Saint Alphonsus Medical Center - Ontario

2020

Community Health Needs Assessment

Saint Alphonsus
A Member of Trinity Health

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ACKNOWLEDGEMENTS

Saint Alphonsus Medical Center-Ontario would like to thank the following partners and agencies that contributed to the 2020 Community Health Needs Assessment

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LGBTQIA+ Partners
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Malheur County United for Housing Task Force
Nyssa Food Bank
Origins Faith Community
Saint Alphonsus Medical Center- Ontario and Fruitland Health Plaza
Southwest District Health Department- Payette and Washington County CHATs
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Weiser Senior Center

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Barb Higginbotham and Heather Echeveste, Community in Action
Travis Johnson, Malheur County Sheriff
Judge Dan Joyce and Stephanie Williams, Malheur County Court
Sarah Poe, Rebecca Stricker, and Angie Gerrard, Malheur County Health Department
Shawna Peterson and staff/Board members, Eastern Oregon Border Economic Development Region Board

EXECUTIVE SUMMARY

INTRODUCTION

As a Catholic health system, Saint Alphonsus is committed to advocacy for and service to individuals whose social condition puts them at the margins of society. The Community Health Needs Assessments (CHNAs) conducted by Saint Alphonsus Medical Center- Ontario allow us to be responsible stewards of our resources and target our efforts and financial investments to where there is the greatest need and increased potential for effectiveness.

APPROACH & METHODS

The 2020 Ontario region CHNA was conducted by Saint Alphonsus Health System with Health Resources in Action (HRiA) as a research partner to better understand the social influencers of health that affect individual and community health directly and indirectly in the following three counties: Payette, Washington, and Malheur. These communities were selected for review as they comprise the primary service area where the bulk of SAMC-Ontario patients draw from. To get an in depth understanding of these communities' needs, quantitative and qualitative data was gathered from a variety of sources. The Trinity Health Data Hub was utilized as the primary source for secondary data, in addition to localized data sources provided by the Advisory Committee members. A community survey that engaged 318 residents was created to gather primary data in these three communities. Qualitative data was gathered through interviews and focus groups with individuals from multi-sector organizations, residents, and community stakeholders. It should be noted that this report was developed prior to the 2020 Coronavirus Pandemic and reflects the state of the community prior to the impacts and outcomes that resulted.

QUANTITATIVE DATA SOURCES

- American Community Survey
- Idaho Department of Health and Welfare
- Oregon Health Authority
- Behavioral Risk Factor Surveillance Survey

QUALITATIVE DATA PARTICIPATION

- 11 Focus Groups with approximately 42 Participants
- 11 Key Informant Interviews with a total of 15 Participants

Priority Areas

The CHNA Advisory Committee convened for a two-hour meeting on February 5th, 2020 to review and discuss the preliminary results of the CHNA and identify and prioritize significant health needs. Each participant was asked to rank the significant health needs individually while considering each in terms of impact, severity, magnitude, urgency, and the overall concern of residents regarding the issue.

The significant health needs are presented below in rank order.

1. Affordable, safe housing and homelessness
2. Financial stability and cost of living
3. Mental health and wellbeing
4. Substance use, including tobacco and vape use
5. Childcare and education
6. Access to healthcare, including oral healthcare
7. Chronic diseases
8. Wages and job availability
9. Sexually Transmitted Infections, access to birth control, and teen pregnancy
10. Food security
11. Transportation
12. Physical activity and recreation opportunities

KEY FINDINGS

Regional Snapshot

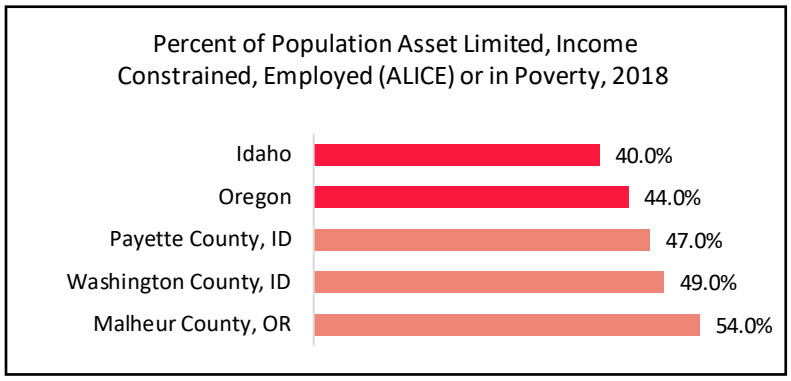
The Ontario Region is a tight knit community uniquely set up between the Idaho and Oregon border where nearly one in four residents identify as Hispanic or Latino.

The Ontario Region is unique in that the population who live, work, learn, and play there are quite mobile across the Idaho and Oregon border, meaning many live in one state, but work, recreate, shop, etc. in the other. Between 2014 and 2018, the population slightly decreased (0.9%) in the Assessment Region, though the populations in Idaho and Oregon overall increased by 5.7% and 4.9% respectively. Assessment participants reflected that there was a constant flow of people coming in and out of the Ontario region. In 2018, the population 65 years and older was approximately 17%, with a higher percentage in Washington County. Nearly one in four people in the region identified as Hispanic or Latino with Malheur county having the largest percentage at 33%. Almost 4% of community survey respondents identified as lesbian, gay, bisexual, transsexual, queer or questioning, intersex, asexual or ally, or other (LGBTQIA+). When examining the built, and social environments in the region, participants shared that they believed the region needed to be more walkable, but they felt safe in their neighborhoods and that people were very willing to help each other out.

> *"The community takes care of each other. If there's a house fire, the whole community comes together."*

Financial Stability

Low minimum wages across the region, especially in Idaho, and competing costs of living—healthcare, child care, housing, and transportation—make it difficult for many people to meet their basic needs.



An individual's employment and income level directly impact their ability to afford access to healthcare, healthy food, and housing, all of which influence myriad health outcomes. In 2018, the percent of population at or below the 200% Federal Poverty Level (FPL) ranged from 37% in Payette County to almost 48% in Malheur County. Assessment participants often said Malheur County was the poorest county in Oregon and that there are many "working poor" that are struggling to make ends meet. Community members discussed the difference in wages between Oregon and Idaho. Minimum wage in Oregon ($11.50 for non-urban areas such as Ontario effective July 2020) is $4 more than the minimum wage in Idaho ($7.25). Participants spoke about how it was not uncommon to see people living in Idaho but working in Oregon because the difference in wages is so great. ALICE, a United Way acronym that stands for Asset Limited, Income Constrained, Employed, represents the growing number of individuals and families who are working, but are unable to afford the basic necessities such as food, housing, child care, transportation, and healthcare. Among the Ontario region in 2018, the percentage of the population who are ALICE or in poverty ranged from 47% in Payette County to 54% in Malheur County. Almost half of the people across the area are making too much to qualify for many

subsidies, but not enough to make ends meet. Food insecurity was a concern among many assessment participants, though some believed food insecurity is not as much of a problem as it was in the past because more resources have been made available locally. In the Ontario region overall during the 2016-2017 school year, approximately 63% of children were eligible for free and/or reduced-price lunch, ranging from 54% in Payette County to 73% in Malheur County. This was higher than the 46% in Idaho and 49% in Oregon.

