# 2022 COMMUNITY HEALTH NEEDS ASSESSMENT

Wallowa County, Oregon

Sponsored by

Wallowa Memorial Hospital and Medical Clinics
Building Healthy Families
Wallowa Valley Center for Wellness
Winding Waters Medical Clinic
Northeast Oregon Network


2021-1033-02

# TABLE OF CONTENTS

# INTRODUCTION

# PROJECT OVERVIEW

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in Wallowa County. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was sponsored by a collaboration of local organizations — including Wallowa Memorial Hospital and Medical Clinics, Building Healthy Families, Wallowa Valley Center for Wellness, Winding Waters Medical Clinic, Northeast Oregon Network — and was conducted by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

## Methodology

This assessment incorporates data from multiple sources, including primary research (through the PRC Community Health Survey and PRC Online Key Informant Survey), as well as secondary research (vital statistics and other existing health-related data). It also allows for comparison to benchmark data at the state and national levels.

### PRC Community Health Survey

#### Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by the sponsoring organizations and PRC.

#### Community Defined for This Assessment

The study area for the survey effort is defined as each of the residential ZIP Codes comprising Wallowa County in Oregon, which reflects the primary service area of Wallowa Memorial Hospital and Medical Clinics and is an area of focus for each of the organizations collaborating on this study. This community definition is illustrated in the following map.


## Sample Approach & Design

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed a mixed-mode methodology was implemented. This included targeted surveys conducted by PRC via telephone (landline and cell phone) as well as a community outreach component promoted by Wallowa Memorial Hospital and Medical Clinics and its partner organizations through social media posting and other communications.

RANDOM-SAMPLE SURVEYS (PRC) ► For the targeted administration, PRC administered 200 surveys throughout the region.

COMMUNITY OUTREACH SURVEYS (Sponsors) ► PRC also created a link to an online version of the survey, and Wallowa Memorial Hospital and Medical Clinics and its community partners promoted this link throughout the county in order to drive additional participation and bolster overall samples. This effort yielded an additional 208 surveys to the overall sample.

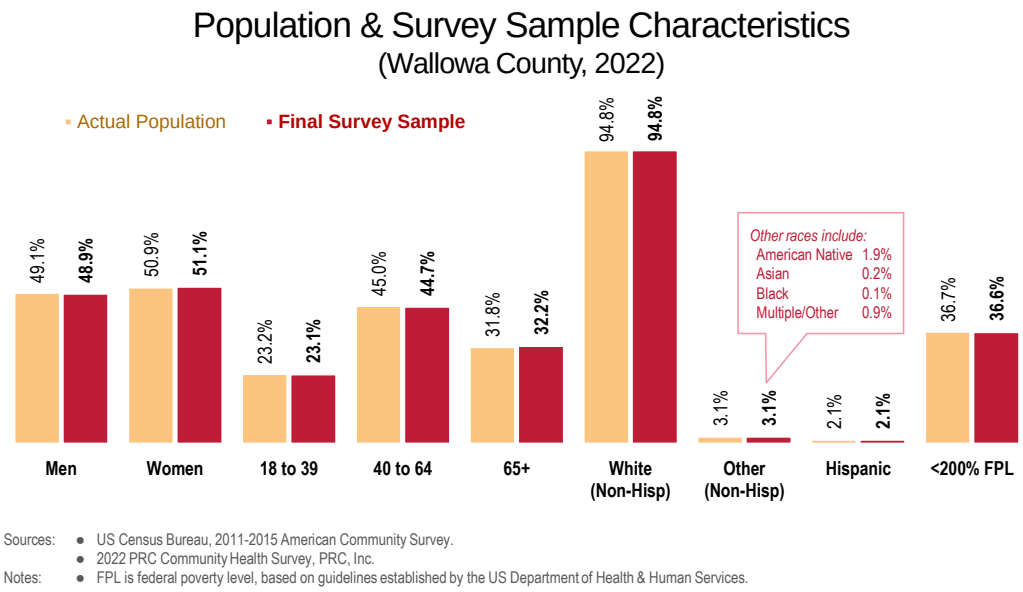
In all, 408 surveys were completed through these mechanisms.

For statistical purposes, the maximum rate of error associated with a sample size of 408 respondents is ±4.9% at the 95 percent confidence level.

## Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.

The following chart outlines the characteristics of the Wallowa County sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s health care needs, and these children are not represented demographically in this chart.]




The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

### INCOME & RACE/ETHNICITY

**INCOME ►** Poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2021 guidelines place the poverty threshold for a family of four at $26,500 annual household income or lower). In sample segmentation: "low income" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; "mid/high income" refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

**RACE & ETHNICITY ►** While the survey data are representative of the racial and ethnic makeup of the population, the samples for Hispanic and non-White race groups were not of sufficient size for independent analysis.

## Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Wallowa Memorial Hospital and Medical Clinics; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 88 community stakeholders took part in the Online Key Informant Survey, as outlined below:

| ONLINE KEY INFORMANT SURVEY PARTICIPATION | |
|---|---|
| KEY INFORMANT TYPE | NUMBER PARTICIPATING |
| Physicians | 4 |
| Public Health Representatives | 3 |
| Other Health Providers | 9 |
| Social Services Providers | 15 |
| Other Community Leaders | 57 |

Final participation included representatives of the organizations outlined below.

- Affordable Integrated Medicine
- Blue Butterfly Counseling
- Building Healthy Families
- CASA
- City of Enterprise
- City of Lostine
- Community Connections
- Department of Human Services
- Devco Engineering
- Eagle Cap Wellness
- Enterprise Christian Church
- Enterprise Electric
- Enterprise Liquor Store
- Enterprise Schools
- Fishtrap
- Genuine Wallowa County
- Intermountain Education Services District
- JayZee Lumber
- Jones Excavating
- Joseph Schools
- Josephy Center for Arts and Culture
- Local Community Advisory Council (LCAC)
- Maxville Heritage Interpretive Center
- Northeast Oregon Network (NEON)
- Northeast Oregon Economic Development District
- Oregon Department of Fish and Wildlife
- Patient Family Advisory Council
- Perry & Associates
- Ruby Peak Naturals
- Ruby Peak Realty
- Safe Harbors
- Summitt Church
- The Nature Conservancy
- Troy School District
- Viridian Management
- Wallowa County
- Wallowa County Chamber of Commerce
- Wallowa County Department of Youth Services
- Wallowa County Education Services District
- Wallowa County Health Care District
- Wallowa County Sheriff
- Wallowa County Veterans Office
- Wallowa Land Trust
- Wallowa Memorial Hospital
- Wallowa Memorial Medical Clinic
- Wallowa Schools
- Wallowa Valley Center for Wellness
- Wallowa Valley Health Care Foundation
- Wallowa Valley Senior Living
- Winding Waters Clinic

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE ► These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants' opinions and perceptions of the health needs of the residents in the area.

## Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for Wallowa County were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

# Benchmark Data

## Oregon Risk Factor Data

Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data represent the most recent *BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trends Data* published online by the Centers for Disease Control and Prevention. State-level vital statistics are also provided for comparison of secondary data indicators.

## Nationwide Risk Factor Data

Nationwide risk factor data, which are also provided in comparison charts, are taken from the *2020 PRC National Health Survey*; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

## Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the U.S. Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

# Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/ transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

## Public Comment

Wallowa Memorial Hospital and Medical Clinics made its prior Community Health Needs Assessment (CHNA) report publicly available on its website; through that mechanism, the hospital requested from the public written comments and feedback regarding the CHNA and implementation strategy. At the time of this writing, Wallowa Memorial Hospital and Medical Clinics had not received any written comments. However, through population surveys and key informant feedback for this assessment, input from the broader community was considered and taken into account when identifying and prioritizing the significant health needs of the community. Wallowa Memorial Hospital and Medical Clinics will continue to use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

# IRS Form 990, Schedule H Compliance

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

| IRS FORM 990, SCHEDULE H (2019) | See Report Page |
|---|---|
| Part V Section B Line 3a<br>A definition of the community served by the hospital facility | 4 |
| Part V Section B Line 3b<br>Demographics of the community | 27 |
| Part V Section B Line 3c<br>Existing health care facilities and resources within the community that are available to respond to the health needs of the community | 120 |
| Part V Section B Line 3d<br>How data was obtained | 4 |
| Part V Section B Line 3e<br>The significant health needs of the community | 12 |
| Part V Section B Line 3f<br>Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups | Addressed Throughout |
| Part V Section B Line 3g<br>The process for identifying and prioritizing community health needs and services to meet the community health needs | 13 |
| Part V Section B Line 3h<br>The process for consulting with persons representing the community's interests | 6 |
| Part V Section B Line 3i<br>The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s) | 126 |

# SUMMARY OF FINDINGS

## Significant Health Needs of the Community

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

| AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT | |
|---|---|
| ACCESS TO HEALTH CARE | ▪ Outmigration (Especially for Specialty Care) |
| CANCER | ▪ Leading Cause of Death |
| DIABETES | ▪ Prevalence of Borderline/Pre-Diabetes |
| HEART DISEASE & STROKE | ▪ Leading Cause of Death<br>▪ High Blood Pressure Prevalence |
| INJURY & VIOLENCE | ▪ Unintentional Injury Deaths<br>– Including Falls [Age 65+] Deaths |
| MENTAL HEALTH | ▪ Suicide Deaths<br>▪ Key Informants: Mental health ranked as a top concern. |
| NUTRITION, PHYSICAL ACTIVITY & WEIGHT | ▪ Overweight [Adults]<br>▪ Key Informants: Nutrition, physical activity, and weight ranked as a top concern. |
| ORAL HEALTH | ▪ Dental Insurance Coverage |
| POTENTIALLY DISABLING CONDITIONS | ▪ Activity Limitations<br>▪ High-Impact Chronic Pain<br>▪ Caregiving |
| SOCIAL DETERMINANTS OF HEALTH | ▪ Housing<br>▪ Child Care |
| RESPIRATORY DISEASE | ▪ Key Informants: Coronavirus/COVID-19 ranked as a top concern. |
| SUBSTANCE ABUSE | ▪ Key Informants: Substance abuse ranked as a top concern. |
| TOBACCO USE | ▪ Key Informants: Tobacco use ranked as a top concern. |

## Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among community stakeholders (representing a cross-section of community-based agencies and organizations) in conjunction with the administration of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Mental Health
2. COVID-19 / Respiratory Disease
3. Substance Abuse
4. Nutrition, Physical Activity & Weight
5. Tobacco Use
6. Potentially Disabling Conditions
7. Oral Health
8. Diabetes
9. Heart Disease & Stroke
10. Cancer
11. Injury & Violence
12. Access to Health Care Services

Not prioritized within the list above are the social determinants of **Housing** and **Child Care**, which potentially impacts outcomes for all of the above.

## Hospital Implementation Strategy

Wallowa Memorial Hospital and Medical Clinics will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Note: An evaluation of the hospital's past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.

## Summary Tables: Comparisons With Benchmark Data

The following tables provide an overview of indicators in Wallowa County, grouped by health topic.

### Reading the Summary Tables

In the following tables, Wallowa County results are shown in the larger, gray column.

The columns to the right of the Wallowa County column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether Wallowa County compares favorably (☀), unfavorably (🌧), or comparably (☁) to these external data.

Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.

*Tip: Indicator labels beginning with a "%" symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*

| SOCIAL DETERMINANTS | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| Linguistically Isolated Population (Percent) | **0.3** | ☀ 2.7 | ☀ 4.3 | |
| Population in Poverty (Percent) | **13.6** | ☁ 13.2 | ☁ 13.4 | 🌧 8.0 |
| Children in Poverty (Percent) | **21.0** | 🌧 16.6 | ☁ 18.5 | 🌧 8.0 |
| No High School Diploma (Age 25+, Percent) | **6.9** | ☀ 9.3 | ☀ 12.0 | |
| % Unable to Pay Cash for a $400 Emergency Expense | **17.3** | | ☀ 24.6 | |
| % Worry/Stress Over Rent/Mortgage in Past Year | **19.6** | | ☀ 32.2 | |
| % Worry/Stress Over Paying Utility Bills in Past Year | **19.9** | | | |
| % Currently Homeless | **1.2** | | | |
| % Homeless in the Past Year | **1.9** | | | |
| % Housing Emergency in Past Year | **4.8** | | | |

| SOCIAL DETERMINANTS OF HEALTH (continued) | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % Worried About Losing Current Housing | 10.8 | | | |
| % Type of Housing Wanted is Not Available | 22.4 | | | |
| % Unhealthy/Unsafe Housing Conditions | 8.7 | | 12.2 | |
| % Lack of Transportation Was a Barrier in the Past Year | 5.7 | | | |
| % Food Insecure | 15.8 | | 34.1 | |
| % [Parents] Worry/Stress Over Child Care in the Past Year | 30.5 | | | |
| % [Parents] Worry/Stress Over Affording Child Care | 27.2 | | | |
| | | better | similar | worse |

| OVERALL HEALTH | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % "Fair/Poor" Overall Health | 12.4 | 18.2 | 12.6 | |
| % 3+ Days of Poor Physical Health in the Past Month | 33.4 | | | |
| | | better | similar | worse |

| ACCESS TO HEALTH CARE | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % [Age 18-64] Lack Health Insurance | **7.0** | 12.9 | 8.7 | 7.9 |
| % [Parents] Child Is Uninsured | **1.3** | | | |
| % Went Without Coverage in the Past Year | **4.9** | | | |
| % Difficulty Accessing Health Care in Past Year (Composite) | **29.2** | | 35.0 | |
| % Cost Prevented PCP Visit in Past Year | **5.8** | 13.5 | 12.9 | |
| % Cost Prevented Getting Prescription in Past Year | **7.0** | | 12.8 | |
| % Difficulty Getting PCP Appointment in Past Year | **9.2** | | 14.5 | |
| % Inconvenient Hrs Prevented PCP Visit in Past Year | **5.2** | | 12.5 | |
| % Difficulty Finding PCP in Past Year | **4.1** | | 9.4 | |
| % Transportation Hindered PCP Visit in Past Year | **5.4** | | 8.9 | |
| % Language/Culture Prevented Care in Past Year | **0.4** | | 2.8 | |
| % Difficulty Getting Child's Health Care in Past Year | **6.7** | | 8.0 | |
| % Skipped Prescription Doses to Save Costs | **9.1** | | 12.7 | |
| % Understanding Written Health Info Is “Seldom/Never” Easy | **10.1** | | 13.4 | |
| % Struggle With Reading and Filling Out Forms | **3.6** | | | |
| Primary Care Doctors per 100,000 | **108.2** | 127.5 | 100.3 | |

| ACCESS TO HEALTH CARE (continued) | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % Have a Personal Physician or Healthcare Provider/Team | 95.0 | | | |
| % Outmigration for Medical Care in the Past Year | 51.7 | | | |
| % Have Had Routine Checkup in Past Year | 69.7 | 73.1 | 70.5 | |
| % Child Has Had Checkup in Past Year | 90.1 | | 77.4 | |
| % Eye Exam in Past 2 Years | 66.3 | | 61.0 | 61.1 |
| % Local Medical Care is “Fair/Poor” | 4.8 | | | |
| | | better | similar | worse |

| CANCER | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| Cancer (Age-Adjusted Death Rate) | 123.1 | 147.1 | 146.5 | 122.7 |
| Cancer Incidence Rate (All Sites) | 336.4 | 430.5 | 448.6 | |
| Female Breast Cancer Incidence Rate | 99.3 | 128.0 | 126.8 | |
| Prostate Cancer Incidence Rate | 74.5 | 93.3 | 106.2 | |
| Lung Cancer Incidence Rate | 25.6 | 52.6 | 57.3 | |
| % Cancer | 11.7 | 13.4 | 10.0 | |
| | | better | similar | worse |

| DIABETES | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS vs. OR | vs. US | vs. HP2030 |
|---|---|---|---|---|
| Diabetes (Age-Adjusted Death Rate) | 17.3 | 23.6 | 21.7 | |
| % Diabetes/High Blood Sugar | 8.2 | 8.6 | 13.8 | |
| % Borderline/Pre-Diabetes | 19.5 | | 9.7 | |
| % [Non-Diabetics] Blood Sugar Tested in Past 3 Years | 50.9 | | 43.3 | |
| | | better | similar | worse |

| HEART DISEASE & STROKE | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS vs. OR | vs. US | vs. HP2030 |
|---|---|---|---|---|
| Diseases of the Heart (Age-Adjusted Death Rate) | 120.2 | 131.1 | 164.4 | 127.4 |
| % Heart Disease (Heart Attack, Angina, Coronary Disease) | 5.3 | 6.1 | 6.1 | |
| Stroke (Age-Adjusted Death Rate) | 27.6 | 39.1 | 37.6 | 33.4 |
| % Stroke | 2.0 | 3.2 | 4.3 | |
| % Told Have High Blood Pressure | 45.5 | 30.6 | 36.9 | 27.7 |
| % Told Have High Cholesterol | 38.0 | | 32.7 | |
| % 1+ Cardiovascular Risk Factor | 84.3 | | 84.6 | |
| | | better | similar | worse |

| INFANT HEALTH & FAMILY PLANNING | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS vs. OR | vs. US | vs. HP2030 |
|---|---|---|---|---|
| Low Birthweight Births (Percent) | 5.3 | 6.5 | 6.5 | |
| Births to Adolescents Age 15 to 19 (Rate per 1,000) | 9.8 | 16.8 | 20.9 | 31.4 |
| | | better | similar | worse |

| INJURY & VIOLENCE | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS vs. OR | vs. US | vs. HP2030 |
|---|---|---|---|---|
| Unintentional Injury (Age-Adjusted Death Rate) | 67.2 | 47.2 | 51.6 | 43.2 |
| [65+] Falls (Age-Adjusted Death Rate) | 109.2 | 99.1 | 61.6 | 63.4 |
| Violent Crime Rate | 263.4 | 265.8 | 416.0 | |
| % Victim of Violent Crime in Past 5 Years | 2.4 | | 6.2 | |
| % Victim of Intimate Partner Violence | 14.3 | | 13.7 | |
| | | better | similar | worse |

| KIDNEY DISEASE | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS vs. OR | vs. US | vs. HP2030 |
|---|---|---|---|---|
| % Kidney Disease | 5.8 | 3.1 | 5.0 | |
| | | better | similar | worse |

| MENTAL HEALTH | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % "Fair/Poor" Mental Health | 17.0 | | 13.4 | |
| % Symptoms of Chronic Depression (2+ Years) | 33.1 | | 30.3 | |
| % 3+ Days of Poor Mental Health in the Past Month | 33.4 | | | |
| % Typical Day Is "Extremely/Very" Stressful | 14.4 | | 16.1 | |
| % Diagnosed w/Some Type of Ongoing Mental Issue | 19.4 | | | |
| % Have Someone to Turn to "Little/None of the Time" | 82.5 | | | |
| % Unable to Talk Out Issues w/Someone in the Past Year | 17.7 | | | |
| % Have Some Type of Mental Health Coverage | 78.5 | | | |
| % Unable to Get Mental Health Svcs in Past Yr | 3.3 | | | |
| % Local Mental Health Care is "Fair/Poor" | 18.9 | | | |
| Suicide (Age-Adjusted Death Rate) | 24.8 | 18.2 | 13.3 | 12.8 |
| Mental Health Providers per 100,000 | 148.8 | 281.4 | 115.6 | |
| % Taking Rx/Receiving Mental Health Trtmt | 20.0 | | 16.8 | |
| % Unable to Get Mental Health Svcs in Past Yr | 3.3 | | 7.8 | |
| | | better | similar | worse |

| NUTRITION, PHYSICAL ACTIVITY & WEIGHT | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| Population With Low Food Access (Percent) | 25.1 | 25.1 | 22.2 | |
| % "Very/Somewhat" Difficult to Buy Fresh Produce | 21.7 | | 21.1 | |
| % No Leisure-Time Physical Activity | 23.3 | 23.9 | 31.3 | 21.2 |
| % Child [Age 2-17] Physically Active 1+ Hours per Day | 49.6 | | 33.0 | |
| % Healthy Weight (BMI 18.5-24.9) | 31.3 | 34.0 | 34.5 | |
| % Overweight (BMI 25+) | 67.7 | 63.9 | 61.0 | |
| % Obese (BMI 30+) | 31.0 | 29.0 | 31.3 | 36.0 |
| % Child Diagnosed as Overweight | 11.5 | | | |
| | | better | similar | worse |

| ORAL HEALTH | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % Have Dental Insurance | 58.5 | | 68.7 | 59.8 |
| % [Age 18+] Dental Visit in Past Year | 72.5 | 68.0 | 62.0 | 45.0 |
| % Child [Age 2-17] Dental Visit in Past Year | 88.6 | | 72.1 | 45.0 |
| % Local Dental Care is “Fair/Poor” | 14.2 | | | |
| % 3+ Days of Poor Dental Health in the Past Month | 15.8 | | | |
| % Diagnosed w/Ongoing Dental Health Issue | 21.4 | | | |
| | | better | similar | worse |

| POTENTIALLY DISABLING CONDITIONS | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % 3+ Chronic Conditions | 33.0 | | 32.5 | |
| % Activity Limitations | 34.1 | | 24.0 | |
| % 3+ Days of Limited Activities in the Past Month | 28.2 | | | |
| % With High-Impact Chronic Pain | 23.9 | | 14.1 | 7.0 |
| % Health Issue Prevents Employment | 5.7 | | | |
| % Caregiver to a Friend/Family Member | 28.7 | | 22.6 | |
| % "Always/Usually" Stressed About Elder Care | 3.5 | | | |
| | | better | similar | worse |

| RESPIRATORY DISEASE | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| CLRD (Age-Adjusted Death Rate) | 28.0 | 37.5 | 39.1 | |
| Pneumonia/Influenza (Age-Adjusted Death Rate) | 13.5 | 9.1 | 14.4 | |
| % [Adult] Asthma | 9.5 | 11.1 | 12.9 | |
| % [Child 0-17] Asthma | 6.7 | | 7.8 | |
| % COPD (Lung Disease) | 5.1 | 6.1 | 6.4 | |
| | | better | similar | worse |

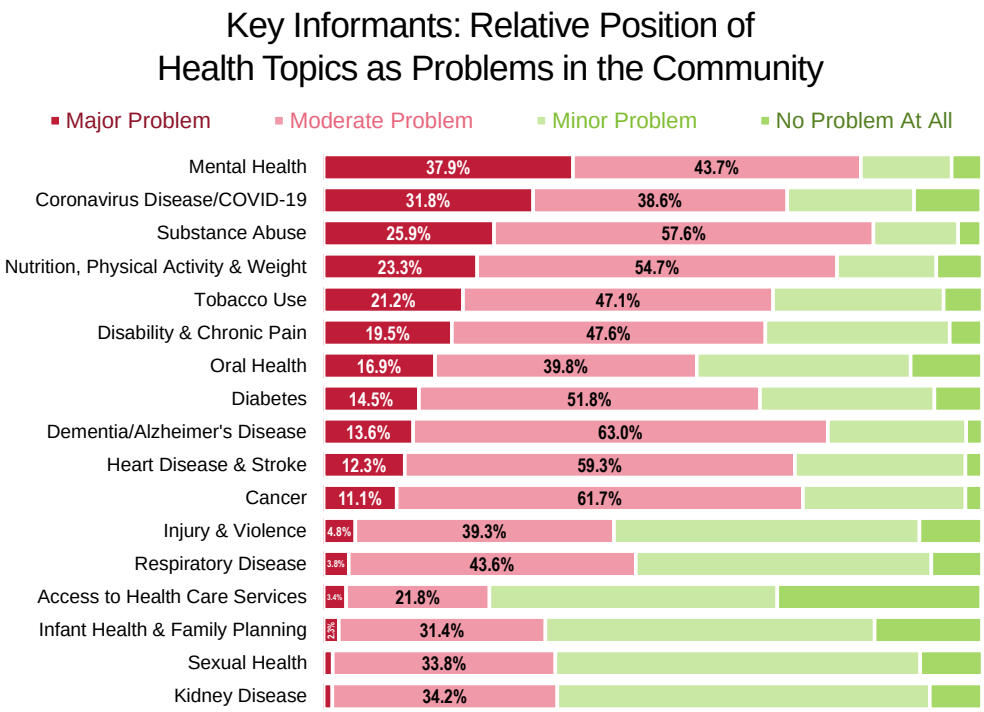
| SEXUAL HEALTH | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| Chlamydia Incidence Rate | 127.6 | 464.0 | 539.9 | |
| Gonorrhea Incidence Rate | 85.1 | 142.7 | 179.1 | |
| | | better | similar | worse |

| SUBSTANCE ABUSE | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % Excessive Drinker | 17.2 | 19.6 | 27.2 | |
| % Illicit Drug Use in Past Month | 0.0 | | 2.0 | 12.0 |
| % Used a Prescription Opioid in Past Year | 14.9 | | 12.9 | |
| % Ever Sought Help for Alcohol or Drug Problem | 7.8 | | 5.4 | |
| % Difficulty Getting Substance Abuse Help in the Past Year | 4.3 | | | |
| % Personally Impacted by Substance Abuse | 41.2 | | 35.8 | |
| | | better | similar | worse |

| TOBACCO USE | Wallowa County | WALLOWA COUNTY vs. BENCHMARKS | | |
|---|---|---|---|---|
| | | vs. OR | vs. US | vs. HP2030 |
| % Current Smoker | 7.2 | 14.5 | 17.4 | 5.0 |
| % [Tobacco Users] Have Quit Tobacco in the Past Year | 19.5 | | | |
| % Someone Smokes at Home | 6.9 | | 14.6 | |
| % [Household With Children] Someone Smokes in the Home | 11.5 | | 17.4 | |
| % Currently Use Vaping Products | 3.6 | 4.4 | 8.9 | |
| % Use Smokeless Tobacco or Chew | 8.7 | | | |
| | | better | similar | worse |

## Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 17 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)




# DATA CHARTS & KEY INFORMANT INPUT

The following sections present data from multiple sources, including the population- based PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey.

Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.

# COMMUNITY CHARACTERISTICS

## Population Characteristics

### Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

**Total Population**
(Estimated Population, 2015-2019)

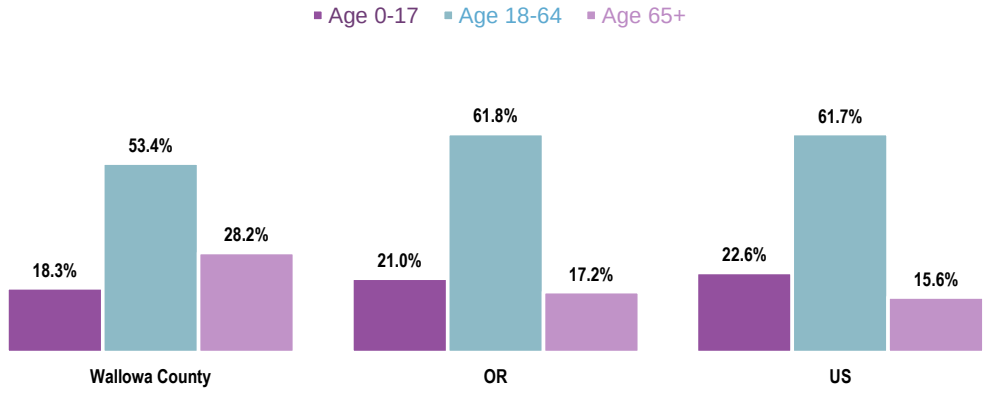
| | TOTAL POPULATION | TOTAL LAND AREA (square miles) | POPULATION DENSITY (per square mile) |
|---|---|---|---|
| Wallowa County | 7,004 | 3,145.90 | 2.23 |
| Oregon | 4,129,803 | 95,986.65 | 43.02 |
| United States | 324,697,795 | 3,532,068.58 | 91.93 |

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

### Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

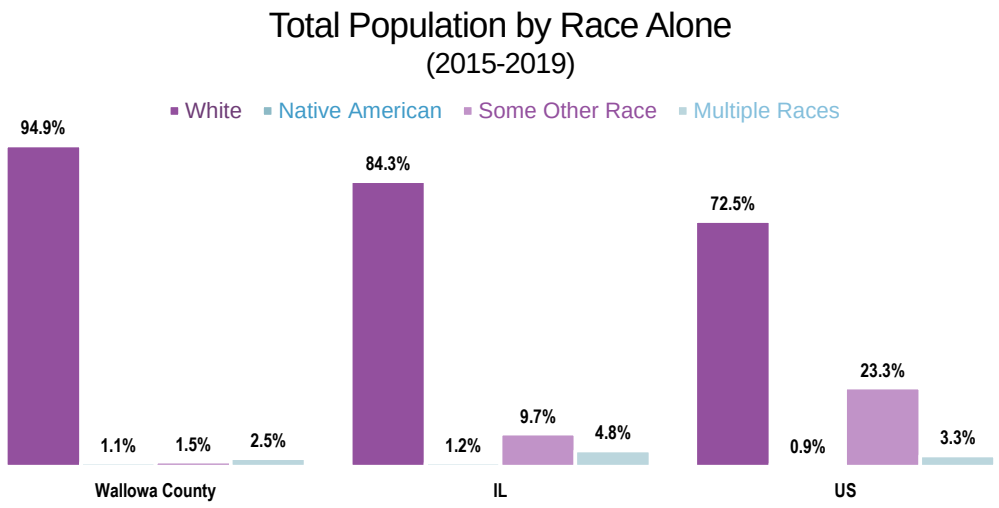
**Total Population by Age Groups**
(2015-2019)



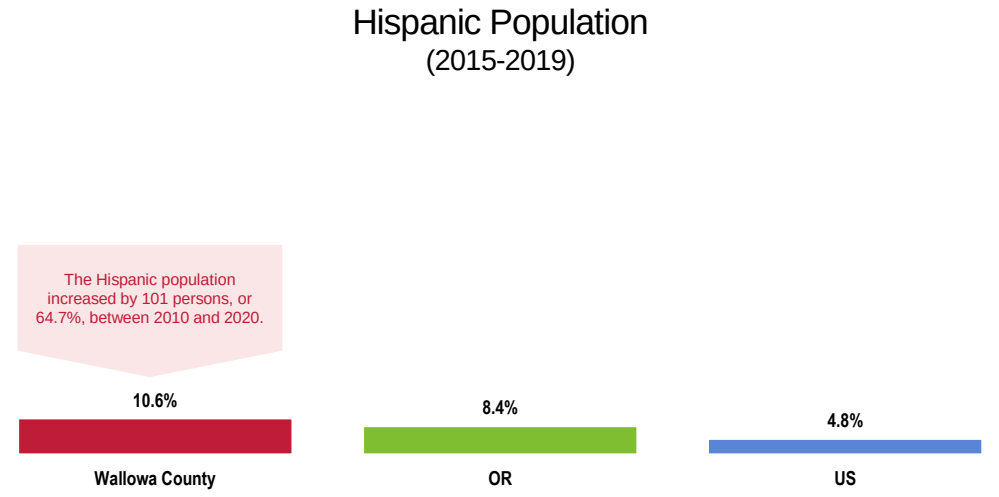

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

## Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).




Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

# Social Determinants of Health

## ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

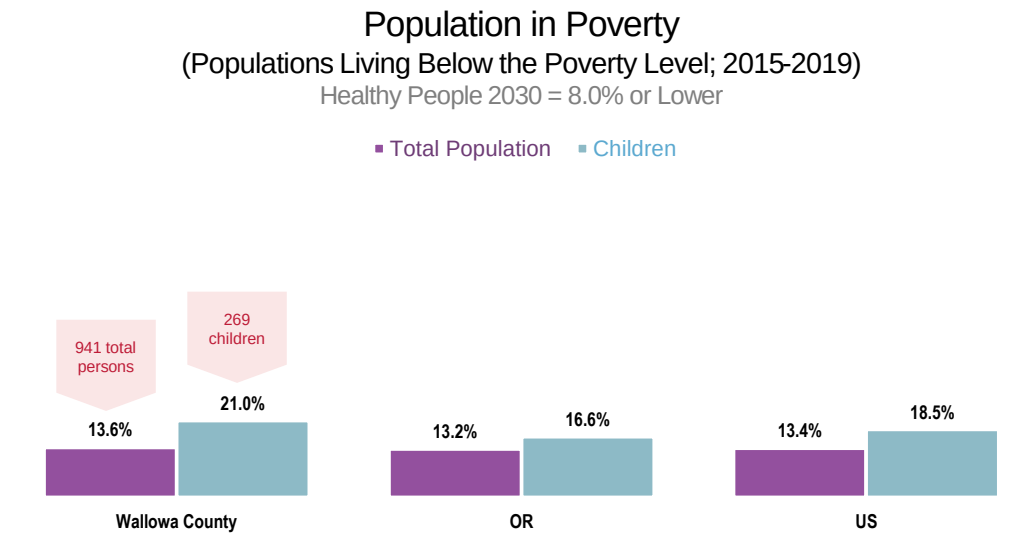
Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

- Healthy People 2030 (https://health.gov/healthypeople)

## Income

### Poverty

The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions.



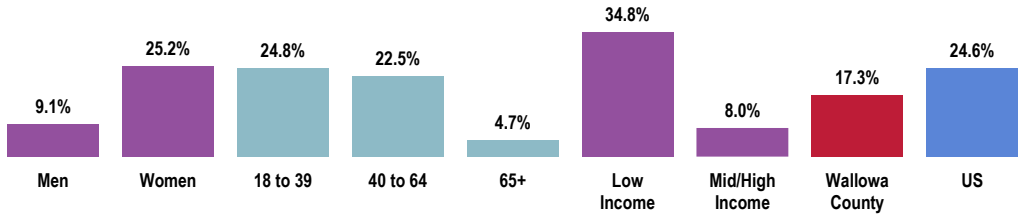

Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.

## Financial Resilience

**"Suppose that you have an emergency expense that costs $400. Based on your current financial situation, would you be able to pay for this expense either with cash, by taking money from your checking or savings account, or by putting it on a credit card that you could pay in full at the next statement?"**

### Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Wallowa County, 2022)




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 63]
- 2020 PRC National Health Survey, PRC, Inc.

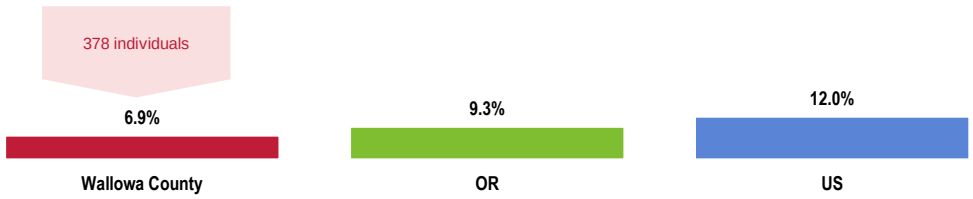
Notes:
- Asked of all respondents.
- Includes respondents who say they would not be able to pay for a $400 emergency expense either with cash, by taking money from their checking or savings account, or by putting it on a credit card that they could pay in full at the next statement.

# Education

## Education Level

Education levels are reflected in the proportion of our population without a high school diploma.

### Population With No High School Diploma
(Population Age 25+ Without a High School Diploma or Equivalent, 2015-2019)

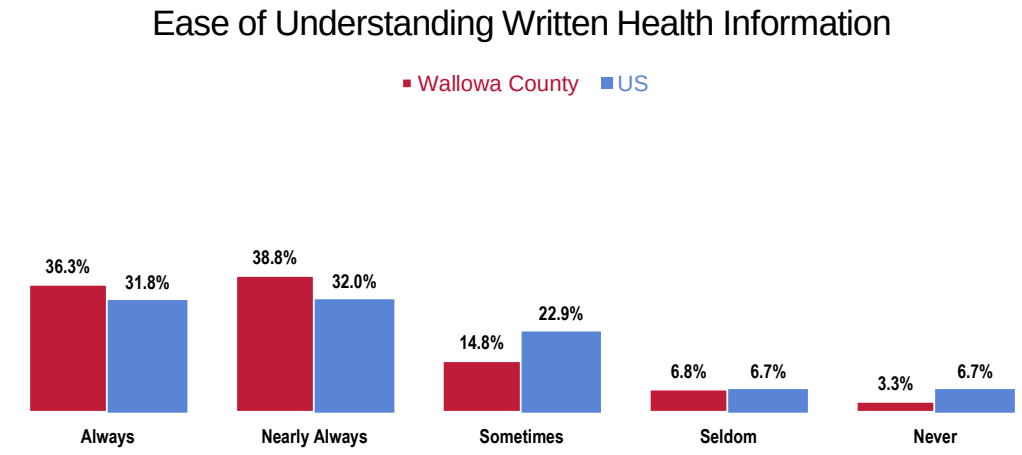



Sources:
- US Census Bureau American Community Survey 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because educational attainment is linked to positive health outcomes.

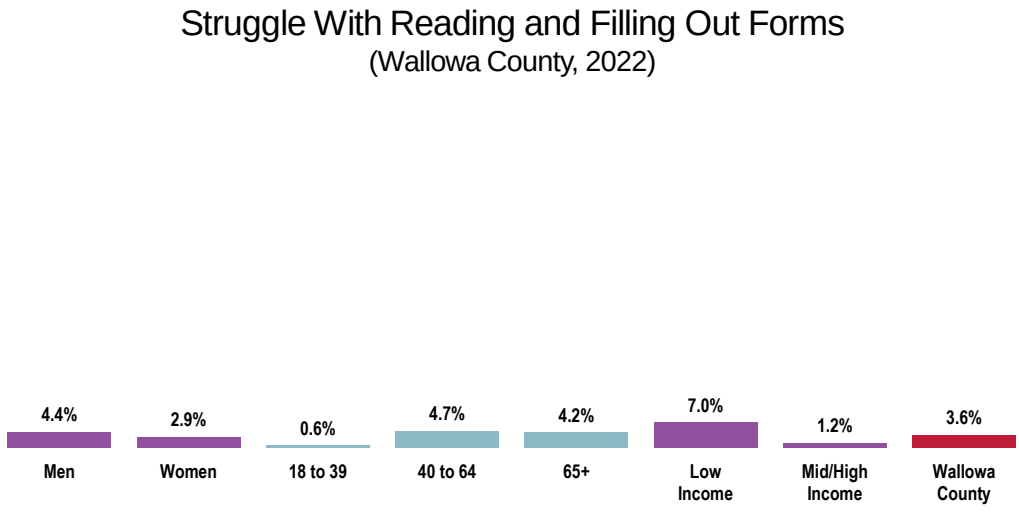
## Health Literacy

**"How often is health information written in a way that is easy for you to understand? Would you say: always, nearly always, sometimes, seldom, or never?"**




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 326]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

**"Do you struggle with not being able to read well enough to fill out a form, such as a job application, a medical form, a housing form, etc.?"**



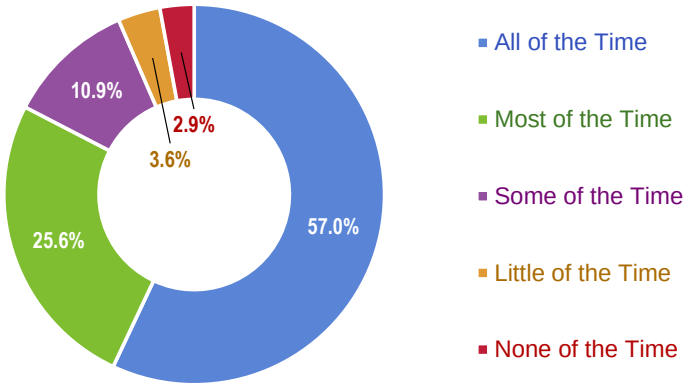

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 327]
Notes: ● Asked of all respondents.

## Social Support

**"In the past month, how often have you had someone you could turn to if you needed or wanted help? Would you say: All of the Time, Most of the Time, Some of the Time, Little of the Time, or None of the Time?"**

**"Was there a time in the past 12 months when you needed or wanted to talk with another person about problems you were having—such as with work, housework, or personal, family, or health issues—but were NOT able to?"**

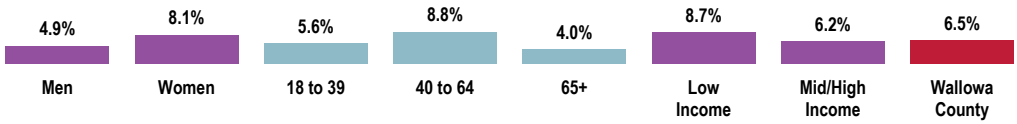
### Had Someone to Turn to for Help in the Past Month
(Wallowa County, 2022)




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 330-331]
Notes: ● Asked of all respondents.

### Had Someone to Turn to for Help in the Past Month
("Little/None of the Time" Responses; Wallowa County, 2022)

In a separate inquiry, 17.7% of respondents had a time in the past year when they needed or wanted to talk with another person about problems they were having, but were not able to.



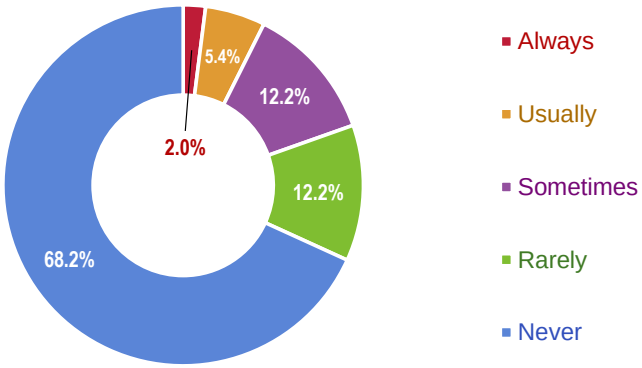

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 331]
Notes: ● Asked of all respondents.
● Represents "all of the time/most of the time" responses.

## Housing

### Housing Insecurity

**"In the past 12 months, how often were you worried or stressed about having enough money to pay your rent or mortgage? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"**

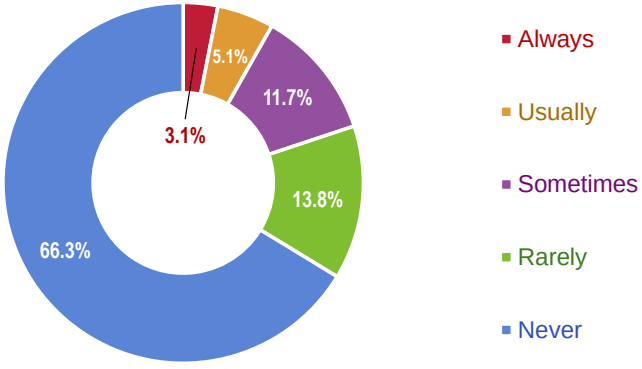
Frequency of Worry or Stress
About Paying Rent or Mortgage in the Past Year
(Wallowa County, 2022)




Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 66]
Notes: • Asked of all respondents.

**"In the past 12 months, how often were you worried or stressed about having enough money to pay your utility bills, such as water, electric, gas, etc.? Would you say you were worried or stressed: always, usually, sometimes, rarely, or never?"**

Frequency of Worry or Stress
Over Paying for Utility Bills in the Past Year
(Wallowa County, 2022)




Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 322]
Notes: • Asked of all respondents.

## Housing Instability

**"Do you currently have a place to live but are worried about losing it in the future?"**

**"Because of an emergency, have you had to live with a friend or relative in the past 12 months, even if this was only temporary?"**

**"Has there been any time in the past 12 months when you were without a stable home or were living on the street, in a car, or in a temporary shelter?"**

**"Are you currently homeless?"**

**"Do you have money for housing, but the type of housing you can afford is not available?"**

### Housing Instability

- 71.3% of respondents own a home
- 17.8% currently rent
- 6.5% live with family or in subsidized housing

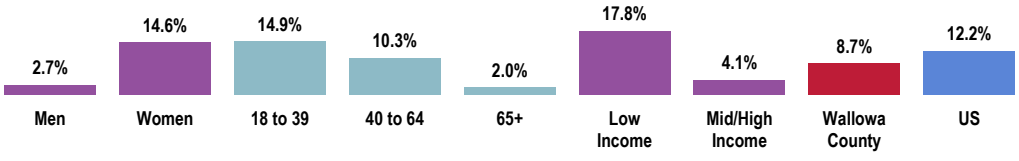
22.4% of respondents say that, although they money, the type of housing they can afford is not available.


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 64, 317-321]
Notes: ● Asked of all respondents.

## Unhealthy or Unsafe Housing

**"Thinking about your current home, over the past 12 months have you experienced ongoing problems with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe?"**

### Unhealthy or Unsafe Housing Conditions in the Past Year
(Wallowa County, 2022)

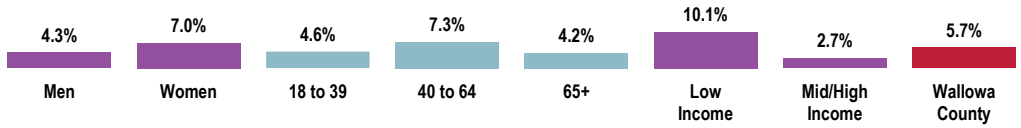



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 65]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

## Transportation

**"Was there a time during the past 12 months when a lack of transportation made it difficult or prevented you from getting to work or school, or completing necessary tasks like shopping for food?"**

Lack of Transportation Prevented Getting to Work, School, or Errands at Some Point in the Past Year
(Wallowa County, 2022)




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 323]
Notes: ● Asked of all respondents.

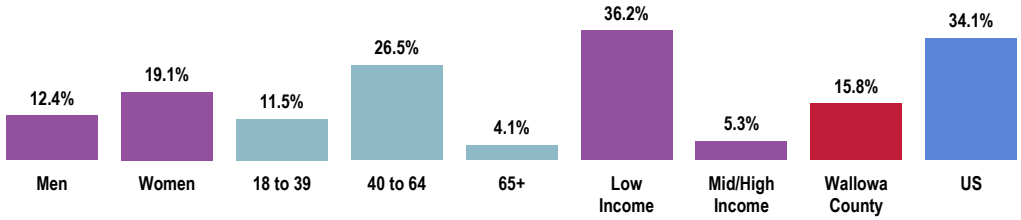
## Food Insecurity

**"Please tell me whether each of the following statements was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.**

- The first statement is: 'I worried about whether our food would run out before we got money to buy more.'
- The next statement is: 'The food that we bought just did not last, and we did not have money to get more.'"

Agreement with either or both of these statements ("often true" or "sometimes true") defines food insecurity.

Food Insecurity
(Wallowa County, 2022)



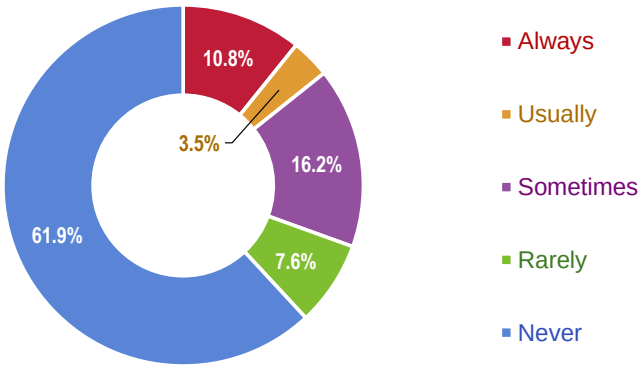

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 112]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents; includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

## Childcare

[Parents] **"During the past 12 months, how often were you worried or stressed about having childcare when you needed it? Would you say: always, usually, sometimes, rarely, or never?"**

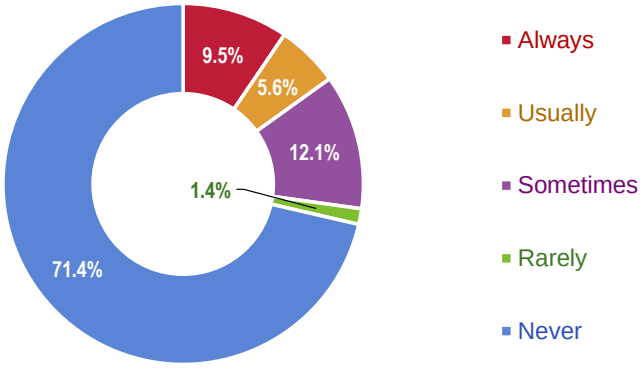
[Parents] **"During the past 12 months, how often were you worried or stressed about being able to afford childcare? Would you say: always, usually, sometimes, seldom, or never?"**

Frequency of Worry or Stress
About Having Childcare in the Past Year
(Wallowa County Parents, 2022)




Sources: 2022 PRC Community Health Survey, PRC, Inc. [Item 346]
Notes: Asked of all respondents with children <18 at home.

Frequency of Worry or Stress About
Being Able to Afford Childcare in the Past Year
(Wallowa County Parents, 2022)

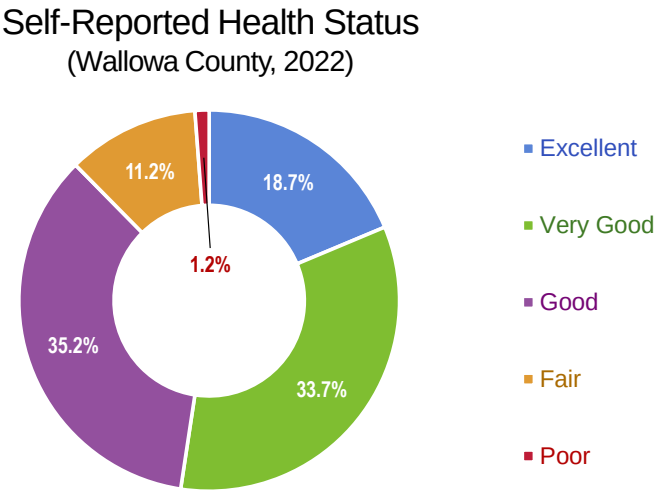



Sources: 2022 PRC Community Health Survey, PRC, Inc. [Item 347]
Notes: Asked of all respondents with children <18 at home.

# HEALTH STATUS

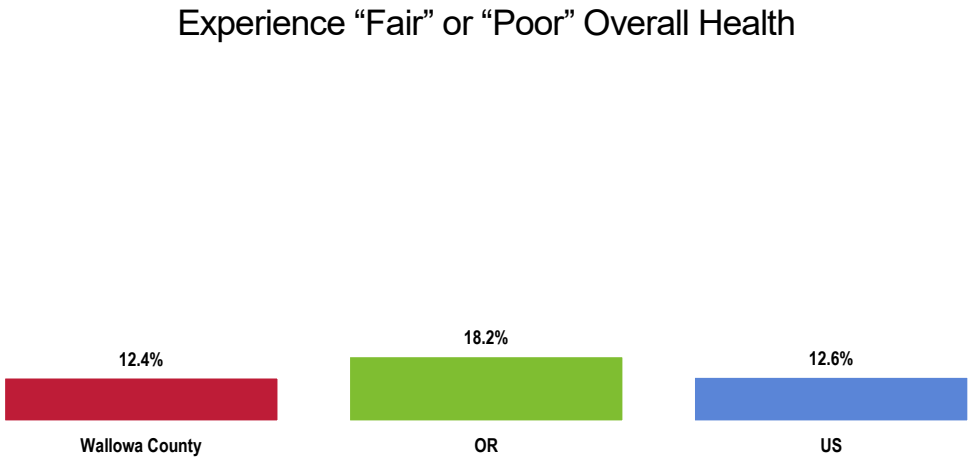
## Overall Health

**"Would you say that in general your health is: excellent, very good, good, fair, or poor?"**



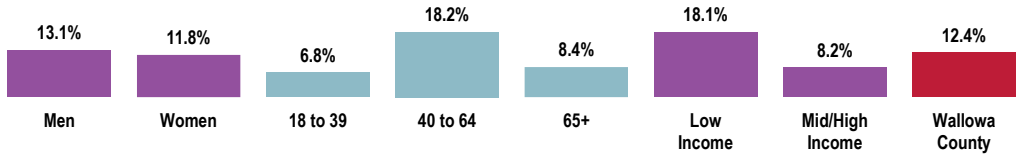

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

The following charts further detail "fair/poor" overall health responses in Wallowa County in comparison to benchmark data, as well as by basic demographic characteristics (namely by sex, age groupings, and income [based on poverty status].




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

## Experience “Fair” or “Poor” Overall Health
(Wallowa County, 2022)

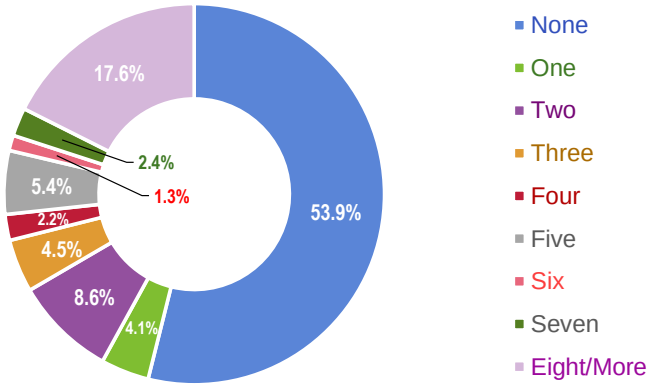



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 5]
Notes: ● Asked of all respondents.

## Days of Poor Physical Health

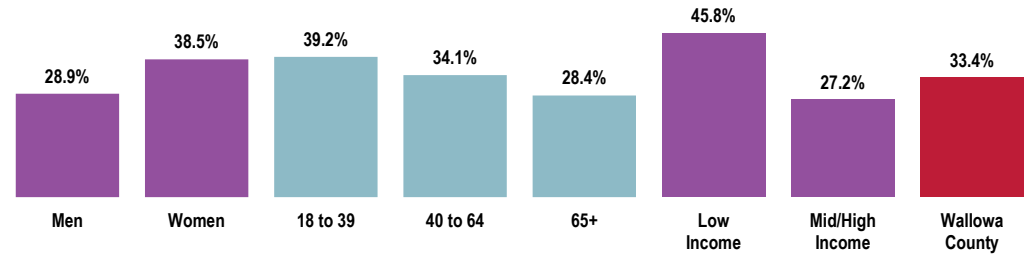
**“Thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?”**

### Days of Poor Physical Health in the Past Month
(Wallowa County, 2022)




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: ● Asked of all respondents.

## 3+ Days of Poor Physical Health in the Past Month
(Wallowa County, 2022)




Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 302]
Notes: • Asked of all respondents.

# Mental Health

## ABOUT MENTAL HEALTH & MENTAL DISORDERS

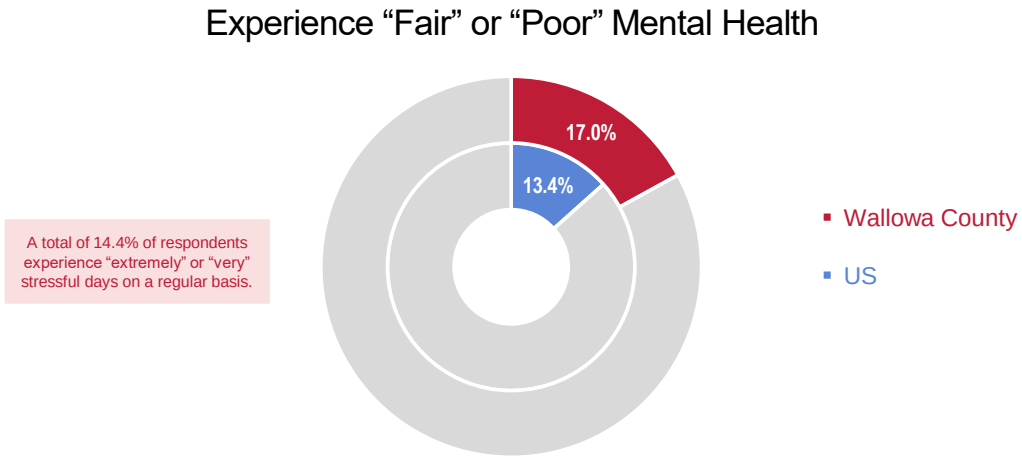
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

## Mental Health Status

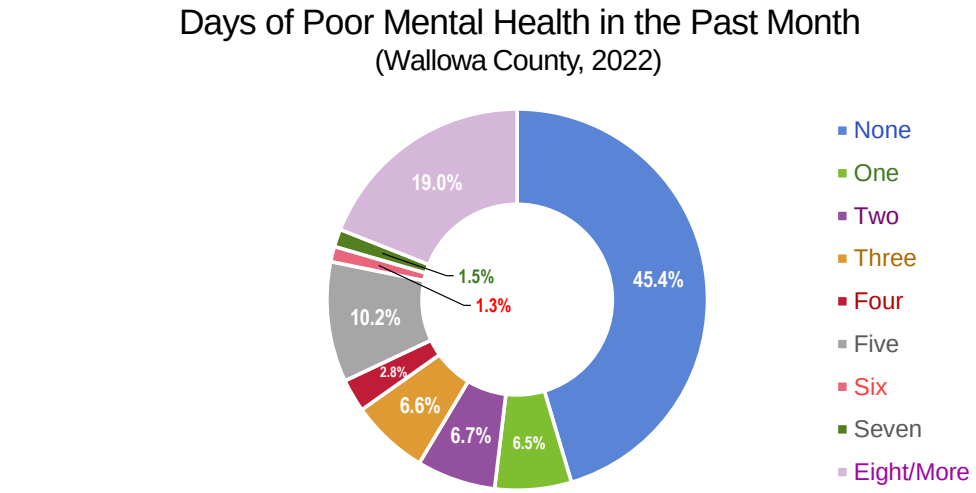
**"Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"**



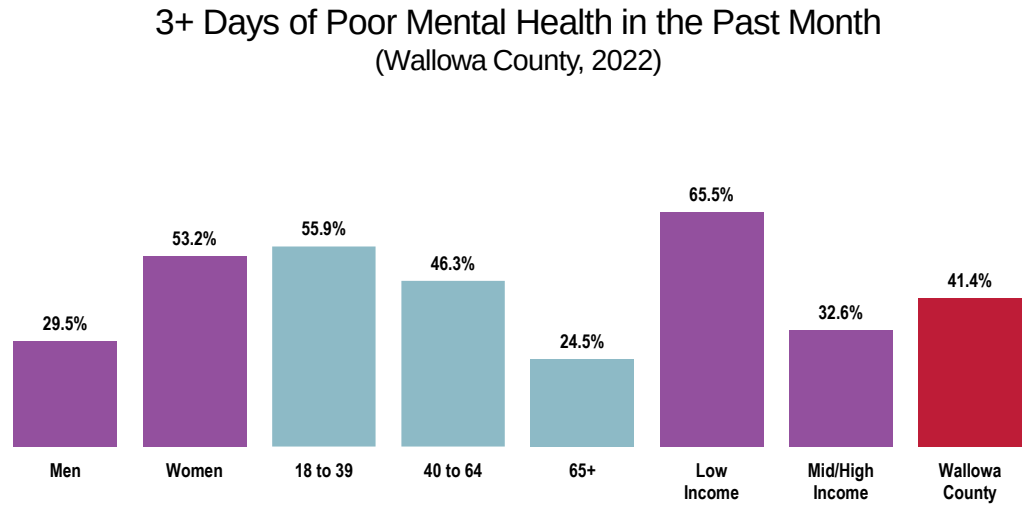

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 90, 92]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

## Days of Poor Mental Health

**"Thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days would you say your mental health was not good?"**




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 333]
Notes: ● Asked of all respondents.

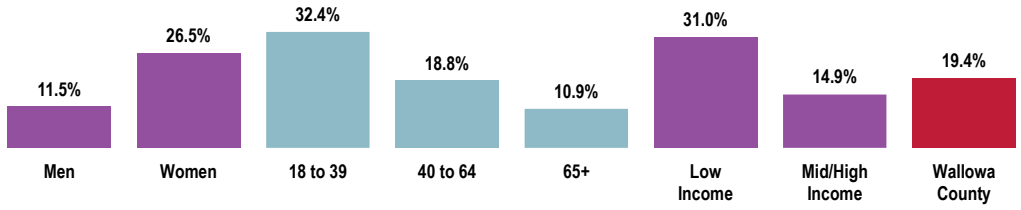



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 333]
Notes: ● Asked of all respondents.

## Chronic Mental Health Issues

**"Has a doctor, nurse, or other health provider told you that you have an ongoing mental health condition or emotional problem?"**

Health Professional Has Diagnosed
an Ongoing Mental Health Condition or Emotional Problem
(Wallowa County, 2022)

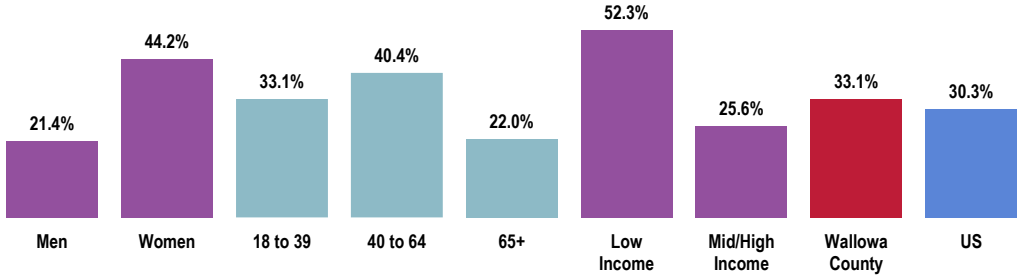



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 334]
Notes: ● Asked of all respondents.

## Symptoms of Depression

**"Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?"**

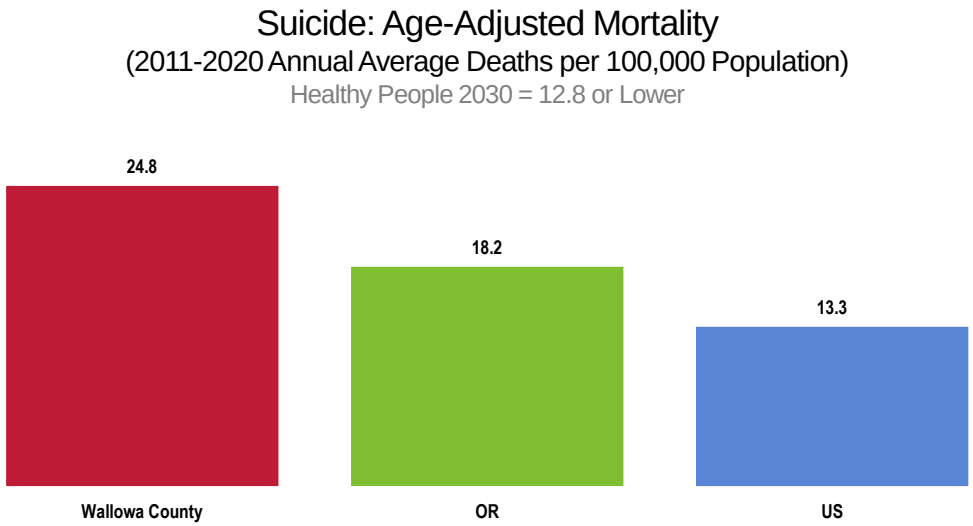
Have Experienced Symptoms of Chronic Depression
(Wallowa County, 2022)




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 91]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

## Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population (refer to “Leading Causes of Death” for an explanation of the use of age-adjusting for these rates).

