is a severe constraint for the region.

23.5% of Diverse Communities report:

- 23.5% living with their adult children
- 10% report living with their parents or partner's parents

★ Access to healthy foods – the degree of access to healthy foods and decreased access to unhealthy foods/beverages in all the places we live, work, learn, play and worship. In our region, the people who experience higher levels of food insecurity include Low income households, Adults on Medicaid, Adults on Medicare and Diverse Communities. [Requirements: ① ③ ④] [Data Sources: R3, R5, R15]

What are the overall numbers?

From the Consumer Survey:

- 10% went without food or meals sometime in the past 12 months
- 23% of Migrant/Seasonal farmworker households went without food or meals
- 27% worried about running out of food before having money to buy more
- 50% of adults on Medicaid worry about running out of food
- 6% are affected by distance or lack of transportation to get food
- 55% have two or more servings of fruit per day
- 64% have two or more servings of veggies per day
- People eat more veggies than fruit

School-based meal programs are a primary means of addressing childhood hunger in our region. Many of our schools have more than 50% of the student population meeting the existing requirements for a free or reduced-price lunch. The 2019 Oregon Student Success Act expands participation in the school-based meal program to include serving breakfast in schools with 70% or greater free and reduced-price students and offering free meals for households up to 300% of the Federal Poverty Level. This expansion draws even more attention to the capacity constraints at The Dalles High school which currently has seating for 10% of the student population. This represents approximately 22% of our high school teen population.

WIC data:

- 5 out of 7 WIC participants are infants or children under five.
- 2436 total participants in Hood River County and North Central Public Health District
- $845,846 total dollars spent by WIC's participants at local stores in 2018
- 98% WIC moms start out breastfeeding
- 42% WIC moms exclusively breastfeed for six months

WIC Farm Direct Nutrition Program (FDNP) provides families in Hood River County and North Central Public Health District with an additional source of nutritious food and education on selecting and preparing fresh produce.

- 46 participating farmers at local farmers markets and farm stands
- $14,660 FDNP dollars paid to local farmers

County Health Rankings show:

- 17% of all residents have limited access to healthy foods
- 13% of all residents have food insecurity
- 49% of Gorge children are eligible for free or reduced-price lunch at school

What's changed since 2016 or what stands out?

The two largest high schools have very different levels of health services for their students. Hood River Valley High School has a cafeteria to support the entire student population and an onsite school-based health center. In contrast, The Dalles High School does not have either. In 2016, slightly more than 10% went without food, this decreased slightly to 10%. Increases were seen, 55% in the number reporting eating 2 or more servings of fruit compared to 51% in 2016. Those who eat 2 or more veggies stayed steady at 64%. Households with young children eat more fruits and vegetables.

★ Mobility and Transportation

– People who have safe access to sidewalks, bike lanes, bus or transportation can actively participate in their communities. The absence of mobility and transportation can lead to isolation and poor health – especially in rural communities. In the Gorge, people who experience barriers with accessing basic needs and services due to transportation include Families with young children, Low income households, Adults on Medicaid, and Diverse Communities. [Requirements: ①⑧] [Data Sources: R3, R5]

What are the overall numbers?

General Transportation:

- 13% went without transportation due to finances
- 19% of Diverse Communities went without transportation

Survey showed transportation or distance barriers caused:

- 8.2% of households went without healthcare
- 5.9% of households went without food or meals
- 3.5% of households went without childcare
- 14.6% of households went without social activities
- 10.2% of households went without Exercise or sports

Commuting transportation data from County Health Rankings

- 72% drive in their car alone to work, of those 28% reported commuting more than 30 minutes
- 61% Hispanics drive alone to work
- 75% White drive alone to work

! What's changed since 2016 or what stands out?

Transportation is the highest unmet need. See Basic Needs section on page 31.
Since 2016 more Low Income households have gone without transportation. In 2016 21.7% of Low Income reported going without transportation and in 2019 this increased to 26%. Transportation has improved for Diverse Communities, in 2016 23% went without transportation compared to 19% in 2019.

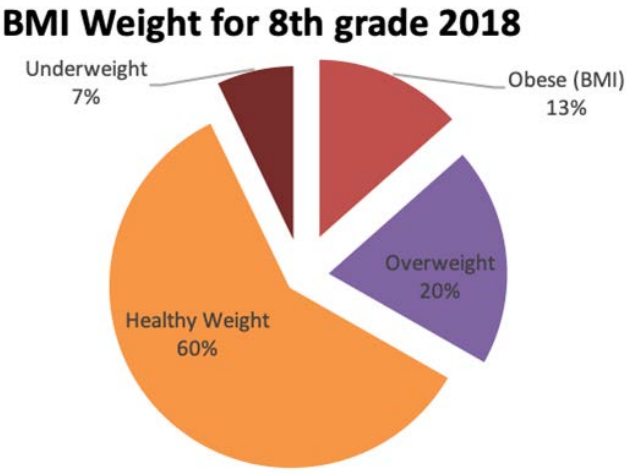
★ Equity in physical activity opportunities – Physical activity is an important component for healthy living in addition to healthy foods. Ensuring all neighborhoods have spaces for physical activity and children have equitable access to participate in physical activities and sports provides a foundation for healthy weight and addressing obesity rates. [Requirements: ①④❶❷] [Data Sources: R3, R14, R17, R5]

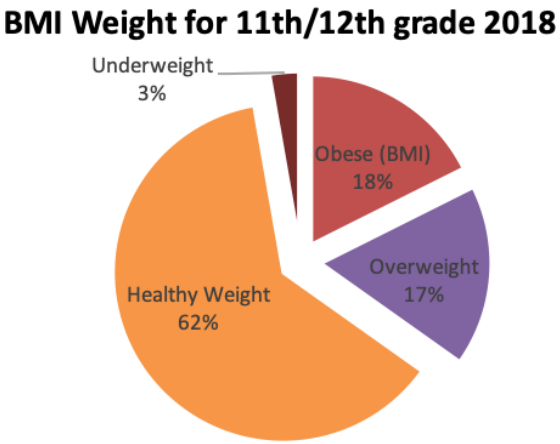
What are the overall numbers for Youth?

5% of parents indicate their children have been diagnosed as overweight by a health professional.

However, 25%-40% of health professionals' health records indicate that children are overweight.

BMI is Body Mass Index and is calculated using a person's height and weight. BMI = kg/M^2 where Kg is a person's weight in kilograms and M^2 is their height in meters squared. For children and teens, BMI is age and sex specific and is expressed as a percentile relative to children in the US who participated in national surveys conducted 1963-65 and 1988-94.





Oregon (OR) and Washington (WA) teen survey data shows 40% of 8th graders are not at a healthy weight. In addition, 38% of 11th or 12 graders are not at a healthy weight.

Overall numbers for Adults?

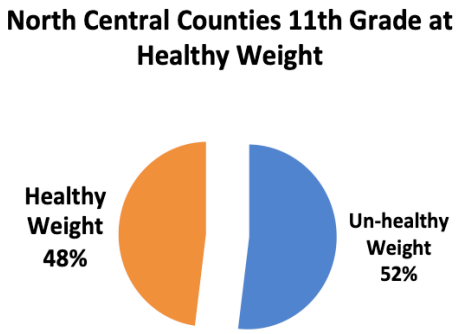
County health rankings indicate

- About 30% of Adults say they have been diagnosed as overweight by a health professional
- 18% of all seven county's residents report no physical activity during leisure time
- 79% of community has access to places for physical activity
- 13% of households went without sports or physical exercise due to lack of money.

! What's changed since 2016 or what stands out?

In 2016 approximately 33% of youth were overweight or obese. In 2018 this stayed approximately the same for 8th grade but 11/12th graders the overweight or obese rate has risen to 35%.

48% of 11th graders in North Central Public Health District counties are at a healthy weight.

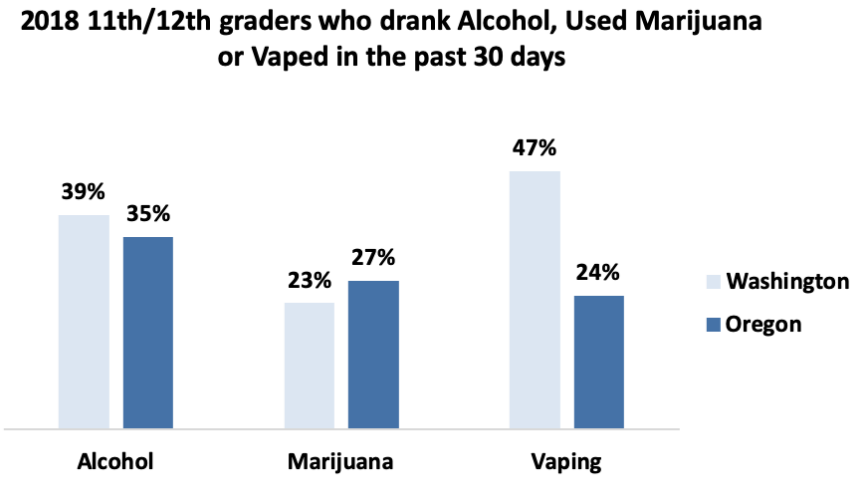


★ Youth safety – The youth in the community need to feel safe to engage in the community in which they live, play and learn. Feeling safe and being free of harms includes the home, school, playgrounds, and streets they navigate. Unsafe, unwelcoming and traumatic environments can lead to depression and suicide. [Requirements: ①②⑧❶❷] [Data Sources: R3, R14, R17]

What are the overall numbers?

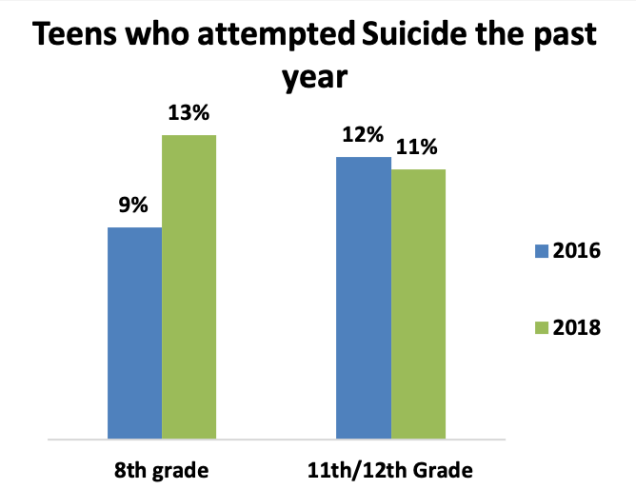
Self-reported teen survey data for Oregon and Washington showed:

- The number of teens smoking cigarettes has decreased since 2016
- Vaping usage has gone up since 2016
- Alcohol usage for 11/12th grade increased 28% 2016 to 37% 2018

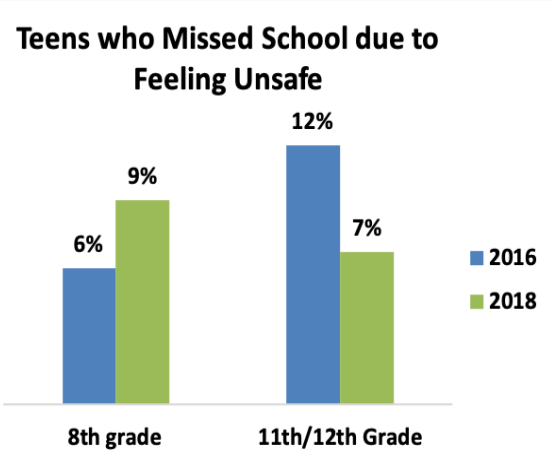


For 2016 and 2018, teens were surveyed at school. Teens self-reported the following about their attempts at suicide, staying home from school and being bullied.

- 8th Grade self-reported suicide rates increased considerably while 11/12th self-reported rates dropped slightly. Overall, the self-reported rates increased between 2016 to 2018.



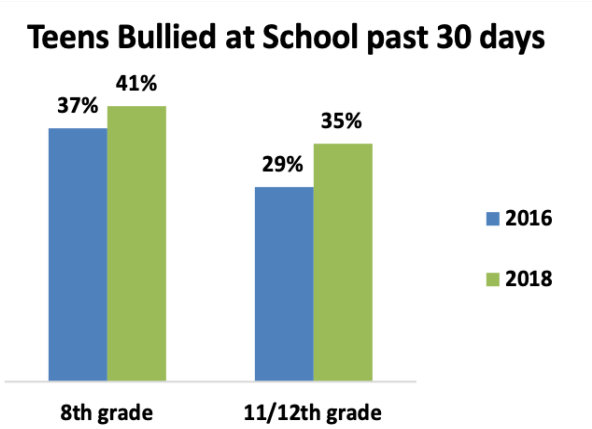
- The self-reported rate for 8th graders who did not go to school at least one day in the past 30 days because they felt unsafe rose 3% while the self-reported rate for 11/12th graders dropped 5% since 2016.
- Teens self-reported bullying rate has significantly increased in the past few years. 8th graders report an increase of 4% and 11/12th graders report an increase of 6% with a 2018 overall average of 38% for teens.



! What's changed since 2016 or what stands out?

For teens, alcohol and vaping rates have increased since 2016. Self-reported suicide attempts by 8th graders rose 4% to 13% who reported they attempted suicide in the past year.

Teens who reported being bullied increased since 2016, 4-6% for 8th and 11/12th graders.



★ Basic Needs overall – Looking at all basic needs from housing, food, transportation as well as childcare and clothing, gives insight to who is experiencing overall financial insecurity. [Data Sources: R3]

Transportation is the highest unmet need for all categories of people except Seasonal Farmworkers who list Utilities or phone higher.

% of households going without a specific Basic Need	Housing	Utilities or phone	Food or meals	Transportation	Clothing	Childcare
All Households	5%	9%	10%	13%	11%	4%
Low Income	8%	16%	18%	26%	19%	6%
Diverse Communities	9%	17%	18%	19%	18%	7%
Medicaid	8%	17%	21%	25%	19%	4%
Uninsured	13%	18%	16%	22%	18%	7%
Seasonal Farm Worker	20%	30%	23%	27%	13%	17%
Caregivers	5%	14%	15%	15%	15%	5%
Families with children 0-5	6%	11%	9%	16%	11%	10%

20% of households overall went without 1 or more basic needs because of lack of money. Low income households and Seasonal Farmworker households have the highest rates of unmet needs.

Basic Needs in total	All Basic Needs Met	1 or 2 Basic Needs Not met	3 or more Basic Needs not met
All Households	80%	12%	8%
Low Income	63%	22%	15%
Diverse Communities	68%	16%	16%
Medicaid	64%	20%	16%
Uninsured	70%	13%	17%
Seasonal Farm Worker	53%	27%	20%
Caregivers	69%	16%	15%
Families with children 0-5	75%	14%	11%

In 2019, the Consumer survey was expanded to look at access to social activities and exercise or sports. The below chart shows what percent of households went without social and exercise needs because a lack of money.

% of households going without Social and Physical Activities	Social activities	Exercise or sports
All Households	22%	13%
Low Income	36%	21%
Diverse Communities	27%	19%
Medicaid	29%	21%
Uninsured	36%	29%
Seasonal Farm Worker	33%	33%
Caregivers	29%	17%
Families with children 0-5	24%	18%

! What's changed since 2016 and what stands out overall?

We see improvement in:

- Basic needs overall - Percent of households that went without a basic need due to money went from 23% in 2016 to 20% in 2018
- Food - Percent of households that went without food improved, except Low Income stayed at the same rate as 2016
- Transportation – Percent that went without transportation improved for Diverse Communities, Uninsured and Medicaid

Transportation barriers increased since 2016. The percent of households that went without transportation increased for Low Income from 22% in 2016 to 26% in 2018

Parents awareness of overweight status of their children - The difference in reporting on overweight or obese rates between healthcare professionals and parents is startling. Adults are accurately self-reporting their own unhealthy weight diagnosis from their provider but the self-reporting on their children is nearly 6 times lower than the data indicates. Data appears to indicate that the communication between HealthCare providers and parents on weight status of youth is insufficient. This gap in shared understanding on overweight and obesity rates deserves further understanding.

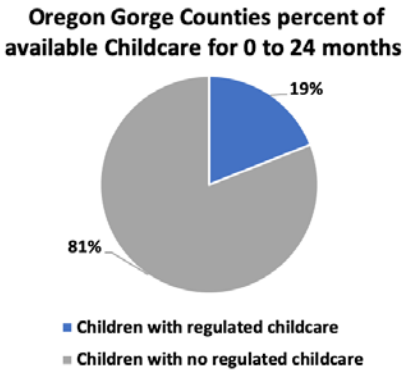
Driver 3.2 Social and Economic Environment

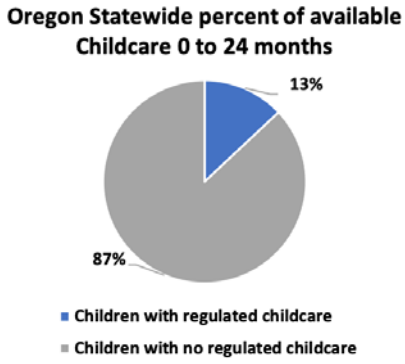
Research points to strong connections between our environment, economic vitality, and health. We know that children who attend preschool are more likely to stay in school, go on to hold jobs and earn more money—all of which are linked to better health.

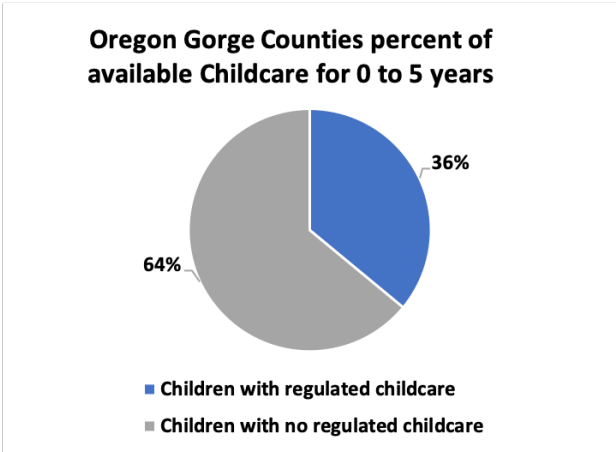
Early childhood education – Community settings and policies support well-being by affording equitable access to health opportunities and resources. These include upstream influences on health such as enrollment in early childhood education. [Requirements: ③❷] [Data Sources: R8, R3]

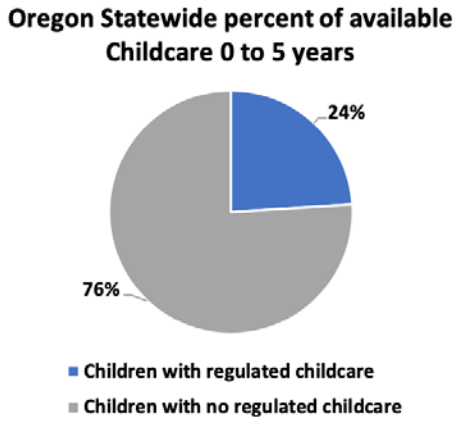
What are the overall numbers?