Housing

A low number of affordable housing units in the region has caused an increase in housing cost for the average family.

Unstable housing and homelessness can lead to stress, isolation, chronic disease (e.g., asthma), substance use, mental health issues, and violence**.** Community survey results showed that almost 60% of respondents believed affordable housing is a top issue for the community. In 2018 in Payette County, there were approximately 18 affordable and available units for every 100 people who had extremely low income (<30% Area Median Income [AMI]), approximately 74 available units for every 100 people with very low income (30-50% AMI), and approximately 106 units for every 100 people with low income (50-80% AMI). These data support assessment participants' perception of a lack of affordable housing options for very low-income individuals and families. Housing insecurity was seen as a growing issue among people coming to the Ontario region from Boise and the surrounding areas.

> *"There is not a housing inventory at all even for individuals and families who have a decent income. People are forced to rent or buy in Idaho because there is no stock in Ontario proper."*

Transportation

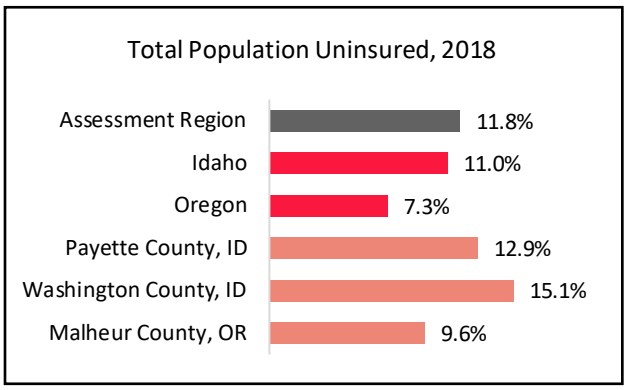
The lack of transportation options in the region has made it difficult for people to get around and leads to issues in healthcare access.

Transportation can affect one's physical activity, injury levels, respiratory related illnesses, and access to goods and services, including healthcare. In 2018, approximately 5.7% of households in the Ontario region did not have access to a motor vehicle. This supports assessment participants' perceptions that a car was needed to get around the area due to the poor public transportation infrastructure. Availability of public transportation was ranked as the top transportation concern among 35% of community survey respondents. Qualitatively, participants often spoke about how the lack of transportation options affected their access to medical and social services.

> *"Lack of transportation is lack of medical attention which then makes health conditions worse."*

Health

Though rates of insurance coverage are generally high, there are barriers to accessing services in the region such as language access and cost of services.

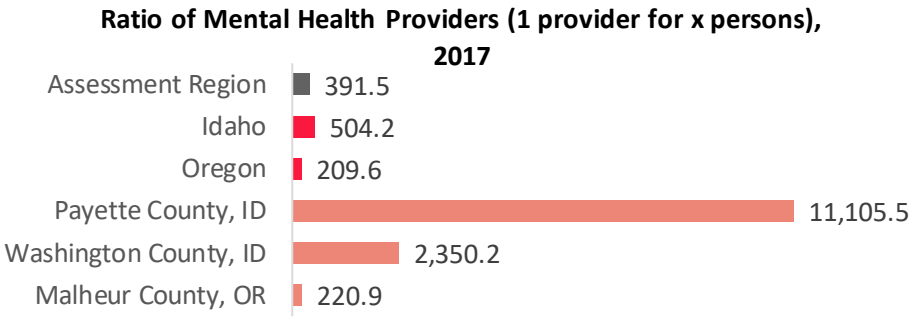


Approximately one-third of survey respondents identified insurance coverage as a barrier to obtaining healthcare. In 2018, the percentage of the population without insurance ranged from 10% in Malheur County to 15% in Washington County. Within the Ontario region in 2018, the percentage of the insured population receiving Medicaid ranged from 22% in Washington County to 39% in Malheur County. Assessment participants shared that community members with Medicaid still had to pay for needed medical services and expensive prescription medications out of pocket because Medicaid did not provide full coverage. Aside from insurance barriers, there were also several access barriers such as availability, language and cost. In 2019, the entire population in the Ontario region was living in a health professional shortage area compared to 67.1% in Idaho and 50.6% in Oregon. Approximately 19% of community survey respondents reported that they had no regular doctor or source of healthcare.

Behavioral Health: Mental Health and Substance Use

Behavioral health, especially suicide and access to services, was a major concern in the region.

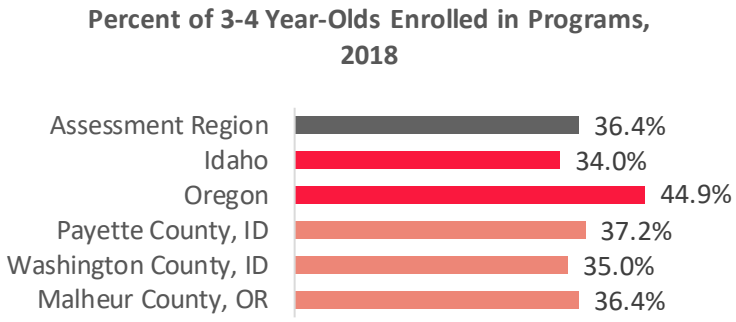
Community survey respondents were concerned about mental health; 44% listed mental health and stress as a top five health issue in their community. In the Assessment Region overall in 2017, adults aged 20 and over reported having on average 4.4 poor mental health days in a month. Youth suicide has become a public health crisis in Idaho and Oregon. In Oregon, it is the second leading cause of death for youth ages 10-24 and in Idaho it is the second leading cause of death for Idaho residents ages 15-34 and for males up to age 44. Contributing to regional behavioral health challenges, in 2019 the entire population in the Ontario region was living in a health professional shortage area.



Substance use was also a top health concern for the community identified by 42% of community survey respondents. In 2014, the state of Oregon legalized the recreational use of marijuana which brought concerns for some participants who believe legalization will cause addiction, especially among youth. Vaping was mentioned as a substance of particular concern among youth in the Ontario region. In Idaho, 48% of high school students reported they had ever used an electronic vapor product in their lifetime.

Education

Enrollment in early childhood programs was much lower in the Ontario region than the nation. Educational attainment also lags.



The first six years of a child's life are vital for a child's development and future success. In the Ontario region, all of the counties are considered child care deserts. In 2018, approximately 36% of children aged 3-4 years old were enrolled in programs compared to approximately 40% for 3-year-old and 70% for 4-year-old children nationally. High-quality K-12 education is key to developing essential knowledge and skills in children and teens that they can carry into their adult lives. In the Ontario region in 2018, approximately 17% of the population over the age of 25 did not have a high school diploma and only approximately 14% of the population over 25 years of age had a bachelor's degree or higher.