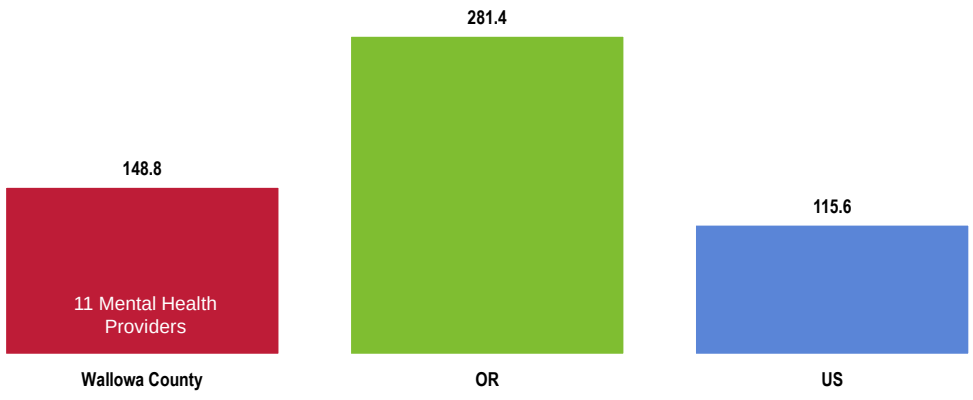



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

## Mental Health Treatment

The following chart outlines access to mental health providers, expressed as the number of providers (psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care) per 100,000 residents.

Here, “mental health providers” includes psychiatrists, psychologists, clinical social workers, and counsellors who specialize in mental health care. Note that this indicator only reflects providers practicing in Wallowa County and residents in Wallowa County; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.



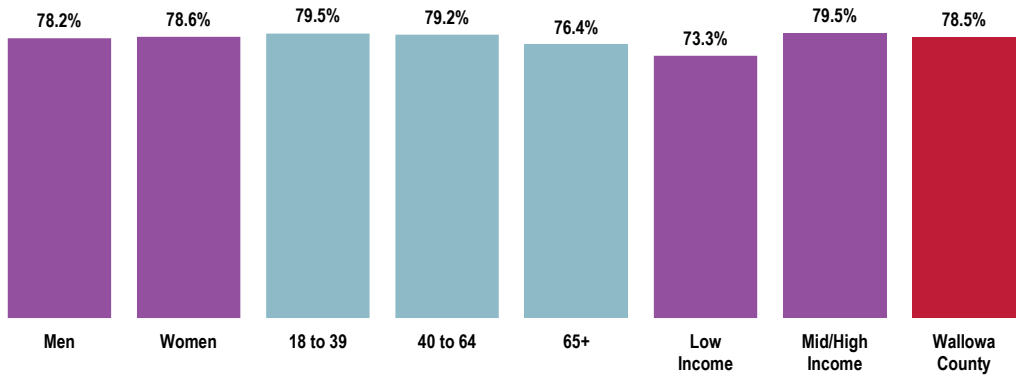

Sources:
- University of Wisconsin Population Health Institute, County Health Rankings.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

## Insurance Coverage for Mental Health

**"Do you currently have any health insurance coverage that pays for at least part of the cost of mental health services?"**

### Have Some Type of Mental Health Insurance Coverage
(Wallowa County, 2022)

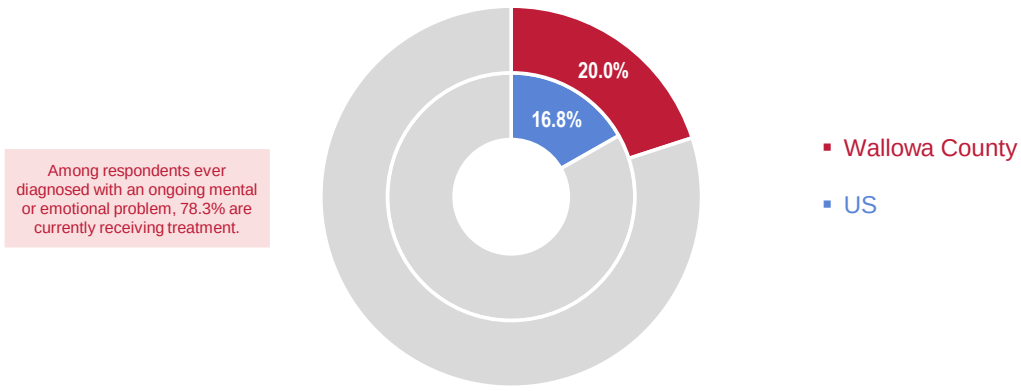



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 335]
Notes: ● Asked of all respondents.

## Mental Health Treatment

**"Are you now taking medication or receiving treatment from a doctor, nurse, or other health professional for any type of mental health condition or emotional problem?"**

### Currently Receiving Mental Health Treatment



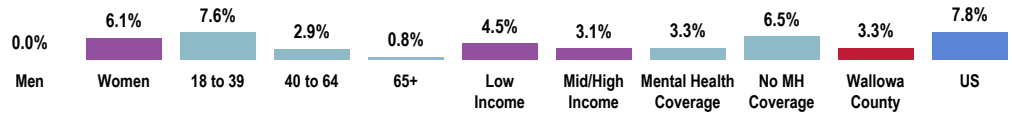

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 94, 334]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.
● "Treatment" can include taking medications for mental health.

## Difficulty Getting Mental Health Care

**"Was there a time in the past 12 months when you needed mental health services but were not able to get them?"**

### Unable to Get Mental Health Services When Needed in the Past Year
(Wallowa County, 2022)

Among parents, 2.9% report there was a time in the past year when they needed mental health services for any child in their household but could not get them.

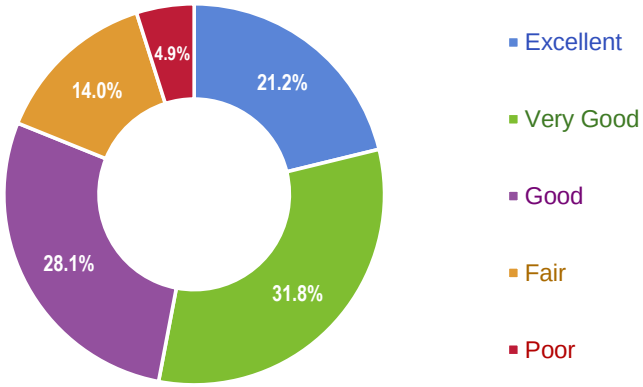



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 95, 344]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

## Ratings of Local Mental Health Care

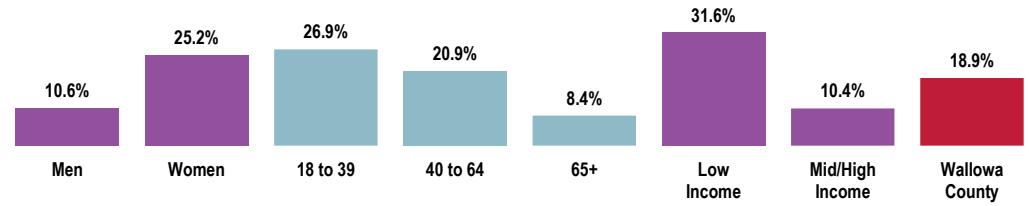
**"In general, how would you rate the overall mental healthcare services available to you? Would you say: excellent, very good, good, fair, or poor?"**

### Ratings of Local Mental Health Care
(Wallowa County, 2022)




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 332]
Notes: ● Asked of all respondents.

## Local Mental Health Care is “Fair/Poor”
(Wallowa County, 2022)

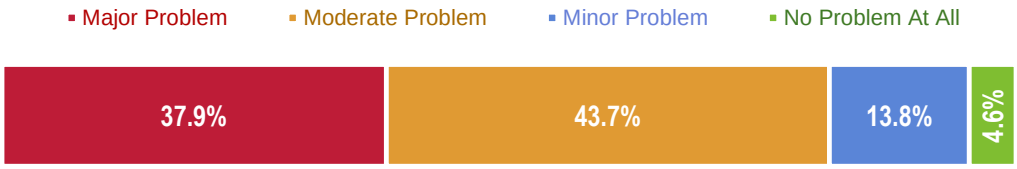



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 332]
Notes: ● Asked of all respondents.

## Key Informant Input: Mental Health

The following chart outlines key informants’ perceptions of the severity of *Mental Health* as a problem in the community:

### Perceptions of Mental Health as a Problem in the Community
(Key Informants, 2022)




Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

### Contributing Factors

> Our local Wallowa Valley Center for Wellness has a number of effective programs. Their A & D program handles quite a few cases. The Center for Wellness operates at least 2 residences for people with mental disabilities and there is one private residence that I know of. The VA program is active and Winding Waters Clinic employs counselors to work with clients in person and on-line. Safe Harbors works with victims of abuse. The county problems for mental health occur from reluctance of people who need psychological help to seek it out and the enormous amount of alcohol addiction in the county. When someone has an extreme critical meltdown, they must be transported out of the county by the sheriff's department; and that causes issues for law enforcement. Identification privacy rules limit the amount of information in the county and the majority of citizens do not understand the problems. – Community Leader

Lack of resources. There is a gap between the criminal justice system and mental health services, such that mentally ill people end up in jail where they do not belong. Those who are mentally committed, have not been able to be placed in a secure facility due to COVID limitations/shut downs, and are released back out into the community, where they commit new crimes and end up in jail. Those who don't meet criteria for commitment, continue to commit low level crimes, placing themselves in danger, and victimizing others in the community, but are not dangerous enough to hold in jail, so get released back out into the community, where they commit more crimes. – Community Leader

Our mental health system is stretched thin. It is hard for the Center for Wellness to hire more people because they are not able to pay particularly well and there is a housing shortage in the County so they can't recruit effectively from outside of the County. We need more staff. We also need more specialized trainings for mental health practitioners to understand concerns from people who are LGBTQIA+, BIPOC, religious minorities, and neurodivergent, such as autistic. Wallowa County is so rural that it is easy to feel isolated. Our culture also tears down those who are different, often especially in the schools, which can contribute to mental health issues for students. We need to foster more acceptance, understanding, and support of people with all different kinds of identities to reduce alienation. – Social Service Provider

Access to psychiatry (inpatient especially, outpatient as well). When in mental health crisis patients often sit in the hospital for days/weeks waiting for placement. This is not a great situation as we do not have ready access to psychiatrists to help manage these patients. Anonymity seems to be an issue for many patients as well as they do not want to share their psychiatric struggles with someone who lives here in the community. – Physician

Limited access to services or not enough for proper treatment. I also think there is a stigma that we are constantly fighting to reach out for mental health services. – Social Service Provider

Access to the system, from personal experience, access to the center for wellness was clunky and not exactly welcoming, after a first time experience that didn't go well during a vulnerable time I am very reluctant to reach out to them again. We are a community that wants to "get things done" and sometimes getting things done takes priority over being persistent with accessing mental health services, the name mental health carries a stigma with it and an idea that mental health is for "those people" or "other people, but I don't need it..." – Social Service Provider

Access to education regarding mental health care. Mental Health is still treated as a social stigma. – Community Leader

There are no local mental health representatives for people of color, LGBTQ specific representatives. There is still stigmatized relationship to mental health for our population that prevent residents from coming forward. – Community Leader

With the pandemic, political stresses, fiscal stresses there has been an increase of individuals in crisis, increase in suicide completion and attempts. Increase of individuals being seen for mental health related issues. – Community Leader

For those with housing assistance – assimilating in the community. These people are blamed for and are seen to be securing all the housing that otherwise would be available for the medium wage workforce. People are not able to move here to take new positions because they cannot find adequate housing. For those who are functioning in a work/home environment it is the stigma and fear of people knowing they are suffering. It keeps them from seeking help when they need it. – Community Leader

Our students thankfully have access to great counselors, sometimes the issue is the fear of talking about mental health and then engaging the family in the process. I also believe the pandemic has heightened concerns over a variety of topics that have really spiked concerns with mental health with a lot of people in our community. Some of the issues revolve around people not asking for help, not knowing where to go for help, and understanding that it is ok to talk to a therapist or others about mental health. – Community Leader

## Access to Care/Services

Registration for The Wellness Center for an appointment is very overwhelming and time consuming. To meet with a psychologist or psychiatrist through WWMC can be difficult due to the providers slim schedule options. I would also like to see an option for group meetings so people with mental illness can talk with other people with mental illnesses. – Community Leader

There is Mental Health services in our community but not a lot of follow up or follow through. There are also not a lot of placement opportunities in the State of Oregon for these people. There seem to be more people with mental health issues than we have services for – Public Health

There is no available help nearby. – Community Leader

There is a small mental health ad log facility. Then Winding Waters contracted the psychiatrist that only their patients can see this doctor, kicking out the majority of the community to this service. – Other Health Provider

Access to mental health services that are appropriate and timely. – Community Leader

Limited access to care. Great care for persistently and chronically mentally ill, but not as much access to universal or daily mental health. – Social Service Provider

There is frequently a need for family respite, extended treatment, therapeutic foster care and such. – Community Leader

> The intake process for people to access traditional mental health is time consuming and creates a barrier to people accessing the care they need. – Public Health

### Denial/Stigma

> Confidentiality and cultural stigma. – Community Leader
>
> There's a stigma when it comes to admitting and helping people with mental health issues. I think an education campaign would be helpful. In schools, in articles in the paper and on the radio. Again, there's not a go-to source for Wallowa community members to learn. – Community Leader
>
> Mental health is a stigma condition and many people don't want to reach out for the help they can get through an amazing program like Center for Wellness. I feel that during a time like now our community is divided and people are struggling and the connection is being lost of STRONG COMMUNITY! – Social Service Provider
>
> Stigma. – Social Service Provider

### Diagnosis/Treatment

> Lack of supervision. Accessing individuals and whether or not they are safe to be in our family communities. In Enterprise specifically, we have facilities for those with mental health conditions, but they aren't monitored during the day. – Community Leader

### Lifestyle

> They being willing to seek and receive the services they need. The services are there, but parents are unwilling to attend or to get the help they need or allow their child to get the preventative help that is needed. – Community Leader

### Awareness/Education

> Where do you go?  What resources are there out there?  I don't know. – Community Leader

### Senior Population

> Elder isolation. – Physician

### Lack of Providers

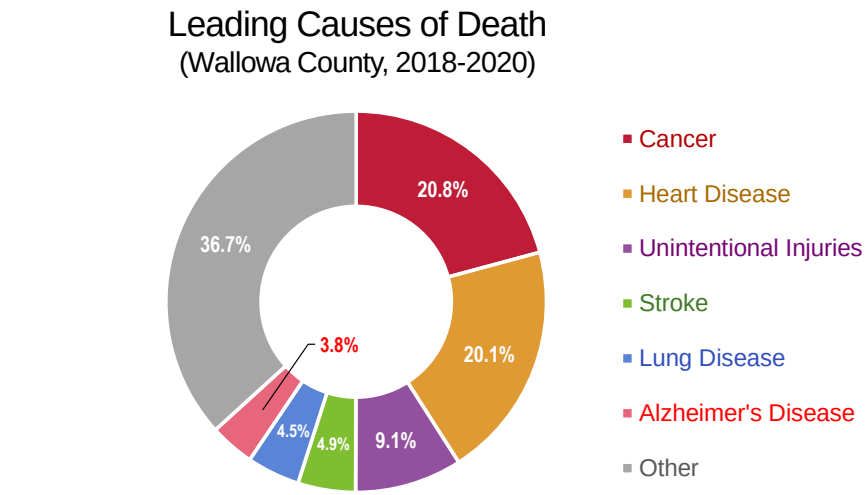
> Not having a medical management specialist here. – Other Health Provider

# DEATH, DISEASE & CHRONIC CONDITIONS

## Leading Causes of Death

### Distribution of Deaths by Cause

Cancers and heart disease are leading causes of death in the community.




Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
Notes: ● Lung disease is CLRD, or chronic lower respiratory disease.

### Age-Adjusted Death Rates for Selected Causes

#### AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, Oregon and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these "age-adjusted" rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in Wallowa County.

For infant mortality data, see *Birth Outcomes & Risks* in the **Births** section of this report.

## Age-Adjusted Death Rates for Selected Causes
(2018-2020* Deaths per 100,000 Population)

| | Wallowa County | Oregon | US | HP2030 |
|---|---|---|---|---|
| **Malignant Neoplasms (Cancers)** | 123.1 | 147.1 | 146.5 | 122.7 |
| **Diseases of the Heart** | 120.2 | 131.1 | 164.4 | 127.4** |
| **Falls [Age 65+]** | 109.2 | 99.1 | 61.6 | 63.4 |
| **Unintentional Injuries** | 67.2 | 47.2 | 51.6 | 43.2 |
| **Chronic Lower Respiratory Disease (CLRD)** | 28.0 | 37.5 | 39.1 | — |
| **Cerebrovascular Disease (Stroke)** | 27.6 | 39.1 | 37.6 | 33.4 |
| **Intentional Self-Harm (Suicide)** | 24.8 | 18.2 | 13.3 | 12.8 |
| **Diabetes** | 17.3 | 23.6 | 21.7 | — |
| **Pneumonia/Influenza** | 13.5 | 9.1 | 14.4 | — |

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov.

Note:
- *Rates reflect 2018-2020 deaths or most recent available.
- **The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

# Cardiovascular Disease

## ABOUT HEART DISEASE & STROKE

Heart disease is the leading cause of death in the United States, and stroke is the fifth leading cause. …Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

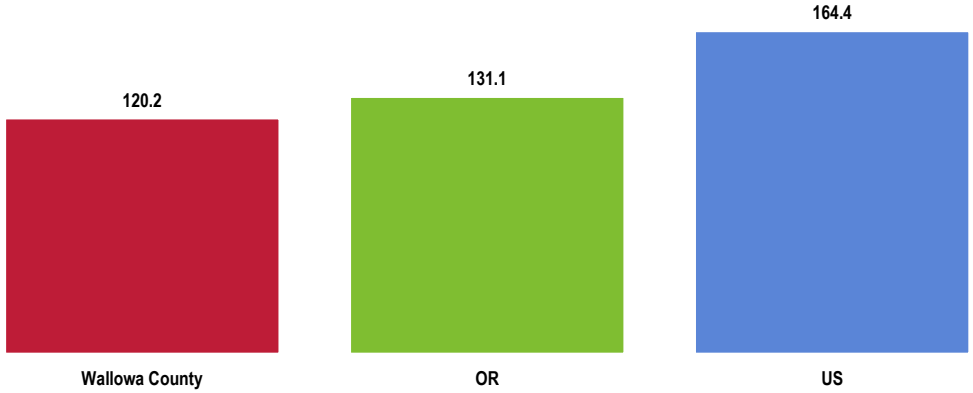
## Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.

### Heart Disease: Age-Adjusted Mortality

(2018-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 127.4 or Lower (Adjusted)



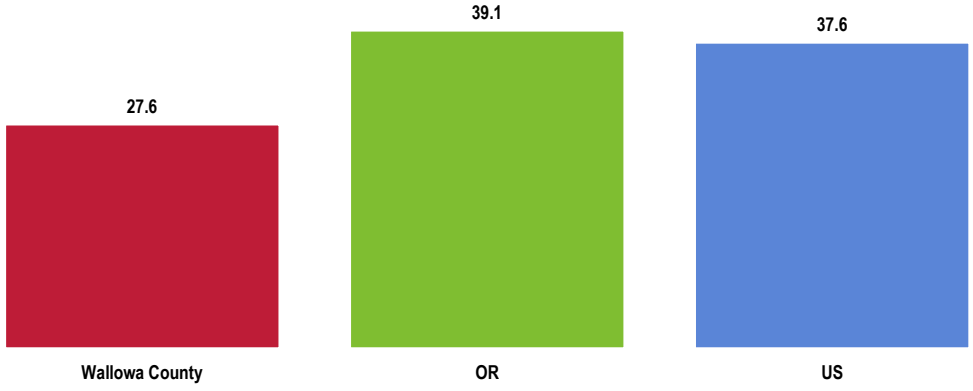

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- The Healthy People 2030 Heart Disease target is adjusted to account for all diseases of the heart.

### Stroke: Age-Adjusted Mortality

(2016-2020 Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



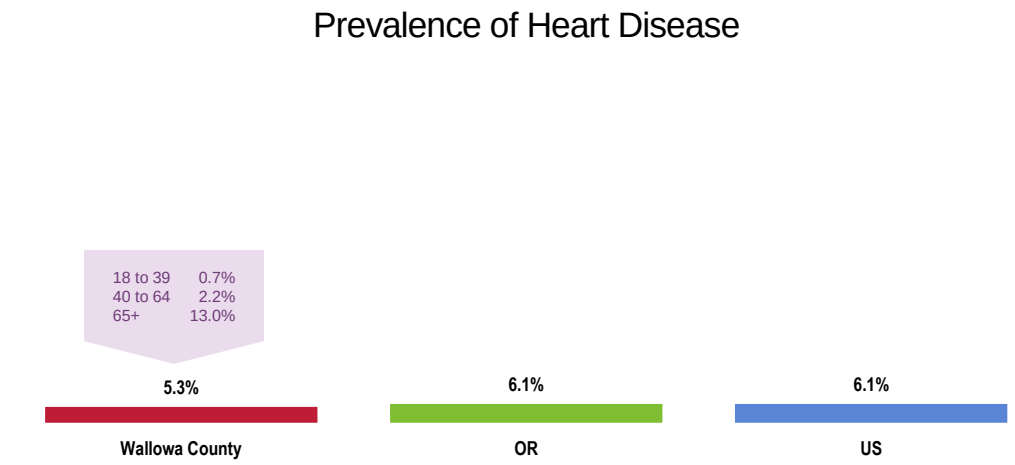

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

## Prevalence of Heart Disease & Stroke

**"Has a doctor, nurse, or other health professional ever told you that you had:**

- A heart attack, also called a myocardial infarction?
- Angina or coronary heart disease?"

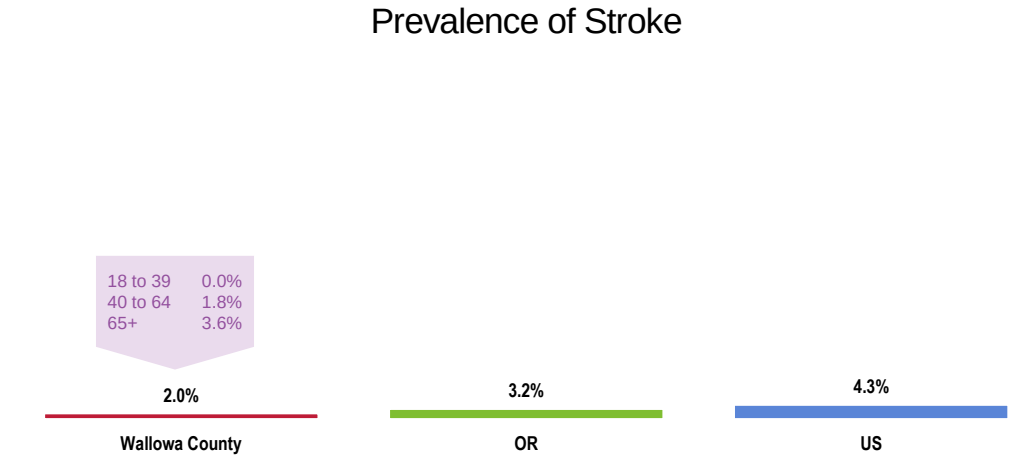
Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 114]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes diagnoses of heart attack, angina, or coronary heart disease.

**"Has a doctor, nurse, or other health professional ever told you that you had a stroke?"**




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 29]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

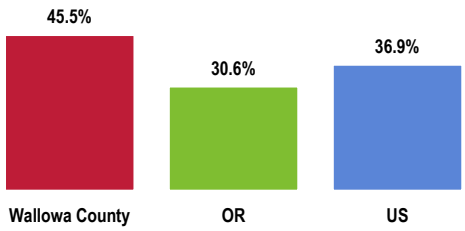
## Cardiovascular Risk Factors

### Blood Pressure & Cholesterol

**"Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"**

**"Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?"**

Prevalence of
High Blood Pressure
Healthy People 2030 = 27.7% or Lower




Prevalence of
High Blood Cholesterol


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 35-36]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

## Total Cardiovascular Risk

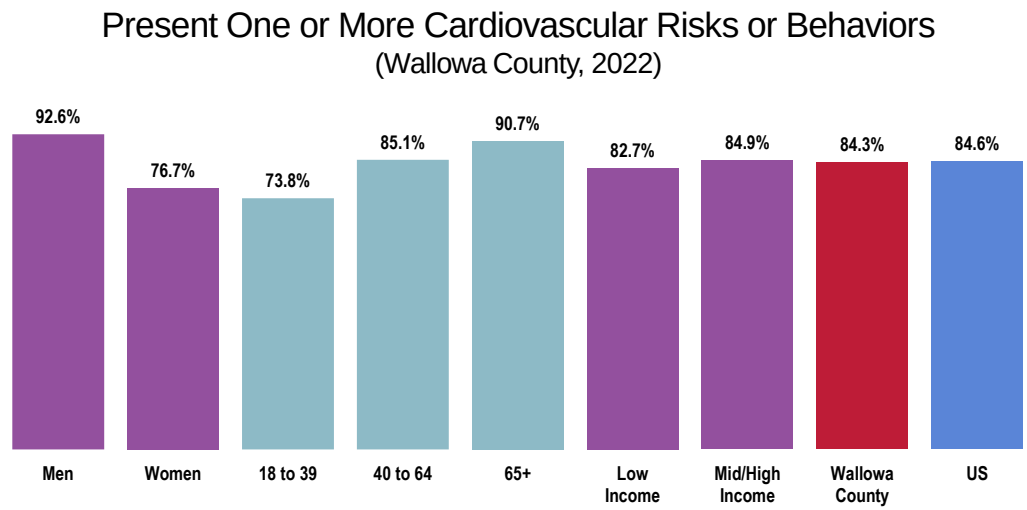
RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

Total cardiovascular risk reflects the individual-level risk factors which put a person at increased risk for cardiovascular disease, including:

- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

Modifying these behaviors and adhering to treatment for high blood pressure and cholesterol are critical both for preventing and for controlling cardiovascular disease.

The following chart reflects the percentage of adults in Wallowa County who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol.

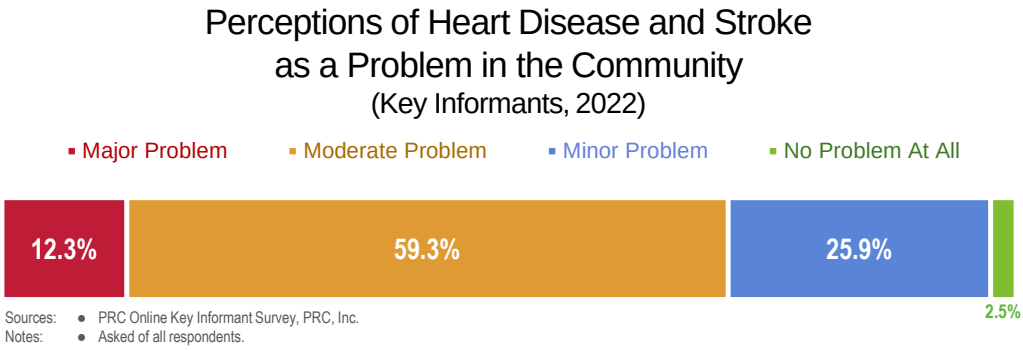



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 115]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.
- Cardiovascular risk is defined as exhibiting one or more of the following: 1) no leisure-time physical activity; 2) regular/occasional cigarette smoking; 3) high blood pressure; 4) high blood cholesterol; and/or 5) being overweight/obese.

## Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants' perceptions of the severity of *Heart Disease & Stroke* as a problem in the community:




Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

### Lack of Local Care Options

> A lot of heart and stroke patients travel out of the country for care of their issues. It would be great if they could receive more of that care here. – Community Leader
>
> Again, no nearby health care. – Community Leader
>
> We are a distance from trauma care and heart specialists. – Community Leader

### Aging Population

> I see a lot of this in the elderly patients. – Other Health Provider
>
> Older population, lots of heart disease and strokes. – Physician

### Contributing Factors

> Baby boomers are a large group and the age group that is susceptible. Also diets and exercise. We should get Chips program back. – Community Leader

### Co-Occurrences

> We have a large population with high risk chronic conditions that lead to heart disease and stroke. – Physician

### Incidence/Prevalence

> Again, it seems to be that more individuals are struggling with heart disease and strokes, especially at younger ages. – Community Leader

### Lifestyle

> The lifestyle choices people make in the community, as with most Americans, contributes significantly to the development of heart disease, stroke, diabetes and hypertension. – Physician

# Cancer

## ABOUT CANCER

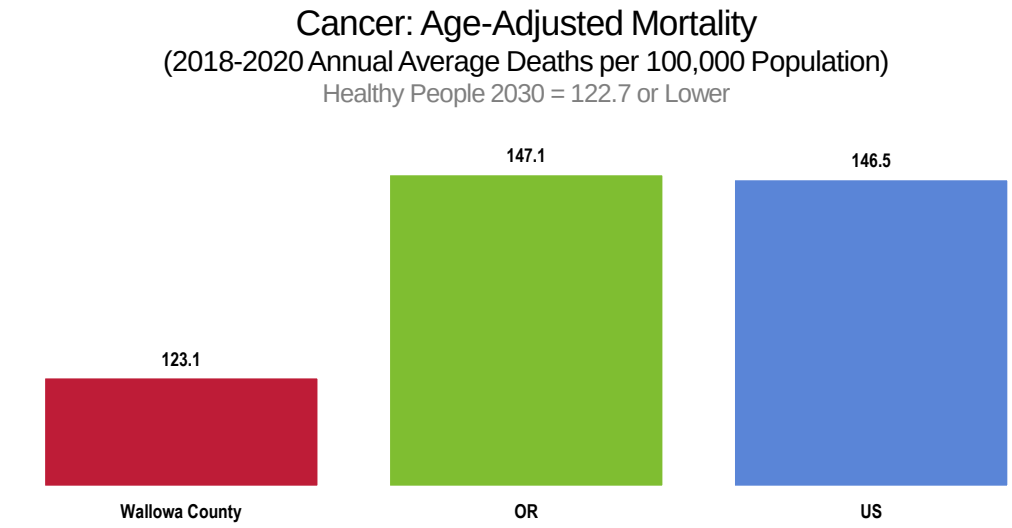
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

## Age-Adjusted Cancer Deaths

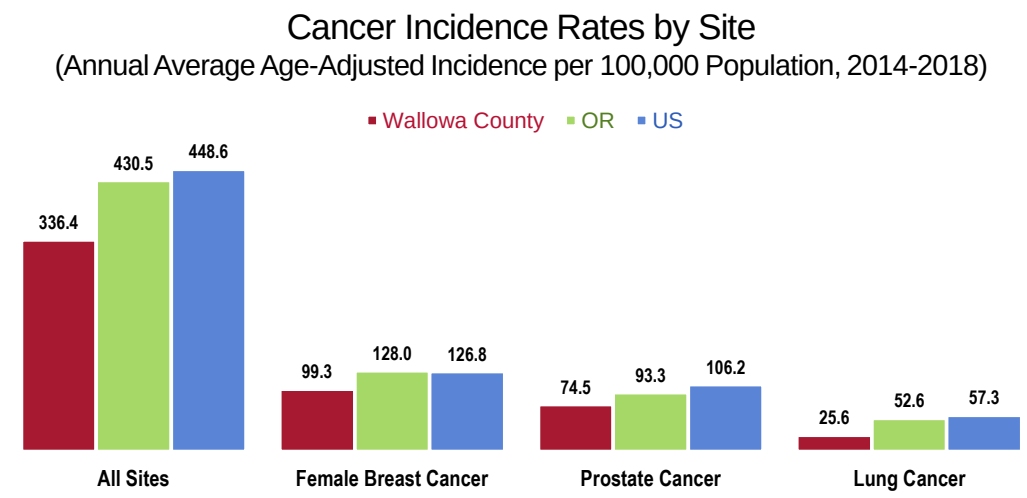
The following chart illustrates age-adjusted cancer mortality (all types) in Wallowa County.




Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

## Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.




Sources:
- State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

### ABOUT CANCER RISK

Reducing the nation's cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

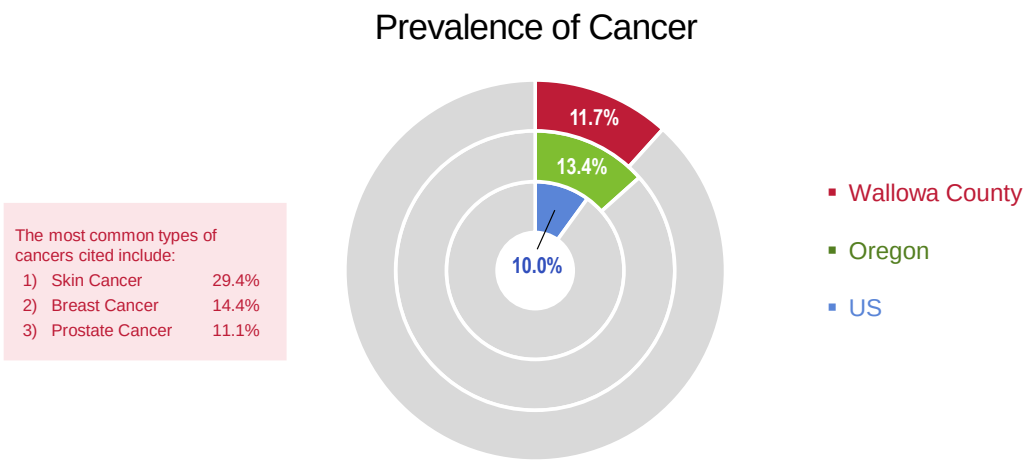
- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
  - National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

## Prevalence of Cancer

**"Have you ever suffered from or been diagnosed with cancer?"**

RELATED ISSUE
See also *Nutrition, Physical Activity & Weight* and *Tobacco Use* in the **Modifiable Health Risks** section of this report.

**"Which type of cancer were you diagnosed with?** (If more than one past diagnosis, respondent was asked about the most recent.)




The most common types of cancers cited include:

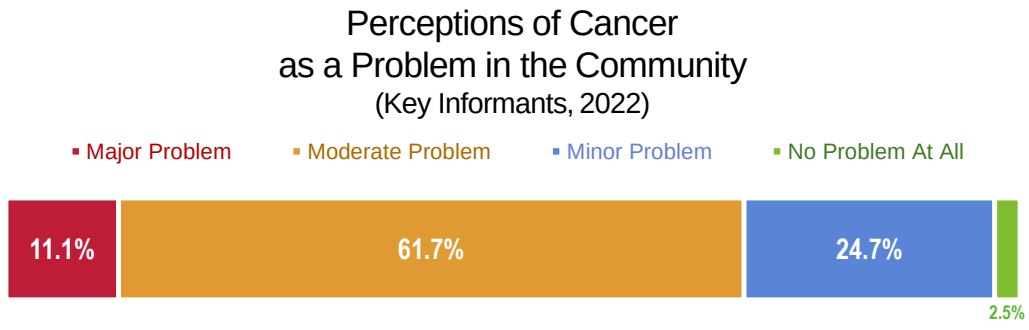
| | | |
|---|---|---|
| 1) | Skin Cancer | 29.4% |
| 2) | Breast Cancer | 14.4% |
| 3) | Prostate Cancer | 11.1% |

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 25-26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Reflects all respondents.

## Key Informant Input: Cancer

The following chart outlines key informants' perceptions of the severity of *Cancer* as a problem in the community:




Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

### Lack of Local Care

> An abnormally large part of community has dealt with cancer and is mostly treated outside of this county. – Community Leader
>
> I seem to encounter many people with cancer, and they often have to travel moderate distances, 70 to 120 miles, for treatment. – Social Service Provider

> From my understanding we do not have the facilities to care for our cancer patients in the county. A recent friend had to travel to Walla Walla for 15-minute daily radiation treatments. Four hours of driving, finding someone each day to drive you and then making it home. – Community Leader
>
> I think this is an area of concern and if there is a diagnosis, cancer care access is limited in the area. – Community Leader

### Incidence/Prevalence

> The percentage of population being treated or have been treated for cancer in any form. – Community Leader
>
> Troy has had several people contract cancer in the last few years and at least one death. – Community Leader
>
> Anecdotally it feels like cancer rates are climbing in Wallowa County. – Community Leader
>
> So many cases of cancer in all ages, sometimes treatable and sometimes not. – Community Leader

### Aging Population

> Older population, lots of cancer. – Physician

# Respiratory Disease

## ABOUT RESPIRATORY DISEASE

Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

Interventions tailored to at-risk groups can also help prevent and treat other respiratory diseases — for example, pneumonia in older adults and pneumoconiosis in coal miners. And increasing lung cancer screening rates can help reduce deaths from lung cancer through early detection and treatment.

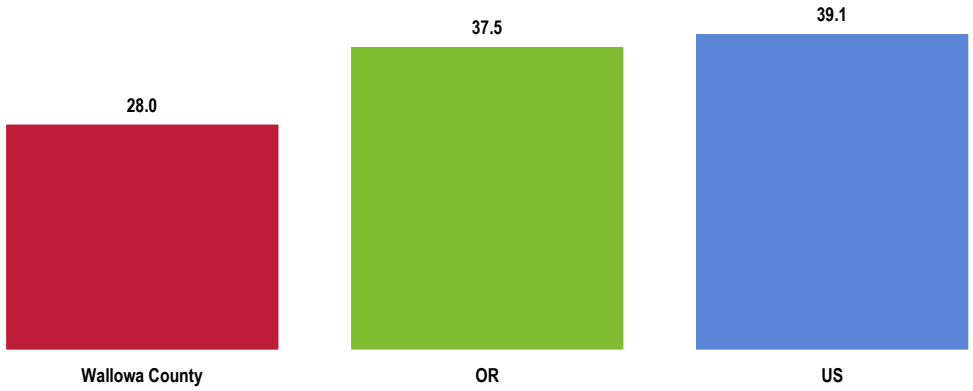
– Healthy People 2030 (https://health.gov/healthypeople)

## Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis. Mortality for CLRD is illustrated in the charts that follow.

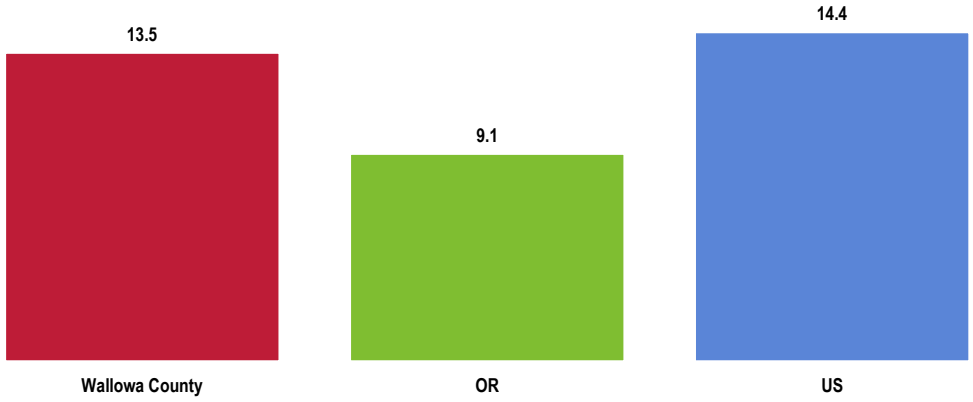
Pneumonia and influenza mortality is also illustrated.

## CLRD: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)




Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
Notes: ● CLRD is chronic lower respiratory disease.

## Pneumonia/Influenza: Age-Adjusted Mortality
(2011-2020 Annual Average Deaths per 100,000 Population)



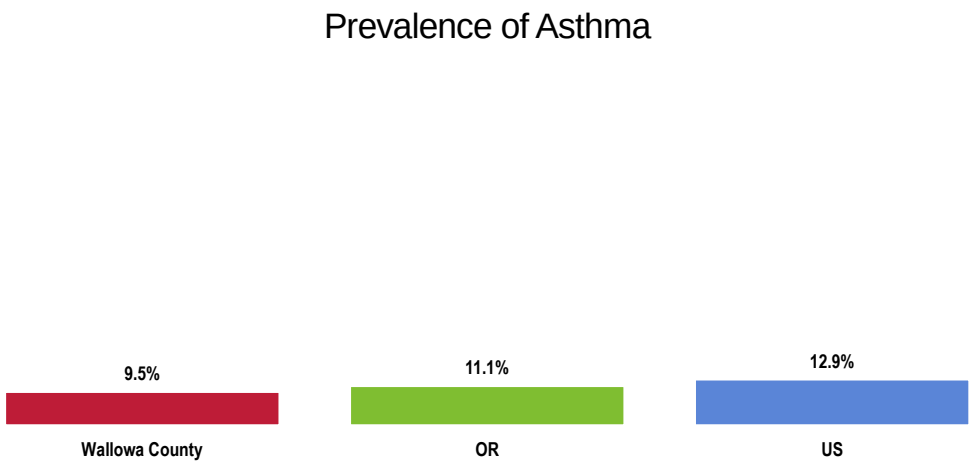

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.

## Prevalence of Respiratory Disease

### Asthma

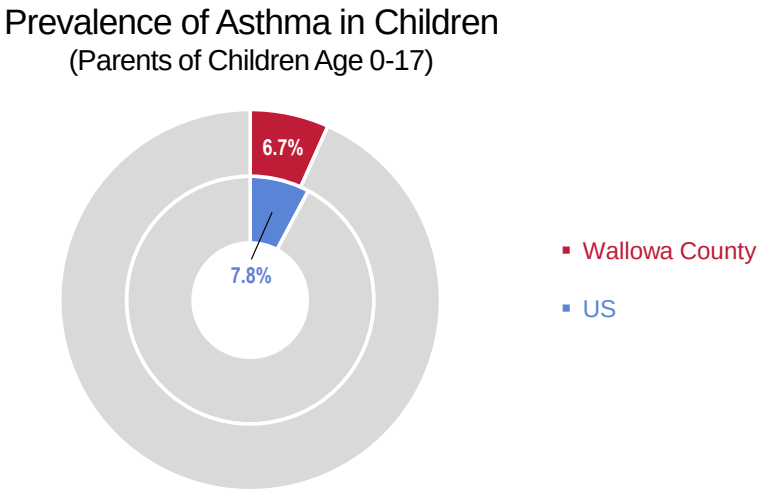
ADULTS ► **"Have you ever been told by a doctor, nurse, or other health professional that you had asthma?" and "Do you still have asthma?"** (Calculated here as a prevalence of all adults who have ever been diagnosed with asthma and who still have asthma.)

CHILDREN ► **"Has a doctor or other health professional ever told you that this child had asthma?" and "Does this child still have asthma?"** (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma.)




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 119]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those who have ever been diagnosed with asthma and report that they still have asthma.



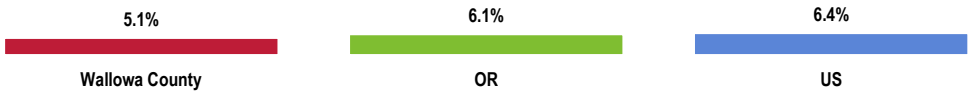

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 120]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma and are reported to still have asthma.

## Chronic Obstructive Pulmonary Disease (COPD)

**"Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?"**

Prevalence of
Chronic Obstructive Pulmonary Disease (COPD)



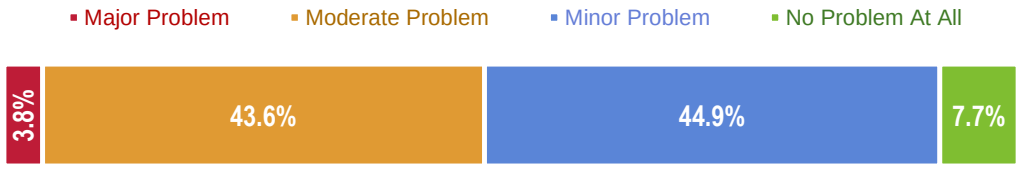

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.

# Key Informant Input: Respiratory Disease

The following chart outlines key informants' perceptions of the severity of *Respiratory Disease* as a problem in the community:

Perceptions of Respiratory Diseases
as a Problem in the Community
(Key Informants, 2022)




Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

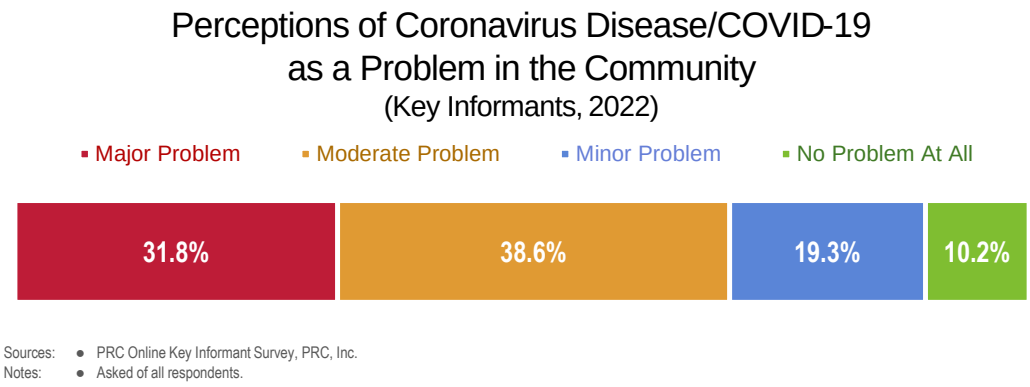
Among those rating this issue as a "major problem," reasons related to the following:

### Contributing Factors

> Older population, decent amount of smoking so decent amount of COPD. – Physician
>
> Smoking, lack of exercise. – Community Leader

## Key Informant Input: Coronavirus Disease/COVID-19

The following chart outlines key informants' perceptions of the severity of *Coronavirus Disease/COVID-19* as a problem in the community:




Among those rating this issue as a "major problem," reasons related to the following:

### Lack of Adherence to Public Health Mitigation Measures

> Wallowa County citizens are not taking personal responsibility for curbing the spread of the disease. Not enough getting vaccine and way too many not wearing masks in public. – Community Leader
>
> Many cases, lots of vaccine hesitancy and mask hesitancy. – Physician
>
> Because of our low vaccination rate, high positivity rate, lack of leadership in our community on this topic and high resistance to any sort of mandates. Go to any store in the community and chances are the employees won't be wearing masks and maybe half the shoppers are. – Community Leader
>
> Covid 19 is a major problem because our community is not taking the threat seriously. People are going about their normal lives, unvaccinated, not wearing masks, and not distancing. This is reflected in our case counts. – Social Service Provider
>
> Too many people are not getting vaccinated and aren't wearing masks. After a few months of comfort in being vaccinated, we are back to distancing and wearing masks. Because of our skyrocketing numbers, are health care providers are working so hard to care for those getting sick – Community Leader
>
> It has divided the community. There are people within the health field, or at the edges of it, including a retired doc, who are anti-vax. People are blaming deaths on the underlying conditions, when taking care of covid would have saved their lives. Masks have been largely abandoned by storekeepers and customers. The county leadership has not taken strong stands on vaccines and masking, and we are, with the rest of Eastern Oregon, suffering for it. – Community Leader
>
> Many people in the community that will not mask and won't be vaccinated because the pandemic has been so politicized. – Community Leader
>
> Not enough people are willing to take precautions, follow medical advice or get vaccinated. – Social Service Provider
>
> Many people coming from outside of Troy refuse to mask up. – Community Leader
>
> We currently have the second-highest rate of COVID transmission in the entire state. Our county commissioners don't think it is a problem and think that affirming the value of "freedom" and "individual choice" is more important than keeping people healthy or saving people's lives. Folks refuse to get vaccinated or wear a mask, the two things most proven to reduce transmission of COVID. Due to tension between the county commissioners and the state, I don't even know whether a mask mandate is currently in place in businesses here – everything at this point seems to be up to personal/business/agency choice (other than in schools and medical clinics), and many people are making choices not to mask or vax. I believe our rate of transmission is currently higher than it has ever been, and it keeps getting worse. People are getting sick and dying. It is not okay. – Social Service Provider
>
> There is a very observable lack of persons following the infection control precautions in the community. People are not wearing their source control masks, not following social distancing, not utilizing hand sanitizer and not testing when they feel sick. This social problem has created community side spread illness that threatens everyone's safety. – Community Leader
>
> Taking the most basic preventative actions, masking, social distancing and taking the vaccine have become political issues. The lack of centralized local tracking, and good messaging that relates to our local residence is inconsistent. – Community Leader

## Contributing Factors

> Covid-19 has been moving through the community at a high rate, putting strain on the local medical resources, and posing a risk to those in the community. It also brings about a psychological response that has been harmful to individuals. – Community Leader
>
> Low percentage of vaccinated people. Lack of hospital space for patients. – Community Leader
>
> The positive covid-19 case count in the county is an obvious problem. Our case count is escalating while the case count in most areas of the country, except some southern states, is declining. Trustworthy modeling projections by UW epidemiologists show that the actual number of covid positivity figures are at least double what is reported; I suspect that is an underestimate in Wallowa County. I am disappointed in the weak community public health outreach campaign by our community leaders, including the hospital. There are at least 3 MDs with MPH degrees as well as PR officials. Yet all we see are occasional Facebook messages. Many older people don't "do" Facebook. A more robust public health outreach campaign to encourage adoption of covid prevention measures (vaccinations, masks) is needed: repeated messaging from MDs/RNs in the Chieftain, radio, billboards around town with the face of our MDs more visible. – Community Leader

## Lack of Vaccination Coverage

> The vaccination rate is low, test positivity rate is high. There is a lot of division around the topic in general which is leading to mental health issues related to Covid. – Public Health
>
> Unwillingness of individuals to get vaccinated, leading to firing of employees and lack of staff causing stress and major problems of work life balance on vaccinated staff. – Other Health Provider
>
> Too many individuals who refuse vaccinations and following public health mitigation. – Community Leader
>
> There are still many people that are not willing to vaccinate or wear masks in public, even in medical educational settings where they are more restrictive. – Community Leader
>
> There are community members who will not get the vaccine because they feel it will harm them rather than protect them. They are reading and hearing incorrect information and wrongly blaming the government. Re-education is essential for these people. – Community Leader
>
> Covid 19 is running rampant in our community. The problem comes in because there is an easy solution and people are turning it political. It is a very frustrating time to work in healthcare. Normally patients take our advice to heart and now they have the answers themselves. I wish our leaders in the county would be more vocal. Vaccine mandates are nothing new in our country. Everyone is acting like this is the first time this has happened. Our leadership should show that vaccine mandates are already in place and try to squash rumors instead of feeding them. – Other Health Provider
>
> I will also use this space to say that I find it appalling that all health care workers are not required to be vaccinated against COVID. I am avoiding my own preventive care because I don't want to expose myself to COVID in a clinic setting, and do not trust that I am safe there. – Community Leader

## Denial/Stigma

> I don't believe enough people think the disease is real. There is more concern with right-fighting than preventing the spread of Covid. – Community Leader
>
> Far too many deny or don't take seriously the disease, and especially the shared responsibility and shared cost of the disease. – Community Leader

## Incidence/Prevalence

> At this time, the Delta variant is spreading and the number of cases we have is putting a strain on our health care workers and health care system. – Social Service Provider

## Lifestyle

> Personal choice. – Social Service Provider

# Injury & Violence

## ABOUT INJURY & VIOLENCE

**INJURY ►** In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

**VIOLENCE ►** Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

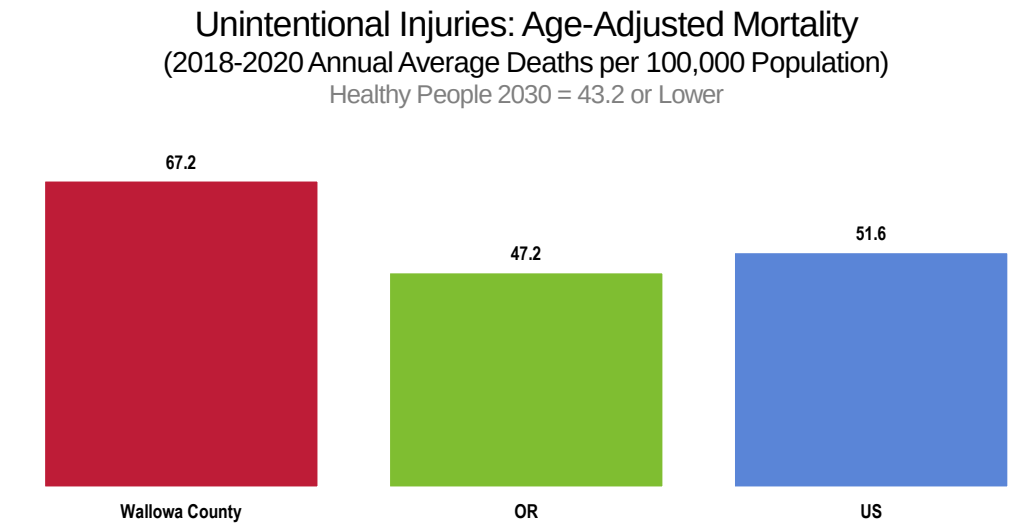
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

## Unintentional Injury

### Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area.

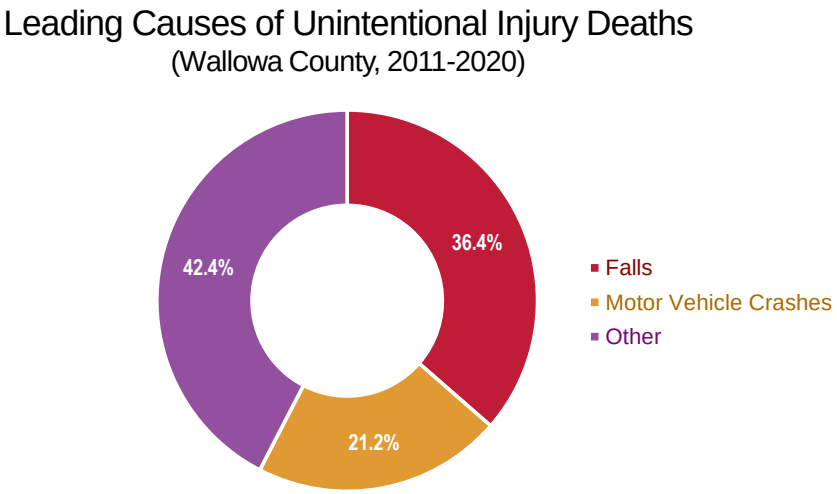



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

## Leading Causes of Unintentional Injury Deaths

RELATED ISSUE
For more information about unintentional drug-related deaths, see also *Substance Abuse* in the **Modifiable Health Risks** section of this report.

Leading causes of accidental death in the area include the following:



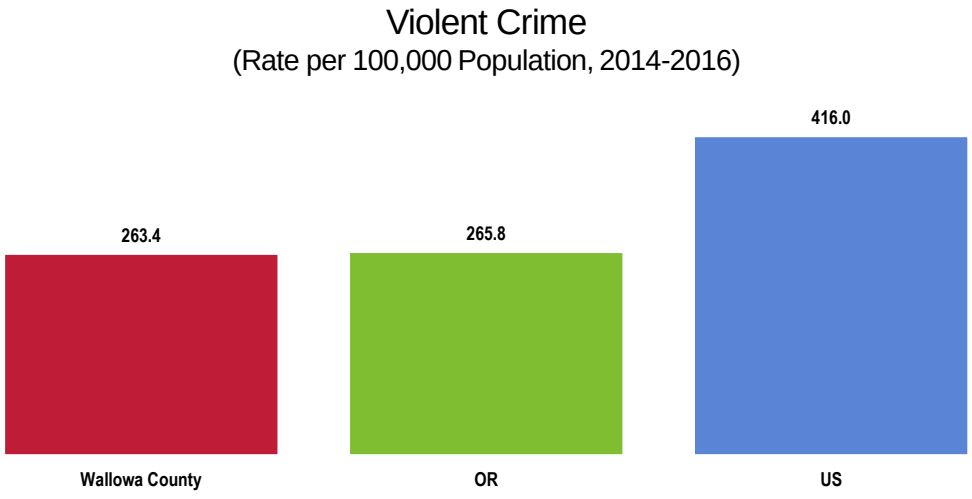

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.

# Intentional Injury (Violence)

## Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.




Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
- Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

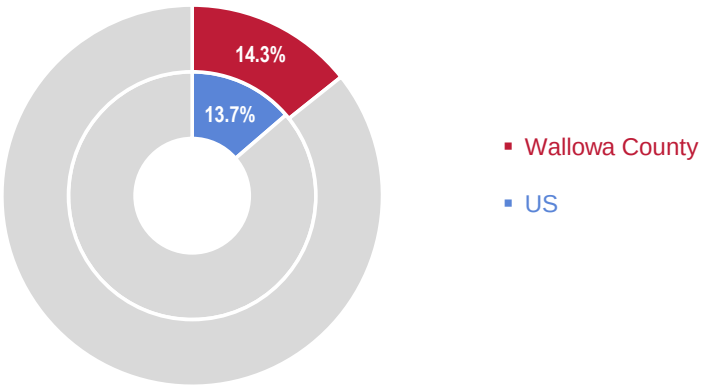
VIOLENT CRIME EXPERIENCE ► **"Have you been the victim of a violent crime in your area in the past 5 years?"**

## Victim of a Violent Crime in the Past Five Years
(Wallowa County, 2022)


Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 38]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

INTIMATE PARTNER VIOLENCE ► **"The next questions are about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"**

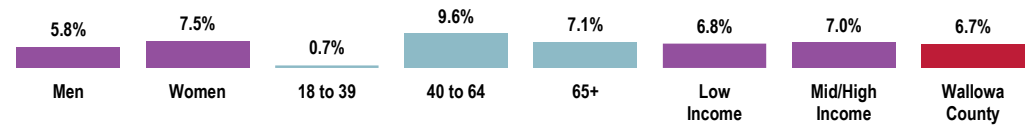
## Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 39]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

**"In your living situation, do you feel safe from verbal, emotional, or physical abuse?"**

Feel Verbally, Emotionally, or Physically Unsafe at Home
(Wallowa County, 2022)

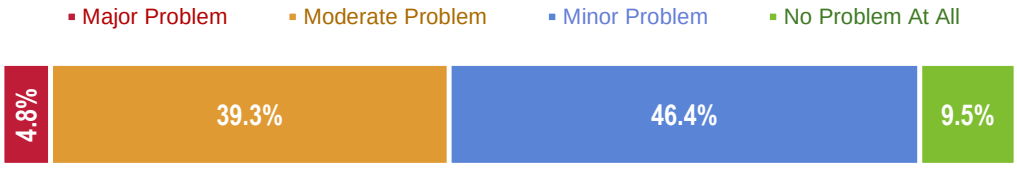



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 313]
Notes: ● Asked of all respondents.

## Key Informant Input: Injury & Violence

The following chart outlines key informants' perceptions of the severity of *Injury & Violence* as a problem in the community:

Perceptions of Injury and Violence as a Problem in the Community
(Key Informants, 2022)




Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

### Contributing Factors

> Specifically, I think that domestic violence is a major issue here because of culture and isolation. And because of lifestyles, injuries are inevitable. – Community Leader
>
> Our county has disproportionately high rates of domestic violence. Wallowa County is an easy place for abusers to isolate and hide the people they abuse, whether they are originally from the County or came here specifically because it was an easy place to isolate the people they abuse (this happens more often than one might guess). Violence is not only in shootings, stabbings, or physical injury. Violence exists in the ways our culture here alienates and isolates those it considers "other." The ways that lower-income and LGBTQIA+ students are bullied. The hate crimes that have been committed against minorities, including LGBTQIA+ people and religious minorities such as Jews. Alienation, bullying, and hate that cause people to have mental health issues is also violence. All of these are strong here, and major institutions such as schools, the court system, and the police are not preventing them – they are often feeding into them. – Social Service Provider
>
> I am not sure if this qualifies or not, but an issue that could be related health wise is domestic violence, sexual assault, teen violence, etc. I would say for that health concerns need to be combined with safety. Health and safety should be the topic of this survey collectively. – Community Leader

### Intolerance

> I believe that intolerance/hate/xenophobia is a major public health issue as it fosters violence and degrades mental health. I believe it is a major problem in our community because it is a rampant, ingrained part of our culture that exists in all of our institutions, including our schools, our government, our court system, and our police force. Racism, sexism, homophobia, transphobia, anti-Indigenous sentiment, ableism, classism, and other oppressions cause those affected to have much poorer mental and physical health. Our default in this County is to assume that we don't have many "minorities," so it is not an issue. The reality is that we DO have significant numbers of people who are LGBTQIA+, BIPOC, neurodivergent, practice religions other than Christianity, disabled, and poor. We need to pay attention to this and figure out ways of creating a different culture. – Social Service Provider

### Denial/Stigma

> I believe that this county still hides away its victims of violence. – Community Leader

# Diabetes

## ABOUT DIABETES

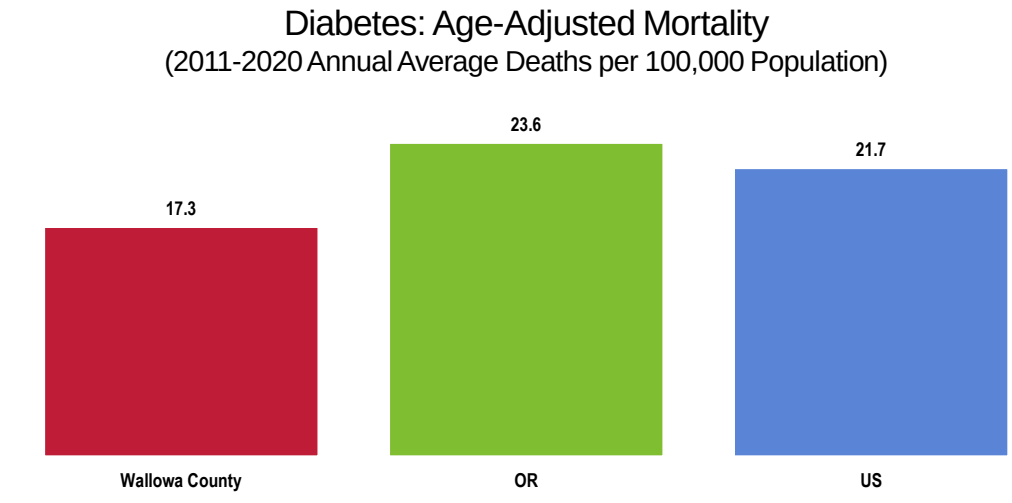
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

## Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart.




Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2021.
Notes: ● The Healthy People 2030 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.

## Prevalence of Diabetes

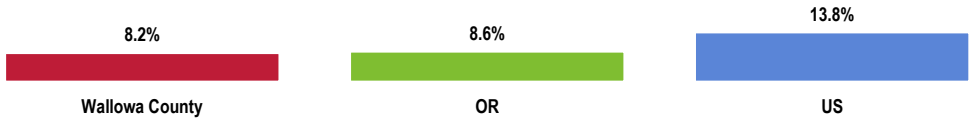
**"Have you ever been told by a doctor, nurse, or other health professional that you have diabetes?** (If female, add: not counting diabetes only occurring during pregnancy?)**"**

**"Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?** (If female, add: other than during pregnancy?)**"**

[Adults who do not have diabetes] **"Have you had a test for high blood sugar or diabetes within the past three years?"**

### Prevalence of Diabetes

Another 19.5% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes. (US = 9.7%)

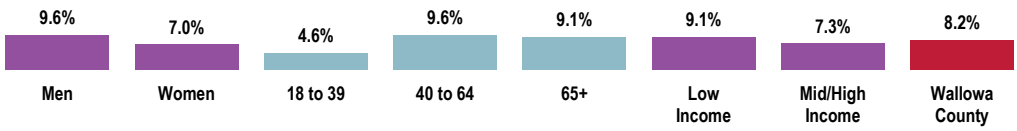



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 121]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

### Prevalence of Diabetes
(Wallowa County, 2022)

Note that among adults who have not been diagnosed with diabetes, 50.9% report having had their blood sugar level tested within the past three years.