The Oregon 5-county region has a total of 104 regulated childcare facilities with 39% being Center-based facilities and 61% being Home-based facilities. These regulated childcare facilities provide a total of 1,602 childcare spots for a total of 4,475 children from 0-5. Of those 1,602 spots, 428 are for 0-24 months aged babies. This results in an uneven amount of regulated childcare options for parents. 19% of the babies 0-24 months in the region have a regulated childcare opportunity compared to 13% Oregon statewide. Children in 2+ to 5 years age group have more regulated childcare opportunity.





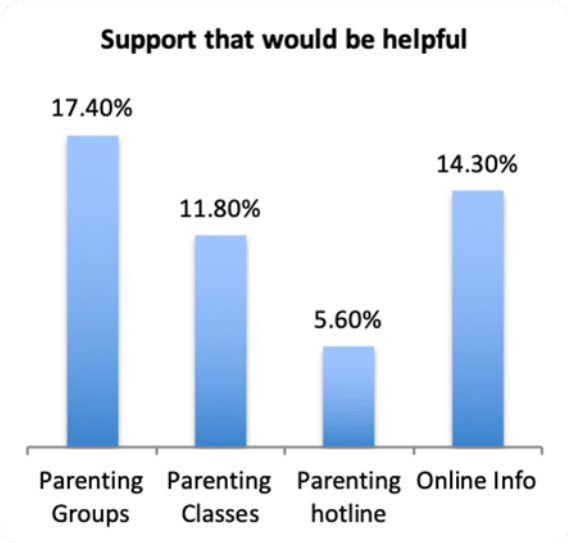




Survey reports 34% of parents needed or wanted ideas and help for raising children or grandchildren.

What's changed since 2016 or what stands out?

Parenting support and childcare information is new for 2019. It is alarming that 81% of newborns to 24 months do not have a regulated childcare spot available to them. The absence of capacity in childcare is impacting all income levels.



Action Area 4: Strengthening Integration of Health Services and Systems

This Action Area aims to strengthen a system of coordinated, quality care that integrates and better balances medical treatment, public health, and social services. It calls for a care delivery system that rewards value rather than volume and increases consumer engagement, shared decision-making, and transparency of data showing cost and quality of care.

★ Driver 4.1 Access

Several factors influence access to health services, including the expansion of health insurance coverage. But access must be more than having insurance. It must include being able to get comprehensive, continuous health services when needed and having the opportunity and tools to make healthier choices.

★ Access to healthcare services including medical, dental, and mental health services –

Comprehensive patient-centered primary care homes provide accessible, continuous and coordinated care. Oral diseases affect what we eat, how we look, the way we communicate, and how we feel about ourselves. They also affect academic success and economic productivity by limiting our ability to learn, work and succeed. Receiving appropriate and equitable dental care at every stage of life, including the prenatal stage is essential. People who experienced more barriers in accessing healthcare include: Low income households, Diverse Communities, Households with young children, Adults on Medicaid or Uninsured for some or all the year [Requirements: ①②③④⑧⑨❶❷] [Data Sources: R1, R3, R4, R19, R10]

What are the overall numbers?

For healthcare services, looking at the community overall is useful for planning and setting policy. The numbers reflected here are based on the entire community from the Consumer Survey.

What are the numbers for those seeking care? Not all services are needed by every community member. These numbers are based on those seeking services.

From the Consumer Survey for adults seeking needed services:

- 8.6% did not get needed medical care

- 25.1% did not get needed dental services
- 23.6% did not get needed mental health services

From the Consumer Survey, parents said their children:

- 5.3% did not get needed medical care
- 6.0% did not get needed dental services
- 24.8% did not get needed mental health services
- 15.7% did not get speech, developmental services

CCO Metric data reports:

- 84% of CCO adults said it was easy to get the medical care, tests or treatment they needed
- 86% of CCO parents said it was easy to get their children medical care, tests or treatment they needed
- 55% of CCO adults said they had a regular dentist and would go for checkups and cleanings
- 86.7% of CCO parents said their children had a regular dentist and would go for checkups and cleanings

From Advantage Dental Services OHP members specifically:

- 42.7% of Advantages Dental Service members aged 0-5 living in Sherman, Gilliam, Hood River or Wasco County.

Which households are under-served?

Underserved areas who wanted Medical Care:

- Diverse Communities went without care 17.4%
- Low Income households went without care 14.1%
- Medicaid went without care 9.7%
- People who were Uninsured for some or all the year went without care 46.7%

Getting to the clinic was too hard was the main reason for going without medical, dental, counseling or mental health care for the following groups:

- 4.5% Families with young children
- 5.6% Uninsured
- 5.1% Diverse Communities
- 2.6% Low Income
- 4.1% Washington
- 13% Oregon

What's changed since 2016 or what stands out?

- 46.7% of the uninsured went without medical care
- Percent of population who reported needing medical care but having to go without it was substantially lower in 2019 (7.9%) than in 2016 (16.8%). The decrease in going without needed medical care from 2016 to 2019 may reflect improvement in access to medical care in the Gorge Region
- OHP dental benefit expanded coverage for partial and full dentures effective July 1, 2016, allowing full dentures every 10 years and partial dentures every 5 years

Community based dental access

In 2019, Advantage Dental's community-based dental care team started participating in the Virtual Dental Home pilot led by the Department of Community Dentistry, School of Dentistry,

OHSU, providing tele-dentistry services at Sherman County Medical Clinic and Arlington Medical Clinic, to all members of the community.

Advantage Dental's community-based dental care program, Everybody Brush!, provided free preventative oral health services at preschools, Head Starts, WIC sites, K-12 schools, medical and behavioral health sites and correctional facilities. Services were provided to all patients regardless of insurance status in the following counties:

- Gilliam County 131 patients ages 3-18
- Sherman County 65 patients ages 0-15
- Wasco County 1658 patients All ages
- Hood River 335 patients ages 0-36

For the 2019/2020 school year, One Community Health (OCH) provides free dental sealants to kids grades 1-8, as well as to high school students 14 years old and younger from our onsite mobile dental clinic for Hood River County.

★ Access to mental health for high needs members – Mental health services are available to meet the needs of members with complex circumstances and non-urgent needs. [Data Sources: R19]

What are the overall numbers?

Emergency Department visits for CCO members age 6 and older resulting in a mental illness diagnosis who had a follow-up visit for mental illness within 7 days:

- 64% Gorge CCO members, 75.5% were seen within 30 days
- 67.8% Eastern Oregon CCO members, 79.2% were seen within 30 days

CCO members newly diagnosed with alcohol or other drug dependence who began treatment within 14 days of the initial diagnosis:

- 37.8% Gorge CCO members began treatment
- 34% of Eastern Oregon CCO members began treatment

★ Integrated services and settings – An increasing body of research indicates that access to healthcare is best achieved when there are multiple integrated access points for community members. Achieving integration requires supports in payment models, changes in screening venues and proper training and education. [Requirements: ②④⑤⑨⓿] [Data Sources: R3]

What are the overall numbers?

Families with young children reported:

- 8.6% did not get all the medical care needed
- 11.4% of their children needed mental health treatment and of those 14.3% did not get mental health treatment
- 70.3% of their children needed dental care and of those 100% received dental care needed
- 21.7% of their children needed developmental care such as speech therapy or help with a learning disability
- 31.3% of their children went without any needed medical, dental, counseling or developmental care

Integrated Settings

19% needed Mental health care treatment in the past 12 months. Of those getting care, 24% received counseling or mental health care in their Primary Care doctor's office.

★ Collaboration on information sharing – Coordination and shared information among cross-sector providers helps to ensure quality, safety, and continuity of care. [Requirements: ①②③④⑤⑦⑨] [Data Sources: R26, R28]

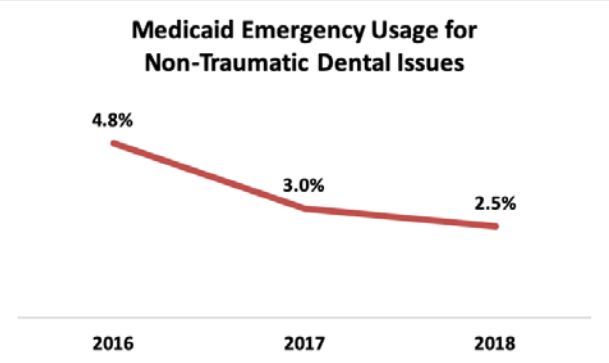
What are the overall numbers?

See information below in Driver 4.3 Balance and Integration - on page 42

The Clinical Advisory Panel endorsed a change in standard protocols in the Gorge to have practicing providers refer all pregnant women to The Family Network operated by the public health departments as the default option (an opt-out model) at the first pre-natal visit.

What's changed since 2016 or what stands out?

Emergency Room usage for non-traumatic dental issues has decreased for Medicaid patients since 2016 by 2.3%.



★ Measuring results of Health Care Access – [Data Sources: R1, R3, R5, R10, R14, R16, R17, R19, R20, R21, R22, R27, R29]

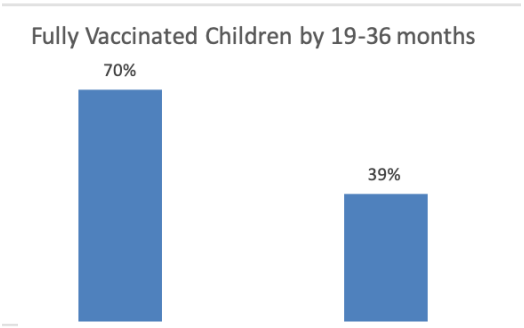
Immunizations

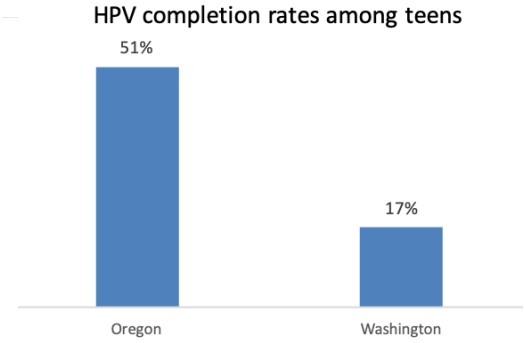
Adults

- 28% Flu vaccination rate

Children

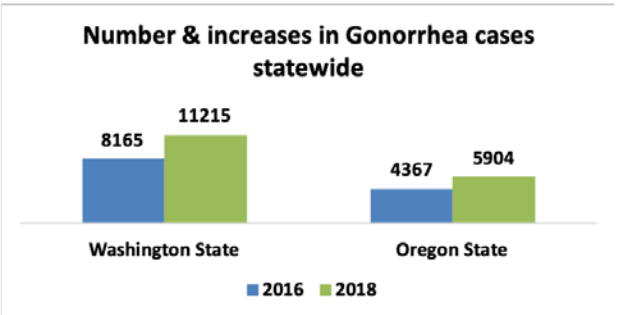
- 70% of 2-year-olds in Oregon's 4 counties are fully vaccinated
- 39% of 19-35 month olds in Washington's 2 counties are fully vaccinated
- HPV vaccination completion rates among 13- to 17-year-olds
  - 2018 data shows 31% Klickitat and Skamania counties teens have had one does of HPV vaccine, approximately 15-17% have completed the series
  - 51% in 2019 in Hood River, Wasco, Gilliam and Sherman counties have completed the series and 46% in 2018

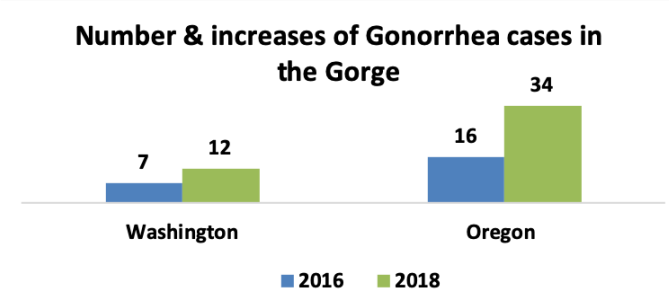




Health conditions for Adults

- 84% of survey respondents say their health is good to excellent
- 11% are Diabetic, 2% higher than Oregon and Washington state rates
- CCO metrics show 21.2% of adult patients with diabetes had poor control defined as A1c>9.0%
- 16% of adults smoke cigarettes or e-cigarettes
- 66 cases of HIV infection in the 7 Gorge counties from County Health Rankings 2019
- Gonorrhea cases have risen from 2016 to 2018





Dental conditions for Adults

Advantage Dental Services OHP members:

- 55 of 858 members 55 years or older in Sherman, Gilliam, Hood River or Wasco Counties had a complete upper and lower denture, indicating the loss of all natural teeth from 2015-2018.

40% - 50% of pregnant women do not get a dental visit during pregnancy

- One Community Health Dental patients - 60% pregnant dental patients received services in 2018 (71/120)
- 50% of Medicaid pregnant women receive a dental visit during pregnancy. This number has not changed between 2017 and 2018.

Health conditions for Children and Teens

- 83% of Oregon teens reported good to excellent Physical Health in the Student Wellness survey 2018
- 72% of Oregon teens reported good to excellent emotional and mental health
- CCO metrics report 93.4% of all children and teens who had a primary care visit in 2018
- Teen birth rate is **25** per 1000 females aged 15-19 - Oregon and Washington rates are **20**

Number of reported Chlamydia cases for 13 to 18 year-olds			
	2016	2017	2018
Hood River	16	20	19
Wasco	21	17	11

Social complexity for Children and Teens

Center of Excellence on Quality of Care Measures for Children with Complex Needs (COE4CCN) defines social complexity as "a set of co-occurring individual, family or community characteristics that have a direct impact on health outcomes or an indirect impact by affecting a child's access to care and/or a family's ability to engage in recommended medical and mental health treatments". Oregon Pediatric Improvement Partnership (OPIP), Oregon Health Authority (OHA) and Department of Human Services came up with 12 factors of social complexity, 5 child-level factors and 7 parent/family level factors. Child-level factors include poverty, foster care, mental health, substance abuse, child abuse or neglect. Parent/family factors include poverty, parental death, incarceration, mental health, substance abuse, limited English, and parental disability.

Social complexities of the Gorge CCO's 4,326 children:

- 16% - 0 social complexity
- 32% - 1 social complexity
- 20% - 2 social complexities (842 kids)
- 12% - 3 social complexities (507)
- 8% - 4 social complexities (328)
- 6% - 5 social complexities (239)
- 4% - 6 social complexities (156)
- 3% - 7 social complexities (107)
- 1.5% 8 social complexities (63)
- .4% 9 social complexities (16)
- Remaining % - 7 or more social complexities (208)

Dental conditions for Children and Teens

Of Advantage Dental Services OHP members in Sherman, Gilliam, Hood River or Wasco Counties:

- 11.5% of members age 6-14 had at least one new cavity from the previous year
- 10.4% of members age 8-9 had at least one cavity in their permanent teeth

One Community Health Dental services QIM Metrics:

- 2.2% medical and dental pts ages 0-5 who received fluoride varnish (30/1369) Pediatric Oral Health Sept 2019
- 10.5% Medical Well Child Check with subsequent completed dental appt (25/238) Sept 2019
- 100% of perinatal women that are sent a 1st tooth, 1st birthday dental visit reminder for baby to establish a dental home (19/19) Aug 2019

★ Access to stable health insurance – The number of people with stable and continuous health insurance to meet their health needs. [Requirements: ①④] [Data Sources: R3]

What are the overall numbers?

Medical Care Insurance:

86.2% had insurance for the past 12 months
5.8% had insurance for some of the 12 months
8.0% had no insurance for the past 12 months

Dental Care:

64.5% had dental insurance for the past 12 months
8.5% had dental insurance for some of the 12 months
27.0% had no dental insurance for the past 12 months

Vision Care:

61.0% had vision insurance for the past 12 months
7.5% had vision insurance for some of the 12 months
31.5% had no vision insurance for the past 12 months

Long-Term Care

35.8% have Long Term care insurance for the past 12 months
2.7% had Long Term care insurance for some of the past 12 months
61.5% had no Long-Term care insurance for the past 12 months

What's changed since 2016 or what stands out?

- 1 in 7 may not have insurance at any given point the same as 2016
- 8% of the population had no medical insurance for all of the past 12 months, this is the same as 2016

Families with young children

- 16.4% went without medical insurance for some or all of the past 12 months
  - 9.7% had no medical insurance for all of the past 12 months
  - 6.7% had no medical insurance for some of the past 12 months
- 30.2% went without dental insurance for some or all of the past 12 months (17.8% had none for the entire year and 12.4% has insurance for some of the year)

Driver 4.2 Consumer Experience and Quality

Consumer Experience – When people don't feel connected to, or in control of, the full complement of medical and social services, they are more likely to delay or avoid care. Health care providers help patients thrive by planning for the care that's needed inside and outside the clinic. This means that all individuals are treated with dignity, and that cultural differences are honored and respected. [Requirements: ②③④⑤⑦⑨❷] [Data Sources: R23, R25]

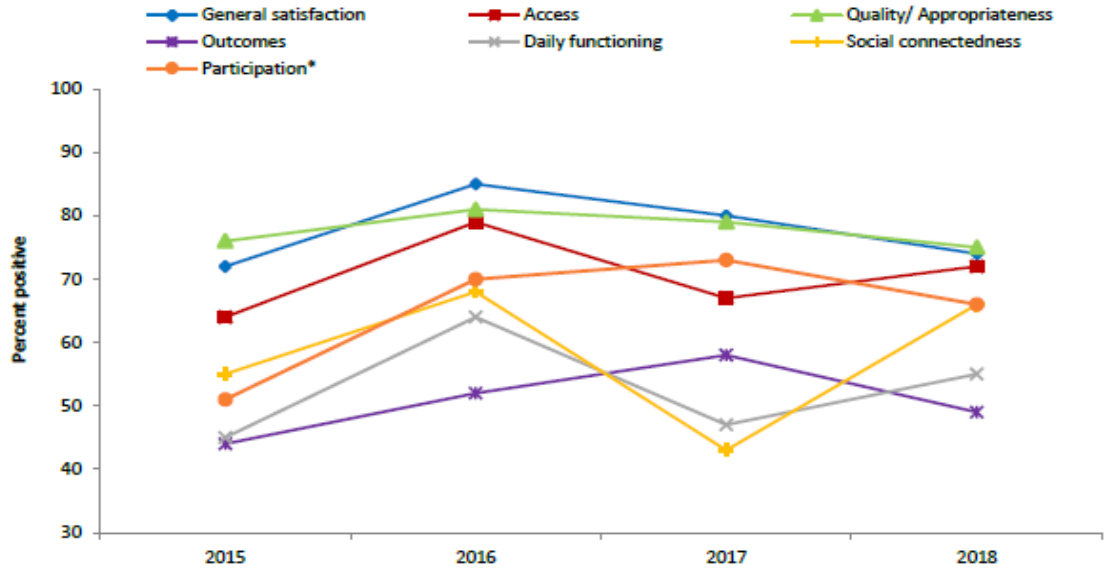
What are the overall numbers?