Conclusion

While the Ontario region generally has positive health outcomes, the assessment has revealed various areas of need and opportunity in the community. Conversations with community members and analysis of various data sources reveal the need to address the social influencers of health to improve the overall well-being of the community. When those social influencers of health, such as education, financial stability, housing and transportation, are addressed, the health outcomes for the area should improve. In order to address these issues long term, collective action and community buy-in will be paramount. Policy, systems, and environmental changes will be needed with the full participation of a range of stakeholders, including nonprofits, hospitals, community leaders, grassroots organizations, and businesses. Data from this report and the twelve identified priority areas can guide the development of goals, objectives, strategies and performance measures for community health improvement planning going forward.

INTRODUCTION

As a Catholic health system, Saint Alphonsus is committed to advocacy for and service to individuals whose social condition puts them at the margins of society. We are called to minister to those less fortunate and to ensure the dignity of all people.

Our Mission calls us to serve together with Trinity Health, in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. The Community Health Needs Assessments (CHNAs) allow Saint Alphonsus to be responsible stewards of our resources and target our efforts and financial investments to where there is the greatest need and increased potential for effectiveness.

A Community Health Needs Assessment provides the opportunity to:
» Gain insights into the needs and assets of the communities served
» Identify and address the needs of vulnerable populations within the community
» Enhance relationships and opportunities for collaborative community action
» Provide information for community outreach planning, evaluation and assessment

About Saint Alphonsus Medical Center – Ontario

History

Ontario's one and only hospital began with a small group of Dominican Sisters of the Portuguese Congregation of St. Catherine of Sienna. The Sisters began in a tent with limited resources. With the ambition of the Sisters and the community's overwhelming support the hospital went from a dream to a reality, breaking ground September 18, 1911, and completing ahead of schedule on April 15, 1912. Bishop O'Reilly named the hospital in honor of the Holy Rosary. On April 1, 2010, Holy Rosary Medical Center (Ontario, Oregon), Mercy Medical Center (Nampa, Idaho), St. Elizabeth Health Services (Baker City, Idaho), Saint Alphonsus Regional Medical Center (Boise, Idaho), and Saint Alphonsus Regional Rehabilitation Hospital (Boise, Idaho) joined together to form the Saint Alphonsus Health System with Ontario, Nampa, and Baker City each changing their respective names to Saint Alphonsus Medical Center. The five-hospital, 754-bed integrated health system was created to serve the 21st century healthcare needs of the people of southwestern Idaho, eastern Oregon and northern Nevada. Also connected to this powerful Health System is Saint Alphonsus Medical Group, with over 270 primary care and specialty care providers at 125 clinic locations throughout Western Idaho and Eastern Oregon. As a not-for-profit, Saint Alphonsus Health System (SAHS) reinvests profits back into the community and works to improve the health and well-being of those we serve by emphasizing care that is patient-centered, innovative and community-based. Saint Alphonsus Health System is a member of Trinity Health, Livonia, Michigan. Trinity Health is one of the largest multi-institutional Catholic healthcare delivery systems in the nation. It serves people and communities in 22 states from coast to coast with 92 hospitals, 109 continuing care facilities and home health and hospice programs that provide nearly 2.8 million visits annually. The organization was formed in May 2013, when Trinity Health and Catholic Health East closed their consolidation to strengthen their shared mission, increase excellence in care, and advance transformative efforts with their unified voice.

Mission Statement

We, Saint Alphonsus and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Core Values

Reverence: We honor the sacredness and dignity of every person.
Commitment to Those Who are Poor: We stand with and serve those who are poor, especially those most vulnerable.
Justice: We foster right relationships to promote the common good, including sustainability of Earth.
Stewardship: We honor our heritage and hold ourselves accountable for the human, financial and natural resources entrusted to our care.
Integrity: We are faithful to who we say we are.
Safety: We embrace a culture that prevents harm and nurtures a healing, safe environment for all.

Facilities Owned & Operated by Saint Alphonsus Medical Center-Ontario

- Saint Alphonsus Medical Center – Ontario (SAMC-Ontario)
- Fruitland Health Plaza
- 2 free-standing Saint Alphonsus Medical Group facilities in Ontario

Services Provided

SAMC-Ontario is a not-for-profit 49-bed, acute care hospital serving Ontario and the surrounding communities in eastern Oregon and southwest Idaho. SAMC – Ontario not only provides quality healthcare but as part of our Mission, is committed to contribute to the well-being of the community through health education, outreach programs, screenings, health fairs, seminars, community partnerships and more. SAMC-Ontario also provides primary and specialty care through the Fruitland Health Plaza.

Services provided include: • Breast Care • Cancer Care • Diabetes Care & Education • Dietary Services • Emergency Care • Heart Care • Hospice • Laboratory & Radiology • Maternity Care • Neurology • OB/GYN Services • Orthopedics • Primary Care • Rehabilitation Services • Sleep Disorders Treatment • Surgical Services • Tele-stroke Services

Conducting the 2020 Community Needs Assessment

SAMC-Ontario completed a coordinated comprehensive Community Health Needs Assessment (CHNA) that was adopted by the Ontario Community Hospital Board on June 19, 2020. SAMC-Ontario performed the CHNA in adherence with certain federal requirements for not-for-profit hospitals set forth in the Affordable Care Act and by the Internal Revenue Service. The assessment took into account input from representatives of the community, community members, and various community organizations. It is available publicly online at https://www.saintalphonsus.org/about-us/community-benefit/community-needs-assessment/ , or by request from the Saint Alphonsus Health System Community Health and Well-Being Department.

The 2020 assessment was conducted by Saint Alphonsus Health System with Health Resources in Action (HRiA) as a research partner. Three Counties: Payette, Washington and Malheur were the primary service areas

studied, with analysis and comparison of county/health district, state, and national data wherever available. These communities were selected for review as they comprise the primary service area where the bulk of SAMC-Ontario patients draw from. This assessment was completed concurrently with the 2020 Treasure Valley Community Assessment covering the Boise and Nampa Saint Alphonsus Healthy System service areas using the same contractor and processes for regional data comparison. The Trinity Health Data Hub was utilized as the primary source for secondary data, in addition to localized data sources provided by the Advisory Committee members. Additional duties of the Advisory Committee, whose members are listed in the Acknowledgements, included selecting secondary data indicators, developing the community survey and focus group/interview instruments, disseminating community surveys, conducting and participating in focus groups and key informant interviews, selecting significant health needs, and providing review and revision to the draft assessment report, and drafting the plan for communications and dissemination of the completed assessment.

The 2020 Community Health Needs Assessment processes and drafts were presented to the SAMC-Ontario Community Hospital Board on May 12, 2020. The Board elected a designee to provide final adoption of the assessment. All approvals for adoption were received by June 19, 2020.

Comments

Any additional comments on this report may be submitted to Rebecca Lemmons, Saint Alphonsus Health System Regional Manager of Community Health and Well-Being at Rebecca.Lemmons@saintalphonsus.org.