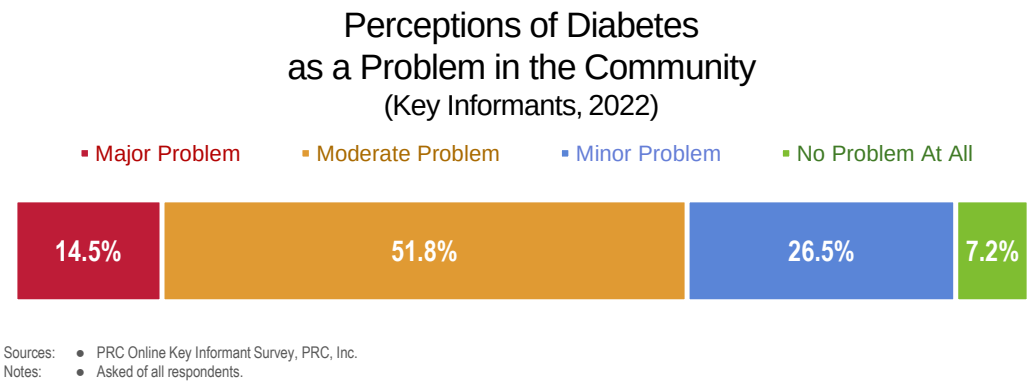



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 33, 121]

Notes:
- Asked of all respondents.
- Excludes gestational diabetes (occurring only during pregnancy).

## Key Informant Input: Diabetes

The following chart outlines key informants' perceptions of the severity of *Diabetes* as a problem in the community:




Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

### Contributing Factors

> Access to affordable healthy eating options and education. The stigma associated with diabetes. – Social Service Provider
>
> Access to healthy food at reasonable cost, lack of exercise and safe accessible places to exercise. – Community Leader
>
> Lack of access to healthy food. Lack of access to nutrition classes that aren't a meatless approach. Lack of access to affordable food. Lack of a gym to work out. Long winters that limit outdoor exercise options. Lack of a pool for exercise. – Social Service Provider
>
> Learning about healthy food choices and having access to healthy food choices that are reasonably priced. Also access to safe places for regular physical activity. – Physician
>
> Healthful diet and exercise to reduce A1C and need for medication. Local gym closed and it is tough for many to exercise in the winter. No public pool for exercise, which would also be great. – Physician

### Access to Affordable Healthy Food

> Following provider recommendations and access to affordable health food choices. – Public Health
>
> Lack of affordable health foods. – Public Health

### Awareness/Education

> Poor information as to lifestyle factors contributing the diabetes and its treatment. – Physician
>
> Healthy choices, education about this in schools. – Other Health Provider

### Access to Care/Services

> No access to dialysis. – Community Leader

# Kidney Disease

## ABOUT KIDNEY DISEASE

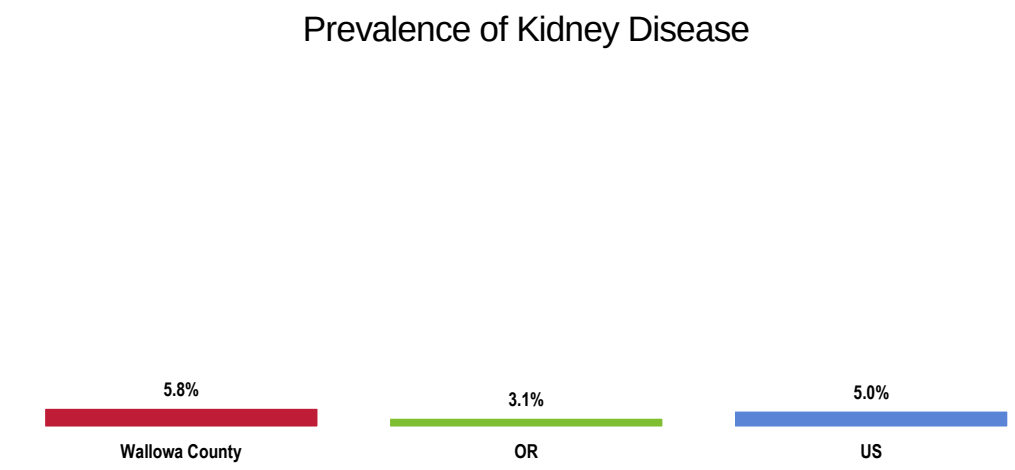
More than 1 in 7 adults in the United States may have chronic kidney disease (CKD), with higher rates in low-income and racial/ethnic minority groups. And most people with CKD don't know they have it. …People with CKD are more likely to have heart disease and stroke — and to die early. Managing risk factors like diabetes and high blood pressure can help prevent or delay CKD. Strategies to make sure more people with CKD are diagnosed early can help people get the treatment they need.

Recommended tests can help identify people with CKD to make sure they get treatments and education that may help prevent or delay kidney failure and end-stage kidney disease (ESKD). In addition, strategies to make sure more people with ESKD get kidney transplants can increase survival rates and improve quality of life.

– Healthy People 2030 (https://health.gov/healthypeople)

## Prevalence of Kidney Disease

**"Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?"**

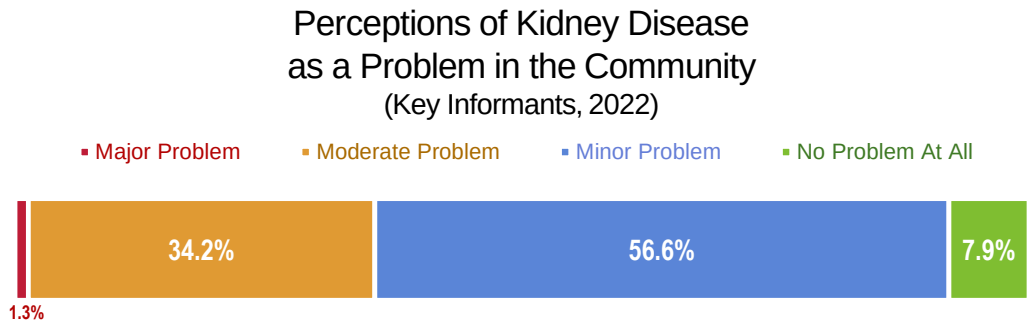



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

## Key Informant Input: Kidney Disease

The following chart outlines key informants' perceptions of the severity of *Kidney Disease* as a problem in the community:




Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

### Aging Population

> Older population, lots of chronic kidney disease. – Physician

# Potentially Disabling Conditions

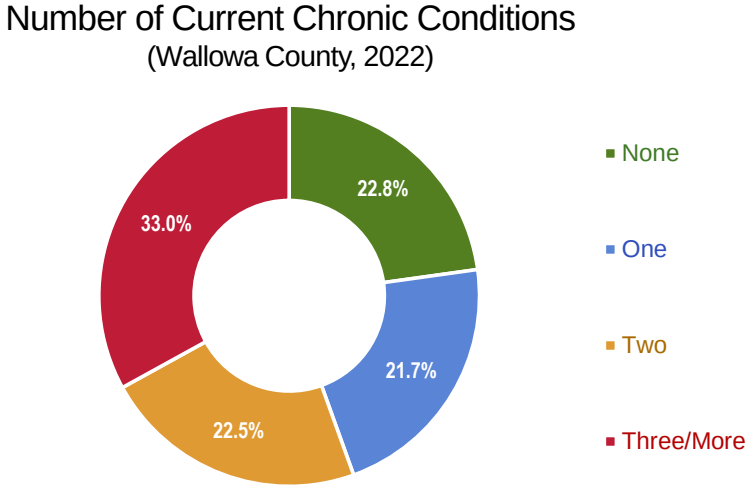
## Multiple Chronic Conditions

The following charts outline the prevalence of multiple chronic conditions among surveyed adults, taking into account all of the various conditions measured in the survey.

For the purposes of this assessment, chronic conditions include:

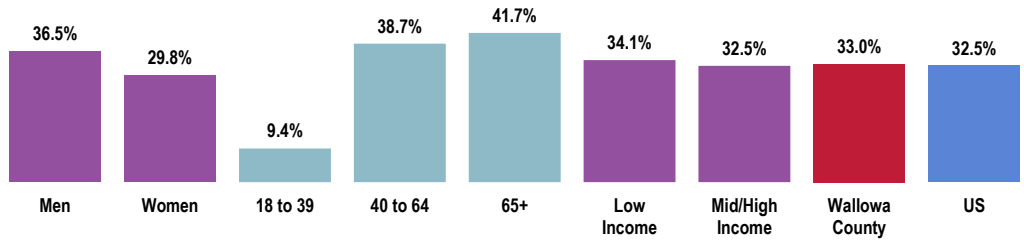
- Asthma
- Cancer
- Chronic pain
- Diabetes
- Heart attack/angina
- High blood cholesterol
- High blood pressure
- Kidney disease
- Lung disease
- Obesity
- Stroke

Multiple chronic conditions are concurrent conditions.




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
Notes: ● Asked of all respondents.
● In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, and/or obesity.

## Currently Have Three or More Chronic Conditions
(Wallowa County, 2022)




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 123]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- In this case, chronic conditions include lung disease, cancer, kidney disease, heart attack/angina, stroke, asthma, high blood pressure, high blood cholesterol, diabetes, high-impact chronic pain, and/or obesity.

# Activity Limitations

### ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

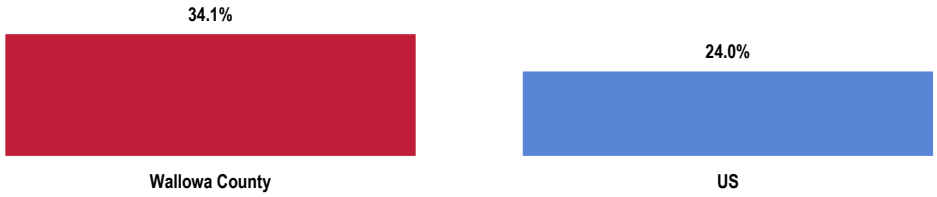
## Prevalence of Limitations

**"Are you limited in any way in any activities because of physical, mental, or emotional problems?"**

[Adults with activity limitations] **"What is the major impairment or health problem that limits you?"**

### Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem

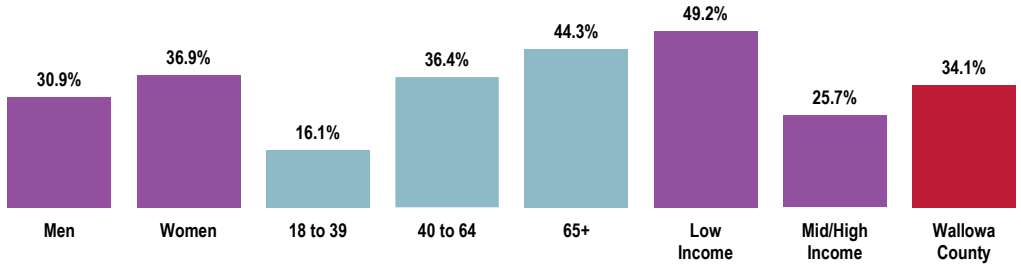
Most common conditions:
- Back/neck problems
- Bone/joint injury
- Arthritis
- Depression/mental health
- Lung/breathing problem
- Walking problem




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 96-97]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

### Limited in Activities in Some Way Due to a Physical, Mental or Emotional Problem
(Wallowa County, 2022)

6.2% of respondents have a disability that requires adjustments or accommodations in order to hold paid employment.

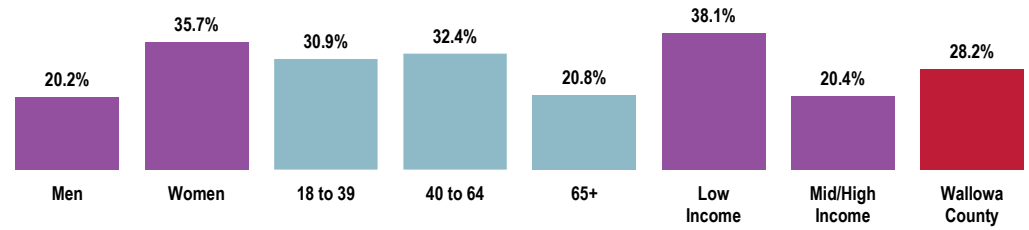



Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 96, 337]
Notes: ● Asked of all respondents.

## Days of Limited Activities

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

### 3+ Days Last Month When Poor Physical or Mental Health Limited Activities
(Wallowa County, 2022)




Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 338]
Notes: • Asked of all respondents.

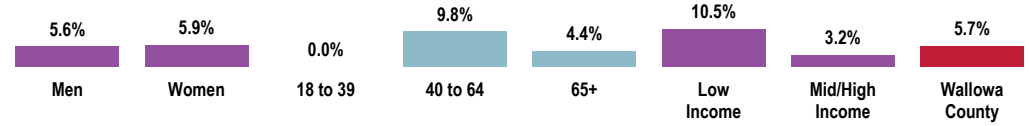
## Limitations & Employment

**"Does a physical, mental, or emotional health issue prevent you from getting or keeping a job?"**

**"Do you have any disability that requires adjustments or accommodations for you to hold paid employment?"**

### Physical, Mental, or Emotional Health Issue Prevents Employment
(Wallowa County, 2022)

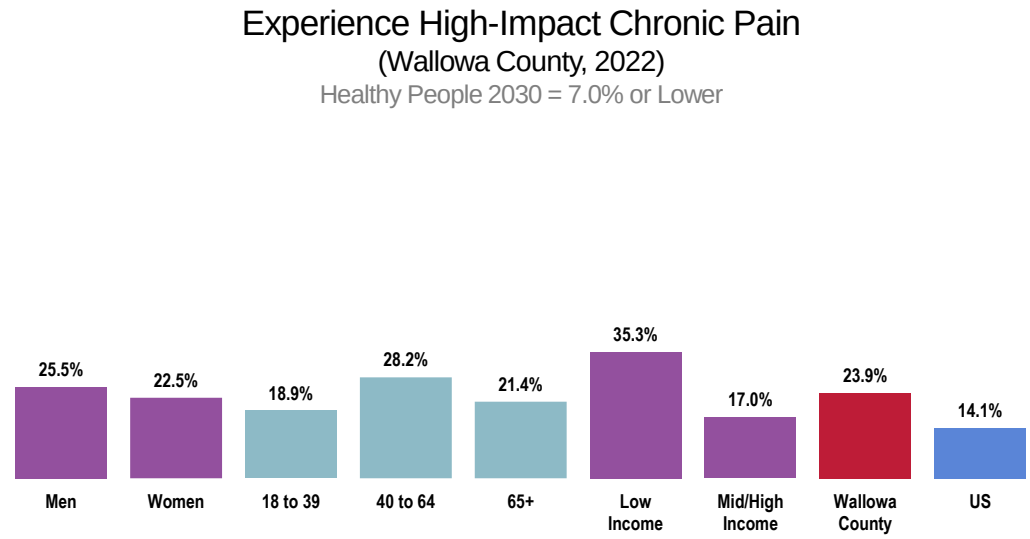
In a separate inquiry, 6.2% of respondents having a disability that requires accommodations to maintain employment.




Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 336]
Notes: • Asked of all respondents.

## High-Impact Chronic Pain

**"Over the past six months, how often did physical pain limit your life or work activities? Would you say: never, some days, most days, or every day?"** (Reported here among those responding "most days" or "every day.")

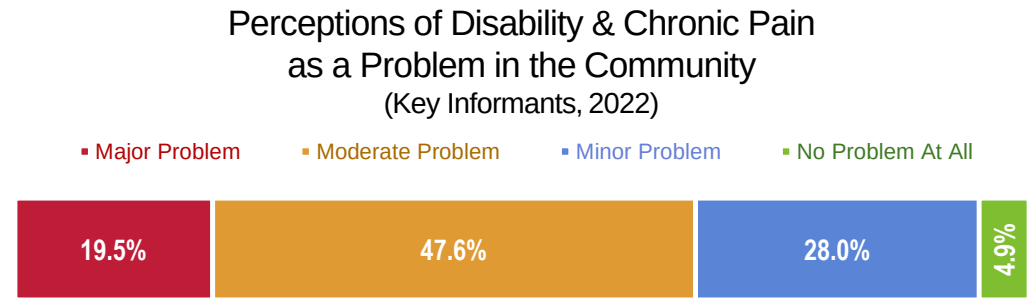



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 37]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective MICH-8.1]

Notes:
- Asked of all respondents.
- High-impact chronic pain includes physical pain that limits life or work activities on "most days" or "every day" of the past six months.

## Key Informant Input: Disability & Chronic Pain

The following chart outlines key informants' perceptions of the severity of *Disability & Chronic Pain* as a problem in the community:




Sources:
- PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

## Contributing Factors

> I believe we have an aging population and as people age they go through more pain, our community does not have many resources to help manage the pain from a movement aspect, as far as a swimming pool or smooth walking paths. We also have a lot of people living in poverty and generational poverty which leads to difficult lifestyle choices and chronic pain as they age. Being at a distance from metropolitan areas that offer a variety of resources that would benefit people with disabilities makes it difficult to access specialized resources, and depending on how long a person has been experiencing a disability makes a difference for how long they have not had access to specialized resources that would help manage a disability. In particular, in thinking about pediatric patients our community has a limited variety of resources and therapies to offer support to families and developing children. – Social Service Provider

> We have a high prescription drug abuse rate. People here work hard and play hard which results in injuries and pain. We have a large amount of disabled people living in residential treatment facilities here. – Social Service Provider

> A high proportion of our community are older and so many older folks as well as some who are younger have disabilities or chronic pain. We also have a number of veterans who are disabled and, or have chronic pain. – Social Service Provider

> We used to have a strong Living Well Program but without the buy in support from providers Community Connection was not able to continue to have the classes and with this loss people are getting overwhelmed by MATERIALS from providers and not hands on education in a group where they feel supported. The silos of care in the community do not support the community in a whole. Some providers don't want to work with community partners to allow the partners to do what they have done GREAT and have done for years. When you get one GAINT in the game it takes away from the strong community – Social Service Provider

> From my point of view, there are a lot of people who work physically intense jobs in this area and have pain due to injury or overuse that they assume they have to just live with. There is also some stigma about being tough and not needing help. A physical therapy place with pools and such would be really great. In addition, I don't think that all places in Wallowa County have great access for different disabilities. – Community Leader

## Incidence/Prevalence

> There are a lot of people in our community that are on disability and on pain medication for chronic pain issues. – Public Health

> Large population of veterans with disabilities in our communities and chronic pain is an additionally common complaint. – Social Service Provider

> A fairly large population of patients with chronic pain and resulting disability. – Physician

## Access to Care/Services

> We have no pain clinic in an aging community. With religious based providers that don't want to prescribe as the government is making it impossible for providers to take care of their patients without fear of repercussions. – Other Health Provider

> There is no source of reliable pain management in the near area. – Community Leader

## Aging Population

> The average age of our county is high. – Community Leader

> Age and the years of hard physical labor of many. – Community Leader

## Prevention/Screenings

> In this county there is good care and good referral for all the major maladies. Cancer, falls, and broken bones, diseases, etc. so, the aftermath is caring for all the consequences that people love with. Our hospital does a great job at this. Prevention or progressive health programs and then after care such as physical therapy should be high on the list for our county. Actually, WMH is doing a great job all around. Adding an orthopedic surgeon was a great step for our system. – Community Leader

# Caregiving & Elder Care

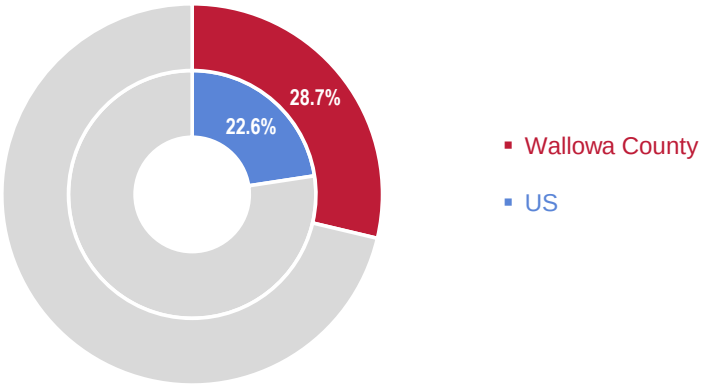
**"People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"**

[Among those providing care] **"What is the main health problem, long-term illness, or disability that the person you care for has?"**

## Act as Caregiver to a Friend or Relative with a Health Problem, Long-Term Illness, or Disability

The top health issues affecting those receiving their care include:

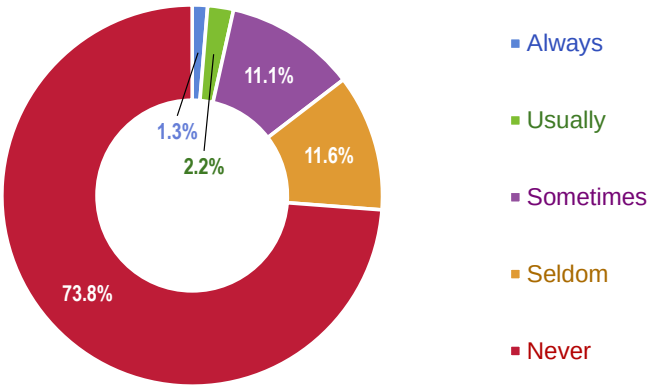
- Mental illness
- Old age/frailty
- Dementia/cognitive impairment
- Cancer
- Diabetes




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 98-99]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

**"During the past 12 months, how often were you worried or stressed about having elder care when you needed it? Would you say: always, usually, sometimes, seldom, or never?"**

## Frequency of Stress About Elder Care in the Past Year
(Wallowa County, 2022)




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 339]
Notes: ● Asked of all respondents.

# Key Informant Input: Dementia/Alzheimer's Disease

## ABOUT DEMENTIA

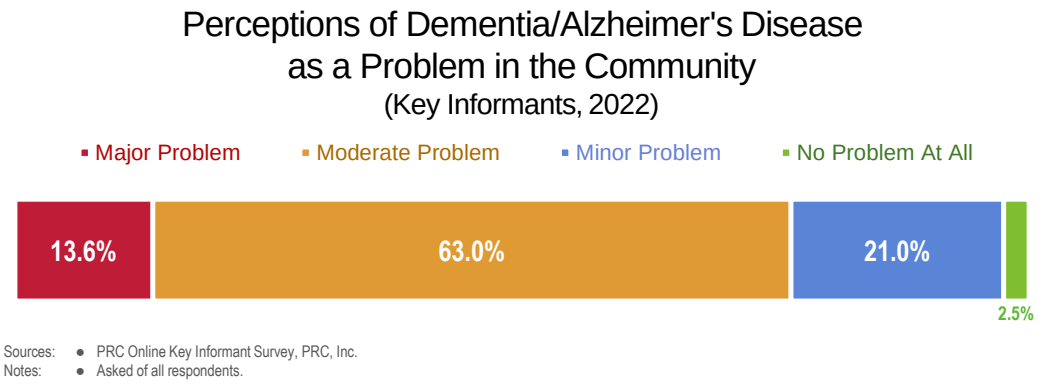
Alzheimer's disease is the most common cause of dementia and the sixth leading cause of death in U.S. adults.1 Nearly 6 million people in the United States have Alzheimer's, and that number will increase as the population ages.

Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

While there's no cure for Alzheimer's disease, early diagnosis and supportive care can improve quality of life. And efforts to make sure adults with symptoms of cognitive decline — including memory loss — are diagnosed early can help improve health outcomes in people with dementia. Interventions to address caregiving needs can also help improve health and well-being in people with dementia.

– Healthy People 2030 (https://health.gov/healthypeople)

The following chart outlines key informants' perceptions of the severity of *Dementia, Including Alzheimer's Disease* as a problem in the community:




Among those rating this issue as a "major problem," reasons related to the following:

### Access to Local Care

> We have limited places for families to turn to if they need help with their family member with Dementia or Alzheimer's as well limited resources for these families. – Social Service Provider
>
> We only have one memory care unit in the county. Bed space is limited to I believe 20 residents. It's full and rotating at all times. – Other Health Provider
>
> There are not a lot of resources for people with Dementia or Alzheimer's. – Social Service Provider
>
> Well over 25 percent of the county population is over 65 years of age. There are less than half a dozen beds in the local Senior Living Center for dementia patients. Most Wallowa County Alzheimer's patients have to be taken to facilities more than 75 miles away from their families -- a hardship to those families living in the county. – Community Leader
>
> There are more families and their loved ones seeking help for Dementia or Alzheimer's disease care than there are available apartments. – Community Leader

> A lot more could be said about about our mental health services shortfall as well as our geriatric medicine limitations. For example, there exists NO neuropsychological services in the county when neuropsychological diagnostic testing is pivotal to diagnosing dementia and, more importantly, functional limitations associated with dementia and other cognitive disorders. All geriatric medicine units I'm familiar with are equipped with neuropsychological services capacity. A small community probably cannot afford a geriatric medicine MD (usually an internist), but the need for one nevertheless exists. Relatedly, a much more robust wrap-around elder care service is needed in this county. For example, send out pharmacists to homes of elderly who are credentialed for prescriptive authority, immunizations, etc. – Community Leader

### Contributing Factors

> We have an older population than state averages. My understanding is that our facilities are quite limited for advanced dementia care in our community. – Community Leader
>
> Aging population, high prevalence of disease, very limited memory care options. – Physician
>
> I seem to be hearing of more individuals being diagnosed with a dementia in the community. The impact that has on the families trying to provide care for their loved one. – Community Leader

### Aging Population

> High rate of people over the age of 60, 28% of the entire county population, and no specialty services available. Multiple misdiagnosis of Alzheimer's and Dementia. Doctors are continually stating it is old age. – Social Service Provider

### Follow-Up/Support

> Family, community supports are limited in the rural area. – Community Leader

# BIRTHS

## ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

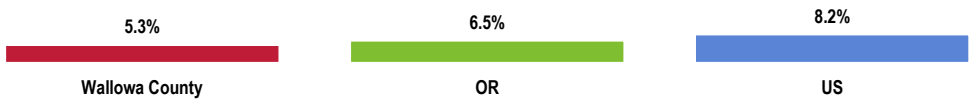
# Birth Outcomes & Risks

## Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.

Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable.

Low-Weight Births
(Percent of Live Births, 2013-2019)




Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted December 2021.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.

# Family Planning

## ABOUT FAMILY PLANNING

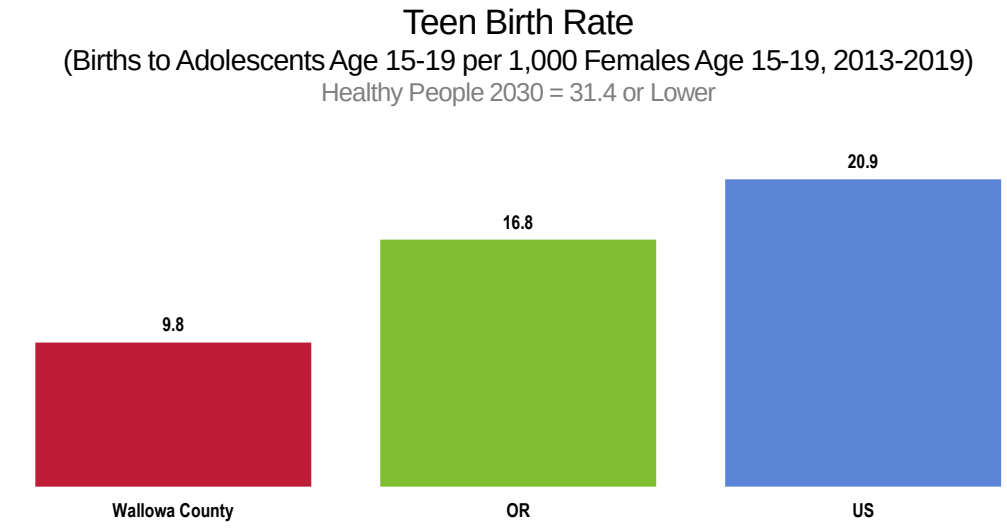
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

## Births to Adolescent Mothers

The following chart describes births to adolescent mothers under the age of 20 years.

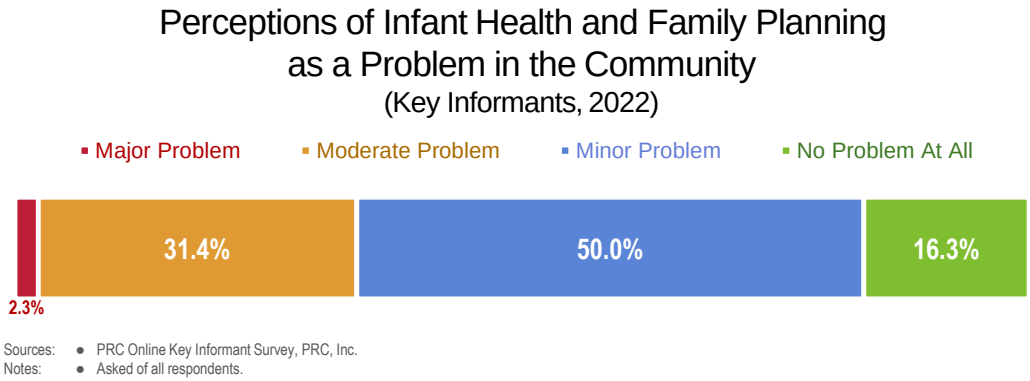



Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

Notes:
- This indicator reports the rate of total births to women under the age of 15–19 per 1,000 female population age 15–19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.

# Key Informant Input: Infant Health & Family Planning

The following chart outlines key informants' perceptions of the severity of *Infant Health and Family Planning* as a problem in the community:




Among those rating this issue as a "major problem," reasons related to the following:

## Awareness/Education

> I selected this as a major problem for the family planning part more than the infant health. We have excellent general med doctors who have taken great care of my growing family. What I think is a major problem is early sex education and access to birth control and other things for youth and adults. It is hard in a small town to reach out for issues around sexual health or family planning when you may know everyone in a clinic. – Community Leader

## Maternal and Child Health

> Maternal and baby health. LCAC has been working to address this by getting two IBCLC's and now they are working on getting two certified birthing doulas. High C-section rate at our local hospital. – Social Service Provider

## Lack of Providers

> We have no real pediatricians or OB/GYN. – Other Health Provider

# MODIFIABLE HEALTH RISKS

## Nutrition

### ABOUT NUTRITION & HEALTHY EATING

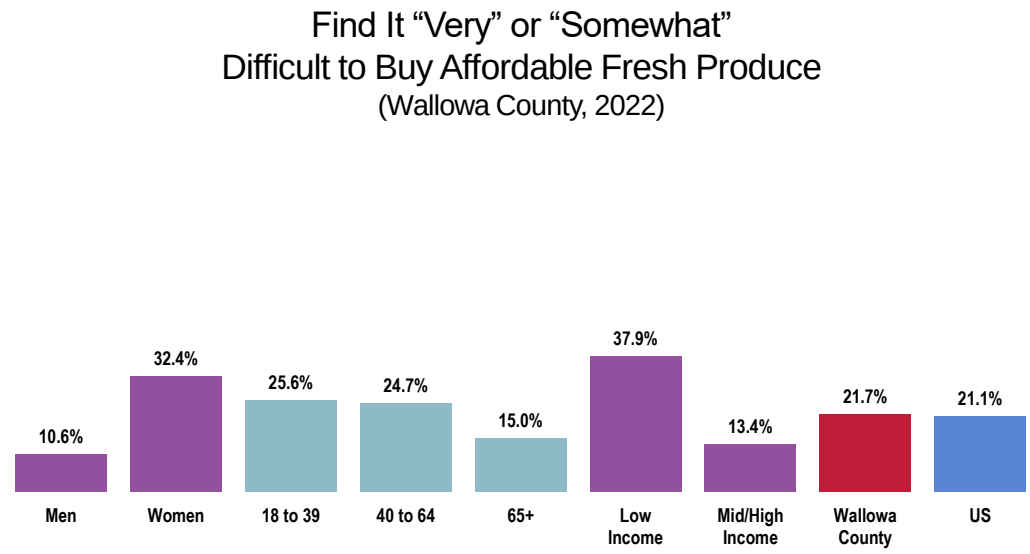
Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

### Access to Fresh Produce

**"How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?"**




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 79]
- 2020 PRC National Health Survey, PRC, Inc.