Oregon Health Authority (OHA) conducts an annual Mental Health Statistic's Improvement Program (MHSIP) survey in which teens and adults are surveyed on perception of services. For 2018, the results of the survey were:

- General satisfaction is trending downward 67% (2018) over 80% (2016)
- Access satisfaction is slightly lower than 2016 (almost 80%) to 70%
- Adult Outcome satisfaction rates at 45% is lower than 2017 (58%)

Adult Survey Results (Outpatient Respondents)

Figure 1. 2015–2018 CCO's Domain Scores: Adult Outpatient Survey



Employing trauma-informed care is another strategy for providing customer-centered care. The Gorge Region received a two-year grant funded by the Robert Wood Johnson Foundation and the California Endowment under the Mobilizing Action for Resilient Communities (MARC) initiative. MARC is designed to assist communities to address Adverse Childhood Effects (ACEs) and become more trauma informed and resilient. MARC communities were selected from a group of invited applicants on the basis of having an existing multi-sector network committed to building resilience and addressing early childhood adversity through and explicit application of the ACEs science, language and local data. The network is called Resilience Network of the Gorge.

The Resilience Network hosted the Trauma & Resiliency Summit which was attended by 214 cross-sector participants and played a significant role in building momentum for the trauma informed practices and resilience effort. Surveys showed an increase of knowledge in ACEs, the neurobiology of trauma, and resilience. The following organizations show increased implementation of trauma-informed practices internally: Federally qualified health center, Law enforcement, Domestic violence and sexual assault, Education (Head Start), and DHS.

Two organizations have been implementing trauma-informed practices since 2015: One Community Health and North Central Public Health District.

Protect the community from health hazards – water fluoridation [Requirements: ④⑧]– [Data Sources: R6, R7, R5]

What are the overall numbers?

Fluoride is added to city water in The Dalles, this is the only water system in the 7 counties to add fluoride to water.

- One water system adds fluoride – The City of The Dalles
- One county (Wasco) had the presence of a drinking water violation
- Average drinking water Z-Score for all 7 counties is -0.74

Driver 4.3 Balance and Integration -

This area is about a better balance between prevention and acute/chronic care services, as well as the intentional integration of public health, social service, and health care systems. When these systems work in sync, we will see an improvement in the efficiency and quality of care delivered, leading to reduced hospital re-admissions, decreased health costs, and a more seamless health care experience. More people will get the preventive and social services they need early and avoid unnecessary medical care.

Electronic medical record linkages – physicians who share data with other providers and hospitals, with the goal of encouraging integration, collaboration, and communication [Requirements: ⑤⑨]– [Data Sources: R26, R11, R9]

What are the overall numbers?

The Columbia Gorge region uses a regional Health Information Exchange capability from Reliance eHealth Collaborative. This includes a closed-loop eReferral system and an aggregated Community Health Record. The current data contributors to the Community Health Record are:

- 75% of Gorge Primary Care Providers including:
  - Mid-Columbia Medical Center including hospital and outpatient
  - One Community Health
  - Providence Hood River including hospital and outpatient
  - Deschutes Rim
- 4 of the 7 counties local Public Health department records
- 100% of NORCOR Regional jail clinic records
- All Emergency Department data for Oregon and Washington State
- Admits, Discharges and Transfers (ADTs) from 24 additional Health Information Exchanges from states and regional hubs. Most relevant to the Gorge region are Idaho, Montana, California and Arizona.
- PacificSource Health Plan claims and pharmacy fill data
- Eight neighboring health care providers in Central Oregon including Mosaic and St. Charles health system which includes hospital and outpatient clinics.

Hospital Partnerships

Mid-Columbia Medical Center

- $34.3 million in total community benefit from 2016 to 2018. Of that:
  - $27.1 million billable services
  - $7.2 million programs or activities to promote health and health in response to community need.

Providence Hood River Memorial Hospital

- $42.8 million in total community benefit from 2016 to 2018
  Of that:
  - $54.5 million in billable services
  - $8.9 million in grants and programs to promote health and health in response to community need

Appendix A - Robert Wood Johnson Foundation Culture of Health Framework

★ means CHIP Topic

ACTION AREAS	DRIVERS	MEASURES
1 MAKING HEALTH A SHARED VALUE	1.1 MINDSET AND EXPECTATIONS	Value on health interdependence Value on well-being Public discussion on health promotion and well-being
	★ 1.2 SENSE OF COMMUNITY	Sense of community Social support Effective referrals
	1.3 CIVIC ENGAGEMENT	Voter participation Volunteer engagement
2 FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING	2.1 NUMBER AND QUALITY OF PARTNERSHIPS	Local health department collaboration Opportunities to improve health for youth at schools Business support for workplace health promotion and Culture of Health
	2.2 INVESTMENT IN CROSS-SECTOR COLLABORATION	U.S. corporate giving Federal allocations for health investments related to nutrition and indoor and outdoor physical activity
	2.3 POLICIES THAT SUPPORT COLLABORATION	Community relations and policing Youth exposure to advertising for healthy and unhealthy food and beverage products Climate adaptation and mitigation Health in all policies (support for working families)
3 CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES	★ 3.1 BUILT ENVIRONMENT/ PHYSICAL CONDITIONS	Housing affordability Access to healthy foods Youth safety Equity in physical activity opportunities Mobility and transportation
	3.2 SOCIAL AND ECONOMIC ENVIRONMENT	Residential segregation Early childhood education Public libraries
	3.3 POLICY AND GOVERNANCE	Complete Streets policies Air quality
4 STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS	★ 4.1 ACCESS	Access to comprehensive primary care Access to stable health insurance Access to mental health services Routine dental care Collaboration on information sharing
	4.2 CONSUMER EXPERIENCE & QUALITY	Consumer experience Population covered by an ACO/CCO
	4.3 BALANCE AND INTEGRATION	Electronic medical record linkages Hospital partnerships Practice laws for nurse practitioners Social spending relative to health expenditure
OUTCOME	**OUTCOME AREAS**	**MEASURES**
O IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY	O.1 ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING	Well-being rating Caregiving burden
	O.2 MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS	Adverse child experiences (ACEs) Disability associated with chronic conditions
	O.3 REDUCED HEALTH CARE COSTS	Family health care cost Potentially preventable hospitalization rates Annual end-of-life care expenditures

Appendix B – List of the local, state and national requirements for Community Health Assessments

The thirteen different Requirements include:

① Regional 2017 Community Health Improvement Plan – the collaborative work product from previous years which needs to be represented in the third Community Health Assessment to measure progress.

② Southwest Washington Accountable Communities of Health (SWACH) – the priorities and focus areas as outlined on the SWACH website.

③ Early Learning System Plan (ELSP) – just released in late November 2018, this plan outlines several areas for changes and improvements in the overall early care and education, education, health, housing, human services ecosystems including stable housing, consistent health care, and affordable, quality care and education.

④ Oral Health Strategic Plan 2020 (Oral Health 2020)– this plan highlights strategies intended to deliver better care, better health and lower costs for Oregonians of all ages, backgrounds and geographic areas. It includes overall Infrastructure, Prevention and Systems of Care and Workforce Capacity.

⑤ CCO 2.0 – in mid-October 2018, Oregon Health Policy Board adopted 43 different policy recommendations with each area including one to five specific objectives. The overarching themes include: Improve the behavioral health system; Increase value and pay for performance; Focus on social determinants of health and health equity; and Maintain sustainable cost growth.

⑥ IRS Tax Exempt Hospitals – the IRS lays out specific requirements for Community Health Needs Assessment for Charitable Hospital Organizations.

⑦ Public Health Accreditation Board (⑦) – to achieve or maintain accreditation, public health organizations have 12 Domain areas each with a set of Standards and Measurements in which they need to describe their work.

⑧ Public Health Accountability Metrics – the Oregon Public Health entities have eight measures that need to be incorporated

⑨ Transformation and Quality Strategy (TQS) – CCOs has a requirement for a transformation plan which includes 15 separate sections and sub categories underneath

⑩ Biennium Implementation Plan (BIP) - Local Mental Health Authorities are required to use information from their community needs assessment to describe the overall system, strengths and areas for improvement in the system, and a budget plan for the biennium.

⓿ Oregon HB 2675 Care Integration Requirements (HB 2675)– Oregon legislation requiring care integration to be included in the Community Health Improvement Plan (CHIP)

❶ Oregon State Health Improvement Plan (Oregon SHIP) – a set of Oregon statewide health improvement areas with a new requirement that at least one of these appear in the Gorge Regional Community Health Improvement Plan (CHIP).

❷ Washington State Health Improvement Plan (WA SHIP) – a Washington states set of statewide health improvements areas.

Appendix C – List of Data Sources and References

R1 Advantage Dental Services & OHP, Advantage Dental info CHA, word document

R2 Blue Zones Project, CAC feedback on Executive summary, PDF

R3 Consumer Survey, Spreadsheet of Consumer Survey data (mailed survey and hand fielded survey blended), spreadsheet

R4 Providence Center for Outcomes Research and Education, PDF, 2019 Community Health Survey Gorge Service Area August 2019, PDF

R5 County Health Rankings, 2019 County Health Rankings OR WA 7 Counties combined, https://www.countyhealthrankings.org/app/washington/2019/rankings/skamania/county/outcomes/overall/snapshot

R6 Fluoride rates Oregon, Oregon.gov, https://yourwater.oregon.gov/fluoride.php?sort=cs

R7 Fluoride rates Washington, Washington Department of Health, https://www.doh.wa.gov/Portals/1/Documents/4200/FluorideCommunities.pdf

R8 Four Rivers Early Learning Hub, 4RELC Childcare Rates in Oregon email

R9 Mid-Columbia Medical Center, provided via email

R10 OCH One Community Health, provided copy of CHA via email

R11 Providence Hood River Memorial Hospital, provided via email

R12 Skyline Hospital, provided via email

R13 Oregon Healthy Teen Survey (2017, 2019), Oregon Health Authority Oregon Healthy Teens Survey, https://www.oregon.gov/oha/PH/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx

R14 Oregon Student Wellness Survey (2016,2018), Oregon Health Authority, https://oregon.pridesurveys.com/

R15 Women, Infants and Children (WIC), WIC Fact Sheets 2018 North Central Public Health District and Hood River County Health Department

R16 OHA 2 year-old immunization rates & HPV, Oregon Health Authority Oregon Immunization Program Data and Reports, https://www.oregon.gov/OHA/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/Pages/research.aspx

R17 Washington State Healthy Youth Survey, HYS Fact Sheets, https://www.askhys.net/FactSheets

R18 Columbia Gorge Health Council, Existing Committed Funds Summary, PDF

R19 CCO Metric Data, Oregon Health System Transformation CCO Metrics 2018 Final Report, https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2018-CCO-Report-FINAL.pdf

R20 Washington State Immunization Rates by County, Washington Public Health Immunization Measures by County,

https://www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/ImmunizationDataDashboards/PublicHealthMeasures

R21 Oregon Sexually Transmitted Disease Rates, Oregon County STD data, https://www.oregon.gov/oha/PH/DISEASESCONDITIONS/COMMUNICABLEDISEASE/DISEASESURVEILLANCEDATA/STD/Pages/index.aspx

R22 Washington Sexually Transmitted Disease Rates, Washington Department of Health Sexually Transmitted Disease (STD), https://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/SexuallyTransmittedDisease

R23 PacificSource, 2018 OHA Mental Health Survey - PacificSource Community Solutions - Columbia Gorge 2018 Survey Results, PDF

R24 Mid-Columbia Housing Authority, provided via email

R25 Mobilizing Action for Resilient Communities (MARC), MARC Data Report, Phase II, word document

R26 Reliance eHealth Collaborative status reports and responses to specific data requests.

R27 PacificSource OHA PIP on Oral Health Care during Pregnancy, PDF

R28 PacificSource Medicaid Dental Services: Structure, Benefits, Access and Oversight September 2019, PDF

R29 PacificSource, Report Health Complexity Pacific Source Gorge, PDF

R30 MCCFL, 2019 HAS Brochure, word document

R31 Childcare Desert WA, https://www.childcaredeserts.org/?state=WA&urbanicity=Rural

R32 Oregon Childcare regulated centers for Hood River and Wasco, email

R33 Supported Housing rates from Mid-Columbia Center for Living, email

Appendix D - Definitions for groups of people.

In reviewing the data, information was grouped in different ways to determine whether any group of people are underserved by the system as compared to the region overall. When identifying these groups, our language is intended to highlight where the system is failing and not place blame on the people represented in any demographic. Our groups or demographic segments are:
Individuals – groups of Individuals who are a certain age, ethnicity, race. The groups used include:

- Adults – all individual-specific responses together from the Consumer Survey independent of race, ethnicity, income or abilities.
- Teens or students – 8th, 11th or 12th graders who completed a Healthy Teen or Student Wellness survey.
- White - people who self-identify as Non-Hispanic, White, from Questions 61 and 62 on the Consumer Survey
- Diverse Communities - people who self-identify as Hispanic or Latino from Question 61 or self-identify as American Indian or Alaska Native, Black or African American, Asian or Asian American, Native Hawaiian or Other Pacific Islander, or Other from Question 62 on the Consumer Survey.
- Diverse abilities – people who self-identify as having difficulties with seeing, hearing, walking, concentrating or selfcare as listed on Question 34 on the Consumer Survey.
- Caregivers – people who self-identify as helping an adult relative, loved one, or friend with their living or health needs as noted in question 50 on the Consumer Survey.

Households – means 1 or more people in a household who have meet a specific group definition.

- Households - all household-specific responses together from the Consumer Survey independent of race, ethnicity, income or abilities.
- Families with young children – households who have one or more children between the age of newborn to 5 years of age in the household as noted on Question 70 on the Consumer Survey. This includes all income levels.
- Low Income Households – households with income of under 200% of the Federal Poverty Level (FPL) or $24,120 per year for single adults and $49,200 per year for a family of 4. This is based on Questions 69 and 70 on the Consumer Survey to determine FPL.
- Adults on Medicaid – households with adults on Medicaid including Seniors. This represents an income of 138% below FPL or $16,753 per year for single adults and $34,638 per year for a family of 4. For Seniors, this is often called ‘Duals’ as they enrolled in both Medicaid + Medicare. This is based on Question 2 of the on the Consumer Survey.
- Medicare – households with Adults who are 65 years of age or older and on Medicare only. This is based on Question 2 of the on the Consumer Survey
- Migrant/Seasonal Farmworker Household – people who self-identify with at least one member of the household being a Migrant and Seasonal Farmworker on the Consumer Survey.

Appendix E – Consumer Survey Data by location and groups

	Oregon	Washington	Hood River	Wasco	Klickitat	Skamania
Age						
18 to 39 years	30.3%	25.9%	29.1%	35.5%	23.6%	34.8%
40 to 64 years	40.8%	47.4%	39.0%	46.5%	50.9%	36.1%
65 to 79 years	20.1%	21.1%	21.6%	14.0%	20.3%	24.4%
80+ years	8.8%	5.6%	10.3%	4.0%	5.1%	4.6%
Ethnicity and Race						
Hispanic or Latino/Latina/Latinx	21.3%	11.6%	23.2%	21.0%	11.6%	13.6%
White	84.0%	83.4%	84.4%	81.8%	82.4%	86.5%
Black or African American	0.2%	0.7%	0.0%	0.6%	0.8%	0.0%
Asian or Asian American	2.5%	1.6%	2.4%	3.5%	0.4%	4.5%
Native Hawaiian or Other Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
American Indian or Alaska Native	5.3%	4.3%	2.2%	10.9%	4.1%	6.3%
Do not know or not sure	1.0%	0.5%	1.8%	0.0%	0.3%	0.9%
Other	5.1%	3.7%	5.5%	5.3%	4.0%	4.5%
What language do you speak best						
English	86.1%	90.9%	83.0%	87.8%	90.4%	90.9%
Spanish	9.0%	5.0%	10.4%	8.4%	5.4%	0.0%
Other	4.9%	4.2%	6.5%	3.8%	4.2%	9.1%
What language do you read and write best						
English	87.6%	91.7%	85.1%	89.1%	91.1%	95.5%
Spanish	9.3%	5.0%	10.1%	9.6%	5.4%	0.0%
Other	3.1%	3.3%	4.8%	1.3%	3.5%	4.5%

Adult Insurance						
No Medical Care Ins for some or all 12 months	13.4%	14.2%	10.0%	21.4%	15.6%	6.4%
No Dental Care Ins for some or all 12 months	35.1%	33.6%	33.8%	36.8%	37.5%	13.8%
No Vision Care Ins for some or all 12 months	40.0%	34.3%	37.5%	44.2%	37.4%	19.3%
No Long-term Care Ins for some or all 12 months	62.2%	66.3%	62.6%	62.8%	65.4%	74.1%
Location of Non-Emergency care						
A Tribal Clinic	0.7%	0.9%	0.0%	2.5%	1.0%	0.0%
A VA Clinic	0.5%	2.5%	0.4%	0.3%	2.7%	0.9%
A hospital emergency room	0.9%	0.9%	0.4%	1.7%	1.0%	0.0%
An urgent care clinic	0.0%	0.5%	0.0%	0.0%	0.7%	0.0%
A Primary Care Clinic	89.2%	82.7%	91.1%	87.2%	80.9%	90.7%
Health Department	0.2%	1.6%	0.0%	0.8%	2.3%	0.0%
A Mental Health clinic	2.0%	0.9%	2.3%	2.1%	1.0%	0.0%
Other	5.8%	9.4%	5.1%	4.7%	9.8%	8.4%
I don't have a place to go	0.7%	0.5%	0.8%	0.6%	0.5%	0.0%