Review of 2017 CHNA

As with the 2020 Community Health Needs Assessment, the prior 2017 Community Health Needs Assessment utilized an advisory committee as the primary method of gathering public input on the draft reports between January and April 2017. The community organizations that made up the 2017 Advisory Committee were provided with drafts of the assessment report and provided comments back to Saint Alphonsus for inclusion in the final document. No notable revisions or changes were noted at that time. Additionally, the SAMC-Ontario Community Hospital Board was provided with drafts of the assessment and contributed to the selection of the 2017 CHNA priorities.

The 2014 and 2017 SAMC-Ontario Community Health Needs Assessments can be found online at: https://www.saintalphonsus.org/about-us/community-benefit/community-needs-assessment/

The prior CHNA, completed in April 2017, identified five significant health needs within the SAMC-Ontario community:

Nutrition, Physical Activity, and Weight Status

- Prevalence of obesity & diabetes
- Low fruit and vegetable consumption
- Lack of affordable physical fitness opportunities
- High levels of food assistance

Education

- Access to high quality preschool programs
- High school graduation rates

- Low college enrollment rates/ student loan debt
- Access to educational support and family/parental support
- Access to training and development opportunities
- Disconnected youth

Access to Health Services

- Access to basic health services
- Lack of medical, dental, mental health, and vision insurance coverage and utilization
- Prescription costs
- Low levels of prenatal care
- Transportation barriers
- Idaho insurance gap

Financial Stability

- Unemployment/underemployment
- Affordable housing/housing assistance
- Living wage jobs
- Financial education/training
- College/vocational training
- Job training
- Transportation barriers
- Children living in poverty

Injury & Violence Prevention

- Unintentional injury deaths
- Family violence
- Human trafficking
- Suicide
- Drug and alcohol abuse

The 2017 Community Health Needs Assessment was reviewed in detail within the Saint Alphonsus Health System Community Health and Well-Being Department in partnership with Health Resources in Action in summer and Fall 2019, prior to the development of the 2020 Community Health Needs Assessment processes and tools.

Accomplishments from the 2017 Community Needs Assessment

SAMC-Ontario acknowledged the wide range of priority health issues that emerged from the 2017 CHNA process, and determined that it could effectively focus on only those health needs which it deemed most pressing, under-addressed, and within its ability to influence. SAMC-Ontario developed and/or supported initiatives to improve the health needs of nutrition-physical activity-weight status, education, and access to health services.

Nutrition, Physical Activity and Weight Status

- SAMC-Ontario provided professional athletic trainers for local high schools to reduce student injuries and create more opportunities for schools to provide physical activities for students.

    - 2017: 1,732.5 hours, 903 injuries addressed
    - 2018: 2,106.25 hours, 1,325 injuries addressed, 27,607 athletes overseen
    - 2019: 2,062.75 hours, 1,666 injuries addressed, 31,706 athletes overseen
- Saint Alphonsus Health System provide GoNoodle for elementary students in southern Idaho and eastern Oregon.
    - 2016-2017 School Year- 6,828 Oregon students reached; 978,460 minutes of student activity
    - 2017-2018 School Year - 5,554 Oregon students reached; 689,666 minutes of student activity
    - 2018-2019 School Year - 5,439 Oregon students reached; 800,030 minutes of student activity
- SAMC-Ontario provided $25,000 to support the creation of a splash pad within the Ontario community parks system to provide an affordable physical activity for the community. The splash pad opened in May 2019.

Education

- SAMC-Ontario supported the Treasure Valley Technical (TVT) program by serving as an educational site for CNA students, providing speakers and mentors to classes/students, acting in an advisory role for TVT board and CNA programs, providing supplied for CNA classes, and providing free medical screenings to allow CNA students to be licensed in the state of Oregon. Between 2017-2019, the program reached 800 students.
- SAMC-Ontario provided leadership staff to the Malheur County Poverty to Prosperity (P2P) organization working to develop additional educational programs for local high school and community college students, as well as the underemployed in the community. Between 2017-2019, there were 1200 participants.
- SAMC-Ontario partnered with the Treasure Valley Relief Nursery to provide nutrition classes as well as $3,600 financial support in its efforts to support at risk families with preschool age children. Between 2017-2019, these efforts reached 149 participants.

Access to Health Services

- SAMC-Ontario maintained the Health Resource Center (HRC) until 2018. The HRC served members of the community with healthcare access issues, as well as assisting them with getting access to health insurance and other local mental health service providers, via the utilization of Community Health Workers. Between 2017-2019, Community Health Workers have served 274 patients.
- SAMC-Ontario performs annual community and hospital open enrollment events for Oregon and Idaho Medicaid. Between 2017-2019, these events reached 1850 participants.

METHODS AND LIMITATIONS

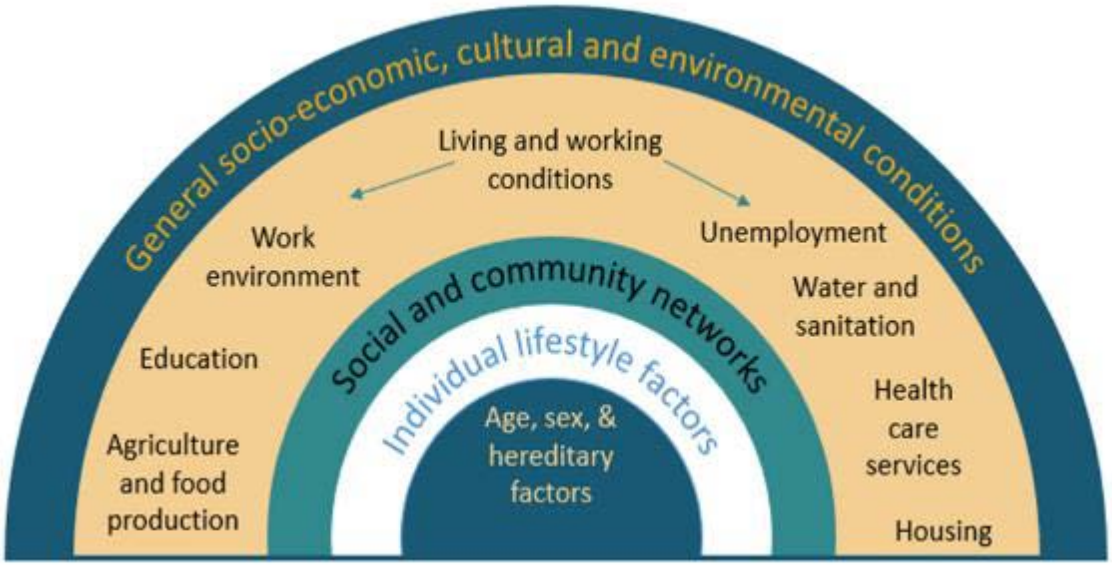
The following section describes the frameworks used to guide the assessment process, as well as how data for the assessment were collected.

Social Influencers of Health Framework

It is important to recognize that multiple factors have an impact on health, and that there is a dynamic relationship between community members and their lived environments. The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors are influenced by more upstream factors, such as employment opportunities and housing. The World Health Organization further

defines the social influencers, or determinants, of health as "the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources." In this report, social determinants of health will be referred to as social influencers of health because it is the shared belief of the authors of this report that people are resilient and often able to survive and thrive despite the circumstances around them. Additionally, while these factors play a significant role in impacting people's health on an individual and community level, it is the intention of many organizations to be able to improve the factors that influence health by working collectively to address them.