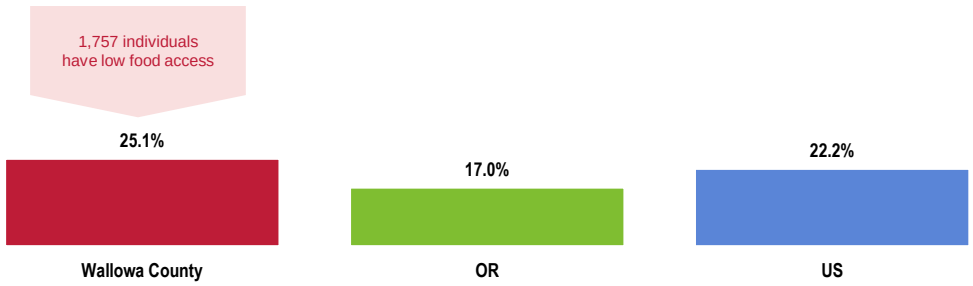
Notes:
- Asked of all respondents.

## Low Food Access

Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This related chart is based on US Department of Agriculture data.

### Population With Low Food Access

(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2019)




Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the percentage of the population with low food access. Low food access is defined as living more than ½ mile from the nearest supermarket, supercenter, or large grocery store. This indicator is relevant because it highlights populations and geographies facing food insecurity.

# Physical Activity

## ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

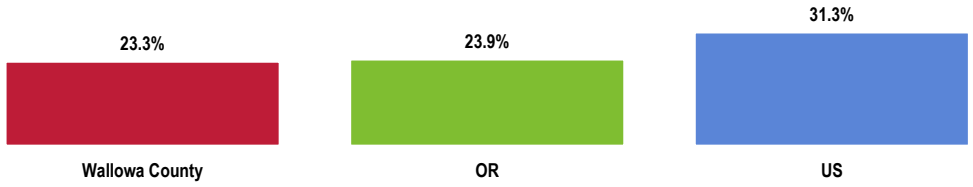
– Healthy People 2030 (https://health.gov/healthypeople)

## Leisure-Time Physical Activity

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

### No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.2% or Lower




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 82]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

## Barriers to Physical Activity

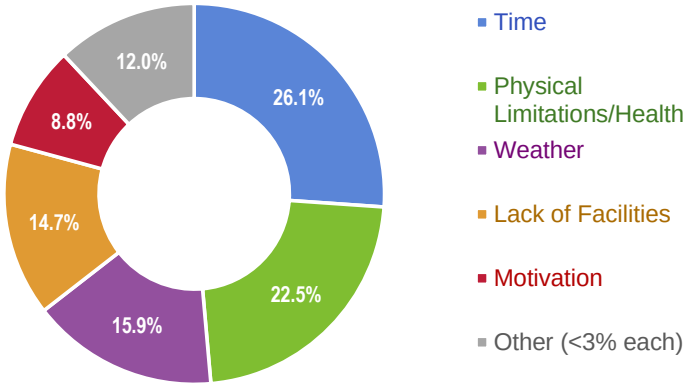
Barriers to physical activity are things that prevent people from being as physically active as they would like to be, such as weather, a lack of facilities, cost factors, or safety concerns.

**"For you, what is the most important barrier to physical activity or exercise?"**

**"What type of physical activity would you like to do most if you had better access?"**

## Biggest Barrier to Physical Activity/Exercise
(Wallowa County, 2022)

Respondents would most often choose **swimming** if they had better access to physical activity, followed by **aerobics**, **walking**, and going to the **gym**.




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 328-329]

Notes:
- Asked of all respondents.

## Children's Physical Activity

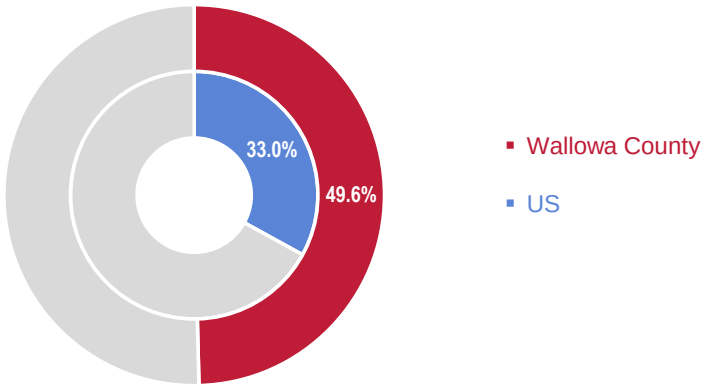
### CHILDREN: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

Children and adolescents should do 60 minutes (1 hour) or more of physical activity each day.

– 2013 Physical Activity Guidelines for Americans, US Department of Health and Human Services. www.cdc.gov/physicalactivity

**"During the past 7 days, on how many days was this child physically active for a total of at least 60 minutes per day?"**

## Child Is Physically Active for One or More Hours per Day
(Parents of Children Age 2-17)




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 109]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children age 2-17 at home.
- Includes children reported to have one or more hours of physical activity on each of the past seven days.

# Weight Status

## ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared ($m^2$). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 $kg/m^2$ and obesity as a BMI ≥30 $kg/m^2$. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 $kg/m^2$. The increase in mortality, however, tends to be modest until a BMI of 30 $kg/m^2$ is reached. For persons with a BMI ≥30 $kg/m^2$, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 $kg/m^2$.

– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

## Adult Weight Status

| CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI | BMI ($kg/m^2$) |
|---|---|
| Underweight | <18.5 |
| Normal | 18.5 – 24.9 |
| Overweight | 25.0 – 29.9 |
| Obese | ≥30.0 |

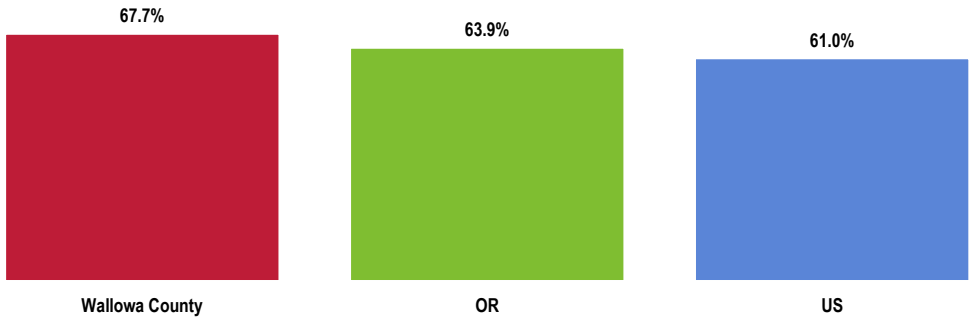
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

**“About how much do you weigh without shoes?”**

**“About how tall are you without shoes?”**

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).

## Prevalence of Total Overweight (Overweight and Obese)

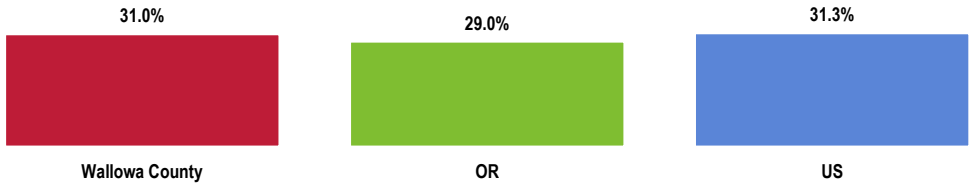



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of overweight is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 25.0, regardless of gender. The definition for obesity is a BMI greater than or equal to 30.0.

## Prevalence of Obesity

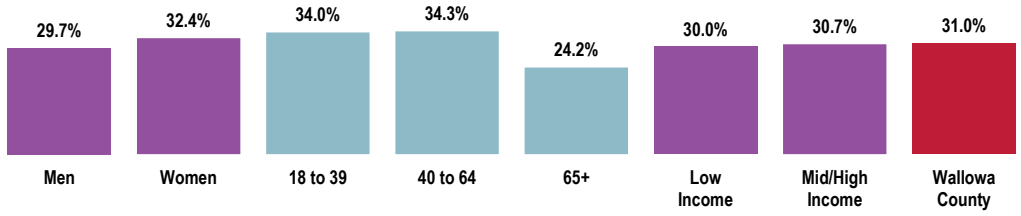
Healthy People 2030 = 36.0% or Lower




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

## Prevalence of Obesity
(Wallowa County, 2022)
Healthy People 2030 = 36.0% or Lower



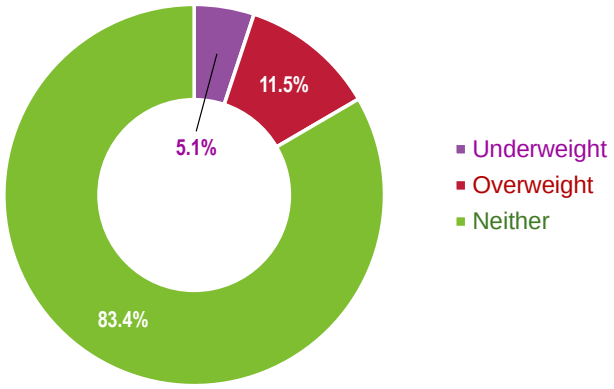

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 128]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

## Children's Weight Status

**"Has a healthcare provider or someone at this child's school ever told you that this child is: underweight, overweight, both, or neither?"**

### Child's Weight According to a Healthcare Provider or School Professional
(Parents of Children Age 5-17)

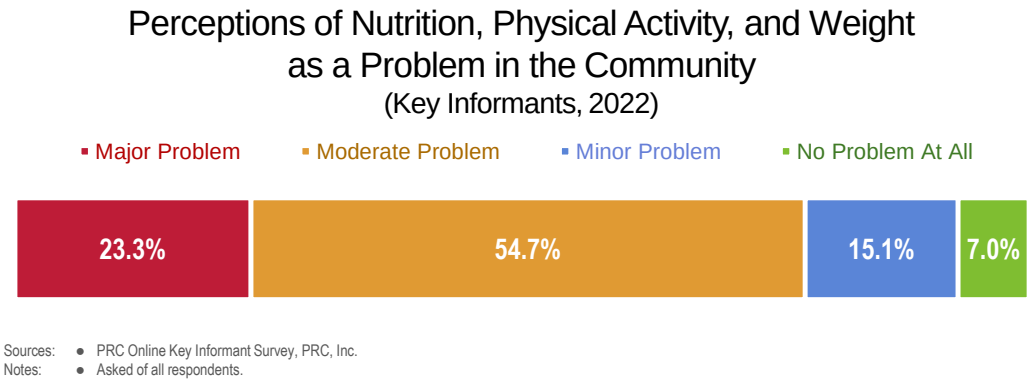



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 341]

Notes:
- Asked of all respondents about a child age 5 to 17.

## Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants' perceptions of the severity of *Nutrition, Physical Activity & Weight* as a problem in the community:




Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

### Contributing Factors

> High cost of food, access to healthy diet information, long cold winters and lack of suitable places to exercise. – Community Leader
>
> I think the cost of healthy food and ability to have fresh healthy foods is a challenge for individuals in our community. Our local grocery store prices are higher than others as we are resort community, but on a limited budget. We no longer have gym access and when we did the cost was for too many high. Although we are blessed to have so many places to hike and explore for some these are not easily accessible. The lack of sidewalks can make it difficult to go for walks. The walking path is an excellent resource around the hospital, but again you have to make it to the location to use. I also believe education related to nutrition, physical activity and weight is limited and instead it needs to be explaining the benefits. – Social Service Provider
>
> Affordable healthy food choices, exercise options that are accessible all year. – Public Health
>
> Lack of healthy affordable eating options for nutrition and then education for nutrition. Physical activity that is affordable and for all ages, fitness levels and interests. As well the stigma that people want to be the way they are is hard and the divde in the community is GROWING! – Social Service Provider
>
> Long, cold winters and not enough access to exercise indoors during winter, especially for our older and younger population, our geographic location and limited access to fresh healthy food through the winter. – Social Service Provider
>
> We have a lot of unhealthy overweight people here. We have one gym (other closed) and limited places to go close to town where you can safely walk, run or ride your bike. Everything has to be on the roads. Also, access to healthy, locally grown food is limited. – Community Leader
>
> Taking a long walk at least 3 times a week would be good for everyone but it is hard to get folks to do it because they don't feel they have the time or need some incentive. Many people rely on fast foods instead of making home cooked healthy meals. I think these are the 2 challenges. – Community Leader
>
> Motivation seems to be a problem in this community. People need to somehow get motivated to eat right, exercise, and watch their weight. Maybe better communication and facilities would help to motivate people to take better care of themselves. – Community Leader

### Awareness/Education

> There is inefficient teaching based on the science of lifestyle choices that is being done in the community and at the school levels to help people make the best choices in what they eat, how they move, and to obtain and maintain an ideal weight. – Physician
>
> Health Education (for children and teens especially, but for all) seems inadequate (even though I realize there are HUGE efforts on the part of multiple organizations to address this). So many kids seem to grow up susceptible to misinformation and bad habits that affect their lifelong health prospects, and I would just love to see exercise and good nutrition and mental health skills (meditation, etc.) incorporated into the heart of all curriculum for the children in the county. – Community Leader

> I just think that most people in general don't understand what healthy eating/living is or looks like. It blows my mind how many people still think buying low fat products are healthy! With the obesity problem in America, I keep hoping that doctors start showing their patients what real healthy living looks like, then many of the other listed health problems will decrease. – Community Leader
>
> Either people are not being told forcefully that they have a problem, or people or choosing not to do anything about their own personal health. Observing others eating habits causes concern. – Community Leader

### Built Environment

> No public swimming pool. For physical therapy and weight loss from toddler to geriatric. – Other Health Provider
>
> In the winter we do not have many places for people to go and work on weight and practice physical activity. – Social Service Provider

### Obesity

> So many people, Americans in general, are overweight and obese and at risk of many medical issues. – Community Leader

### Affordable Care/Services

> Cost. – Social Service Provider

### Cultural/Personal Beliefs

> Cultural acceptance of poor health and diet. – Community Leader

### Nutrition

> Too much junk food and not enough activity. – Community Leader

# Substance Abuse

## ABOUT DRUG & ALCOHOL USE

More than 20 million adults and adolescents in the United States have had a substance use disorder in the past year. …Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

## Alcohol

Excessive drinking includes heavy and/or binge drinkers:

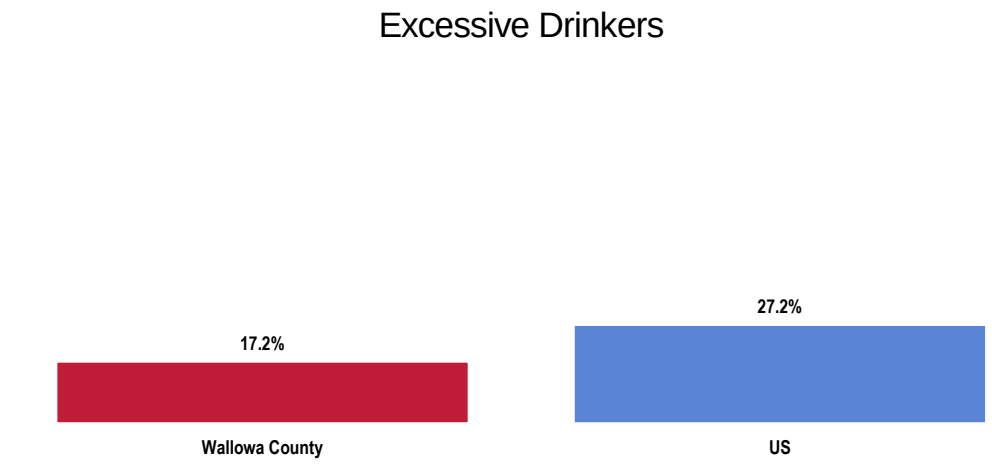
- HEAVY DRINKERS ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.
- BINGE DRINKERS ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

### Excessive Drinking

**"During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?"**

**"On the day(s) when you drank, about how many drinks did you have on the average?"**

**"Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5** (if male)**/4** (if female) **or more drinks on an occasion?"**




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 136]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Excessive drinking reflects the number of persons aged 18+ who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5+ drinks during a single occasion (for men) or 4+ drinks during a single occasion (for women) during the past 30 days.

# Drugs

## Illicit Drug Use

**"During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?"**

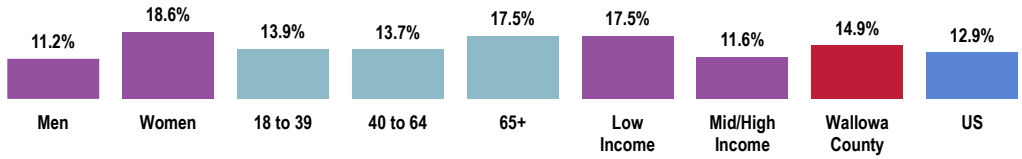
*None of the respondents surveyed acknowledged illicit drug use in the past 30 days. However, as a self-reported measure – and because this indicator reflects potentially illegal behavior – it is expected that this would be underreported.*

## Use of Prescription Opioids

Opioids are a class of drugs used to treat pain. Examples presented to respondents include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. Common brand name opioids include Vicodin, Dilaudid, Percocet, OxyContin, and Demerol.

**"Opiates or opioids are drugs that doctors prescribe to treat pain. Examples of prescription opiates include morphine, codeine, hydrocodone, oxycodone, methadone, and fentanyl. In the past year, have you used any of these prescription opiates?"**

Used a Prescription Opioid in the Past Year
(Wallowa County, 2022)




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 50]
- 2020 PRC National Health Survey, PRC, Inc.

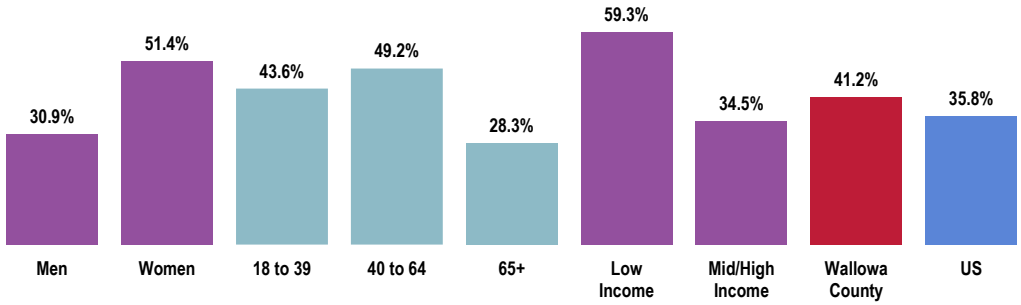
Notes:
- Asked of all respondents.

## Personal Impact From Substance Abuse

**"To what degree has your life been negatively affected by your own or someone else's substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?"**

### Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)
(Wallowa County, 2022)

7.8% of respondents have sought professional help for an alcohol or drug-related problem



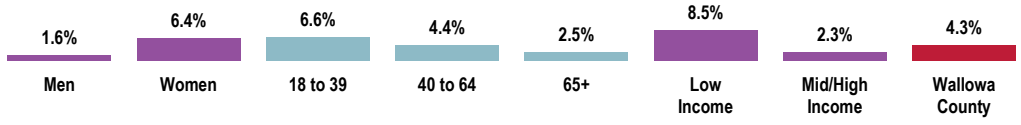

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 51-52]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes response of "a great deal," "somewhat," and "a little."

## Difficulty Getting Substance Abuse Treatment

**"In the past year, have you had difficulty getting help for your own or someone else's alcohol or drug use concern?"**

### Difficulty Getting Help for Substance Abuse in the Past Year (Whether for Self or Someone Else)
(Wallowa County, 2022)

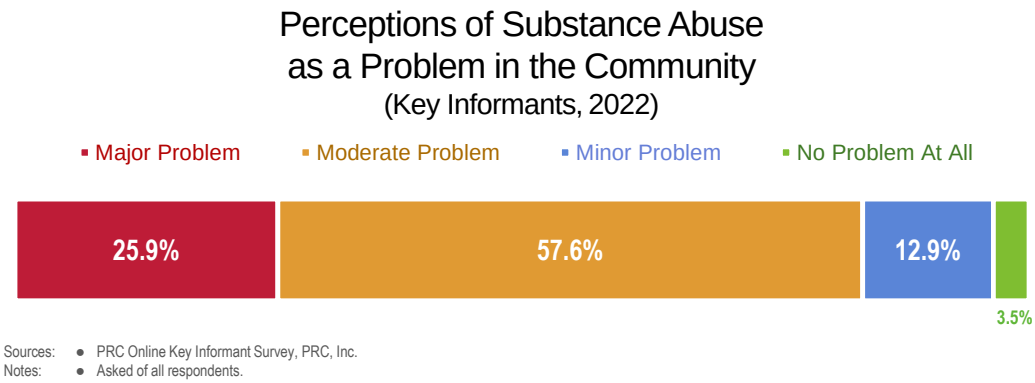



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 316]

Notes:
- Asked of all respondents.

## Key Informant Input: Substance Abuse

The following chart outlines key informants' perceptions of the severity of *Substance Abuse* as a problem in the community:




Among those rating this issue as a "major problem," reasons related to the following:

### Contributing Factors

> Information about availability. Local education. Local culture, punishment versus treatment, tolerance. – Community Leader
>
> Personal acknowledgement that the substance is not controlled. Pandemic has become a shelter to manage rather than address SA. Facilities are dealing with Covid sufferers and the system is strained. – Community Leader
>
> Stigma of being treated, limited access to rehab beds for more acute issues. – Physician
>
> Stigma, confidentiality, prevalence, limited choices. – Other Health Provider
>
> Lack of funding and facilities. The new laws do not positively contribute to this problem. – Community Leader
>
> Lack of providers and education programs. – Social Service Provider

### Willingness to Obtain Help

> Lack of motivation for the addict. Now that we have decriminalized hard drugs, we no longer have the external motivator of the court system to push people to engage in treatment. Although I agree that voluntary engagement is the best outcome, that is often not the choice that is made, and the addict and the community suffer. – Community Leader
>
> People have to be at a place where they are ready to access the services. I think this is the biggest hurdle for people to overcome when accessing substance abuse treatment. – Public Health

### Community Norms

> Overdose is huge … multiple calls a week. Our EMTs and first responders are on calls almost daily of someone over-dosing or reactions to drugs. Pot is huge... meth.... PCP.... heroine... alcohol.... mixing them. We have adults that are doing all this and youth that think it is normal to be high or drunk. Kids doing pot in school, vaping it, and teachers are not at all aware. We have teachers/administrations that turn their heads the other way. We have parents who turn the other way. COVID is not maxing out our EMTs … it's drugs in Wallowa County, reactions to drugs! Listen to the scanner. We have kids whose parents are in the medical field that their 15-year-old daughter OD on alcohol on a school night and is taken by ambulance to the ER but nothing happens due to HIPAA; they can't even let the cops know or DA. Yet is it okay that a youth minor gets that drunk and then the actions continue on outside the home with other youth. We have made a society that turns the other cheek and makes excuses. – Social Service Provider
>
> Community norms related to excessive alcohol drinking are probably the biggest problem. A residential treatment center might be helpful. Or half-way residences like Oxford House might also be helpful. I suspect that an increased state tax on beer and alcohol could make a substantial difference. – Community Leader

### Denial/Stigma

> I don't really know; I think it's easy for people to fly under the radar here though. – Social Service Provider
>
> Chronic alcohol abuse is high in the county. Stigma and resistance to treatment are problems. Seen as a character flaw and not a disease. – Community Leader

### Access to Care/Services

> Access to treatment. – Social Service Provider
>
> We don't have dedicated detox or rehabilitation centers anywhere in this county. – Social Service Provider

### Diagnosis/Treatment

> There is no treatment. Referring out is the junky option. As providers we can prescribe sub Oxone, but that's it. No training by the hospitals either. – Other Health Provider

### Youth

> Substance abuse is intergenerational and is impacting families. Youth are increasing usage, especially of varied forms of marijuana. – Community Leader

### COVID-19

> Again, with the pandemic, and other stresses, there has been a substantial increase in substance use and abuse. Increase in overdoses and withdrawals in this community. – Community Leader

### Follow-Up/Support

> Tracking people who have a problem and are required to get treatment. Seems as though a lot of people are ordered by our legal system to get treatment but no one makes sure that it actually gets done. – Community Leader

### Policy

> The state encouraging substance abuse with new laws or lack thereof. – Community Leader

### Privacy

> Privacy. – Community Leader

## Tobacco Use

### ABOUT TOBACCO USE

More than 16 million adults in the United States have a disease caused by smoking cigarettes, and smoking-related illnesses lead to half a million deaths each year.

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

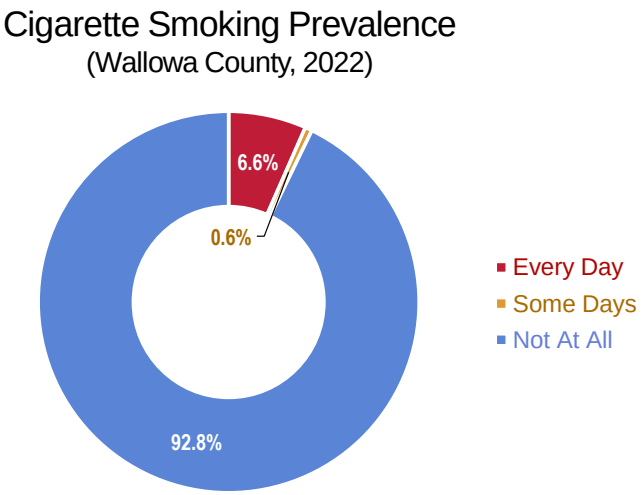
Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

## Cigarette Smoking

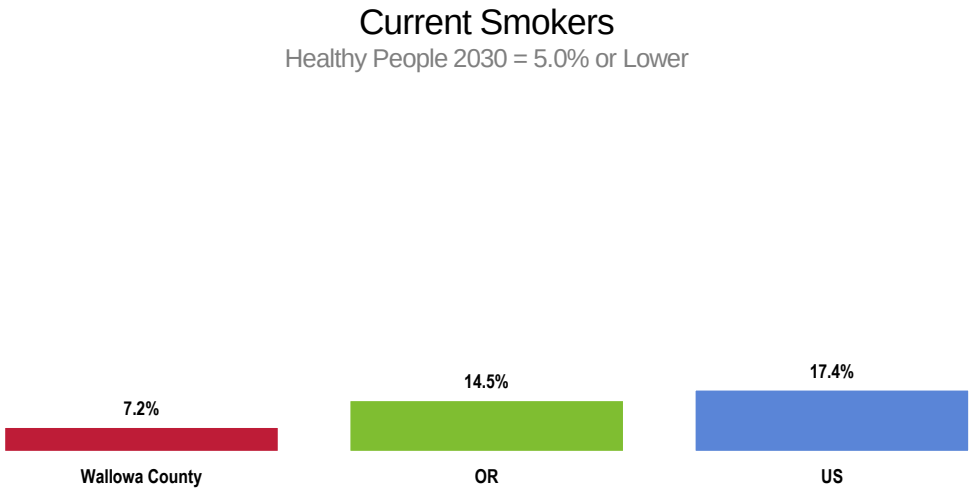
### Current Smoking

**"Do you now smoke cigarettes every day, some days, or not at all?"** ("Current smokers" include those smoking "every day" or on "some days.")




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]

Notes:
- Asked of all respondents.



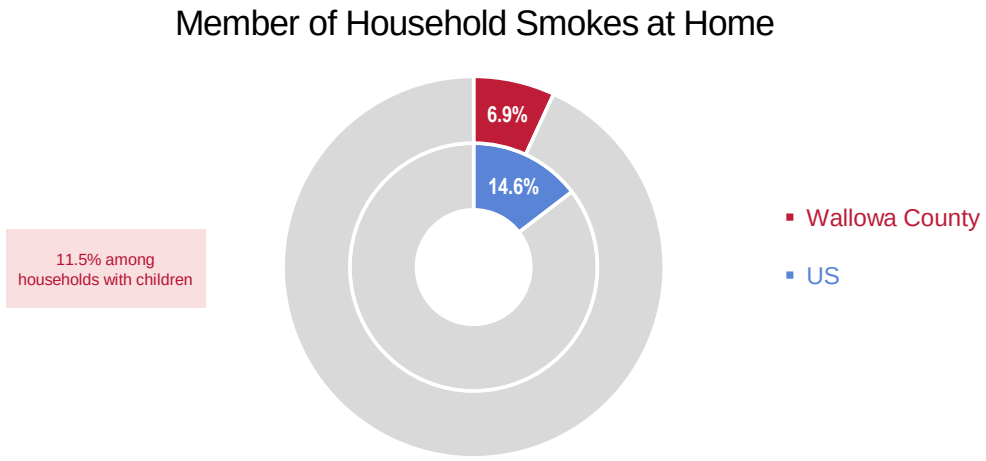

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 40]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).

## Environmental Tobacco Smoke

**“In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?”**

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 43, 134]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- “Smokes at home” refers to someone smoking cigarettes, cigars, or a pipe in the home an average of four or more days per week.

## Use of Vaping Products

**“The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid “e-juice” used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?”**

**“Do you now use electronic vaping products, such as e-cigarettes, “every day,” “some days,” or “not at all”?”**

“Current use” includes use “every day” or on “some days.”

## Currently Use Vaping Products
(Wallowa County, 2022)

19.5% of tobacco users have quit tobacco products for at least one day in the past year


Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 135, 315]
- 2020 PRC National Health Survey, PRC, Inc.

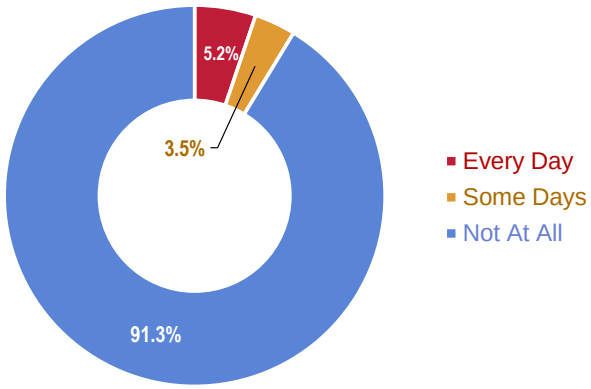
Notes:
- Asked of all respondents.
- Includes regular and occasional users (those who smoke e-cigarettes every day or on some days).

## Use of Smokeless Tobacco

**"Do you currently use smokeless tobacco products or 'chew'?"**

"Current use" includes use "every day" or on "some days."

## Use of Smokeless Tobacco or "Chew"
(Wallowa County, 2022)




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 314]

Notes:
- Asked of all respondents.