	Oregon	Washington	Hood River	Wasco	Klickitat	Skamania
Adult Healthcare Access						
Unmet Medical Care need	7.8%	11.3%	7.9%	9.9%	13.2%	2.3%
Unmet Dental Care need	23.2%	31.7%	18.5%	32.2%	32.5%	36.4%
Unmet Mental Health Care need	24.7%	23.3%	18.2%	28.3%	30.9%	0.0%
Number of issues with adult access to care						
None	37.0%	32.8%	42.1%	31.2%	29.6%	44.6%
1 issue	32.9%	33.3%	32.7%	28.8%	34.6%	34.9%
2 issues	14.8%	14.4%	13.8%	16.0%	13.6%	14.1%
3 or more issues	15.4%	19.6%	11.4%	24.0%	22.3%	6.4%
Where adults went for Mental Health Care						
My primary care doctor's office	35.6%	28.7%	30.2%	28.5%	30.8%	20.7%
Mental Health clinic	43.4%	36.6%	50.6%	42.2%	31.5%	33.4%
VA Clinic	2.2%	3.5%	1.5%	4.2%	3.1%	4.1%
Phone, Online, texting, or video chat service	3.0%	0.0%	0.0%	7.6%	0.0%	0.0%
Other	15.8%	31.2%	17.6%	17.6%	34.7%	41.8%
Chronic conditions in Adults						
No chronic conditions	32.1%	31.6%	36.0%	31.5%	32.0%	31.2%
At least 1 physical condition	32.0%	36.6%	31.7%	27.5%	37.1%	31.0%
At least 1 behavioral condition	9.8%	6.5%	11.8%	10.0%	5.6%	6.2%
At least 1 behavioral and 1 physical condition	26.1%	25.3%	20.6%	31.0%	25.3%	31.6%
A lot of difficulty or cannot do the following:						
Seeing, even if wearing glasses	6.5%	5.8%	4.6%	8.1%	4.8%	12.8%
Hearing, even if using a hearing aid	4.4%	5.1%	4.0%	5.1%	5.6%	1.9%
Walking or climbing steps	8.2%	7.3%	6.4%	9.3%	6.9%	8.6%
Remembering or concentrating	3.0%	5.6%	3.0%	3.5%	5.0%	3.8%
Self-care, such as washing or dressing	1.1%	1.5%	0.3%	2.4%	1.8%	0.0%
Communicating, understanding, or being understood	1.2%	1.9%	1.4%	1.3%	2.1%	0.0%
Tobacco and marijuana Adult personal use						
Smoking tobacco (cigarette, cigar, etc.)	15.9%	17.8%	8.8%	27.8%	17.0%	18.0%
Chewing tobacco	2.5%	2.7%	2.1%	3.0%	2.7%	4.5%
Electronic smoking systems (vape, juul, etc.)	4.3%	6.1%	2.0%	8.3%	6.2%	13.6%
Marijuana products (smoked, vaped, or edibles)	17.9%	14.1%	16.1%	22.1%	14.1%	16.3%
% of tobacco users or smokers who want to quit	60.3%	51.8%	77.3%	53.5%	55.8%	33.4%
Substance use in the household						
Opioids not as prescribed (oxycodone, heroin, morphine, methadone, codeine, etc.,)	5.0%	3.7%	4.6%	4.9%	2.7%	8.0%
Amphetamine type stimulants (meth, speed, diet pills, ecstasy, etc.)	5.3%	3.9%	5.1%	7.2%	4.5%	1.6%
Any other street drug	2.8%	3.1%	2.4%	4.2%	2.9%	6.2%

	Oregon	Washington	Hood River	Wasco	Klickitat	Skamania
Youth Healthcare Access						
Unmet Medical Care need	1.8%	16.4%	0.0%	3.2%	20.6%	0.0%
My children needed Dental Care last year	69.7%	76.8%	71.2%	62.9%	74.8%	92.2%
My children did not need Dental Care last year	30.3%	23.2%	28.8%	37.1%	25.2%	7.8%
Unmet Dental Care need	7.1%	6.7%	4.1%	9.4%	8.8%	0.0%
Unmet Mental Health Care need	22.7%	27.8%	8.5%	43.8%	25.3%	25.0%
Number of issues with youth access to care						
none	77.3%	79.7%	80.3%	72.1%	77.3%	90.4%
1 issue	18.4%	8.6%	16.9%	21.7%	9.4%	6.3%
2 ore more issues	4.3%	11.7%	2.8%	6.2%	13.3%	3.3%
Where Youth went for Mental Health Care						
Their primary care doctor's office	50.0%	37.5%	50.0%	50.0%	33.3%	50.0%
Mental Health clinic	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
School counselor	12.8%	0.0%	12.8%	0.0%	0.0%	0.0%
Phone, Online, texting, or video chat service	0.0%	23.7%	0.0%	0.0%	23.7%	0.0%
Other	37.2%	38.8%	37.2%	0.0%	42.9%	0.0%
Unmet Developmental Care need	8.8%	26.1%	0.0%	12.5%	38.7%	0.0%
Chronic Conditions in Youth						
None	87.0%	74.6%	88.9%	84.2%	76.7%	63.3%
At least 1 physical condition	8.0%	16.6%	6.8%	10.4%	15.1%	27.8%
At least 1 behavioral condition	5.0%	8.8%	4.3%	5.5%	8.2%	9.0%

Housing Status						
Stable housing	74.9%	76.9%	75.1%	71.7%	77.3%	81.1%
Have housing but worried about losing it	8.3%	13.2%	9.3%	7.5%	12.3%	13.5%
Staying in a Hotel	0.6%	0.0%	0.7%	0.6%	0.0%	0.0%
Staying with Friends or family	4.8%	3.6%	5.2%	4.3%	3.9%	0.0%
Shelter, car or on the street	2.7%	1.1%	1.0%	6.2%	1.2%	0.0%
Other	7.0%	5.8%	7.2%	8.6%	5.7%	2.7%
Households paying >50% of income on housing	27.4%	26.0%	25.6%	30.0%	25.9%	38.3%
Food Insecure	26.0%	31.6%	19.2%	37.1%	30.6%	41.0%
Households went without the following because of lack of money						
Food or meals	11.8%	9.4%	8.3%	19.2%	9.4%	10.9%
Utilities or phone	10.7%	8.7%	8.3%	17.0%	8.8%	6.4%
Transportation	13.9%	13.5%	11.5%	18.9%	13.1%	14.5%
Clothing	11.6%	10.9%	7.7%	18.2%	11.7%	10.9%
Housing	6.6%	3.7%	4.4%	11.7%	4.2%	0.0%
Childcare	4.3%	2.5%	3.6%	5.6%	2.4%	4.5%
Social activities	22.7%	23.1%	19.9%	27.8%	22.1%	27.0%
Exercise or sports	13.6%	15.6%	12.4%	18.7%	15.9%	18.1%

	Oregon	Washington	Hood River	Wasco	Klickitat	Skamania
Number of resources gone without because of lack of money (excluding social and exercise)						
None	78.6%	77.8%	83.2%	70.7%	76.9%	80.9%
1 to 2	11.5%	14.5%	8.8%	14.2%	15.8%	8.2%
3 or more	9.9%	7.6%	8.0%	15.2%	7.2%	10.9%
Household went without the following because of no transportation or distance too far						
Food or meals	7.5%	4.1%	6.9%	10.4%	3.5%	6.4%
Healthcare	8.0%	11.1%	5.2%	13.1%	11.5%	8.2%
Childcare	2.3%	3.1%	1.8%	3.7%	3.7%	0.0%
Trust and belonging in the community						
People are willing to help each other	92.0%	82.1%	92.6%	90.0%	80.4%	87.4%
People can be trusted	80.7%	76.7%	87.7%	71.1%	75.4%	84.6%
Adults watch out that children are safe and do not get in trouble	81.1%	82.0%	86.5%	74.1%	81.6%	81.1%
I feel safe here	91.7%	88.4%	93.0%	89.3%	88.1%	87.8%
Insufficient social supports	28.4%	26.7%	25.1%	34.0%	26.8%	29.3%
Caregivers						
% of Caregivers supporting adults	12.8%	22.1%	11.7%	13.0%	21.7%	24.6%
Caregivers who feel they do not have all the support they need	51.9%	43.0%	57.0%	50.2%	46.7%	17.8%
Traumatic experiences of community members						
Witnessed or experienced violence	42.9%	41.7%	38.3%	50.6%	41.3%	48.0%
Made to do something sexual that you did not want to do	23.0%	15.6%	17.4%	29.1%	16.2%	11.7%
Physically hurt or threatened by an intimate partner	24.6%	20.9%	21.8%	27.7%	20.0%	30.1%
Number of traumatic events:						
None	15.9%	20.9%	17.1%	14.0%	18.6%	27.6%
1 to 2	26.0%	23.3%	28.2%	23.8%	24.0%	19.5%
3 to 4	16.7%	17.8%	18.9%	12.9%	17.6%	14.0%
5 to 8	22.7%	24.3%	20.7%	26.2%	26.4%	27.1%
9 or more	18.7%	13.7%	15.1%	23.2%	13.4%	11.7%
% still impacted some or a lot by trauma	70.2%	63.9%	64.9%	76.2%	66.8%	62.1%
% of those who experienced unfair treatment some, most or all the time because of race, ethnicity, gender or sexual orientation	37.4%	32.0%	39.0%	37.0%	33.0%	26.4%
% of those who witnessed others receiving unfair treatment because of race, ethnicity, gender or sexual orientation	67.5%	64.3%	67.4%	68.3%	66.2%	58.0%
% who do not know where to refer someone who is at risk for suicide	31.0%	33.5%	35.3%	27.6%	35.2%	27.4%

	Diverse Communities	Seasonal Farmworkers	Caregivers	Parents with children 0-5
Age				
18 to 39 years	37.4%	25.9%	29.1%	35.5%
40 to 64 years	46.4%	47.4%	39.0%	46.5%
65 to 79 years	14.0%	21.1%	21.6%	14.0%
80+ years	2.2%	5.6%	10.3%	4.0%
Ethnicity and Race				
Hispanic or Latino/Latina/Latinx	69.9%	11.6%	23.2%	21.0%
White	50.5%	83.4%	84.4%	81.8%
Black or African American	0.6%	0.7%	0.0%	0.6%
Asian or Asian American	12.8%	1.6%	2.4%	3.5%
Native Hawaiian or Other Pacific Islander	0.0%	0.0%	0.0%	0.0%
American Indian or Alaska Native	13.1%	4.3%	2.2%	10.9%
Do not know or not sure	0.6%	0.5%	1.8%	0.0%
Other	19.5%	3.7%	5.5%	5.3%
What language do you speak best				
English	62.9%	90.9%	83.0%	87.8%
Spanish	24.1%	5.0%	10.4%	8.4%
Other	13.0%	4.2%	6.5%	3.8%
What language do you read and write best				
English	68.1%	91.7%	85.1%	89.1%
Spanish	26.2%	5.0%	10.1%	9.6%
Other	5.7%	3.3%	4.8%	1.3%

Adult Insurance				
No Medical Care Ins for some or all 12 months	19.6%	46.4%	12.1%	16.4%
No Dental Care Ins for some or all 12 months	21.6%	60.0%	32.3%	30.2%
No Vision Care Ins for some or all 12 months	26.7%	65.4%	38.1%	33.2%
No Long-term Care Ins for some or all 12 months	53.0%	76.5%	74.6%	60.3%
Location of Non-Emergency care				
A Tribal Clinic	1.6%	0.0%	1.6%	2.9%
A VA Clinic	2.4%	0.0%	3.8%	1.6%
A hospital emergency room	0.0%	0.0%	1.0%	1.0%
An urgent care clinic	0.0%	0.0%	0.0%	0.0%
A Primary Care Clinic	81.5%	94.7%	80.2%	86.7%
Health Department	0.4%	0.0%	0.8%	0.0%
A Mental Health clinic	0.4%	0.0%	1.8%	0.0%
Other	12.8%	5.3%	10.9%	6.0%
I don't have a place to go	0.8%	0.0%	0.0%	1.9%

	Diverse Communities	Seasonal Farmworkers	Caregivers	Parents with children 0-5
Adult Healthcare Access				
Unmet Medical Care need	17.4%	5.3%	7.9%	8.6%
Unmet Dental Care need	27.6%	38.9%	28.1%	23.0%
Unmet Mental Health Care need	9.7%	33.3%	18.8%	18.8%
Number of issues with adult access to care				
None	35.6%	10.0%	38.3%	40.6%
1 issue	26.5%	26.7%	31.7%	26.6%
2 issues	14.1%	16.7%	13.9%	13.2%
3 or more issues	23.9%	46.7%	16.1%	19.6%
Where adults went for Mental Health Care				
My primary care doctor's office	27.1%	66.7%	41.7%	45.8%
Mental Health clinic	56.1%	0.0%	20.8%	50.0%
VA Clinic	4.1%	33.3%	10.8%	0.0%
Phone, Online, texting, or video chat service	8.6%	0.0%	0.0%	0.0%
Other	4.2%	0.0%	26.7%	4.2%
Chronic conditions in Adults				
No chronic conditions	29.6%	53.3%	24.7%	45.0%
At least 1 physical condition	35.3%	20.0%	37.9%	22.8%
At least 1 behavioral condition	3.8%	6.7%	5.0%	12.5%
At least 1 behavioral and 1 physical condition	31.4%	20.0%	32.4%	19.8%
A lot of difficulty or cannot do the following:				
Seeing, even if wearing glasses	6.3%	3.5%	7.6%	3.7%
Hearing, even if using a hearing aid	4.4%	0.0%	8.5%	6.7%
Walking or climbing steps	3.0%	0.0%	9.7%	1.5%
Remembering or concentrating	2.6%	3.5%	6.1%	0.7%
Self-care, such as washing or dressing	1.3%	3.5%	2.2%	0.0%
Communicating, understanding, or being understood	1.7%	6.9%	2.7%	0.0%
Tobacco and marijuana Adult personal use				
Smoking tobacco (cigarette, cigar, etc.)	14.1%	33.3%	15.4%	10.8%
Chewing tobacco	1.3%	3.3%	1.5%	1.4%
Electronic smoking systems (vape, juul, etc.)	5.3%	13.3%	3.1%	3.6%
Marijuana products (smoked, vaped, or edibles)	14.1%	30.0%	9.4%	8.1%
% of tobacco users or smokers who want to quit	83.9%	62.5%	67.5%	87.5%
Substance use in the household				
Opioids not as prescribed (oxycodone, heroin, morphine, methadone, codeine, etc.,)	5.0%	3.3%	4.4%	5.9%
Amphetamine type stimulants (meth, speed, diet pills, ecstasy, etc.)	2.2%	10.0%	2.5%	6.0%
Any other street drug	1.3%	3.3%	1.9%	3.0%

	Diverse Communities	Seasonal Farmworkers	Caregivers	Parents with children 0-5
Youth Healthcare Access				
Unmet Medical Care need	11.8%	7.1%	12.1%	2.8%
My children needed Dental Care last year	68.4%	73.3%	78.0%	70.3%
My children did not need Dental Care last year	31.6%	26.7%	22.0%	29.7%
Unmet Dental Care need	2.6%	8.3%	27.1%	0.0%
Unmet Mental Health Care need	11.1%	25.0%	41.7%	14.3%
Number of issues with youth access to care				
none	65.9%	71.4%	82.3%	65.6%
1 issue	27.6%	14.3%	12.5%	28.3%
2 ore more issues	6.6%	14.3%	5.2%	6.2%
Where Youth went for Mental Health Care				
Their primary care doctor's office	40.9%	100.0%	33.3%	25.0%
Mental Health clinic	0.0%	0.0%	0.0%	0.0%
School counselor	0.0%	0.0%	0.0%	0.0%
Phone, Online, texting, or video chat service	0.0%	0.0%	50.0%	0.0%
Other	9.1%	0.0%	16.7%	75.0%
Unmet Developmental Care need	9.4%	33.3%	75.0%	4.5%
Chronic Conditions in Youth				
None	72.4%	90.5%	84.6%	73.4%
At least 1 physical condition	21.0%	4.8%	12.6%	17.4%
At least 1 behavioral condition	6.6%	4.8%	2.8%	9.3%

Housing Status				
Stable housing	68.7%	66.7%	78.2%	70.3%
Have housing but worried about losing it	8.2%	13.3%	10.1%	14.6%
Staying in a Hotel	0.3%	0.0%	0.0%	0.0%
Staying with Friends or family	8.5%	13.3%	3.8%	4.3%
Shelter, car or on the street	0.9%	0.0%	0.0%	0.0%
Other	11.7%	10.0%	6.4%	10.1%
Households paying >50% of income on housing	30.3%	40.0%	28.9%	24.9%
Food Insecure	37.7%	50.0%	30.6%	30.3%
Households went without the following because of lack of money				
Food or meals	17.7%	23.3%	15.4%	9.3%
Utilities or phone	17.0%	30.0%	14.1%	10.8%
Transportation	18.7%	26.7%	15.0%	16.0%
Clothing	18.0%	13.3%	14.8%	10.8%
Housing	8.9%	20.0%	4.6%	5.7%
Childcare	7.3%	16.7%	5.3%	10.2%
Social activities	26.9%	33.3%	28.7%	24.3%
Exercise or sports	18.6%	33.3%	17.3%	18.2%

	Diverse Communities	Seasonal Farmworkers	Caregivers	Parents with children 0-5
Number of resources gone without because of lack of money (excluding social and exercise)				
None	68.3%	53.3%	69.3%	74.7%
1 to 2	15.9%	26.7%	16.1%	14.6%
3 or more	15.8%	20.0%	14.5%	10.7%
Household went without the following because of no transportation or distance too far				
Food or meals	7.9%	13.3%	6.9%	4.3%
Healthcare	10.5%	16.7%	13.1%	6.5%
Childcare	6.1%	13.3%	2.8%	3.6%
Trust and belonging in the community				
People are willing to help each other	85.7%	80.0%	87.5%	87.8%
People can be trusted	73.2%	73.3%	80.4%	78.5%
Adults watch out that children are safe and do not get in trouble	76.3%	72.4%	81.2%	79.7%
I feel safe here	88.8%	80.0%	91.8%	90.3%
Insufficient social supports	24.5%	21.4%	34.9%	23.8%
Caregivers				
% of Caregivers supporting adults	17.8%	14.3%	100.0%	14.2%
Caregivers who feel they do not have all the support they need	59.6%	80.0%	48.2%	50.0%
Traumatic experiences of community members				
Witnessed or experienced violence	44.0%	46.4%	50.8%	46.9%
Made to do something sexual that you did not want to do	20.8%	25.0%	19.4%	21.1%
Physically hurt or threatened by an intimate partner	26.9%	22.2%	27.1%	22.3%
Number of traumatic events:				
None	22.0%	33.3%	18.3%	14.5%
1 to 2	19.1%	20.0%	21.5%	28.0%
3 to 4	15.2%	10.0%	13.5%	14.2%
5 to 8	27.9%	13.3%	29.5%	25.8%
9 or more	15.9%	23.3%	17.1%	17.6%
% still impacted some or a lot by trauma	61.3%	58.6%	68.8%	61.6%
% of those who experienced unfair treatment some, most or all the time because of race, ethnicity, gender or sexual orientation	61.8%	48.3%	39.6%	36.8%
% of those who witnessed others receiving unfair treatment because of race, ethnicity, gender or sexual orientation	75.3%	53.3%	67.3%	71.5%
% who do not know where to refer someone who is at risk for suicide	37.4%	33.3%	24.9%	33.1%