Social influencers of health can affect individual and community health directly and indirectly, including influence on health promoting behaviors. Policies and other interventions influence the availability of these determinants and how they are distributed among different social groups, including those groups defined by socioeconomic status, race and ethnicity, sex, sexual orientation, disability status, and geographic location. Inequitable distribution of social influencers contributes to health inequities. A stronger understanding of how local societal conditions, health behaviors, and access to healthcare affect health outcomes in the community can increase awareness and understanding of what is needed to move toward health equity.



DATA SOURCE: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

Health Equity Framework

Health equity means that every person has a fair and just opportunity to achieve optimal health regardless of:

- The color of their skin
- Level of education
- Gender identity
- Sexual orientation
- Age
- The job they have
- The neighborhood they live in
- Whether or not they have a disability[1]

> **Health Equity** – "The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities." –
> Healthy People 2020, Office of Disease Prevention and Health Promotion

Health equity is fundamental to having a healthy community. Unfortunately, many communities and populations have experienced historical isolation from opportunities that continue today. Where possible, this report incorporates data that highlight disparities in opportunities and their impacts on the health of populations.

As previously noted, this report was conducted prior to the 2020 Coronavirus Pandemic that resulted in statewide stay-at-home orders in Idaho and Oregon in March 2020. While many of the impacts and outcomes of the pandemic are still largely undetermined at the time of publication, it is widely understood that the pandemic has impacted older adults, communities of color, rural communities, people with lower incomes, and other high-risk populations at higher rates in terms of both health and financial impacts. It will be critical for communities to collaborate in coming months and years to assist with the recovery of these populations.

CHNA Oversight

SAMC-Ontario assembled a CHNA Advisory Committee in 2019 to provide strategic oversight of the CHNA process. This committee is comprised of 23 members representing SAMC-Ontario, community health centers, local public health authorities, behavioral health providers, addiction treatment organizations, Coordinated Care Organizations, educational institutions, and other health and human service organizations. The committee provided guidance on each component of the assessment, including the CHNA methodology, recommendation of secondary data sources, identification of key informants and focus group segments, dissemination of the community survey, and communication and dissemination throughout the CHNA process. The Advisory Committee met three times throughout the assessment process, from September 2019 to April 2020.

Data Collection and Analysis Methods

In order to better understand the health of Malheur, Payette, and Washington Counties, the following data collection methods were used.

Review of Secondary Data

This assessment incorporated data on social influencers of health as well as health behavior and outcome data from various sources at national, state, regional, county and local levels. These data sources included but were not limited to the Trinity Health Data Hub, U.S. Census, Idaho Department of Health and Welfare, and Oregon Health Authority. Data

[1] Braveman PA, Kumanyika S, Fielding J, et al. Health disparities and health equity: the issue is justice. Am J Public Health. 2011;101(suppl 1):S149-S155.

included self-report of demographics, health behaviors and outcomes from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS). The CHNA Steering Committee participated in the selection of quantitative data sources and indicators for the assessment.

Focus Groups

In October through December 2019, SAMC-Ontario and its local partners conducted 11 focus groups with approximately 85 individuals from across the Assessment Region. Focus groups were conducted with representatives of priority populations or sectors, including communities of color, seniors, parents, LGBTQIA+, people experiencing homelessness, and rural community members. Focus group discussions explored participants' perceptions of the community, priority health concerns, and suggestions for future programming and services to address these issues. A semi-structured moderator's guide was used across all focus groups to ensure consistency in the topics covered (see APPENDIX A. FOCUS GROUP DISCUSSION GUIDE). Each focus group was facilitated by a trained moderator, and detailed notes were taken during each discussion. On average, focus groups lasted 90 minutes and included 5-10 participants.

Interviews

In October through December 2019, SAMC-Ontario and its local partners conducted 11 interviews with community stakeholders to gauge their perceptions of the community, health concerns, and what programming, services, or initiatives are most needed to address these concerns. Interviews were conducted by in person with 15 individuals representing a range of sectors including community development, social services, law enforcement and healthcare, among others. A semi-structured interview guide was used across all discussions to ensure consistency in the topics covered (see APPENDIX B. KEY INFORMANT INTERVIEW DISCUSSION GUIDE). Each interview was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, interviews lasted approximately 60 minutes.

Community Survey

In October through December 2019, a community survey was developed and distributed in both paper and electronic formats across the Assessment Region to broadly capture and quantify the perspective of stakeholders (see APPENDIX C. SURVEY INSTRUMENT). Surveys were provided in English, Spanish, Arabic, Somali, and Swahili. The survey focused on community members' and providers' perceptions of the community, top health concerns, and barriers to accessing health and social services. The survey was developed by HRiA in collaboration with the CHNA Advisory Committee and used both Likert-type scales and closed-ended response categories. In total, 318 people completed the survey across the Assessment Region.

Data Analysis

The secondary data, qualitative data from interviews and focus groups, and survey data were synthesized and integrated into this community health assessment report by HRiA. The collected qualitative information was coded and then analyzed thematically for main categories and sub-themes using NVivo, Version 12. Data analysts identified key themes that emerged across all discussions as well as the unique issues that were noted for specific populations. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. While county differences are noted where appropriate, analyses emphasized findings common across the region. Selected paraphrased quotes – without personal identifying information – are presented in the narrative of this report to further illustrate points within topic areas.

For the survey data, frequencies and cross-tabulations by demographic characteristics were conducted using SAS statistical software. In most instances, response options from the survey were collapsed for ease of interpretation.

Prioritization of Significant Health Needs

The CHNA Advisory Committee convened for a two-hour meeting on February 5th, 2020 to review and discuss the preliminary results of the CHNA and identify and prioritize significant health needs. Participants received an overview of key themes that emerged in the collection of qualitative and quantitative data. Each participant was asked to rank the significant health needs individually while considering each in terms of impact, severity, magnitude, urgency, and the overall concern of residents regarding the issue. The group then entered their priorities into a Menti.com group poll to tabulate the collective significant health needs.

The significant health needs are presented below in rank order.

1. Affordable, safe housing and homelessness
2. Financial stability and cost of living
3. Mental health and wellbeing
4. Substance use, including tobacco and vape use
5. Childcare and education
6. Access to healthcare, including oral healthcare
7. Chronic diseases
8. Wages and job availability
9. Sexually Transmitted Infections, access to birth control, and teen pregnancy
10. Food security
11. Transportation
12. Physical activity and recreation opportunities

Limitations

As with all assessment efforts, there are some information gaps related to the assessment methods that should be acknowledged. First, for quantitative (secondary) data sources, most data could not be provided at geographic levels smaller than county due to the small population size in the region.

Data based on self-reports should be interpreted with understanding that in some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked.