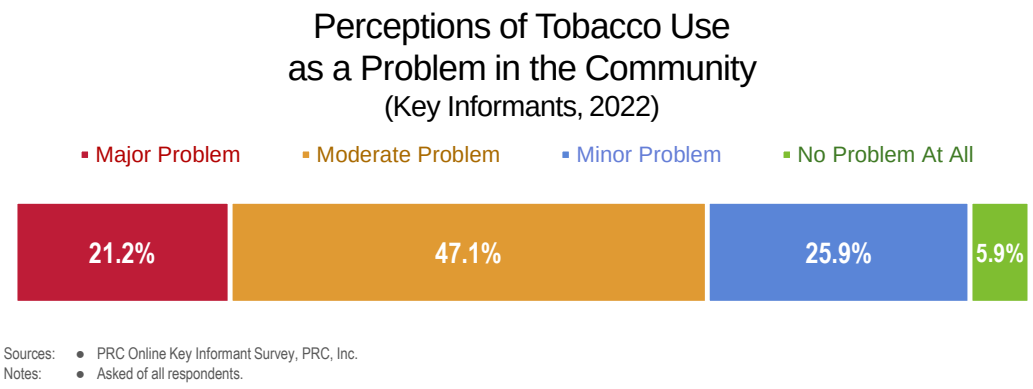
## Tobacco Cessation

**"During the past 12 months, have you stopped using cigarettes, smokeless tobacco, or vaping products for one day or longer because you were trying to quit?"**

*Among the relatively small sample of current users of tobacco in any form (n=46), 19.5% report a serious attempt to quit in the past year.*

## Key Informant Input: Tobacco Use

The following chart outlines key informants' perceptions of the severity of *Tobacco Use* as a problem in the community:




Sources: • PRC Online Key Informant Survey, PRC, Inc.
Notes: • Asked of all respondents.

Among those rating this issue as a "major problem," reasons related to the following:

### Incidence/Prevalence

> Our community has a lot people who smoke and chew tobacco. – Public Health
>
> Numerous people smoking and chewing. – Community Leader
>
> Many people smoke cigarettes. – Community Leader
>
> There is a large number of people who use some form of tobacco, smoking, chewing, vaping. – Public Health
>
> Decent number of smokers. – Physician
>
> It just seems like there are a lot of people of all ages who smoke here. – Social Service Provider
>
> Teens: Our youth vape and the vaping population is growing! And they don't think of this as tobacco use. Kids in junior high and high school are vaping and vaping at school! Parents don't know, teachers know. These kids get it online, order it, and it is shipped, or they have buyers. – Social Service Provider

### Young Adult Usage

> A lot of young people, especially low-income, continue to smoke. A big percentage of adult males chew tobacco. – Community Leader
>
> Increasing use among youth, especially vaping. – Community Leader
>
> I believe there is a high population of teens using tobacco in this community which seems like a significant problem. – Community Leader

### Awareness/Education

> This falls back to the lack of education in school. We used to have a "say no to drugs and alcohol" or "no before 21" (which is obviously more related to alcohol) program in the schools. I would like to see our law enforcement officers be active in the schools and work with the youth through similar programs. Tobacco use, as with alcohol, seems to start at a younger age. – Community Leader

### Impact on Quality of Life

> Tobacco use in this community is very common, and it causes such significant health issues. – Community Leader
>
> Any use is a problem. – Community Leader

### Contributing Factors

> It's the geriatric generation that was raised to smoke. A lot of old farmers that smoke also. Kids vaping. No education in the schools. – Other Health Provider

### Cultural/Personal Beliefs

> Tobacco users are tolerated as part of the culture of rural living. – Community Leader

# Sexual Health

## ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

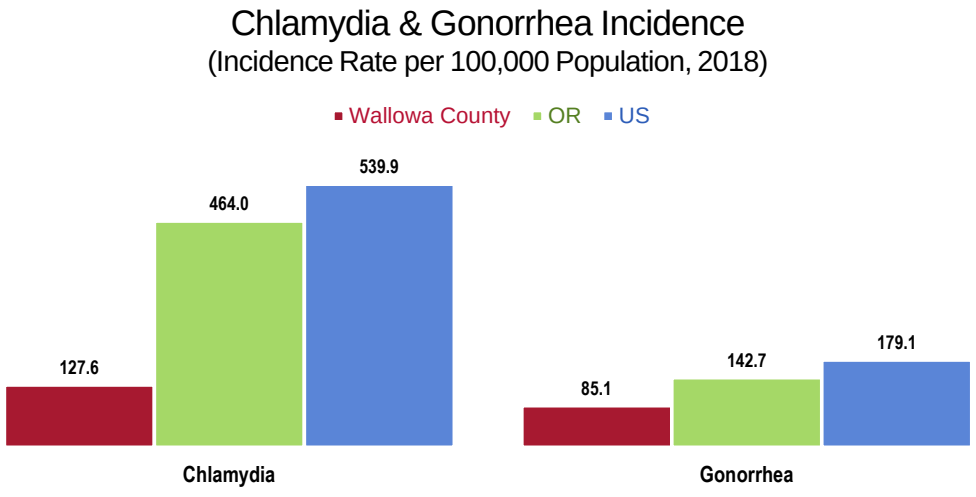
– Healthy People 2030 (https://health.gov/healthypeople)

## Sexually Transmitted Infections (STIs)

CHLAMYDIA ► Chlamydia is the most commonly reported STI in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

GONORRHEA ► Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STIs.

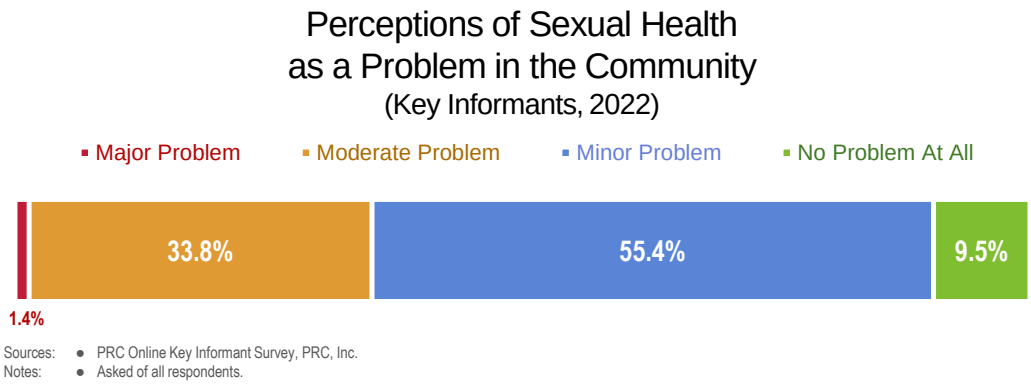



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

## Key Informant Input: Sexual Health

The following chart outlines key informants' perceptions of the severity of *Sexual Health* as a problem in the community:




Among those rating this issue as a "major problem," reasons related to the following:

### Education

> Our youth at a very young age are becoming sexual and the kids are passing along STIs and STDs like mad. It is a joke; they talk about body count and the higher the number the cooler you are. What happened to education around STD and STI? We used to have a very bold health department who would address this topic and many levels and areas, and we don't see this. The kids at school get some education along the way but it is like more are let's not talk about it. Social media is educating our youth and our youth are no longer about safety of sex! – Social Service Provider

# ACCESS TO HEALTH CARE

## ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …About 1 in 10 people in the United States don't have health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

# Health Insurance Coverage

## Lack of Health Insurance

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources.

**"Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid** (or another state-sponsored program)**, or VA/military benefits?"**

**"Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?"**

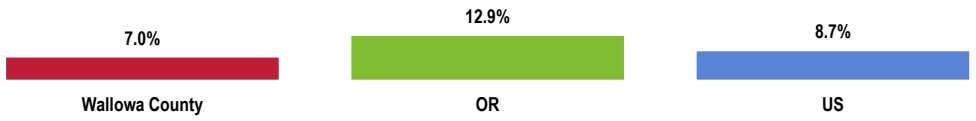
Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

[Parents] **"Does this child currently have health insurance coverage, such as through Medicaid or private insurance?**

[Uninsured Adults] **"If you were eligible for the Oregon Health Plan or a subsidized Qualified Health Plan, how likely would you be to apply to be enrolled? Would you be: Very Likely, Somewhat Likely, or Not At All Likely?"**

## Lack of Health Care Insurance Coverage
(Adults Age 18-64)
Healthy People 2030 = 7.9% or Lower

1.3% of parents indicate that their child is currently insured

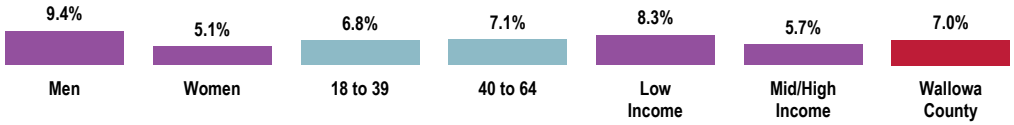



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 137, 340]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents under the age of 65.

## Lack of Health Care Insurance Coverage
(Adults Age 18-64; Wallowa County, 2022)
Healthy People 2030 = 7.9% or Lower

Among uninsured respondents (n=10), all said they would be "very" or "somewhat likely" to apply for enrollment in the Oregon Health Plan or a subsidized qualified health plan if they were eligible.




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 137, 325]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov [Objective AHS-1]

Notes:
- Asked of all respondents under the age of 65.

## Insurance Instability

[Insured Adults] **"During the past 12 months, was there any time that you did not have any health insurance or coverage?"**

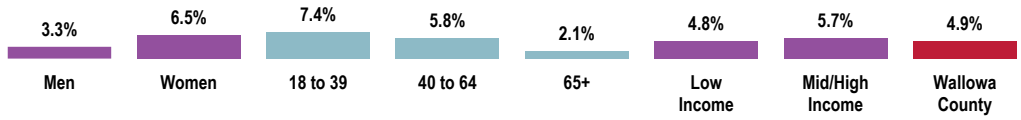
[Parents] **"During the past 12 months, was there a time when any of the children in this household were without health insurance?**

### Went Without Healthcare Coverage in the Past Year

(Among Insured Adults; Wallowa County, 2022)

Healthy People 2030 = 7.9% or Lower

3.7% of parents report that their child was without coverage in the past year.




Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Items 324, 345]
Notes: • Asked of all respondents

# Difficulties Accessing Health Care

## Barriers to Health Care Access

To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a primary care provider or obtaining a needed prescription in the past year. (Note that US comparisons represent survey questions specifying a **physician** versus a **primary care provider**.)

**"Was there a time in the past 12 months when you needed medical care, but had difficulty finding a primary care provider?"**

**"Was there a time in the past 12 months when you had difficulty getting an appointment to see a primary care provider?"**

**"Was there a time in the past 12 months when you needed to see a primary care provider but could not because of the cost?"**

**"Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a primary care provider or making a medical appointment?"**

**"Was there a time in the past 12 months when you were not able to see a primary care provider because the office hours were not convenient?"**

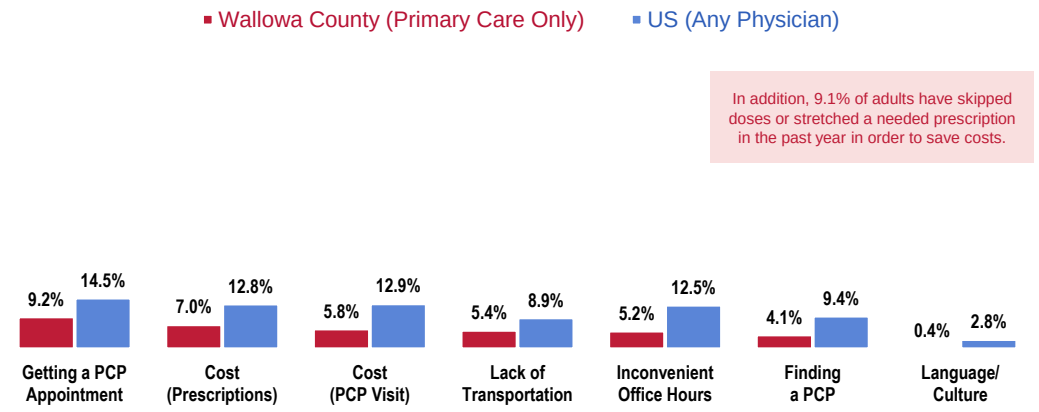
**"Was there a time in the past 12 months when you needed a prescription medicine, but did not get it because you could not afford it?"**

**"Was there a time in the past 12 months when you were not able to see a primary care provider due to language or cultural differences?"**

**"Was there a time in the past 12 months when you skipped doses or took smaller doses in order to make your prescriptions last longer and save costs?"**

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

## Barriers to Access Have Prevented Medical Care in the Past Year

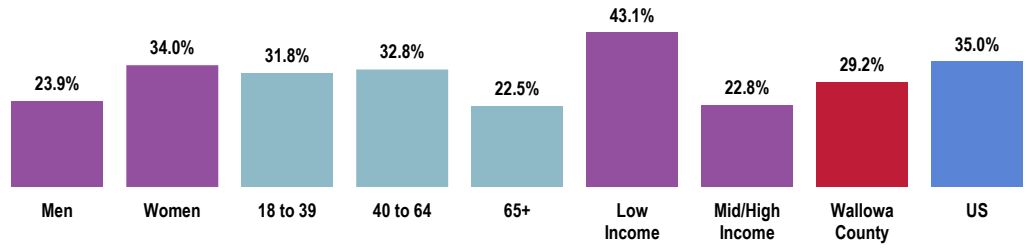



Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 7-14]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Note that the Wallowa County percentages are in response to questions about primary care providers only, while the US survey asked about any physician.

The following chart reflects the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

## Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Wallowa County, 2022)



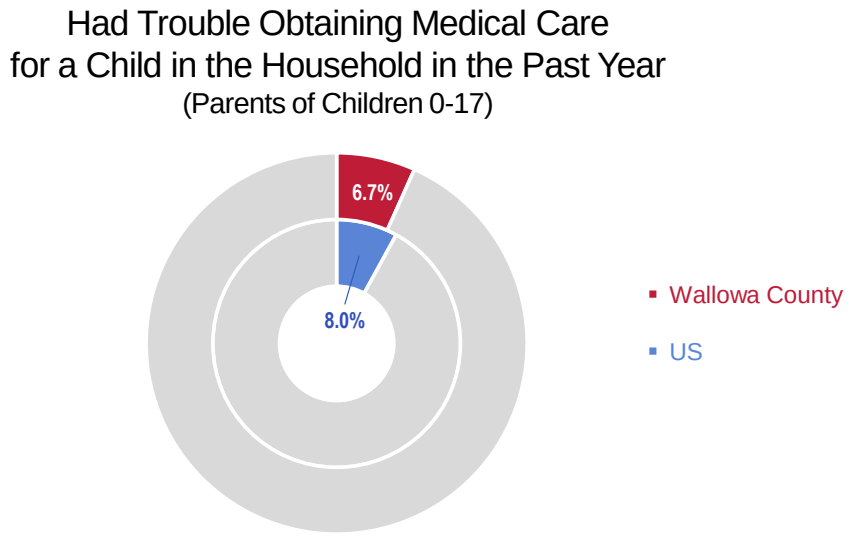

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 140]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Percentage represents the proportion of respondents experiencing one or more barriers to accessing health care in the past 12 months

## Accessing Health Care for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for any child in their household.

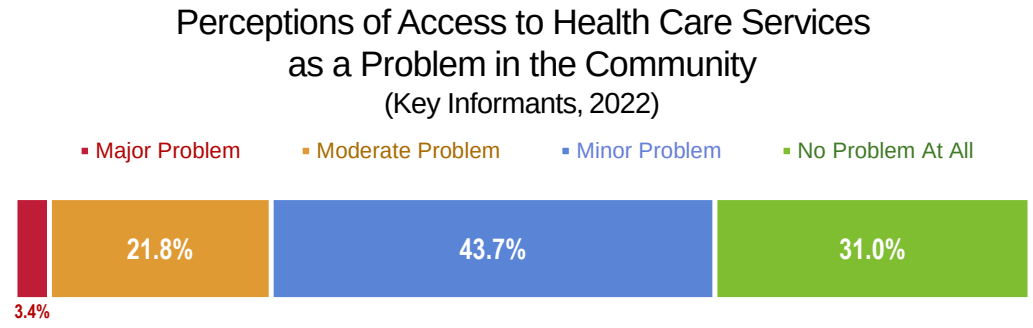
**"Was there a time in the past 12 months when you needed medical care for this child, but could not get it?"**




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 342]
● 2020 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents with children 0 to 17 in the household.

## Key Informant Input: Access to Health Care Services

The following chart outlines key informants' perceptions of the severity of *Access to Health Care Services* as a problem in the community:




Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

## Contributing Factors

> Transportation and cost. – Social Service Provider
>
> Transportation is large and rural. Many people live very far from the closest clinic and/or do not have access to a vehicle. The Community Connections rides only go so far. We need an actual bus system between the towns so people can travel for medical appointments as well as access to healthy food. I am impressed with the existing infrastructure for financial support but also am sure that cost is still prohibitive for many people, even after the income-based discounts. Childcare is very difficult to come by in the county so that is also a barrier for people with children. It would be amazing if one of the clinics had a daycare attached or could provide childcare while parents/caretakers had appointments. It doesn't seem like we have enough home healthcare providers, and from what I have heard, it seems like the process for home healthcare provider certification does not adequately train workers or assure the safety of the care they provide. – Social Service Provider

## Cost

> Health insurance, affordable healthcare. The prices are outrageous for middle class families. – Community Leader
>
> Cost. – Community Leader

## Healthcare Provider Shortage

> The vaccine mandate for our health care professionals is of grave concern. Our medical staff already appear to be short-handed and over worked. Now we will make it even more so by letting a portion of our staff go. Three months ago, our doctors and nurses were celebrated as being heroes; now they are penalized for standing up for their own bodily decisions. I would think the health professionals would know best. The fact there are many unwilling to take the vaccine at the expense of losing their jobs, speaks volumes. – Community Leader

## Hospice Services

> Hospice services are lacking. – Community Leader

## Access to Care/Services

> Distance and speed of getting to a place where healthcare services can be accessed. – Community Leader

## Alternative Care

> Access to alternative care for all health issues. – Other Health Provider

## Provider Burnout

> Burnout of health care providers documentation and productivity expectations. – Community Leader

# Primary Care Services

## ABOUT PREVENTIVE CARE

Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

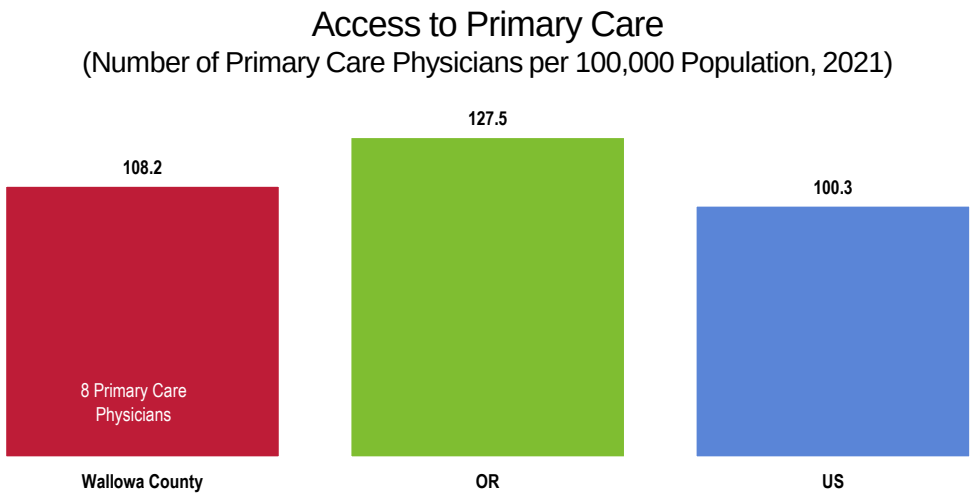
Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

## Access to Primary Care

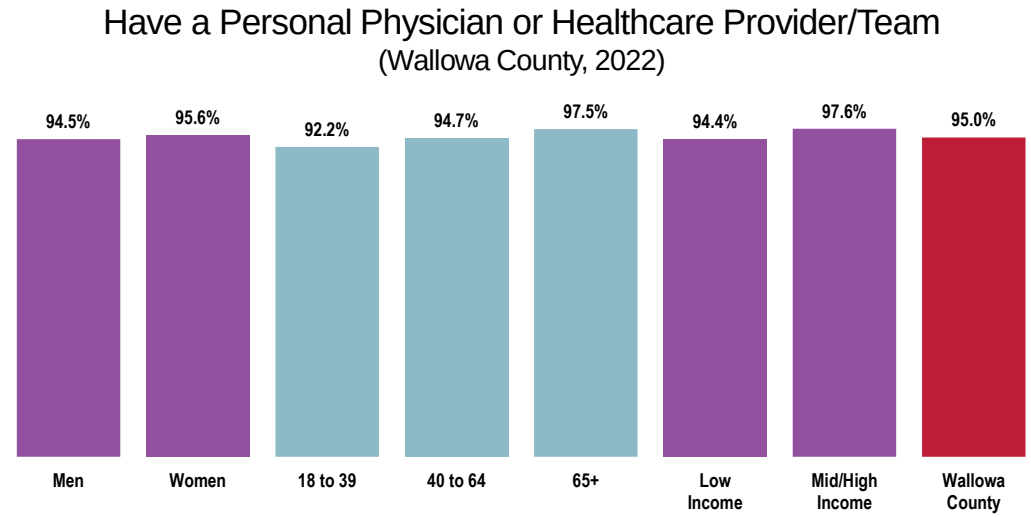
This indicator is relevant because a shortage of health professionals contributes to access and health status issues.




Sources:
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2021 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

**"Do you have a primary care provider, personal doctor, or other healthcare provider, or have a strong connection to a healthcare team?"**

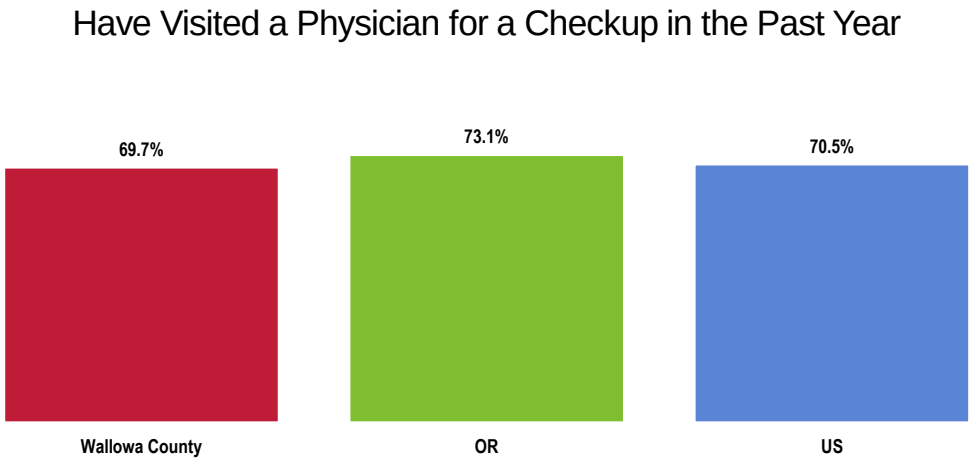



Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 303]
Notes: • Asked of all respondents.

## Utilization of Primary Care Services

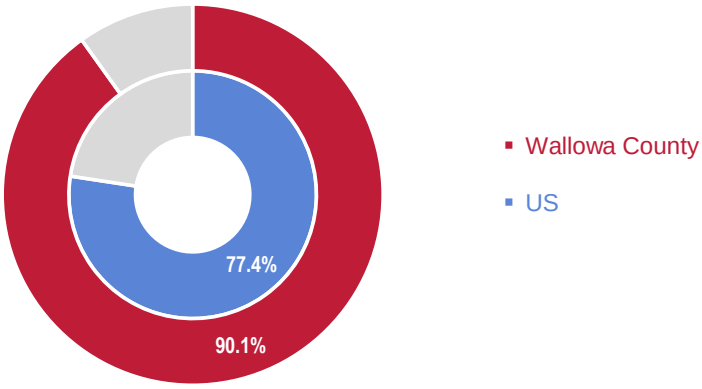
ADULTS ▶ **"A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?"**

CHILDREN ▶ **"About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?"**




Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 18]
• Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
• 2020 PRC National Health Survey, PRC, Inc.
Notes: • Asked of all respondents.

## Child Has Visited a Physician for a Routine Checkup in the Past Year
(Parents of Children 0-17)




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 105]
- 2020 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.

# Oral Health

### ABOUT ORAL HEALTH

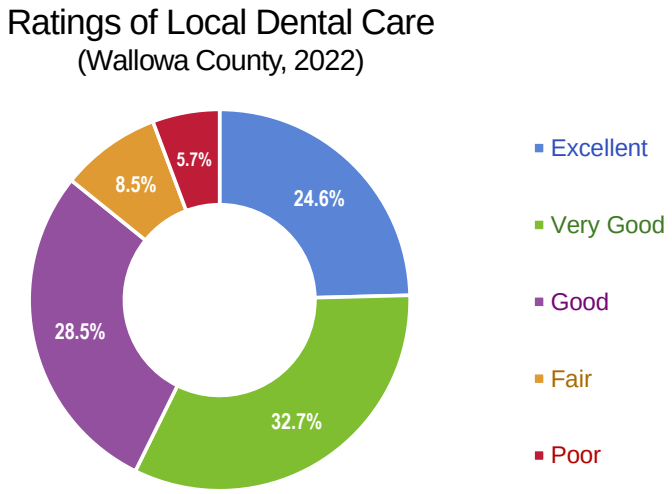
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

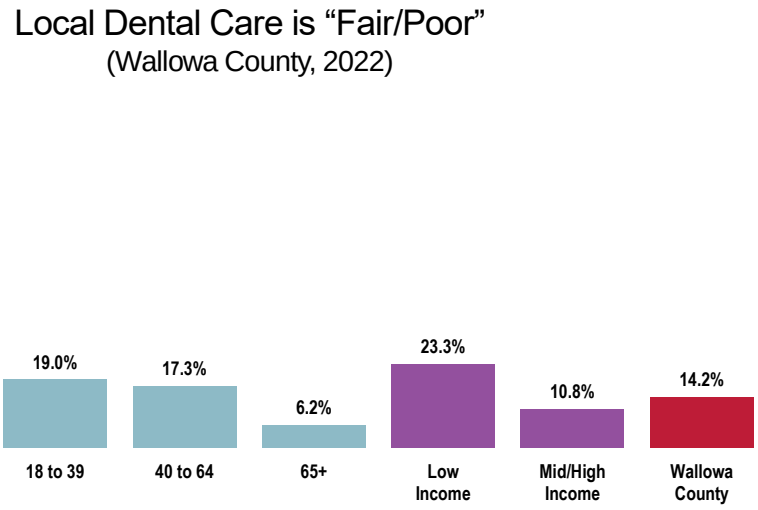
– Healthy People 2030 (https://health.gov/healthypeople)

## Ratings of Local Dental Care

**"How ow would you rate the overall dental care services available to you? Would you say: excellent, very good, good, fair, or poor?"**




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents.

## Dental Care

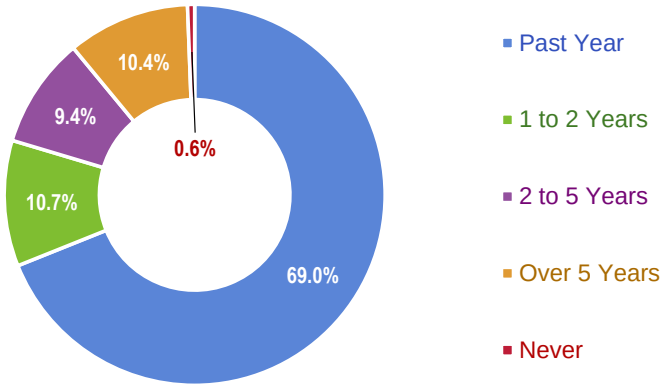
ADULTS ▶ **"A routine dental checkup is a teeth cleaning, X-rays, and an exam by a dentist. About how long has it been since you last visited a dentist for a routine checkup?**

**"About how long has it been since you last visited a dentist or a dental clinic for any reason?"**

**"Do you currently have any health insurance coverage that pays for at least part of your dental care?"**

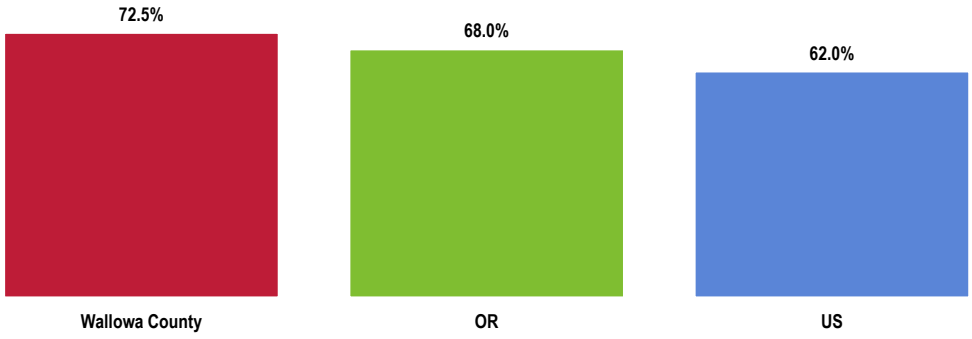
### Most Recent Routine Dental Checkup
(Wallowa County, 2022)

Note that 58.5% of Wallowa County respondents report having insurance coverage for dental care (below the 68.7% that is found nationally).




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 310]
Notes: ● Asked of all respondents.

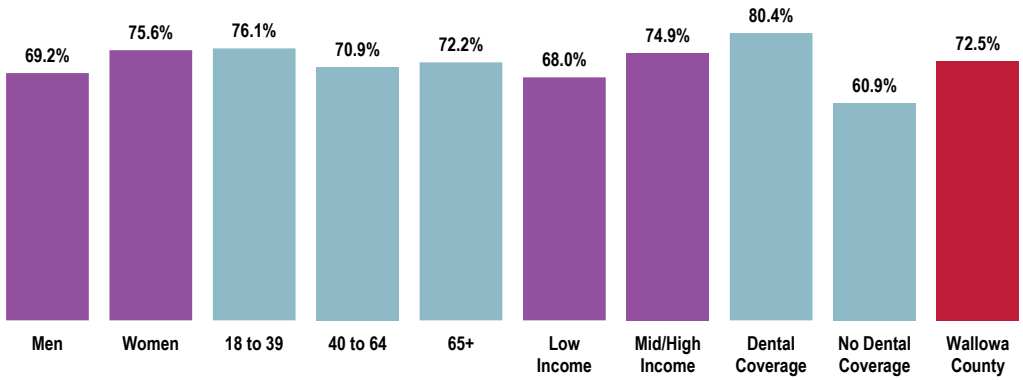
### Have Visited a Dentist or Dental Clinic Within the Past Year (Any Reason)
Healthy People 2030 = 45.0% or Higher




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 348]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2019 Oregon data.
● 2020 PRC National Health Survey, PRC, Inc.
● US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov
Notes: ● Asked of all respondents.

## Have Visited a Dentist or Dental Clinic Within the Past Year (Any Reason)

Healthy People 2030 = 45.0% or Higher




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Item 348]
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

Notes:
- Asked of all respondents.

CHILDREN AGE 2-17 ► **"About how long has it been since this child visited a dentist or dental clinic?"**

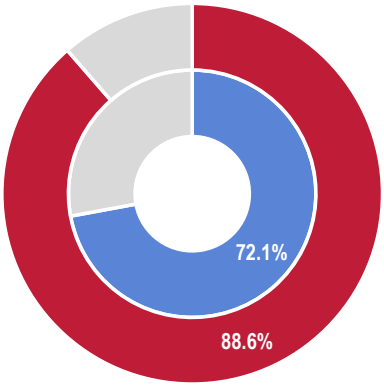
**"Was there a time in the past 12 months when you needed dental care for a child in this household but could not get it?"**

## Child Has Visited a Dentist or Dental Clinic Within the Past Year

(Parents of Children Age 2-17)

Healthy People 2030 = 45.0% or Higher

6.8% of parents report that there was a time in the past year when they needed dental care for any child in their household but could not get it.