	200% FPL or lower	Medicare	Medicaid/ Dual-eligible	Uninsured
Age				
18 to 39 years	29.7%	1.8%	22.0%	49.3%
40 to 64 years	42.6%	10.9%	55.1%	42.0%
65 to 79 years	19.8%	65.3%	16.2%	7.2%
80+ years	7.8%	22.1%	6.7%	1.6%
Ethnicity and Race				
Hispanic or Latino/Latina/Latinx	19.4%	5.1%	16.2%	33.2%
White	83.5%	87.5%	84.7%	74.5%
Black or African American	0.9%	0.0%	0.6%	1.0%
Asian or Asian American	2.6%	1.3%	1.9%	4.6%
Native Hawaiian or Other Pacific Islander	0.0%	0.0%	0.0%	0.0%
American Indian or Alaska Native	6.3%	4.2%	7.5%	3.9%
Do not know or not sure	1.2%	0.3%	2.0%	2.0%
Other	4.5%	2.5%	4.9%	2.9%
What language do you speak best				
English	87.1%	96.4%	87.2%	77.2%
Spanish	9.3%	2.2%	8.0%	20.7%
Other	3.6%	1.4%	4.8%	2.2%
What language do you read and write best				
English	87.1%	96.4%	89.7%	74.2%
Spanish	10.2%	2.7%	7.6%	23.7%
Other	2.6%	0.9%	2.7%	2.1%

Adult Insurance				
No Medical Care Ins for some or all 12 months	19.2%	6.5%	10.5%	90.1%
No Dental Care Ins for some or all 12 months	50.6%	59.9%	36.0%	87.5%
No Vision Care Ins for some or all 12 months	55.4%	53.5%	50.1%	91.1%
No Long-term Care Ins for some or all 12 months	68.7%	69.6%	66.0%	91.8%
Location of Non-Emergency care				
A Tribal Clinic	1.1%	0.0%	0.7%	0.0%
A VA Clinic	1.0%	1.3%	1.3%	0.0%
A hospital emergency room	1.1%	1.5%	0.4%	2.3%
An urgent care clinic	0.0%	0.0%	0.0%	0.0%
A Primary Care Clinic	84.5%	88.5%	81.6%	76.2%
Health Department	0.8%	0.0%	1.2%	2.3%
A Mental Health clinic	1.8%	2.6%	2.7%	10.1%
Other	8.5%	5.6%	10.2%	9.1%
I don't have a place to go	1.2%	0.6%	1.8%	0.0%

	200% FPL or lower	Medicare	Medicaid/ Dual-eligible	Uninsured
Adult Healthcare Access				
Unmet Medical Care need	14.1%	2.2%	9.7%	46.7%
Unmet Dental Care need	41.0%	23.1%	39.5%	54.6%
Unmet Mental Health Care need	26.6%	27.5%	24.9%	37.5%
Number of issues with adult access to care				
None	22.6%	32.5%	29.8%	0.0%
1 issue	32.6%	40.6%	32.7%	0.0%
2 issues	18.1%	19.4%	20.8%	3.6%
3 or more issues	26.7%	7.5%	16.8%	96.4%
Where adults went for Mental Health Care				
My primary care doctor's office	40.4%	20.7%	38.9%	0.0%
Mental Health clinic	32.5%	37.9%	37.7%	0.0%
VA Clinic	4.4%	0.0%	3.9%	0.0%
Phone, Online, texting, or video chat service	5.1%	6.2%	0.0%	50.0%
Other	17.6%	35.2%	19.5%	50.0%
Chronic conditions in Adults				
No chronic conditions	23.9%	18.2%	25.2%	51.4%
At least 1 physical condition	30.4%	49.0%	23.8%	24.0%
At least 1 behavioral condition	10.0%	2.8%	11.5%	16.7%
At least 1 behavioral and 1 physical condition	35.7%	30.0%	39.5%	7.8%
A lot of difficulty or cannot do the following:				
Seeing, even if wearing glasses	9.6%	6.6%	6.5%	8.5%
Hearing, even if using a hearing aid	6.4%	8.2%	8.1%	1.0%
Walking or climbing steps	14.1%	12.4%	14.6%	5.6%
Remembering or concentrating	5.2%	4.8%	7.6%	1.0%
Self-care, such as washing or dressing	2.7%	1.6%	2.2%	1.0%
Communicating, understanding, or being understood	2.9%	1.7%	2.3%	1.0%
Tobacco and marijuana Adult personal use				
Smoking tobacco (cigarette, cigar, etc.)	28.7%	7.8%	27.8%	27.0%
Chewing tobacco	3.3%	1.4%	3.5%	2.9%
Electronic smoking systems (vape, juul, etc.)	6.5%	0.9%	7.0%	7.8%
Marijuana products (smoked, vaped, or edibles)	21.8%	9.0%	23.0%	26.2%
% of tobacco users or smokers who want to quit	59.0%	51.2%	52.2%	69.2%
Substance use in the household				
Opioids not as prescribed (oxycodone, heroin, morphine, methadone, codeine, etc.,)	6.7%	2.3%	8.6%	2.9%
Amphetamine type stimulants (meth, speed, diet pills, ecstasy, etc.)	5.4%	1.2%	6.4%	2.0%
Any other street drug	2.7%	0.7%	3.3%	2.9%

	200% FPL or lower	Medicare	Medicaid/ Dual-eligible	Uninsured
Youth Healthcare Access				
Unmet Medical Care need	5.2%	0.0%	5.0%	4.0%
My children needed Dental Care last year	79.1%	0.0%	76.9%	66.1%
My children did not need Dental Care last year	20.9%	100.0%	23.1%	33.9%
Unmet Dental Care need	10.8%	0.0%	13.4%	5.0%
Unmet Mental Health Care need	22.1%	0.0%	28.3%	16.7%
Number of issues with youth access to care				
none	80.0%	93.0%	77.8%	71.3%
1 issue	13.6%	2.6%	16.1%	14.5%
2 ore more issues	6.4%	4.4%	6.2%	14.2%
Where Youth went for Mental Health Care				
Their primary care doctor's office	33.3%	0.0%	35.7%	50.0%
Mental Health clinic	0.0%	0.0%	0.0%	0.0%
School counselor	17.2%	0.0%	26.3%	0.0%
Phone, Online, texting, or video chat service	15.6%	0.0%	23.7%	0.0%
Other	33.9%	0.0%	14.3%	0.0%
Unmet Developmental Care need	26.7%	0.0%	22.8%	25.0%
Chronic Conditions in Youth				
None	80.3%	96.8%	78.3%	77.9%
At least 1 physical condition	15.2%	3.3%	17.0%	19.5%
At least 1 behavioral condition	4.5%	0.0%	4.8%	2.6%

Housing Status				
Stable housing	64.0%	83.8%	63.7%	72.6%
Have housing but worried about losing it	16.1%	4.8%	17.2%	6.9%
Staying in a Hotel	0.6%	0.0%	0.9%	0.0%
Staying with Friends or family	7.5%	2.7%	6.9%	8.8%
Shelter, car or on the street	3.4%	0.0%	4.4%	1.0%
Other	9.4%	5.9%	9.5%	9.8%
Households paying >50% of income on housing	52.5%	24.7%	47.4%	53.0%
Food Insecure	47.5%	12.2%	49.8%	49.5%
Households went without the following because of lack of money				
Food or meals	17.9%	2.3%	21.3%	16.4%
Utilities or phone	16.3%	2.9%	16.8%	18.3%
Transportation	25.6%	7.1%	24.9%	22.0%
Clothing	18.8%	4.5%	19.0%	18.1%
Housing	8.3%	0.5%	8.3%	12.7%
Childcare	6.0%	0.0%	4.3%	6.9%
Social activities	35.7%	16.4%	29.1%	36.4%
Exercise or sports	21.1%	6.2%	21.3%	29.1%

	200% FPL or lower	Medicare	Medicaid/ Dual-eligible	Uninsured
Number of resources gone without because of lack of money (excluding social and exercise)				
None	63.1%	90.0%	64.2%	70.2%
1 to 2	22.1%	8.3%	19.6%	12.5%
3 or more	14.8%	1.7%	16.2%	17.3%
Household went without the following because of no transportation or distance too far				
Food or meals	9.7%	3.3%	10.6%	10.8%
Healthcare	15.0%	4.6%	16.5%	17.3%
Childcare	3.0%	0.6%	3.0%	6.9%
Trust and belonging in the community				
People are willing to help each other	83.6%	94.6%	80.9%	80.3%
People can be trusted	66.9%	88.9%	69.7%	66.5%
Adults watch out that children are safe and do not get in trouble	67.6%	83.5%	69.5%	73.9%
I feel safe here	84.1%	97.1%	81.8%	83.2%
Insufficient social supports	41.8%	31.7%	37.1%	30.6%
Caregivers				
% of Caregivers supporting adults	20.0%	19.6%	16.7%	9.6%
Caregivers who feel they do not have all the support they need	45.5%	46.3%	40.5%	60.0%
Traumatic experiences of community members				
Witnessed or experienced violence	53.1%	28.7%	58.8%	55.7%
Made to do something sexual that you did not want to do	30.0%	12.8%	34.5%	23.3%
Physically hurt or threatened by an intimate partner	37.9%	11.6%	41.8%	30.4%
Number of traumatic events:				
None	15.6%	20.4%	18.8%	18.0%
1 to 2	21.3%	30.1%	14.2%	24.2%
3 to 4	12.7%	22.0%	12.6%	4.9%
5 to 8	20.8%	19.0%	23.8%	21.4%
9 or more	29.7%	8.6%	30.6%	31.5%
% still impacted some or a lot by trauma	77.2%	60.1%	78.6%	65.1%
% of those who experienced unfair treatment some, most or all the time because of race, ethnicity, gender or sexual orientation	40.0%	22.7%	41.5%	35.4%
% of those who witnessed others receiving unfair treatment because of race, ethnicity, gender or sexual orientation	59.5%	55.1%	65.1%	64.1%
% who do not know where to refer someone who is at risk for suicide	35.9%	33.6%	31.0%	52.8%

Appendix F – References to the Consumer Health Survey

In 2019, we applied plain language best practices to both the English and Spanish versions of the survey. In addition, we localized the survey to have individual clinic organizations listed by name when identifying Primary Care and Mental Health services. As a result, we had 3 variations to the survey to allow for organization-specific listings.

The 6 resulting survey variations included:

- Columbia Gorge region Oregon West English
- Columbia Gorge region Oregon West Spanish
- Columbia Gorge region Oregon East English
- Columbia Gorge region Oregon East Spanish
- Columbia Gorge region Washington English
- Columbia Gorge region Washington Spanish

All 6 versions can be found at www.cghealthcouncil.org/documents

As we compared data gathered through a variety of sources, we found the County Health Rankings information to match closely with the regionally conducted mailed consumer survey efforts. However, neither data gathering approaches were successful in reaching vulnerable populations. The hand-fielded surveys continue to provide a clearer line of sight for very low-income community members and for Diverse Communities.

Appendix G – Consumer Survey Methods

As part of the Regional Community Health Assessment, the Columbia Gorge Health Council contracts with Providence Center for Outcomes Research and Education (CORE) to conduct a consumer health survey. The purpose of the community health survey is to 1) use a representative population sample and mail-based survey to provide statistically valid estimates of health and health needs throughout the community, including needs related to the social determinants of health; and 2) to supplement the mailed survey with *hand-fielded* surveys targeted toward communities of special interest, particularly those likely to be underrepresented in the mail survey.

The survey was based on the same form used in the 2016 Community Health Assessment. Most survey items were selected from nationally validated tools during the 2016 design process; only minor changes were implemented in the 2019 survey in order to preserve continuity of findings. Surveys were available in English and Spanish; Spanish translation was performed by a certified translator and all materials underwent plain-language review. The mail survey was fielded via a multi-stage mailing protocol supported by automated phone reminder calls.

Details on the sampling a response rates can be found at www.cghealthcouncil.org/documents

Appendix H – Top Emergency Room Diagnosis

Chief Complaints	Total visits	% of Total
Abdominal pain	579	14.12%
Chest pain	536	13.07%
Nausea, vomiting and/or diarrhea	437	10.65%
Head injury	287	7.00%
Back pain	191	4.66%
Acute upper respiratory infection, unspecified	175	4.27%
Urinary tract infection	156	3.80%
Dizziness and giddiness	155	3.78%
Fever	154	3.75%
Headache	151	3.68%
Fainting	136	3.32%
Viral infection, unspecified	134	3.27%
Tooth pain, abscess or other teeth issues	114	2.78%
Encounter for screening, unspecified	113	2.75%
Sore throat	112	2.73%
Shortness of breath	86	2.10%
Migraine	74	1.80%
Motor vehicle accident	71	1.73%
Fall	69	1.68%
Person with feared health complaint in whom no diagnosis is made	52	1.27%
Flu-like symptoms	44	1.07%
Chronic obstructive pulmonary disease with (acute) exacerbation	34	0.83%
Unspecified convulsions	31	0.76%
Nosebleed	29	0.71%
Alcohol use	28	0.68%
Kidney stones	28	0.68%
Bronchitis	26	0.63%
Palpitations	25	0.61%
Mental Health	21	0.51%
Trouble breathing	10	0.24%
Cough	9	0.22%
Weakness	7	0.17%
Atypical measles syndrome	7	0.17%
Dehydration	7	0.17%
Blood in urine	7	0.17%
Seizure	7	0.17%

Appendix I – Reference to Collaborative Agreement

The Community Advisory Council of the Columbia Gorge Health Council ("CGHC") and the cohort member have endorsed the following principles of collaboration:

- A collaborative approach to the CHA and the CHIP is better for our region, yielding more accurate and more actionable products, as community providers agree on the needs within our region and communities and as we align our abilities to address those needs together.
- A collaborative approach to the CHA and CHIP will maximize collective resources available for improving health in the region.
- A collaborative approach to the CHA and CHIP must be truly collaborative, requiring commitments of cash or in-kind resources from all participants who would use it to satisfy a regulatory requirement.
- Most importantly, we affirm that our common effort is grounded in commitments to excellence, equity and inclusivity as we develop strengths, address health disparities, and improve systems in our region, together. Our collaboration empowers us to better fulfill each of our respective missions, and thus to advance a culture of health in the Mid-Columbia.

A full copy of the MOU can be found at www.cghealthcouncil.org/documents

Appendix 2. 2019 Community Health Survey Report: Gorge Service Area

2019 COMMUNITY HEALTH SURVEY

Gorge Service Area

August 2019

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CONTENTS

CORE | Center for Outcomes Research and Education

INTRODUCTION & METHODS

1 OVERVIEW

This report summarizes results from a *community health survey* completed as part of Providence St. Joseph Health's 2019 community health needs assessment (CHNA) process. The purpose of the community survey was to use a representative population sample to provide statistically valid estimates of health and health needs throughout the community, including needs related to the social determinants of health. The survey was conducted by CORE in the Spring of 2019.

Data from this survey represent one lens on the community's health and health needs. They are best used in conjunction other elements of the CHNA process, such as community stakeholder interviews or other publically available data, to provide a comprehensive set of data supports for developing a community health action plan.

2 SURVEY DESIGN

The survey instrument was based on the same form used in the 2016 community needs assessment. This included a set of questions designed to capture a range of health and health-related needs including access to essential health services, social determinants of health screenings and assessments, subjective health and well-being outcomes, and others. Most survey items were selected from nationally validated tools during the 2016 design process; only minor changes were implemented in the 2019 survey in order to preserve continuity of findings. Surveys were available in English and Spanish; Spanish translation was performed by a certified translator and all materials underwent plain-language review. A copy of the survey is available in the appendix.

The mail survey was fielded via a multi-stage mailing protocol supported by automated phone reminder calls:

Multi-Stage Mail Survey Process

SURVEY	AUTO CALL	SECOND SURVEY	THANK YOU & INCENTIVE
An initial survey and explanation letter, with a postage-paid return envelope.	Automated phone outreach asking participants to look for the survey in their mail and call with questions.	Second survey sent to participants that did not return the initial survey.	A thank you card and $10 incentive was provided upon receipt of the completed survey.

3 SAMPLE & RESPONSE RATE

We used address-based sampling to capture a representative group of households in the Gorge region. Beginning with a list of all residential addresses in the community, we randomly selected 2,500 households to receive the survey.

Responses from 373 randomly selected households

We used census data to identify zip codes where at least 10% of households reported that Spanish was spoken at home; in those zip codes households received surveys in both English and Spanish. Fielding efforts revealed that surveys for 333 of the sampled households were not ultimately deliverable, leaving a final deliverable sample of 2167 households. We received 373 completed surveys, yielding a 17.3% response rate.

4 DATA QUALITY & LIMITATIONS

Data from these surveys are distinct from results gained by handing surveys out in community settings. Because they are representatively sampled, these data can provide good overall estimates of the true prevalence of certain health conditions and challenges for a community.

However, data collected via population mail surveys also have important limitations. They necessarily only include respondents from people with addresses who can respond to written surveys, and thus may underrepresent those who are unstably housed, challenged by language or literacy barriers, or other vulnerable or underserved populations. Households from diverse racial-ethnic backgrounds or where the primary language is not English are also less likely to respond to population-based mail surveys. Because of these limitations, we recommend using these data in conjunction with other types of data collection, such as hand-fielded surveys or results from community sessions or stakeholder interviews that are better positioned to capture data from populations likely to be underrepresented.