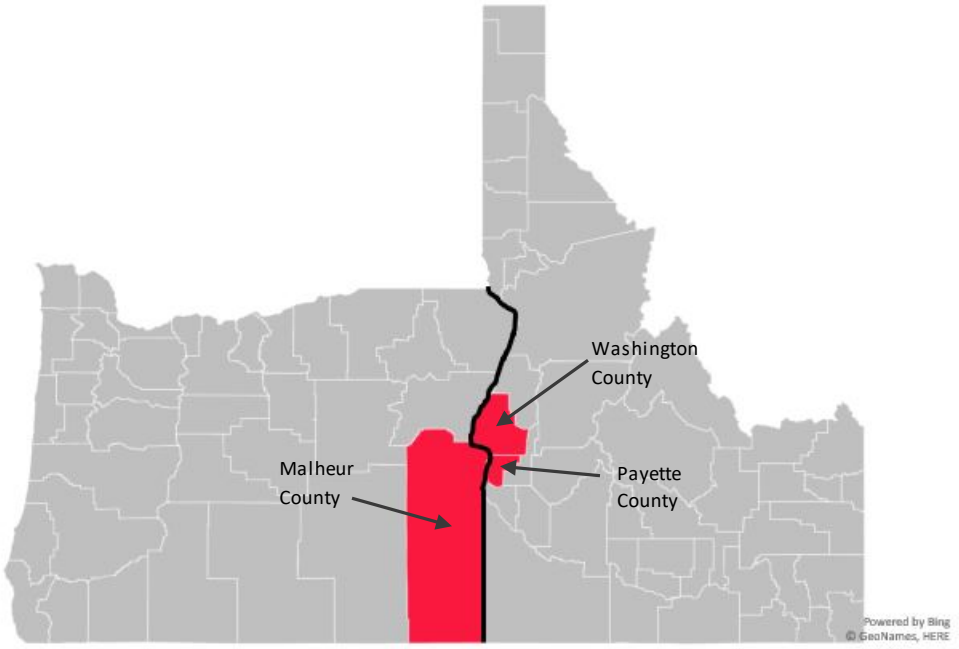
Additionally, while the focus groups and interviews conducted for this CHNA provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. Lastly, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

REGIONAL SNAPSHOT

Population

The Ontario Region is unique in that the population who live, work, learn, and play there are quite mobile across the Idaho and Oregon border, meaning many live in one state, but work, recreate, shop, etc. in the other. Because of the strong interconnection of the communities along the Idaho and Oregon border, this report captures data from Washington and Payette counties in Idaho and Malheur County in Oregon.

Assessment Region

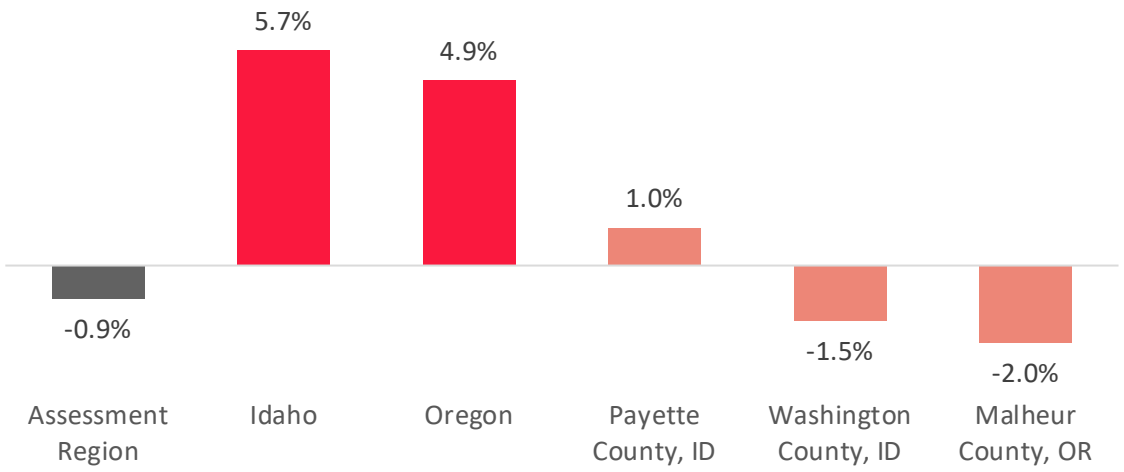


Additional community data can be found in the key findings section and APPENDIX E: ADDITIONAL FINDINGS.

Change, Density, Growth

Between 2014 and 2018, the population slightly decreased (0.9%) in the Assessment Region though the populations in Idaho and Oregon as a whole increased at 5.7% and 4.9% respectively (See Figure 1). These data support focus group and interview participants perceptions of population change within the community. Assessment participants felt as if there was a constant flow of people coming in and out of the region. Participants believed that the new people coming to Malheur County are moving in because of the higher minimum wage available in Oregon compared to Idaho, more affordable housing, and the availability of more social services. Participants believed that the people moving out of the Assessment Region were looking for more "professional" jobs that were not available in the Assessment Region. This will be discussed further in the Financial Stability topic section.

Figure 1: Percent Change in Total Population, 2014 to 2018

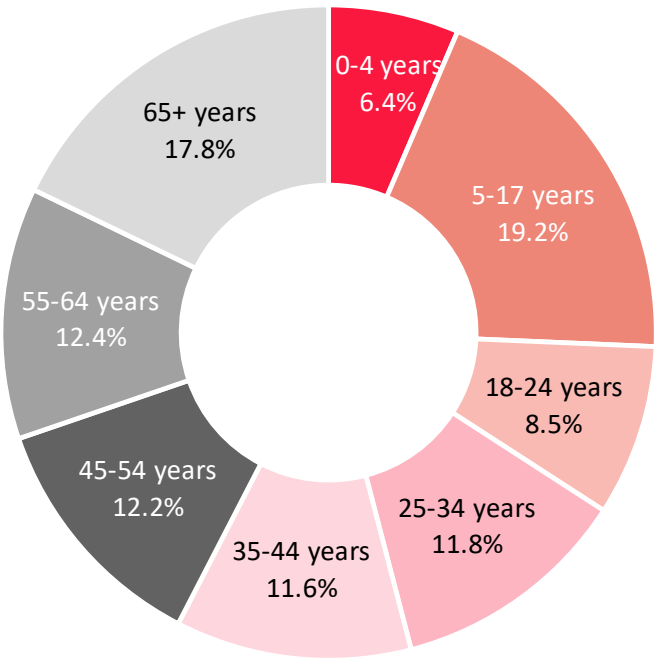


DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Age

In 2018, the age range of residents in the Assessment Region was fairly evenly spread out, with there being slightly higher numbers of children and older adults (Figure 2).