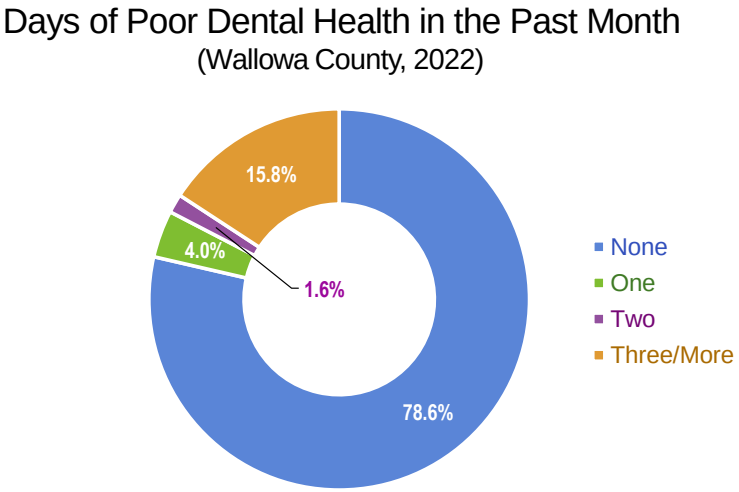

- Wallowa County
- US

Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 108, 343]
- 2020 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. August 2030. http://www.healthypeople.gov

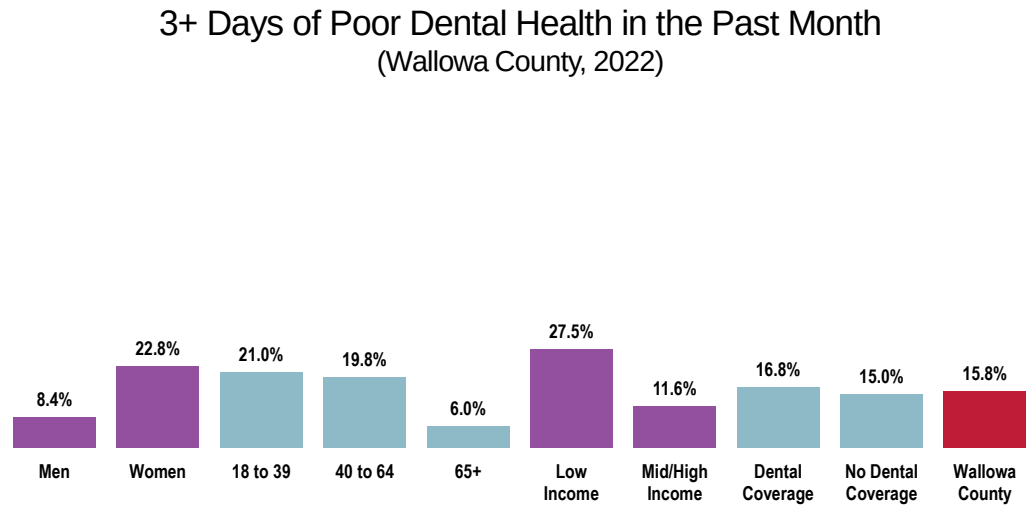
Notes:
- Asked of all respondents with children age 2 through 17.

## Days of Poor Dental Health

**"Thinking about your own dental health, which includes tooth or mouth pain or infection, for how many days during the past 30 days was your dental health not good?"**



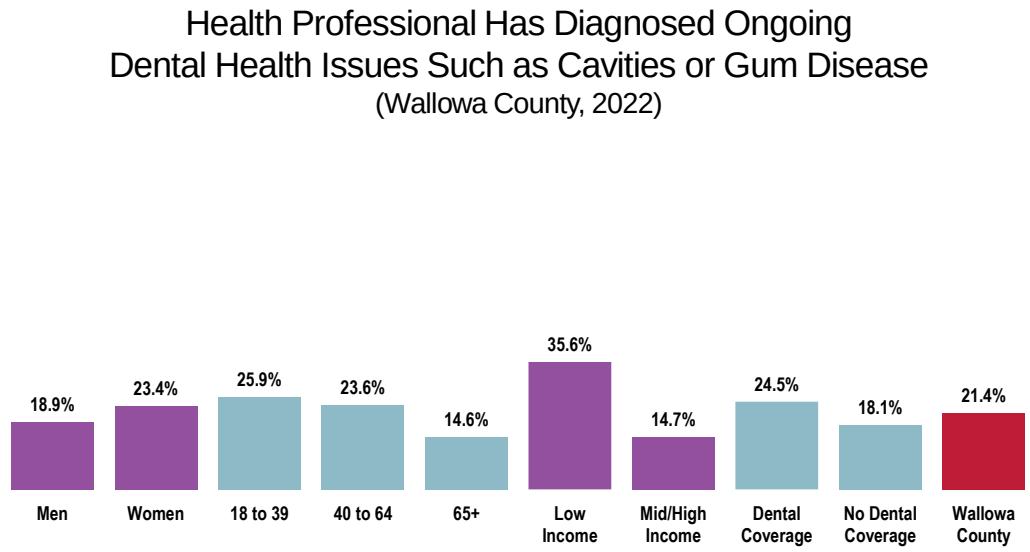

Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 309]
Notes: ● Asked of all respondents.




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 309]
Notes: ● Asked of all respondents.

## Ongoing Dental Health Issues

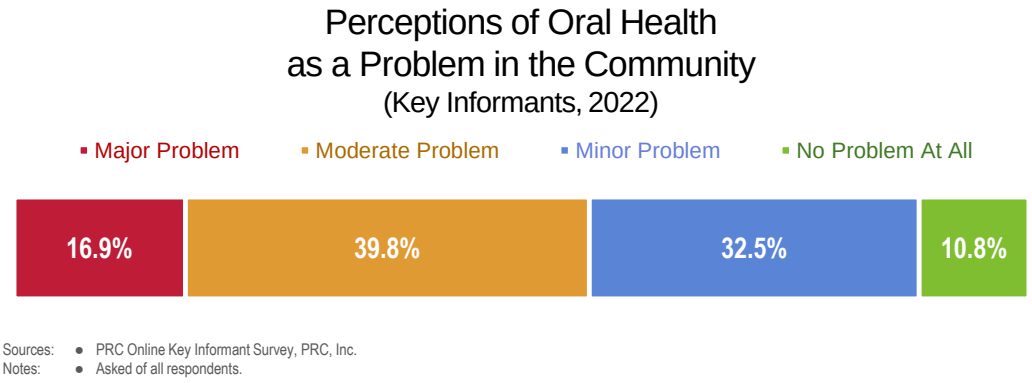
**"Have you been told by a healthcare provider that you have ongoing dental issues such as problems with cavities or gum disease like gingivitis?"**




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 312]
Notes: ● Asked of all respondents.

## Key Informant Input: Oral Health

The following chart outlines key informants' perceptions of the severity of *Oral Health* as a problem in the community:




Sources: ● PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Among those rating this issue as a “major problem,” reasons related to the following:

## Contributing Factors

> It's expensive. There are few providers. Insurance coverage is inadequate. – Community Leader
>
> I've visually seen a lot of bad teeth. And, we have few dentists that are difficult to get into. And, oral health is a world-wide problem. – Community Leader
>
> I feel that oral health and access to oral health is HUGE. We have providers but most people can't afford health insurance much less dental insurance and then providers will not take most that is available. People are not educated in that oral health is HUGE to overall health. The disconnect of the 2 health is where providers and education is dropping the ball. Having education for the community about oral health would be huge, outside parents of infants and schools. – Social Service Provider

## Access for Medicare/Medicaid Patients

> For a long time there has been only one dentist that accepted Oregon Health Plan or any dental insurance. Winding Waters Clinic is staffing up with dentists to handle Medicaid patients, but there is a large backlog. Significant numbers of citizens have had no dental health services for many years. – Community Leader
>
> Historically there were not enough Medicaid dentists or dentists who offered a sliding fee scale so there is a huge amount of major restorative work that needs to be done to help people have healthy mouths. – Public Health

## Affordable Care/Services

> Lack of affordable dental care. Cost of dental care is much higher than most working families can afford. – Community Leader
>
> Lack of dental programs for people who are not low-income but can't afford dental care. – Social Service Provider

## Access to Care/Services

> We've had an incompetent provider for many years in the county that has only recently left. Other provider has overpriced services eliminating a majority of patrons recently retired. Many residents go outside of the county for affordable oral care that can trust. – Community Leader

## Cost

> Very few dentists take insurance as payment and dental hygiene is very expensive, so. I think many choose not to go but those that have OHP can go to one dentist. The income levels accepted for OHP do not make sense. Most middle-class families cannot afford health insurance that covers expensive dentistry bills. – Community Leader

## Environmental Contributors

> No fluoride in the water. – Physician

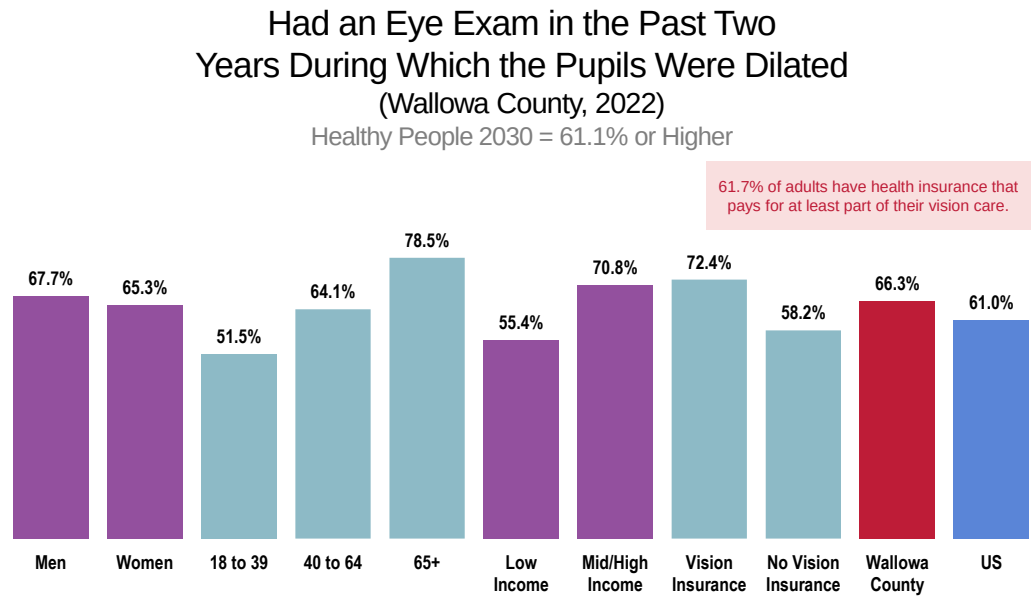
## Lack of Providers

> Providers are limited. – Social Service Provider

# Vision Care

**“Do you currently have any health insurance coverage that pays for at least part of your vision care?”**

**“When was the last time you had an eye exam, which included looking at the back of your eyes?”**




Sources:
- 2022 PRC Community Health Survey, PRC, Inc. [Items 19, 307]
- US Department of Health and Human Services. Healthy People 2030. August 2020. http://www.healthypeople.gov

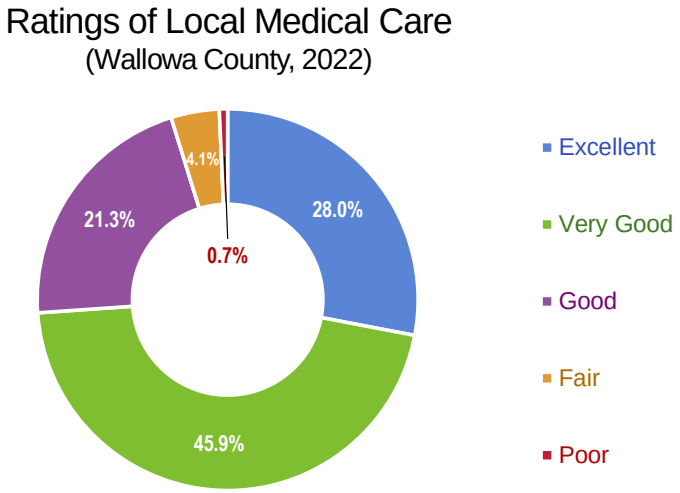
Notes:
- Asked of all respondents.

# LOCAL RESOURCES

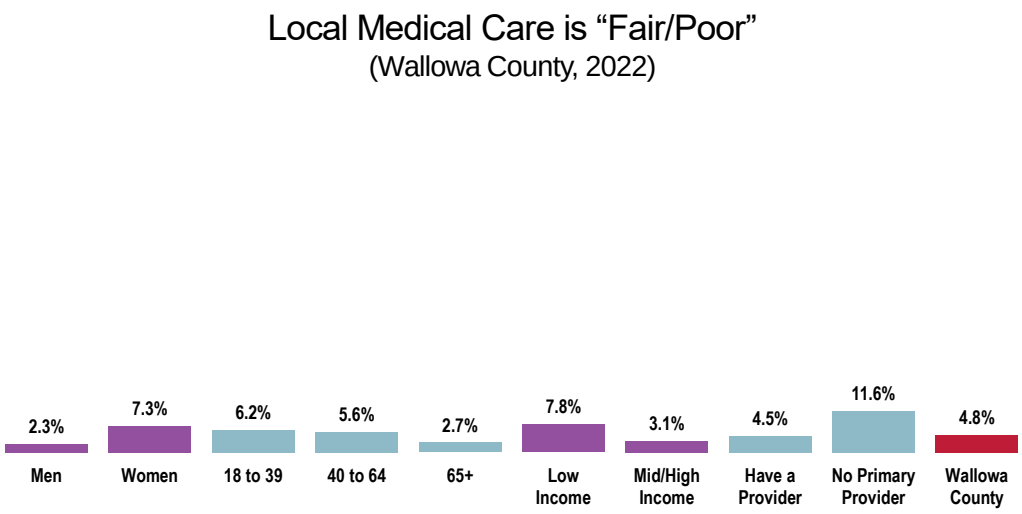
## Local Medical Services

### Ratings of Overall Medical Services

**"How would you rate the overall medical services available to you? Would you say: excellent, very good, good, fair, or poor?"**




Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: • Asked of all respondents.



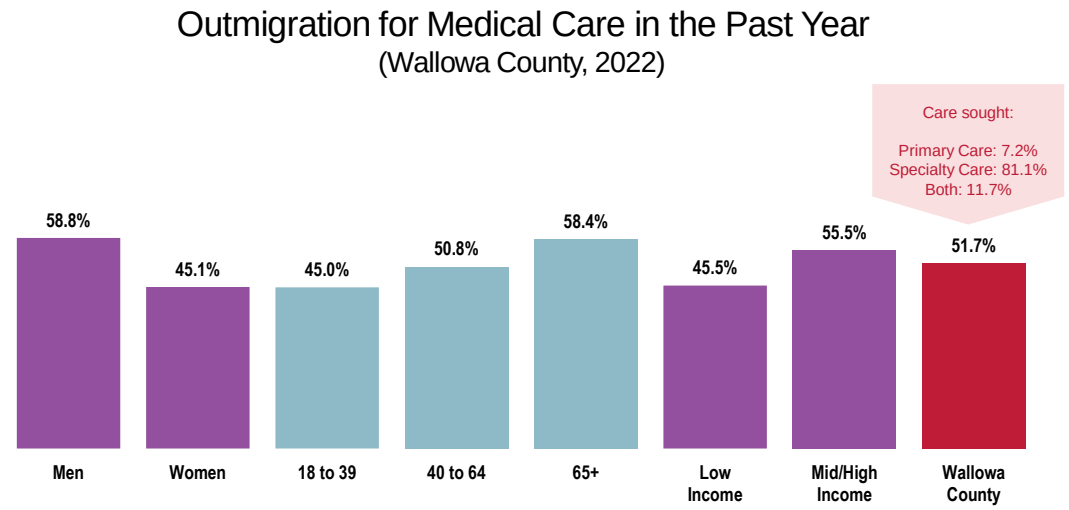

Sources: • 2022 PRC Community Health Survey, PRC, Inc. [Item 301]
Notes: • Asked of all respondents.

## Outmigration for Care

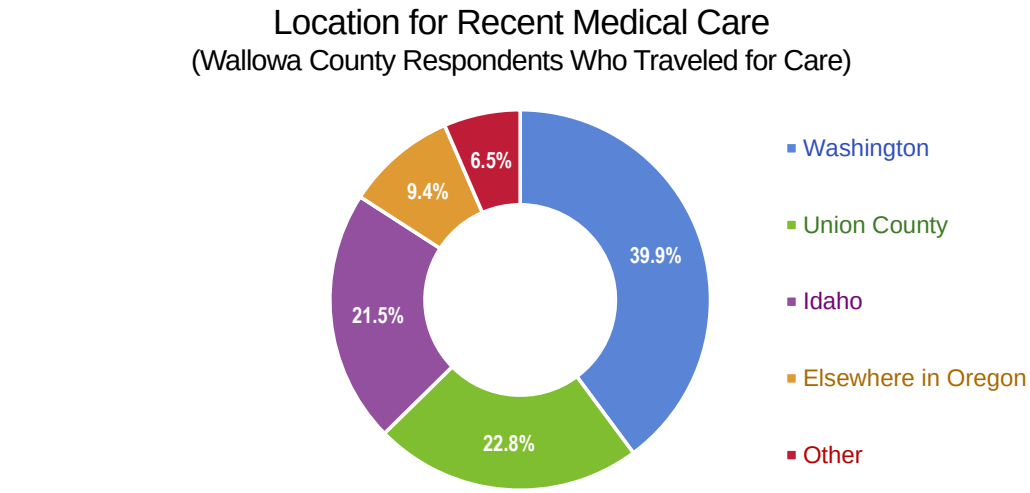
**"During the past 12 months, did you or any member of your household seek medical care outside of the county where you live?"**

[Those Leaving for Care] **"Was that for primary/routine care, specialty care, or both?"**

[Those Leaving for Care] **"When leaving your county for care, where do you most often go?"**




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Items 304-305]
Notes: ● Asked of all respondents.




Sources: ● 2022 PRC Community Health Survey, PRC, Inc. [Item 306]
Notes: ● Asked of those respondents who traveled for medical care in the past year.

# Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

### Access to Health Care Services

- Community Connections
- Department of Human Services
- Doctor's Offices
- HeadStart
- Troy School
- Winding Waters Medical Clinic

### Cancer

- Center for Wellness
- Community Connections
- Doctor's Offices
- Hospitals
- Screenings
- Wallowa Memorial Hospital
- Winding Waters Medical Clinic

### Coronavirus

- Building Healthy Families
- Businesses Supporting Mask Mandates
- Center for Wellness
- Churches
- Community Zoom Forum
- Contact Tracing/Case Investigation
- County Commissioners
- COVID-19 Vaccine and Testing Sites
- Doctor's Offices
- Eastern Oregon Community Resource Network
- Government Officials
- Home Monitoring With Pulse Oximeter
- Hospitals
- Mountain View
- Newspaper
- Olive Branch
- Oregon Health Authority
- Pharmacies
- Safeway Pharmacy
- School System
- Treatment
- Wallowa County Board of Commissioners
- Wallowa County Government
- Wallowa County Health Care District
- Wallowa Memorial Clinics
- Wallowa Memorial Hospital
- Wallowa Mountain Medical
- Wallowa Valley Center for Wellness
- Winding Waters Medical Clinic

### Dementia/Alzheimer's Disease

- Alpine House Nursing Home
- Area Agency on Aging
- Assisted Living Facilities
- Care Facilities
- Center for Wellness
- Community Connections
- Department of Human Services
- Doctor's Offices
- Friends/Family
- Greater Oregon Behavioral Health Initiative
- PACS Trainer
- Senior Centers
- Support Groups
- Wallowa County Health Care District
- Wallowa County Senior Living
- Wallowa Memorial Hospital
- Wallowa Mountain Medical
- Wallowa Valley Center for Wellness
- Wallowa Valley Senior Living Memory Care
- Winding Waters Medical Clinic

### Diabetes

- Complete Health Improvement Program
- Community Connections
- Diabetes Cooking Classes
- Diabetes Educator
- Diabetes Undone Program
- Dietitians
- Doctor's Offices
- Farmer's Market
- Fitness Centers/Gyms
- Group Classes
- Harvest Share

- Hospitals
- Local Community Advisory Council
- Lifestyle Change Programs
- Mountain View
- Online Classes/Memberships
- Oregon State University Extension
- Parks and Recreation
- SNAP Program
- Wallowa County Health Care District
- Wallowa Memorial Clinics
- Wallowa Memorial Hospital
- Winding Waters Medical Clinic

### Disabilities

- Acupuncture
- Affordable Integrated Medicine
- Center for Wellness
- Chronic Pain School
- Community Connections
- DHS
- Doctor's Offices
- Eagle Cap Wellness
- Health and Wellness
- Holistic Health and Healing
- Hospitals
- Massage
- Northeast Oregon Network
- Pain Clinic
- Parks and Recreation
- Physical Therapy
- Senior Centers
- Triple H Clinic
- Wallowa Educational Disability Services
- Wallowa Memorial Hospital
- Wallowa Valley Center for Wellness
- Winding Waters Medical Clinic

### Heart Disease

- Complete Health Improvement Program
- Consultation
- Dietitians
- Doctor's Offices
- Fitness Centers/Gyms
- Group Classes
- Hospitals
- Lifestyle Change Programs
- Parks and Recreation
- Post Stroke Rehabilitation
- Troy School
- Wallowa County Health Care District
- Wallowa Memorial Hospital
- Winding Waters Medical Clinic
- Wallowa Memorial Medical Clinic

### Infant Health and Family Planning

- Breastfeeding Consultants
- Building Healthy Families
- Doctor's Offices
- Holistic Health and Healing
- Winding Waters Medical Clinic

### Injury and Violence

- Batterers Intervention
- Community Connections
- DHS
- Law Enforcement
- Safe Harbors
- School System
- Wallowa Valley Center for Wellness
- Winding Waters Medical Clinic

### Mental Health

- AA/NA
- Blue Butterfly Mental Health
- Building Healthy Families
- Center for Wellness
- Churches
- Counseling
- Doctor's Offices
- Eagle Cap Wellness
- Employee Assistance Programs
- Holistic Health and Healing
- Hospitals
- Hotline for Suicide
- Joseph House
- Mental Health Living Facilities
- Mental Health Services
- Mountain View
- National Hotlines
- Online Therapies
- Pioneer Guest House
- Private Child Consultant
- Safe Harbors
- School System
- The Josephy Center
- Veterans Services
- Wallowa County Health Care District
- Wallowa Memorial Clinics
- Wallowa Memorial Hospital
- Wallowa Valley Center for Wellness
- Wellness Center
- Winding Waters Medical Clinic

### Nutrition, Physical Activity, and Weight

- Building Healthy Families
- Community Outreach
- Dietitians
- Doctor's Offices
- Extension Office
- Farmer's Market
- Fitness Centers/Gyms
- Fresh Alliance
- Harvest Share
- Health Food Store
- Holistic Health and Healing
- Hospitals
- Hotel
- Insurance Providers
- Lifestyle Change Programs
- Motivations
- Oregon State University Extension
- Parks and Recreation
- Rails With Trails
- Ruby Peak Naturals
- School System
- Slow Food
- Wallowa County Health Care District
- Wallowa Memorial Hospital
- Wallowa Mountain Medical
- Wallowa Valley Center for Wellness
- Weight Watchers
- Winding Waters Medical Clinic

### Oral Health

- Dentist's Offices
- Doctor's Offices
- NEON
- Oregon Health Plan
- Tyler Schaffeld Dental
- Wallowa Valley Dental Care
- Winding Waters Medical Clinic

### Respiratory Diseases

- Hospitals
- Wallowa Mountain Medical
- Winding Waters Medical Clinic

### Sexual Health

- Doctor's Offices
- School System

### Substance Abuse

- AA/NA
- Building Healthy Families
- Center for Wellness
- DHS
- Doctor's Offices
- Drug Court
- Hospitals
- Hotline for Substance Abuse
- Justice Department
- Juvenile Probation Staff
- Pioneer Guest House
- Rehabilitation Facility
- School System
- Wallowa County Court
- Wallowa County District Attorney
- Wallowa County Health Care District
- Wallowa County Parole and Probation Office
- Wallowa Memorial Hospital
- Wallowa Valley Center for Wellness
- Winding Waters Medical Clinic

### Tobacco Use

- Bowman Funeral Services
- Doctor's Offices
- Friends/Family
- Health Department
- Hospitals
- Justice Department
- School System
- Smoking Cessation Classes
- Wallowa Memorial Hospital
- Wallowa Valley Center for Wellness
- Winding Waters Medical Clinic
- Wallowa Memorial Medical Clinic

# APPENDIX

# EVALUATION OF PAST ACTIVITIES

## Community Benefit

Over the past three years, Wallowa Memorial Hospital has invested in improving the health of our community's most vulnerable populations. Our commitment to this goal is reflected in:

- Over $3,500,000 in community benefit, excluding uncompensated Medicare.
- More than $300,000 in charity care and other financial assistance programs.

Our work also reflects a focus on community health improvement, as described below.

## Addressing Significant Health Needs

Wallowa Memorial Hospital conducted its last CHNA in 2019 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that Wallowa Memorial Hospital would focus on developing and/or supporting strategies and initiatives to improve:

- Lifestyle Factors
- Injury/Trauma
- Preventable Hospitalizations
- Flu / Pneumonia
- Tobacco Use
- Suicidality

Strategies for addressing these needs were outlined in Wallowa Memorial Hospital's Implementation Strategy. Pursuant to IRS requirements, the following sections provide an evaluation of the impact of the actions taken by Wallowa Memorial Hospital to address these significant health needs in our community.

# Evaluation of Impact

| Priority Area: Lifestyle Factors | |
|---|---|
| **Community Health Need** | Access to affordable healthy foods and exercise |
| **Goal(s)** | • Decrease food insecurity for all ages<br>• Decrease soda consumption<br>• Access to affordable exercise |

| Strategy #1: Explore Community Garden | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Community members of Wallowa County |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Winding Waters Clinic, Wallowa Valley Center for Wellness, Community Connections |
| **Results/Impact** | • Wallowa Memorial Hospital designated land to use<br>• Board Certified Lifestyle Medicine Physician engaged<br>• Plan presented to and approved by Enterprise City Council<br>• Plan to implement 2022 - 2024 |

| Strategy #2: Implement Cardiac Wellness Program | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | Any community member referred by primary care provider for any identified cardiac diagnosis or risk |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Physical Therapy, Winding Waters Clinic, Olive Branch Clinic |
| **Results/Impact** | • Collaboration with County primary care providers<br>• Approximately 50 patients have successfully completed the Cardiac Wellness Program |

| Strategy #3: Install a Walking Path | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All community residents and visitors |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Winding Waters Medical Clinic, City of Enterprise, Wallowa Valley Center for Wellness, Wallowa Memorial Hospital Wellness Committee, Wallowa Memorial Hospital staff |
| **Results/Impact** | • Approximately 0.5 mile walking path installed around Wallowa Memorial Hospital campus<br>• Widely used by community members of all ages |

| Priority Area: Injury / Trauma | |
|---|---|
| **Community Health Need** | Reduction in trauma injuries |
| **Goal(s)** | • Decrease trauma injuries by 20% from 2019 survey<br>• Decrease in reported binge drinking<br>• Decrease in alcohol related motor vehicle accidents |

| Strategy # 1: Implement Trauma Nurses Talk Tough | |
|---|---|
| **Strategy Was Implemented?** | No |
| **Target Population(s)** | Community members involved in or associated with trauma accidents |
| **Partnering Organization(s)** | Local law enforcement, Wallowa Valley Center for Wellness, Wallowa Memorial Hospital, local public schools |
| **Results/Impact** | • Program was put on hold due to COVID restrictions |

| Strategy # 2: Public Education | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All Community Members |
| **Partnering Organization(s)** | Local law enforcement, Wallowa Valley Center for Wellness, Wallowa Memorial Hospital, local public schools, Winding Waters Medical Clinic, Building Healthy Families |
| **Results/Impact** | • Questions about seatbelts, helmets, and other safety mechanisms are being asked at primary care wellness visits<br>• Newspaper articles and social media education / awareness being developed |

| Strategy # 3: Access to Addiction Services | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All Community Members |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Winding Waters Clinic, Wallowa Valley Center for Wellness |
| **Results/Impact** | • SBIRT utilized at all wellness visits in primary care clinics<br>• Referrals to appropriate behavioral health services |

| Priority Area: Preventable Hospitalizations | |
|---|---|
| **Community Health Need** | Decrease the number of preventable hospitalizations |
| **Goal(s)** | • Increase the use of Primary care to reduce hospitalizations<br>•<br>• |

| Strategy # 1: Educate Public on Patient Centered Primary Care Homes | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All Wallowa County community members |
| **Partnering Organization(s)** | Wallowa Memorial Hospital Medical Clinics, Winding Waters Medical Clinic |
| **Results/Impact** | • Education materials provided to patients at all local PCPCH clinics<br>• Newspaper article written and submitted |

| Strategy # 2: Improve Care Management | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All community members |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Winding Waters Clinic, Wallowa Valley Center for Wellness, Building Healthy Families |
| **Results/Impact** | • Readmission Reduction Program started and continuous improvement process in place<br>• Patients and families involved in program<br>• Increased awareness of resources available in community<br>• Increased referrals to community partners |

| Priority Area: Tobacco Use | |
|---|---|
| **Community Health Need** | Decrease incidence of tobacco use |
| **Goal(s)** | • Decrease cigarette smoking incidence<br>• Decrease use of smokeless tobacco<br>• Wallowa Memorial Hospital will be a tobacco free campus |

| Strategy # 1: Have a designated tobacco cessation specialist | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All Community members using tobacco products |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Olive Branch Clinic, Winding Waters Clinic |
| **Results/Impact** | • Wallowa Memorial Hospital Respiratory Therapist attended training to become Tobacco Cessation Specialist<br>• Community Tobacco Cessation Class offered<br>• Individual Tobacco Cessation coaching offered through Cardiopulmonary Department<br>• Increased referrals from primary care for tobacco cessation coaching for both in-patient and outpatient |

| Strategy # 2: Wallowa Memorial Hospital a tobacco free campus | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All visitors and staff of Wallowa County Health Care District campus |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Winding Waters Clinic, Wallowa Valley Center for Wellness, Olive Branch Clinic |
| **Results/Impact** | • Policy in place for tobacco free campus<br>• Staff and public educated on tobacco free campus<br>• Promotion of tobacco cessation assistance<br>• Additional options available for in-patients who use tobacco products |

| Priority Area: Flu/ Pneumonia | |
|---|---|
| **Community Health Need** | Increase immunizations and reduce deaths |
| **Goal(s)** | • Increase the county wide flu vaccination rate<br>• Increase the rate of childhood immunizations<br>• |

| Strategy #: Conduct County Wide Flu Vaccine clinics | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All County residents and visitors |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Winding Waters Clinic, Wallowa Memorial Hospital, Olive Branch Clinic |
| **Results/Impact** | • Vaccine clinics held within the county, including outlying areas<br>• PSA and newspaper articles done around the importance of vaccines. |

| Strategy #: Antimicrobial Stewardship Program | |
|---|---|
| **Strategy Was Implemented?** | Yes |
| **Target Population(s)** | All county residents |
| **Partnering Organization(s)** | Wallowa Memorial Hospital, Winding Waters Clinic, Wallowa Memorial Hospital, Olive Branch Clinic |
| **Results/Impact** | • Pneumonia prescribing practices completed<br>• Provider education complete<br>• Prescribing practices tracked and trended. Results reported at hospital and clinic quality meetings. |