5 ANALYSIS & WEIGHTING

We entered all data in tabular form and analyzed it with a statistical software package (R version 3.3.3). Results were displayed for all respondents and for three key subgroups:

- **Race/ethnicity:** Non-Hispanic white respondents vs. respondents who identify as Hispanic, Latina(o), or other.
- **Household income:** Households reporting earnings less than 200% of the federal poverty level (FPL) vs households reporting earnings 200% of FPL or higher.
- **Coverage type:** Households reporting health coverage from a private employer vs Medicare coverage vs either Medicaid coverage or no coverage.

Testing for Disparities: To test for statistically significant differences between these key subgroups in our data, we used two-tailed chi-square tests of association. We flagged results with a p-value of .10 or less flagged as "statistically significant," indicating a high degree of confidence that the indicated difference between subgroups was not present in the data by simple chance.

Weighting: Since respondents to population surveys are often proportionally older than the actual community, and age is associated with prevalence of many health conditions, we weighted our results to account for the population's actual age distribution. Weighting allows our blended results to be more representative of the actual population in a region. We did not weight results by race/ethnicity, education, or any other variable. Details on our weighting methodology are available on request from CORE.

6 PRESENTATION OF RESEARCH FINDINGS

All data tables in this report (except where specifically noted otherwise) display the weighted percentage -- which adjusts our data by age to match population distributions -- as well as the *actual number of surveys* we received from which those weighted results were computed. Percentages are weighted by age to ensure our estimates are representative of the actual community population.

Major results are presented for each of four survey domains (right). For each survey question, we report the total weighted percentage of respondents who indicated a particular answer. We then break out responses by the three key subgroups of race/ethnicity, income, and insurance. Responses to key survey items are summarized in the body of the report, but complete results for every survey item are available in the **supplementary data tables.**

KEY RESULTS DOMAINS
Access to Care
Health & Health Status
Health Behaviors
Social Determinants of Health

OVERVIEW OF RESPONDENTS

Respondents to the 2019 Gorge survey looked largely similar to those who responded in 2016. Distributions by gender, race/ethnicity, language, and income looked very similar between 2016 and 2019. 2019 respondents were younger than in 2016, and fewer had seasonal employment. The differences in age distribution between our respective samples should not substantially impact comparisons because data from both years were weighted to reflect the true population age distribution in the Gorge.

Overall, respondents to surveys such as this often reflect a population that is older and more likely to be white than the full population, because that is who is most likely to respond to mail surveys. These response patterns are a known weakness of population-based mail surveys, and are one reason data such as this should be supplemented with information collected by other means, including direct or enhanced outreach into diverse communities. When conducting a community needs assessment, data from surveys should always be considered in tandem with other sources of community information.

	2016		2019	
	Total (N)	Percent	Total (N)	Percent
PREFERRED LANGUAGE				
English	641	95.0%	352	94.5%
Other	18	2.7%	12	3.2%
Did not answer	16	2.4%	9	2.4%

	2016		2019	
	Total (N)	Percent	Total (N)	Percent
GENDER				
Male	258	38.3%	142	38.1%
Female	389	57.7%	217	58.3%
Transgender, non-binary, nonconforming, or no answer	27	4.0%	14	3.6%
AGE				
18 to 39 years	78	11.6%	103	29.7%
40 to 64 years	283	42.0%	156	45.0%
65 to 79 years	225	33.4%	68	19.7%
80+ years	70	10.4%	20	5.6%
RACE & ETHNICITY				
White, non-Hispanic	574	85.2%	320	85.8%
Other race/ethnicity	100	14.8%	53	14.2%
WORK IN SEASONAL AGRICULTURE				
Work in seasonal agriculture	26	3.9%	3	0.8%
INCOME				
100% FPL or lower	64	9.5%	37	9.8%
101% to 200% FPL	76	11.3%	60	16.0%
201% FPL or higher	337	50.0%	242	64.8%
Did not answer	197	29.2%	35	9.4%
EMPLOYMENT LEVEL				
Less than 20 hours per week	36	5.3%	42	11.1%
20 hours per week or more	290	43.0%	197	52.9%
Retired/ Unemployed/ Did not answer	348	51.7%	134	36.0%

KEY RESULTS: ACCESS TO CARE

1 INSURANCE COVERAGE

Overall, the estimated uninsured rate remained stable between 2016 (5.4%) and 2019 (4.2%). Rates differed significantly by subgroup – they were higher among Hispanic/Latino(a) and lower income residents.

DO YOU CURRENTLY HAVE ANY KIND OF HEALTH INSURANCE?

CURRENT INSURANCE COVERAGE	2016 Total (n=674)	2019 Total (n=373)
No Insurance	5.4%	4.2%

2019 BY SUBGROUP:			
Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)
3.4%*	13.1%*	11.0%*	2.1%*

* Significant differences between subgroups. Tests only performed if n=20 or more.

Among those reporting no insurance, all respondents identified cost as a main reason why. A handful also listed other reasons, such as not thinking they qualify or finding the enrollment process too confusing (see detailed data tables).

TYPE & CONTINUITY OF INSURANCE: More than half (57.4%) of respondents reported having private insurance, with Medicare (22.9%) and Medicaid (15.6%) making up the balance. When asked about their coverage for other types of services, common coverage gaps included dental (with 67.7% indicated they had dental coverage for all of the last year) and vision (with 63.6% indicating coverage for all of the last year). Relatively few respondents (35.1%) indicated having long-term care coverage.

MOST COMMON COVERAGE TYPES	2016 n= 674	2019 n=373
Private Insurance	55.2%	57.4%
Medicare	24.0%	22.9%
Medicaid	11.7%	15.6%
Uninsured	5.6%	4.2%

2 CONNECTION TO PRIMARY CARE

Most respondents had a usual source of care: only 8.9% reported that they do *not* have a place to go for non-emergency health care, roughly the same as in 2016. A little over one in ten (13.6%) reported not having anyone they think of as their personal doctor or health care provider, a common indicator of strong connections to primary and preventive care. Rates were stable between 2016 and 2019, but connections to primary care varied by subgroup: those on Medicaid or uninsured were significantly more likely to report not having a usual source of care (17.3%) than those on private insurance (8.3%) or Medicare (3.3%).

QUESTIONS ON CONNECTIVITY TO PRIMARY CARE

CONNECTIONS TO CARE	2016 Total (n=674)	2019 Total (n=373)
No usual place for non-emergency care	4.5%	8.9%
Does not have a personal doctor or provider	20.2%	13.6%

2019 BY SUBGROUP:						
Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
8.4%	15.2%	12.2%	7.9%	8.3%*	3.3%*	17.3%*
13.6%	17.1%	12.5%	14.8%	14.8%*	4.4%*	20.1%*

* Significant differences between subgroups. Tests only performed if n=20 or more.

3 ACCESS TO MEDICAL CARE

Most respondents (74.1%) reported needing some kind of medical care in the preceding 12 months, about the same as in 2016. However, the percent of the population who reported needing care but having to go without it was substantially lower in 2019 (7.9%) than in 2016 (16.8%). This may reflect improvements in access to medical care in the Gorge region. Unmet need for care varied significantly by race/ethnicity, income, and coverage.

ACCESS TO MEDICAL CARE IN LAST YEAR	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Needed Care & Got ALL the care they needed	68.2%	74.1%	75.7%*	60.2%*	73.6%*	72.7%*	72.1%*	87.4%*	67.3%*
Needed Care & Sometimes Went Without	16.8%	7.9%	6.3%*	23.8%*	14.3%*	6.5%*	6.4%*	1.3%*	19.9%*
Did Not Need Care	15.0%	18.0%	18.0%*	16.0%*	12.2%*	20.8%*	21.6%*	11.3%*	12.9%*

* Significant differences between subgroups. Tests only performed if n=20 or more.

TYPES OF UNMET MEDICAL NEED: The survey asked respondents who had to go without needed care to indicate if they had gone without any of several specific types of care. Of those who went without care, 24% said they went without routine checkups or exams, 29.2% went without care of an illness or injury, and 17.7% went without visits about their chronic health conditions. Others reported going without medical care of a type not listed in our survey.

4 ACCESS TO DENTAL CARE

Dental care access was more challenging than medical care: nearly 6 out of 10 (58.4%) reported experiencing an unmet need for dental care in the last 12 months, much higher than the 7.9% who went without needed medical care. Rates varied significantly by income level.

ACCESS TO DENTAL CARE IN LAST YEAR	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Needed Care & Got ALL the care they needed	48.8%	25.1%	25.5%	24.0%	39.0%*	19.1%*	19.3%*	31.5%*	34.4%*
Needed Care & Sometimes Went Without	23.5%	58.4%	59.6%	52.1%	34.9%*	66.7%*	69.5%*	49.4%*	35.4%*
Did Not Need Care	27.8%	16.6%	14.9%	24.0%	26.1%*	14.1%*	11.3%*	19.1%*	30.2%*

* Significant differences between subgroups. Tests only performed if n=20 or more.

TYPES OF UNMET DENTAL NEED: The survey asked respondents who had to go without dental care if they had gone without any of several specific types of dental care. Of those who went without care, 40.1% said they went without dental check-ups or teeth cleaning, and 17.3% said a toothache or mouth pain went untreated. Other reported going without dental care of a type not listed on our survey.

ACCESS TO MENTAL HEALTH CARE

Reported access to mental health stayed roughly the same compared to 2016. Just over 2 in 10 (19.2%) of respondents indicated needing mental health care, with 14.8% of all respondents indicating they had experienced unmet need for mental health care, slightly more than those in 2016. No significant differences were found amongst subgroups.

ACCESS TO MENTAL HEALTH CARE IN LAST YEAR	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Needed Care & Got ALL the care they needed	9.2%	14.8%	14.4%	26.1%	19.8%	14.9%	16.1%	9.5%	16.3%
Needed Care & Sometimes Went Without	7.1%	4.6%	5.2%	0.0%	6.6%	4.5%	4.9%	2.1%	7.2%
Did Not Need Care	83.7%	80.6%	80.3%	73.9%	73.6%	80.6%	79.1%	88.4%	76.5%

* No significant differences between subgroups. Tests only performed if n=20 or more.

TYPES OF UNMET MENTAL HEALTH NEEDS: The survey asked respondents who had to go without mental health care if they had gone without any of several specific types of care. Of those who went without care, 17.4% said they went without counseling or help with a personal problem, and 26.2% said they went without treatment for a condition like depression, anxiety, or PTSD. No respondents indicated going without needed treatment for substance use challenges.

LOCATION OF MENTAL HEALTH CARE: We also asked respondents who needed mental health care where they usually went to get that care. One in four (24.2%) reported usually getting such care at their primary care office, and 47.4% reported getting it a mental health clinic. Other respondents reported getting treatment at the VA (2.5%) or via a phone or online service (3.9%). One in five (22.1%) reported getting treatment someplace else not listed on our survey.

KEY RESULTS: HEALTH STATUS

1 OVERALL HEALTH – SELF ASSESSMENT

About one in ten (11.7%) of respondents rated their own health as "poor" or "fair" (vs good, very good, or excellent) – significantly improved from the 16.6% who did so in 2016. We did see significant differences in subjective health assessments between subgroups, with those of Hispanic/Latino decent, lower income respondents, and those on Medicaid or uninsured being much more likely to rate their own health as poor or fair.

SELF-REPORTED OVERALL HEALTH (FAIR OR POOR VS GOOD, VERY GOOD, OR EXCELLENT)

SUBJECTIVE HEALTH	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Fair or Poor (vs. Good or better)	16.6%	11.7%*	9.4%*	38.2%*	22.6%*	7.7%*	5.5%*	20.0%*	19.4%*

* Significant differences between subgroups. Tests only performed if n=20 or more.

2 CHRONIC DISEASE PREVALANCE

OVERALL PREVALANCE OF COMMON CHRONIC ILLNESSES: 56.8% of respondents reported having been diagnosed with at least one of the chronic physical conditions listed on our survey, and 29.7% report at least one chronic behavioral health condition. 20.3% have at least one of each. Changes over time were not significant, but we found evidence of significant differences in complex health challenges by race, income and coverage type among Gorge residents.

CHRONIC CONDITIONS OVERVIEW	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Has at least 1 physical chronic condition	53.1%	56.8%	54.9%*	80.5%*	72.0%*	50.3%*	48.0%*	78.5%*	57.8%*
Has at least 1 behavioral health condition	30.3%	29.7%	29.1%	39.5%	48.7%*	24.9%*	25.8%*	25.8%*	44.6%*
Has at least 1 of each	20.0%	20.3%	18.9%*	39.5%*	36.8%*	16.1%*	15.0%*	24.6%*	29.5%*

* Significant differences between subgroups. Tests only performed if n=20 or more.

PREVALANCE OF SPECIFIC CONDITIONS: The most common chronic condition diagnoses reported by the Gorge Service Area population were being overweight or obese (27.8%), high blood pressure (26.6%) and high cholesterol (26.7%). Common mental health challenges included depression and anxiety (22.9%). Prevalence rates for most conditions in 2019 were comparable to those of the 2016 survey respondents. We saw strong evidence of an income gradient in Gorge's prevalence data, with low-income respondents being more likely to have many health conditions except for asthma and substance use issues. Prevalence of PTSD was particularly high among low-income respondents (20.7%)

when compared to higher income respondents (4.0%). These findings are broadly consistent with national research showing an association between income and health. Race/ethnicity was also a factor in the gorge, with Hispanic/Latino(a) residents reporting significantly higher prevalence of several health conditions.

CHRONIC CONDITION PREVALANCE	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
High Blood Pressure	33.1%	26.6%	26.7%	21.1%	34.6%*	22.8%*	16.7%*	51.7%*	26.7%*
High Cholesterol	29.2%	26.7%	26.1%	21.3%	34.1%*	22.7%*	17.3%*	49.9%*	28.8%*
Asthma	14.9%	11.8%	10.4%*	27.6%*	14.8%	10.8%	12.6%	9.5%	11.4%
Diabetes	11.9%	10.0%	9.0%*	27.4%*	17.8%*	8.0%*	5.9%*	15.7%*	14.7%*
Depression & Anxiety	22.6%	22.9%	22.1%	33.5%	39.1%*	18.4%*	20.4%	21.5%	30.5%
PTSD	6.4%	8.1%	8.4%	2.1%	20.7%*	4.0%*	5.7%*	5.1%*	19.2%*
Dementia or memory condition	n/a	2.2%	2.2%	4.0%	4.9%*	1.5%*	0.0%*	3.7%*	7.2%*
Substance Use Problem	n/a	1.9%	2.1%	0.0%	2.2%	2.0%	1.8%	0.6%	3.6%
Overweight or obese	n/a	27.8%	26.2%*	46.8%*	37.2%*	24.9%*	26.6%	28.9%	30.7%

* Significant differences between subgroups. Tests only performed if n=20 or more.

ANXIETY & DEPRESSION SYMPTOMS

In addition to asking people to identify conditions they have been diagnosed with by a health professional, the survey included questions designed to assess whether a respondent might *currently be* experiencing symptoms of anxiety or depression. These questions are identical to those used in many clinical settings as an initial screener for potential anxiety or depression, and are a good way to capture potential depression or anxiety that is not currently well controlled. Overall, we found relatively few cases of potentially uncontrolled conditions, though symptoms were much more common among lower-income respondents.

Symptoms of Anxiety or Depression (GAD-2 and PHQ-2 Screening Tools).

SYMPTOMS PREVALANCE	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Current symptoms of anxiety	10.4%	5.0%	4.3%	10.7%	9.7%*	3.8%*	4.9%	1.8%	9.1%
Current symptoms of depression	7.0%	4.0%	3.2%*	14.7%*	7.5%*	3.1%*	3.1%	3.3%	6.1%

* Significant differences between subgroups. Tests only performed if n=20 or more.

4 FUNCTIONAL LIVING CHALLENGES

For the first time in 2019, the Gorge asked a series of questions intended to address functional living challenges often associated with aging, such as seeing, hearing, and cognitive function. Overall, respondents reported struggling with a number of functional living challenges, with major differences reported for lower income residents. Interestingly, challenges among the Medicaid and uninsured population were nearly comparable to those among Medicare, a much older population on average. Hispanic and Latino(a) respondents reported very high rates of vision challenges (61.5%), a particular concern given that 38.2% of Hispanic respondents also reported being without any vision coverage for at least some of the last 12 months.

FUNCTIONAL LIVING CHALLENGES	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Seeing, even if wearing glasses	n/a	37.0%	34.5%*	61.5%*	51.6%*	31.6%*	27.5%*	48.6%*	49.1%*
Hearing, even if using a hearing aid	n/a	26.9%	25.1%	31.3%	31.3%	23.5%	16.2%*	48.4%*	32.8%*
Walking or climbing steps	n/a	24.5%	24.4%	21.0%	43.1%*	15.9%*	10.9%*	48.0%*	36.6%*
Remembering or concentrating	n/a	34.8%	33.8%	48.1%	43.3%*	31.7%*	29.4%*	43.1%*	38.9%*
Self-care, such as washing or dressing	n/a	5.0%	4.9%	6.1%	12.6%*	2.0%*	1.6%*	7.2%*	11.3%*

5 CHILDREN'S HEALTH CHALLENGES

Overall, 43.9% of respondents (n=113) reported that they had children under 18 years of age; we asked those respondents to tell us if any of their children had any of a series of health challenges. The most commonly reported physical health challenges was a developmental delay or learning disability (5.3%), behavioral health diagnoses (4.8%), and obesity (4.1%). Results varied significantly by income and insurance type for several of these conditions.

Reported rates for several health conditions were significantly lower in 2019 than in 2016, including asthma and behavioral health diagnoses. These trends should be interpreted with some caution – the survey opportunistically asks respondents with children about the health of their children, but our household-based sampling and weighting strategy was not specifically designed to estimate the prevalence of conditions among children across the Gorge. Since not every respondent has children, these results may represent random sampling variation rather than a true change in prevalence rates among children in the Gorge.

CHRONIC CONDITION PREVALANCE	2016	2019	2019 BY SUBGROUP:						
	Total (n=121)	Total (n=228)	Non-Hispanic White (n=205)	Hispanic/ Latino/Other (n=13)	200% FPL or lower (n=65)	201% FPL or higher (n=142)	Private (n=133)	Medicare (n=41)	Medicaid, Uninsured, Other (n=52)
Asthma	17.0%	3.6%	2.4%	8.6%	1.7%	5.1%	4.2%	1.3%	4.2%
A behavioral health diagnosis	12.9%	4.8%	4.9%	7.7%	6.6%	4.7%	5.8%	2.7%	4.0%
Diabetes	0.0%	0.9%	0.5%	8.6%	1.5%	0.8%	0.8%	0.0%	1.9%
Developmental delay or learning disability	4.8%	5.3%	5.8%	0.0%	4.9%	6.2%	6.6%	2.7%	4.0%
Overweight or obese	n/a	4.1%	4.0%	8.6%	12.4%*	0.8%*	0.8%*	2.7%*	13.5%*
Substance use problem	n/a	0.4%	0.5%	0.0%	1.5%	0.0%	0.0%	0.0%	1.9%
Another ongoing health condition	14.8%	4.8%	5.3%	0.0%	6.6%	4.6%	4.9%	0.0%	8.3%
At least 1 physical condition	17.0%	7.7%	5.9%*	25.7%*	12.4%	6.6%	5.8%*	4.0%*	15.6%*
At least 1 behavioral health condition	26.5%	8.6%	9.1%	7.7%	8.1%	10.1%	11.6%	2.7%	6.0%

* Significant differences between subgroups. Tests only performed if n=20 or more.