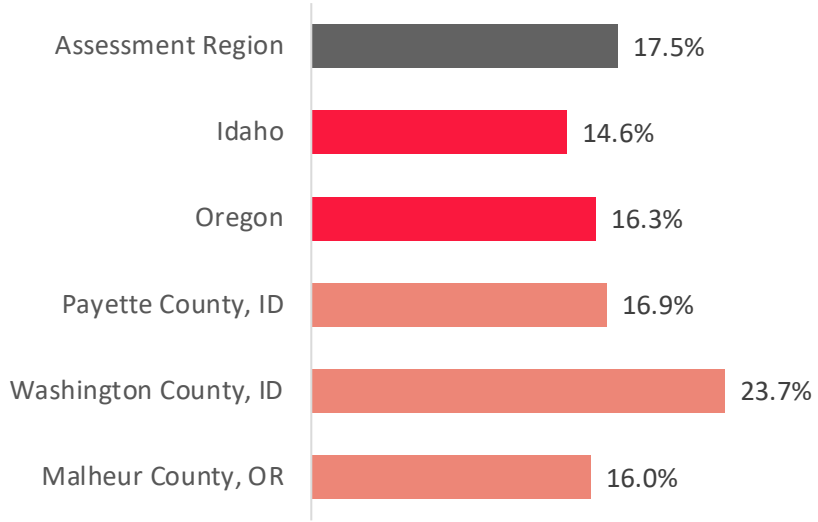
Figure 2: Age Distribution, Assessment Region, 2018



DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as cited by Trinity Health Data Hub, 2014-2018

Among the Assessment Region in 2018, the population 65 years and older typically ranged between 16-17%, with a higher percentage in Washington County (Figure 3). The large number of community members ages 65+ supports resident comments that characterizing the Assessment Region as a "retirement community."

Figure 3: Percentage of Population 65 Years and Older, 2018



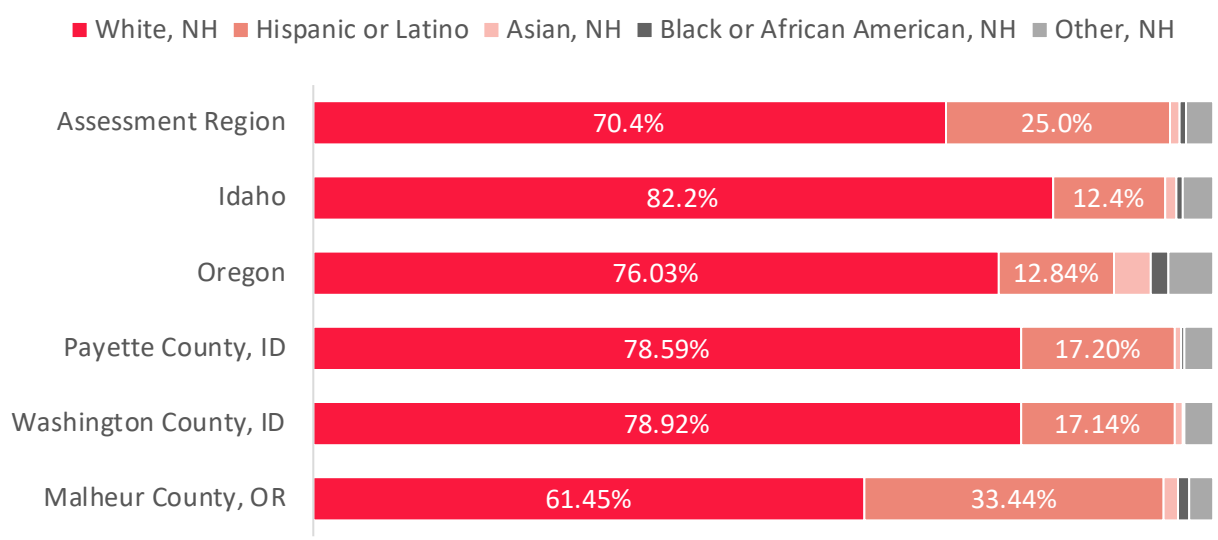
DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as cited by Trinity Health Data Hub, 2014-2018

Race

Most of the community members in the Assessment Region identified as White, non-Hispanic, which is a smaller percentage compared to overall state populations in Idaho and Oregon (Figure 4). Nearly one in four people in the region identified as Hispanic or Latino. Malheur County has a larger percentage of Hispanic or Latino population, at approximately 33%, compared to the Assessment Region as a whole. Assessment participants often talked about the diversity in the region. They believed that there is a lot of diversity, but there needed to be greater representation of Hispanic/Latinos in leadership positions available in the community, such as the school board, since this population makes up a large part of the Assessment Region's total population

"The Latino community is not being represented and our needs are not being listened to. Things are staying the same."

Figure 4: Racial/Ethnic Distribution, 2018

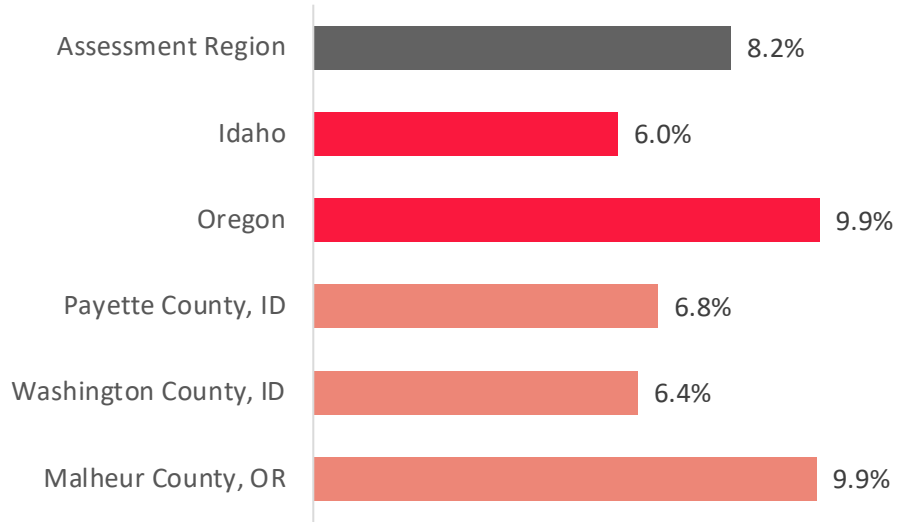


NOTE: Other includes American Indian and Alaskan Native, non-Hispanic; Native Hawaiian or other Pacific Islander, non-Hispanic; some other race, non-Hispanic; and Two or more races, non-Hispanic

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

In 2018, approximately 8% of the population in the Assessment Region was foreign-born; this is slightly lower than in Oregon, and slightly higher than in Idaho. Assessment participants often talked about the large foreign-born population in the Assessment Region coming from Southeast Asia, Eastern Europe, and parts of Africa, demonstrating the importance of culturally competent and translation services across the community.