KEY RESULTS: HEALTH BEHAVIORS

1 QUALITY OF DIET

About half (51.2%) of Gorge respondents reported eating fewer than two servings of fruit per day, and 36.4% report fewer than two servings of vegetables per day – numbers roughly equivalent to results from 2016. Those in the lower income subgroup were more likely to report eating fewer vegetables than those in the higher income subgroup (54.8% vs 28%). Differences were also observed based on insurance type.

Fruit and Vegetable Consumption (per day)

CONSUMPTION PER DAY	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Fewer than two servings of fruit	47.2%	51.2%	50.1%	59.2%	66.4%*	45.4%*	41.6%*	60.3%*	69.2%*
Fewer than two servings of vegetables	30.3%	36.4%	36.2%	44.1%	54.8%*	28.0%*	25.6%*	52.6%*	49.7%*

*Significant differences between subgroups. Tests only performed if n=20 or more.

2 HEALTH RISK BEHAVIORS

We assessed the prevalence of other health risk behaviors, including the use of tobacco, indicators of potential alcohol misuse, and drug use. Prevalence rates were roughly comparable to those seen in 2016 for indicators that were assessed on both surveys. Rates of self-reported smoking and marijuana use were significantly higher among low-income respondents and Medicaid/uninsured respondents. We also found evidence that potential "binge" drinking – having three or more drinks per day of drinking – may be higher among Hispanic respondents, even though the frequency with which they drink in a typical week is less.

Health Risk Behaviors

HEALTH RISK BEHAVIOR PREVALENCE	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Current smoker	12.9%	11.1%	11.3%	13.1%	23.7%*	7.0%*	8.3%*	4.5%*	26.8%*
Four or more drinks per week	22.1%	28.6%	30.4%*	6.3%*	30.6%	26.2%	25.6%	34.6%	34.3%
Three or more drinks per day of drinking	17.1%	15.6%	14.5%*	31.1%*	22.9%	14.0%	14.7%*	8.6%*	26.3%*
Marijuana use	18.7%	13.8%	14.7%	8.8%	20.3%*	12.4%*	14.2%*	8.2%*	20.1%*
Any other drug use	3.1%	5.2%	5.6%	4.4%	5.2%	5.6%	5.9%	2.5%	6.8%

*Significant differences between subgroups. Tests only performed if n=20 or more.

KEY RESULTS: SOCIAL DETERMINANTS OF HEALTH

1 BASIC NEEDS

We asked respondents to tell us whether they had recently had difficulty meeting any basic needs. 22.6% of respondents reported that they or someone in their household had gone without one or more of the listed basic needs (stable housing, food, utilities, transportation, clothing, or child care) in the past 12 months, an increase from 2016 – although the addition of several new items to the question set likely explains this change. Prevalence estimates of most individual basic needs remained largely unchanged between 2016 and 2018. Most notable was the new social need on the 2019 survey – social activities – with 20.3% reporting a lack of sufficient social activities to meet their basic needs.

Percent Going without Basic Needs in the Last 12 Months

PERCENT GOING WITHOUT BASIC NEEDS	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Food	4.2%	3.4%	2.5%*	12.7%*	8.1%*	2.0%*	1.3%*	1.3%*	12.0%*
Clothing	4.8%	7.2%	6.5%*	17.1%*	14.9%*	4.1%*	4.2%*	5.9%*	15.1%*
Transportation	4.1%	6.5%	6.2%	12.3%	19.9%*	1.1%*	1.3%*	7.7%*	18.0%*
Child Care	2.2%	1.7%	1.7%	4.0%	3.9%*	1.1%*	2.6%	0.0%	1.4%
Utilities	2.0%	2.1%	1.0%*	12.7%*	5.8%*	0.9%*	0.0%*	2.6%*	6.0%*
Housing	2.0%	0.3%	0.0%*	4.0%*	0.0%	0.4%	0.0%	0.0%	1.4%
Social activities	n/a	20.3%	19.9%	25.4%	36.7%*	14.9%*	18.1%*	16.6%*	29.4%*
Exercise or sports	n/a	8.3%	8.1%	12.7%	17.0%*	5.0%*	4.2%*	7.0%*	21.2%*
One or more of the above**	10.2%	22.6%	21.6%	33.8%	41.9%*	16.5%*	19.9%*	17.2%*	35.3%*

*Significant differences between subgroups. Tests only performed if n=20 or more.
**Not comparable across years due to changes in the question set

2 CURRENT HOUSING STABILITY

In addition to asking if respondents had experienced housing insecurity in the last 12 months, we asked questions about respondent's *current* housing stability. 11.5% of respondents expressed at least some housing worries – either a lack of stable housing (5.1%) or worries that they were about to lose their stable housing (6.4%). Rates of housing instability were roughly comparable to those observed in 2016, and varied significantly by income and insurance status. It is important to note that because the survey sample was based on residential addresses, the true prevalence of housing insecurity in the region may be higher than what is estimated here.

Current Housing Situation

HOUSING INSECURITY	2016 Total (n=674)	2019 Total (n=373)	2019 BY SUBGROUP: Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Have housing, not worried about losing it	86.7%	87.9%	89.1%	85.2%	78.1%*	92.8%*	90.5%	86.9%	82.9%
Have housing, but worried about losing it	7.2%	6.4%	6.5%	4.4%	11.4%*	5.4%*	6.5%	3.2%	10.5%
Do not have stable housing	6.1%	5.1%	5.1%	8.3%	10.7%*	2.0%*	3.1%*	6.3%*	9.7%*

*Significant differences between subgroups. Tests only performed if n=20 or more.

The Gorge survey also includes several questions about intergenerational households. Almost one in ten (9%) of respondents reported living with their adult children; this was significantly higher among Hispanic respondents (27.5%) and represents a meaningful increase from 4.6% in 2016.

Intergenerational Households

LIVING SITUATION	2016 Total (n=674)	2019 Total (n=373)	2019 BY SUBGROUP: Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Living with adult children	4.6%	9.0%*	7.4%*	27.5%*	12.3%	7.9%	7.8%	8.1%	9.8%
Living with parents	2.5%	1.1%	1.0%	0.0%	2.2%	0.9%	1.3%	1.3%	0.7%

*Significant differences between subgroups. Tests only performed if n=20 or more.

Finally, the Gorge survey included several questions intended to estimate out-of-pocket costs for housing. We did not see significant increases in reported out-of-pocket housing costs between 2016 and 2019.

Out-of-Pocket Costs

OUT-OF-POCKET COST	2016 Total (n=674)	2019 Total (n=373)	2019 BY SUBGROUP: Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Less than $750	42.5%	41.4%	42.3%	38.2%	65.0%*	28.9%*	26.3%*	64.7%*	59.4%*
Between $750-1500	38.4%	39.1%	38.6%	44.3%	31.5%*	43.5%*	47.5%*	25.9%*	28.5%*
More than $1500	19.1%	19.6%	19.1%	17.5%	3.5%*	27.6%*	26.2%*	9.4%*	12.1%*

*Significant differences between subgroups. Tests only performed if n=20 or more.

3 SOCIAL SUPPORT

We asked participants a series of questions drawn from the Social Support Index (SSI) and designed to assess whether they usually have access to certain kinds of social support in their lives. We report the percent of respondents whose answers indicated a **lack** of strong social support in each domain. Overall, Gorge respondents indicated levels of social support comparable to those reported in 2016, with about one in five reporting poor social support for most domains. Low-income respondents, those on Medicare, Medicaid/Uninsured were especially likely to report low social support.

Percent who would NOT usually have someone available to support them by…

PERCENT WITHOUT STRONG SOCIAL SUPPORT	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Love and make feel wanted	14.3%	19.8%	19.6%	9.0%	32.8%*	14.2%*	15.0%*	28.1%*	26.2%*
Give good advice	18.9%	22.1%	21.5%	22.5%	38.2%*	16.1%*	16.4%*	31.5%*	29.6%*
Get together with to relax	25.5%	26.4%	26.2%	18.0%	41.6%*	19.9%*	20.1%*	38.8%*	31.2%*
Confide in, talk about problems	22.5%	27.7%	26.1%	40.3%	44.6%*	21.8%*	22.2%*	36.3%*	34.5%*
Help if confined to a bed	26.1%	26.3%	25.6%	26.8%	36.2%*	22.1%*	22.9%	34.5%	25.8%

*Significant differences between subgroups. Tests only performed if n=20 or more.

4 NEIGHBORHOOD COHESION & SAFETY

We asked participants a series of questions designed to measure neighborhood cohesion within their community, with the numbers representing those who do not agree and thus have unfavorable feelings about their neighborhood. In general, most respondents have good views of their neighborhood along each dimension of the cohesion scale, though lower income respondents are significantly more likely to disagree with the statements and thus express discontent with their neighborhoods. Views of their neighborhood also varied significantly by insurance type with those on Medicaid/Uninsured having less favorable views of their neighborhood.

Percent with Unfavorable Views of their Neighborhood

PERCENT REPORTING THEY DO NOT AGREE	2016	2019	2019 BY SUBGROUP:						
	Total (n=220)	Total (n=118)	Non-Hispanic White (n=92)	Hispanic/ Latino/Other (n=20)	200% FPL or lower (n=26)	201% FPL or higher (n=79)	Private (n=74)	Medicare (n=17)	Medicaid, Uninsured, Other (n=27)
Adults here watch out for children	17.6%	16.2%	15.7%	22.4%	37.8%*	9.7%*	10.9%*	18.2%*	32.6%*
People here can be trusted	16.8%	16.8%	15.3%	24.1%	32.7%*	11.6%*	12.7%*	12.6%*	32.3%*

People here are willing to help each other	8.4%	9.1%		8.7%	8.9%	15.0%*	7.3%*	6.3%*	7.2%*	19.4%*
I feel safe here	7.1%	7.4%		7.1%	8.5%	16.4%*	4.1%*	3.9%*	4.5%*	19.8%*

*Significant differences between subgroups. Tests only performed if n=20 or more

ADVERSE EXPERIENCES ACROSS THE LIFE COURSE

A large body of literature has associated adverse life experiences with poor health outcomes. We asked participants to tell us the extent to which they had experienced any of a series of difficult or traumatic events in their lives. Results reveal a high prevalence in the Gorge region of many types of events that have been shown to be associated with poor long-term health outcomes.

- **Overall Prevalence:** Respondents reported having experienced a wide range of adversities in their lives, including experiencing the unexpected death of a loved one (55.3%), experiencing a life-changing illness or injury (50.7%), living with someone with mental illness or substance abuse issues (37.6%) and witnessing or experiencing violence (33.9%). More than half (57.3%) have experienced three or more of the listed adverse challenges.
- **Trends:** Among questions that were asked in both 2016 and 2019, there were consistent increases in the percent of respondents reporting many adverse events, though many increases were relatively small. This may reflect an actual increase in prevalence, rising awareness of these issues prompting greater rates of reporting, or other factors.
- **Differences:** Low-income respondents were significantly more likely to report nearly all of the adverse experiences. These higher prevalence's may help explain why low-income respondents were also more likely to report experiencing PTSD and anxiety. Response rates also differed significantly by insurance type for all adverse events.
- **Lingering Effects:** When we asked respondents who experienced the above challenges to indicate the degree to which they felt those past challenges still impacted them today, 65.2% indicated that the events still impact them "somewhat" or "a lot." For many people, the impacts of experiencing trauma and adversity often linger, shaping health outcomes across the entire life course.

Percent who have experienced each type of adverse event in their lives…

PERCENT EXPERIENCED ADVERSE EVENT	2016	2019	2019 BY SUBGROUP:						
	Total (n=674)	Total (n=373)	Non-Hispanic White (n=329)	Hispanic/ Latino/Other (n=25)	200% FPL or lower (n=96)	201% FPL or higher (n=242)	Private (n=211)	Medicare (n=84)	Medicaid, Uninsured, Other (n=73)
Life-changing illness or injury	38.4%	50.7%	51.5%	52.5%	61.0%*	49.3%*	44.7%*	56.1%*	60.6%*
Lived with someone with mental illness or substance abuse	32.2%	37.6%	38.4%	36.6%	46.4%*	36.6%*	40.3%*	15.7%*	57.1%*
Witnessed or experienced violence	26.4%	33.9%	32.5%	37.9%	47.4%*	32.0%*	30.8%*	22.8%*	53.9%*
Abuse	25.4%	29.1%	27.3%*	44.5%*	42.9%*	25.6%*	25.4%*	24.6%*	42.7%*
Neglect	16.7%	20.7%	19.3%*	37.7%*	34.4%*	16.7%*	15.1%*	14.0%*	43.5%*

Physically hurt or threatened by intimate partner	11.9%	18.5%	17.7%	27.4%	38.5%*	13.2%*	14.5%*	9.6%*	38.8%*
Made to do something sexual didn't want to	13.2%	17.8%	16.7%	23.5%	28.9%*	15.7%*	15.2%*	15.1%*	28.0%*
Suicide attempt by close friend or family	n/a	29.4%	28.4%	36.4%	33.4%	29.5%	29.0%*	19.6%*	42.7%*
Parents separated as child	30.3%	30.6%	30.9%	31.9%	35.5%*	29.3%*	30.6%*	19.6%*	43.9%*
Unexpected death of a loved one	42.4%	55.3%	56.0%	44.7%	67.3%*	51.4%*	53.3%	56.2%	60.7%
At least one event**	76.8%	86.4%	87.8%	78.6%	90.2%	87.3%	88.5%*	78.6%*	88.2%*
3 or more of the above**	38.3%	57.3%	56.6%	61.8%	63.0%	58.4%	56.3%*	46.5%*	71.9%*

*Significant differences between subgroups. Tests only performed if n=20 or more.
**Not comparable across study years because of changes to question set.

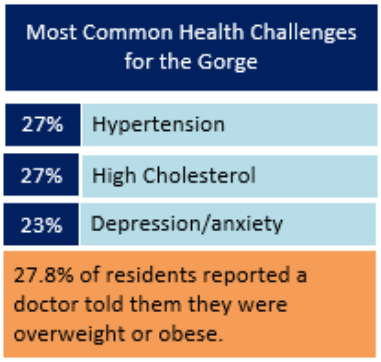
Discrimination: We also asked respondents to indicate how often they had been treated unfairly because of their race, ethnicity, gender, or sexual orientation. Overall, 66.9% of respondents indicated that this happened at least "some of the time, including 70.7% of Hispanic respondents.

SUMMARY OF KEY TAKEAWAYS

Responses from the Gorge region's survey are an important source of information for assessing community needs. Because the survey uses a representative random sampling technique, its results are a good way to estimate the level of key health and social needs throughout the community. Key takeaways from the survey include:

1 MENTAL HEALTH CHALLENGES, ESPECIALLY IN LOWER INCOME HOUSEHOLDS.

Most respondents report that they are in good, very good, or excellent health – only 14.8% characterized their own health as "fair" or "poor." The top three most common health challenges are high cholesterol (27%), high blood pressure (27%), and depression/anxiety (23%). There were especially significant disparities in mental health challenges by family income, with lower income respondents reporting significantly higher rates of depression/anxiety (39% vs 18%) and PTSD (21% vs 4%) compared to those with higher incomes.



2 CHALLENGES WITH ACCESS TO DENTAL CARE.

Most residents reported having a place to go for regular or routine care, with only 8.9% reporting they had no usual place for non-emergency care. Unmet need for medical care was relatively low among 2019 respondents, with only 7.9% reporting that they had needed medical care and not received it, and only 4.6% reporting the same for mental health care. However, many respondents (58.4%) reported experiencing an unmet need for dental care in the previous 12 months, suggesting that access to dental care may be a key challenge in the Gorge. This access gap does not appear to be entirely driven by coverage – 63.8% of respondents reported having dental coverage for all of the last 12 months.

3 KEY SDH CHALLENGES INCLUDE SOCIAL ISOLATION & HOUSING STABILITY.

Social determinants of health (SDH) are important predictors of long-term health outcomes. Rates for many basic needs in the Gorge were comparable between 2016 and 2019, but the addition of a new item – social activities – revealed that one in five residents (20.3%) reported not getting enough social experiences to satisfy their needs. Housing also remains a key challenge – while very few (<1%) respondents reported actually going without housing in the last year, 11.5% of all respondents (and 22.1% of low income respondents) reported either having unstable housing right now or being worried about the stability of their housing.

4 A HIGH PREVALANCE OF TRAUMA, ESPECIALLY AMONG LOWER INCOME HOUSEHOLDS.

Rates of self-reported adversity and trauma were generally somewhat higher in 2019 than in 2016, with notable increases in reporting for intimate partner violence (from 11.9% to 18.5%), witnessing or experiencing violence (26.4% to 33.9%) and sexual abuse (13.2% to 17.8%). It is difficult to know if these trends represent increasing awareness of these issues (which may prompt more reporting) or an actual increase in prevalence. However, low-income respondents were significantly more likely to report experiencing adverse events; perhaps not coincidentally, they also reported significantly higher rates of depression, anxiety, and PTSD than other residents.

FROM KNOWLEDGE TO ACTION

These key takeaways, combined with other information collected as part of the needs assessment process, may suggest several areas of potential focus for community health improvement efforts. To further explore the results of this survey, please refer to the complete data tables accompanying this report.

APPENDIX A. Community Health Survey

COMMUNITY HEALTH SURVEY

INSTRUCTIONS: For each question, please fill in the circle that best represents your answer. Your results are completely private, and you can skip any question you do not want to answer. When you are finished, place the survey in the postage-paid envelope we have provided and drop it in the mail. If you have questions about this survey, please read the included letter or call us at 1-877-215-0686.

PART 1 YOUR HEALTH CARE

1 Do you have any kind of health insurance now?
- ◯ Yes
- ◯ No → **(Go to Question 3)**

2 What kind of health insurance do you have?
Mark all that apply.
- ◯ Medicaid (Oregon Health Plan)
- ◯ Medicaid (Washington Apple Health)
- ◯ Medicare or Medicare Advantage
- ◯ VA, TRICARE, or other military health care
- ◯ Insurance through work or family member's work
- ◯ Insurance I pay for myself
- ◯ Other: _____
- ◯ I do not have any insurance now
- ◯ I do not know → **(Go to Question 4)**

3 If you **do not** have any kind of health insurance now, what are the main reasons why?
Mark all that apply.
- ◯ It costs too much
- ◯ I do not think I need it
- ◯ I am waiting to get it through a job
- ◯ Signing up is too hard
- ◯ I have not had time to deal with it
- ◯ I do not qualify
- ◯ Other: _____

4 For how many of the **last 12 months**, did you have insurance for the following health care?

	All 12 months	**Some** of the 12 months	**None** of the 12 months
Medical Care	◯	◯	◯
Dental Care	◯	◯	◯
Vision	◯	◯	◯
Long-term Care	◯	◯	◯

5 Do you have a place you usually go to get health care when it's not an emergency?
- ◯ Yes
- ◯ No → **(Go to Question 7)**

6 Where do **you** usually go to receive health care when it is not an emergency?
- ◯ A Primary Care Clinic. *Which one?*
  - ◯ Klickitat Valley Health
  - ◯ NorthShore Medical Group
  - ◯ Skyline Family Medicine
  - ◯ Other: _____
- ◯ Health Department. *Which one?*
  - ◯ _____
- ◯ A Mental Health clinic. *Which one?*
  - ◯ Comprehensive Healthcare
  - ◯ Other: _____
- ◯ A Tribal Clinic
- ◯ A VA Clinic
- ◯ A hospital emergency room
- ◯ Other: _____
- ◯ I don't have a place I go

7 Do you have **at least one person** you think of as your doctor or health care provider?
- ◯ Yes
- ◯ No

8 In the **last 12 months**, did **you** need any **medical** care?
- ◯ Yes
- ◯ No → **(Go to Question 10)**

9 Did **you** get all the **medical** care you needed?

- ◯ Yes → **(Go to Question 10)**
- ◯ No → Which types of medical care did you have to go without? *Mark all that apply.*
  - ◯ Checkup or physical exam
  - ◯ Visits for an illness or injury
  - ◯ Visits about a chronic health condition like diabetes or high blood pressure
  - ◯ Other kinds of care

10 In the **last 12 months**, did **you** need any **dental** care?

- ◯ Yes
- ◯ No → **(Go to Question 12)**

11 Did **you** get all the **dental** care you needed?

- ◯ Yes → **(Go to Question 12)**
- ◯ No → Which types of care did you have to go without? *Mark all that apply.*
  - ◯ Dental check-up or teeth cleaning
  - ◯ Tooth ache or mouth pain
  - ◯ Other kinds of care

12 In the **last 12 months**, did **you** need **counseling or mental health treatment**?

- ◯ Yes
- ◯ No → **(Go to Question 15)**

13 Did **you** get all the **counseling or mental health** care you needed?

- ◯ Yes → **(Go to Question 14)**
- ◯ No → Which types of care did you have to go without? *Mark all that apply.*
  - ◯ Support for a personal problem
  - ◯ Treatment for a mental health condition like PTSD, depression, or anxiety
  - ◯ Counseling to quit tobacco, alcohol, or drug use
  - ◯ Other kinds of care

14 In the **last 12 months**, where did you **mostly** go to get counseling or mental health care? *Mark only one.*

- ◯ My primary care doctor's office
- ◯ Mental Health clinic
- ◯ VA Clinic
- ◯ Phone, Online, texting, or video chat service
- ◯ From a pastor, minister, or priest
- ◯ Hospital emergency room
- ◯ Other: _____

15 If **you** went **without any** needed medical, dental, counseling or mental health care in the **last 12 months**, what were the main reasons why? *Mark all that apply.*

- ◯ I did not go without care. I got all the care I needed
- ◯ It cost too much
- ◯ Getting to the clinic was too hard
- ◯ The doctor or clinic did not understand my culture, lifestyle, identity, or my language
- ◯ There was no local doctor that accepted my insurance
- ◯ I did not know where to go
- ◯ I was afraid
- ◯ Other: _____

16 In the **last 12 months**, did **you or anyone in your family** go to Portland, Vancouver, Pendleton, or Central Oregon for any of the following services?

	Yes	No
Addictions treatment	◯	◯
Cancer treatment	◯	◯
Mental Health specialist	◯	◯
Orthopedics	◯	◯
Pain Management	◯	◯
Neurology	◯	◯
Cardiology	◯	◯
Skin Conditions	◯	◯

PART 2 YOUR CHILDREN

If you do not have children, please GO TO Question 31.

17 Do you have any children under 18 years of age?

- ◯ Yes
- ◯ No → **(Go to Question 31)**

18 In the **last 12 months**, did **any of your children** need any **medical** care?

- ◯ Yes
- ◯ No → **(Go to Question 20)**

19 Did **they** get all the **medical** care they needed?

- ◯ Yes → **(Go to Question 20)**
- ◯ No → Which types of medical care did they go without? *Mark all that apply.*
  - ◯ Checkup or physical exam
  - ◯ Visits for an illness or injury
  - ◯ Visits about a chronic health condition like asthma
  - ◯ Other kinds of care

20 In the **last 12 months**, did **any of your children** need any **dental** care?

- ◯ Yes
- ◯ No → **(Go to Question 22)**

21 Did **they** get all the **dental** care they needed?

- ◯ Yes → **(Go to Question 22)**
- ◯ No → Which types of care did they have to go without? *Mark all that apply.*
  - ◯ Dental check-up or teeth cleaning
  - ◯ Tooth ache or mouth pain
  - ◯ Other kinds of care

22 In the **last 12 months**, did **any of your children** need **counseling or mental health** treatment?

- ◯ Yes
- ◯ No → **(Go to Question 25)**

23 Did **they** get all the **counseling or mental health** care they needed?

- ◯ Yes → **(Go to Question 24)**
- ◯ No → Which types of counseling or mental health care did they go without? *Mark all that apply.*
  - ◯ Support for a personal problem
  - ◯ Treatment for a mental health condition or behavioral problem
  - ◯ Counseling to quit tobacco, alcohol, or drug use
  - ◯ Other kinds of care

24 In the **last 12 months**, where did **they mostly** go to get counseling or mental health care? *Mark only one.*

- ◯ Their primary care doctor's office
- ◯ Mental health clinic
- ◯ School counselor
- ◯ Phone, Online, texting, or video chat service
- ◯ From a pastor, minister, or priest
- ◯ Hospital emergency room
- ◯ Other: _____

25 In the **last 12 months**, did **any of your children** need **developmental care**, like speech therapy or help with a learning disability?

- ◯ Yes
- ◯ No → **(Go to Question 27)**

26 Did **they** get all the **developmental care** they needed?

- ◯ Yes → **(Go to Question 27)**
- ◯ No → Which types of developmental care did they have to go without? *Mark all that apply.*
  - ◯ Speech language therapy
  - ◯ Occupational therapy
  - ◯ Treatment for a learning disability or developmental delay
  - ◯ Other kinds of care

27 If **any of your children** went **without any** needed medical, dental, counseling or developmental care in the **last 12 months**, what were the main reasons why? *Mark all that apply*

- ◯ They did not go without care. They got all the care they needed
- ◯ It cost too much
- ◯ Getting to the clinic was too hard
- ◯ The doctor or clinic did not understand our culture, lifestyle, identity, or our language
- ◯ There was no local doctor that accepted their insurance
- ◯ I did not know where to take them
- ◯ They were afraid
- ◯ Other: _____

28 Have you **ever** been told by a doctor or other health professional that **any of your children** have:

	Yes	No
Diabetes or sugar diabetes	◯	◯
Asthma	◯	◯
A behavioral mental health diagnosis like depression, anxiety, or ADHD	◯	◯
A developmental delay or learning disability (like Autism or Dyslexia)	◯	◯
Overweight or obese	◯	◯
Substance Use Problem	◯	◯
Another health condition	◯	◯

Please tell us: _____

29 In the **last 12 months**, how often have you needed or wanted ideas and help for raising your children or grandchildren?

- ◯ Not at all → **(Go to Question 31)**
- ◯ Half of the time
- ◯ Most of the time

30 What support would you find most helpful?
Mark all that apply.

- ◯ Online information
- ◯ Parenting Hotline to call
- ◯ Parenting Classes
- ◯ Neighborhood parenting groups

PART 3 YOUR HEALTH & LIFESTYLE

31 In general, would you say your health is:

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor

32 Have you **ever** been told by a doctor or other health professional that **you** have any of these?

	Yes	No
Diabetes or sugar diabetes	◯	◯
Asthma	◯	◯
High blood pressure	◯	◯
High cholesterol	◯	◯
Dementia or memory condition	◯	◯
Overweight or obese	◯	◯
Depression and anxiety	◯	◯
Post-traumatic stress disorder (PTSD)	◯	◯
Substance Use Problem	◯	◯
Another health condition	◯	◯

Please tell us: _____

33 During the **past 2 weeks**, how often have you been bothered by these?

	Not at all	Some days	Over half the days	Almost every day
Little interest or pleasure in doing things	◯	◯	◯	◯
Feeling down, depressed, or hopeless	◯	◯	◯	◯
Feeling nervous, anxious, or on edge	◯	◯	◯	◯
Not being able to stop or control worrying	◯	◯	◯	◯

34 Do you have any difficulty with the following?

	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all
Seeing, even if wearing glasses?	○	○	○	○
Hearing, even if using a hearing aid?	○	○	○	○
Walking or climbing steps?	○	○	○	○
Remembering or concentrating?	○	○	○	○
Self-care, such as washing or dressing?	○	○	○	○
Difficulty communicating, understanding, or being understood?	○	○	○	○

35 Most days, how many servings of fruit do you eat? *A serving is one piece of fruit or about a cup of cut-up fruit. Do not count fruit juices.*

→ _____ servings per day

36 Most days, how many servings of veggies do you eat? *A serving is about a cup of veggies like green beans, salad, or potatoes. Do not include fried foods like French fries.*

→ _____ servings per day

37 Which of the following have you used in the **last 12 months**? *Mark all that apply.*

- ○ Smoking tobacco (cigarette, cigar, etc.)
- ○ Chewing tobacco
- ○ Electronic smoking systems (vape, juul, etc.)
- ○ Marijuana products (smoked, vaped, or edibles)

38 Do you **currently** smoke cigarettes or e-cigarettes?

- ○ Every day
- ○ Some days
- ○ Not at all → **(Go to Question 40)**

39 Do you want to quit using tobacco or smoking systems?

- ○ Yes
- ○ No

40 How often did you have a drink with alcohol in it in the **last 12 months**? *Drinks with alcohol include beer, wine, and liquor.*

- ○ Never → **(Go to Question 43)**
- ○ Once a month or less
- ○ 2 to 4 times a month
- ○ 2 to 3 times a week
- ○ 4 or more times a week

41 How many **days per week** do you drink alcohol now?

- ○ 0 to 1
- ○ 2 to 3
- ○ 4 to 5
- ○ 6 to 7

42 On the days when you did drink alcohol, how many drinks did you usually have **per day**? *A drink is one beer, one glass of wine, or one shot of liquor.*

- ○ 1 or 2
- ○ 3 or 4
- ○ 5 or 6
- ○ 7 to 9
- ○ 10 or more

43 In the **last 12 months**, have **you or anyone in your household** used any of the following? *Mark all that apply.*

- ○ Opioids not as prescribed (oxycodone, heroin, morphine, methadone, codeine, etc.)
- ○ Amphetamine type stimulants (meth, speed, diet pills, ecstasy, etc.)
- ○ Any other street drug

PART 4 YOUR HOUSEHOLD FUNDS

44 Which of these best describes your housing today? *Mark all that apply.*

- ◯ I have housing of my own, and **I am not** worried about losing it.
- ◯ I have housing of my own, but **I am** worried about losing it.
- ◯ I am staying in a hotel.
- ◯ I am staying with friends or family.
- ◯ I am staying in a shelter, in a car, or on the street.
- ◯ Other: _____

45 How much do you pay out-of-pocket for housing each month?

- ◯ I do not pay for housing
- ◯ Less than $750
- ◯ Between $750 and $1,500
- ◯ More than $1,500

46 In the **past 12 months**, have you **worried** that your food would run out before you had money to buy more?

- ◯ Often
- ◯ Sometimes
- ◯ Never

47 In the **past 12 months**, have you or someone in your household **had to go without** any of these because you did not have the money?

	Yes	No
Food or meals	◯	◯
Utilities or phone	◯	◯
Transportation	◯	◯
Clothing	◯	◯
Housing	◯	◯
Childcare	◯	◯
Social activities	◯	◯
Exercise or sports	◯	◯

48 In the **past 12 months**, have you or someone in your household **had to go without** any of these because of no transportation or the distance was too far?

	Yes	No
Food or meals	◯	◯
Healthcare	◯	◯
Childcare	◯	◯
Social activities	◯	◯
Exercise or sports	◯	◯

PART 5 YOUR COMMUNITY & EXPERIENCES

49 Please tell us about the community where you live now:

	Strongly agree	Agree	Disagree	Strongly disagree
People are willing to help each other	◯	◯	◯	◯
People can be trusted	◯	◯	◯	◯
You can count on adults to watch out that children are safe and do not get in trouble	◯	◯	◯	◯
I feel safe here	◯	◯	◯	◯

50 Do you help an **adult** relative, loved one, or friend with their living or health needs that they would not be able to do without you? *These tasks may include help to manage medication, change bandages, and schedule medical visits.*

- ◯ Yes
- ◯ No → **(Go to Question 53)**

51 How often do you feel you have the support you need to help you deal with the challenges of caring for this adult?

- ◯ All of the time → **(Go to Question 53)**
- ◯ Some of the time
- ◯ None of the time

52 What supports do you need?

- ◯ Respite Care - temporary care for this adult so you can take a break
- ◯ Support groups for myself
- ◯ Instructions on how to do certain tasks
- ◯ Adult Day Care so I can work
- ◯ Other: _____

53 How often do you think you would have someone there for you to do each of these?

	None of the time	**Some** of the time	**Most** of the time	**All** of the time
Love you and make you feel wanted	○	○	○	○
Give you good advice about a crisis	○	○	○	○
Get together with you to relax	○	○	○	○
Confide in or talk to about your problems	○	○	○	○
Help you if you were confined to a bed	○	○	○	○

54 To what extent have you had hard times or traumatic events in your life?

	Not at all	Some	A lot
Life changing illness or injury	○	○	○
Neglect of any kind	○	○	○
Lived with someone with mental illness	○	○	○
Lived with someone with substance abuse issues	○	○	○
Witnessed or experienced violence	○	○	○
Made to do something sexual that you did not want to do	○	○	○
Physically hurt or threatened by an intimate partner	○	○	○
Abuse of any kind	○	○	○
Parents were separated or divorced during your childhood (ages newborn to 18)	○	○	○
A suicide attempt by a close friend or family member	○	○	○
Unexpected death of a loved one	○	○	○
Other traumatic event	○	○	○

55 To what extent do you feel the hard times or traumatic events you have had still impact you today?

- ○ Not at All
- ○ Some
- ○ A lot

56 To what extent have **you experienced** unfair treatment by others because of your race, ethnicity, gender, or sexual orientation?

- ○ None of the time
- ○ Some of the time
- ○ Most of the time
- ○ All of the time

57 To what extent have **you witnessed** others being treated unfairly because of their race, ethnicity, gender, or sexual orientation?

- ○ None of the time
- ○ Some of the time
- ○ Most of the time
- ○ All of the time

58 I know of at least one local resource where I could refer someone who is at risk for suicide.

- ○ Yes
- ○ No

PART 6 YOU & YOUR FAMILY

59 What is your gender?

- ○ Male
- ○ Female
- ○ Transgender
- ○ Gender non-binary
- ○ Gender non-conforming
- ○ Choose not to answer
- ○ Other: _____

60 What year were you born? _____

61 Are you Hispanic or Latino/Latina/Latinx?

- ○ Yes
- ○ No

62 Which one or more of these would you say is your race? *Mark all that apply.*

- ○ White
- ○ Black or African American
- ○ Asian or Asian American
- ○ Native Hawaiian or Other Pacific Islander
- ○ American Indian or Alaska Native
- ○ Other: _____
- ○ Do not know or not sure
- ○ Prefer not to answer

63 What language do you speak best?

- ◯ English
- ◯ Spanish
- ◯ Vietnamese
- ◯ Russian
- ◯ Mandarin/Cantonese
- ◯ Other: _____

64 What language do you read and write best?

- ◯ English
- ◯ Spanish
- ◯ Vietnamese
- ◯ Russian
- ◯ Mandarin/Cantonese
- ◯ Other: _____

65 How many hours per week, on average, do you work at your current job or jobs?

- ◯ I do not work right now
- ◯ Less than 20 hours a week
- ◯ 20 to 39 hours a week
- ◯ 40 to 59 hours a week
- ◯ 60 or more hours a week

66 In the **last 12 months**, have **you or a member of your household**, ever done agricultural work as your main job?

- ◯ Yes
- ◯ No → **(Go to Question 69)**

67 Do **you or a member of your household** work at your current job year-round or on a seasonal basis (part of the year)?

- ◯ Year round
- ◯ Seasonal (part of the year)
- ◯ Do not know

68 Have **you or a member of your household…**
Mark only one.

- ◯ Moved in the last 12 months to another area to work mostly in agriculture?
- ◯ Stayed in this area for the last 12 months to work mostly in agriculture?
- ◯ Does not apply to me

69 What is your gross household income? *Your best estimate is fine. Gross income means before taxes and deductions are taken out.*

- ◯ $0
- ◯ $1 to $10,000
- ◯ $10,001 to $20,000
- ◯ $20,001 to $30,000
- ◯ $30,001 to $40,000
- ◯ $40,001 to $50,000
- ◯ $50,001 to $60,000
- ◯ $60,001 to $70,000
- ◯ $70,001 to $80,000
- ◯ $80,001 to $90,000
- ◯ $90,001 to $100,000
- ◯ More than $100,000

70 In all, how many people are part of your household? *Count adults and children under 18.*

↳ Me, plus _____ other adults,
_____ children ages newborn to 5
_____ children ages 6 to17

71 What adults are part of your household?
Mark all that apply.

- ◯ Just me
- ◯ Spouse or partner
- ◯ My parents or my partner's parents
- ◯ Adult children
- ◯ Other: _____