Figure 5: Percentage of Population Foreign-Born, 2018

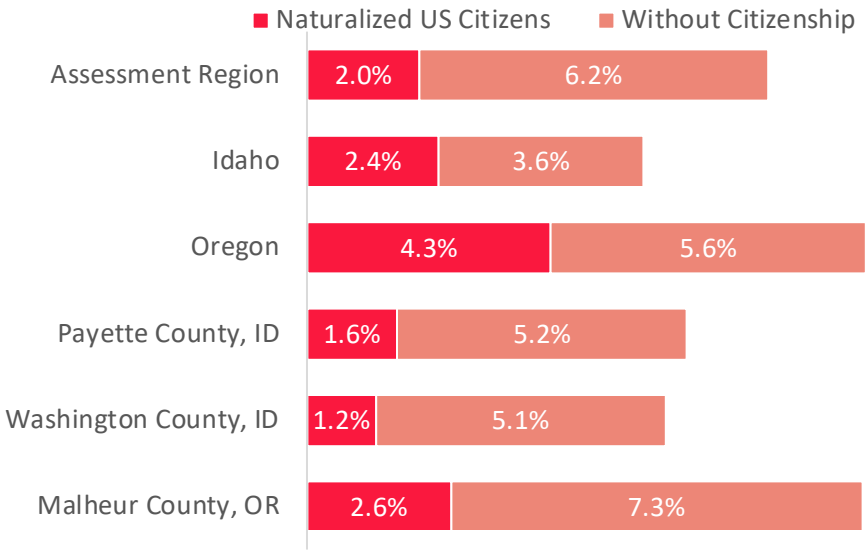


DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

In the Assessment Region in 2018, of the population that was foreign born, approximately 6% did not have U.S. citizenship and 2% did (Figure 6). Focus groups participants stated that they believed undocumented immigrants were not accessing services and resources in the community due to fear.

"People are scared because they are undocumented. They live in fear day in and day out. People don't use services because they fear of being reported. They fear being in the system and what will happen if they get help."

Figure 6: Percentage of Population Naturalized US Citizens and Without Citizenship (within Foreign-Born), 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Language

2015 data from the US Census Bureau indicated that the most common non-English language spoken in the Assessment Region was Spanish or Spanish Creole (Table 1). Assessment participants highlighted the need for more language services and improved multicultural sensitivity within healthcare and social services.

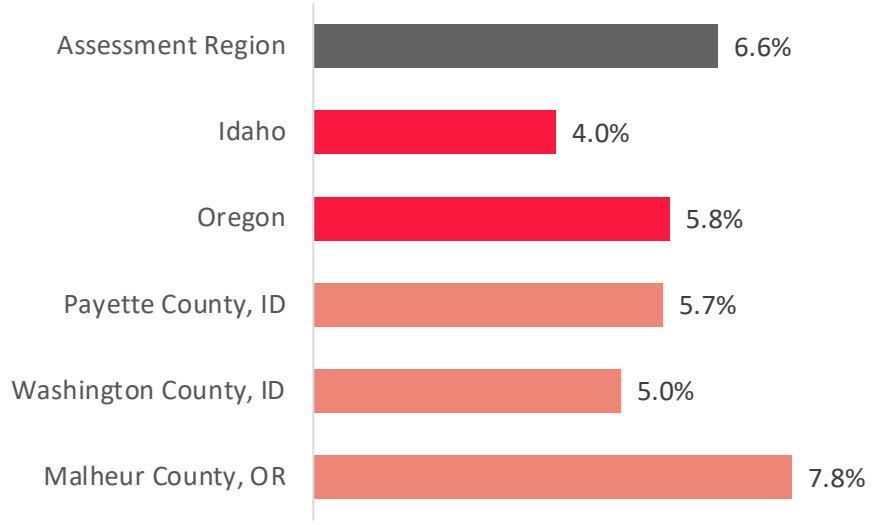
Table 1: Top Five Languages Spoken in Assessment Region, 2015

	n	Percent of Total Population	Percent of Population Speaking a Non-English Language
English Only	48,574	82.2%	-
Non-English Language	10,545	17.8%	-
Spanish or Spanish Creole	9,886	16.7%	93.8%
German	107	0.2%	1.0%
Chinese	101	0.2%	1.0%
Japanese	88	0.1%	0.8%
French (including Patois & Cajun)	65	0.1%	0.6%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as cited by Trinity Health Data Hub, 2013-2017

In the Assessment Region in 2018, approximately 7% of the population aged 5 years and over had limited English proficiency (Figure 7). This was higher than in both Idaho and Oregon.

Figure 7: Percentage of Population Aged 5 and Older with Limited English Proficiency, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

LGBTQIA+

Almost 4% of community survey respondents identified as lesbian, gay, bisexual, transsexual, queer or questioning, intersex, asexual or ally, or other (LGBTQIA+). Assessment participants shared their frustrations about the absence of community inclusion for people who identify as LGBTQIA+. People identifying as LGBTQIA+ believed community members would only accept them if they "behave and don't do anything outwardly 'gay.'" Community members also felt that issues affecting the LGBTQIA+ community are not discussed or taken seriously. Participants shared that LGBTQIA+ students are bullied in school and that there is no space for them to be their authentic selves. Participants also said the healthcare system has little knowledge of how to provide care for people identifying as LGBTQIA+, which exacerbates service access issues.

Table 2: Survey Respondents Sexual Orientation

Sexual orientation (n=268)	n	%
Heterosexual/straight	258	96.3
Lesbian/gay/bisexual	10	3.7

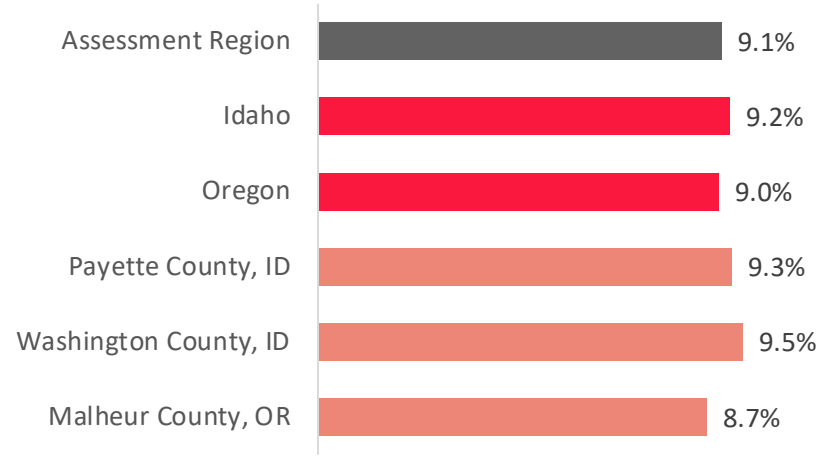
DATA SOURCE: Saint Alphonsus Health System & United Way of Treasure Valley 2020 Community Survey

"There are no resources for parents of LGBT+ - no community center, schools are scared to discuss issues, high levels of trauma and bullying in schools, especially for trans and non-binary students. Main resources are the internet and social media, which leaves young people vulnerable to sexual predators, sex trafficking, and violence."

Veterans

Approximately 9% of the population 18 years and over in the Assessment Region was a veteran in 2018; this was similar to Idaho and Oregon state overall with the largest veteran population living in Washington County. Community survey respondents reported that mental health and stress among veterans was the highest ranked high concern for the community (59.8%) in the category of Mental Health and Stress.

Figure 8: Percentage of Population with Veteran Status (18 and over), 2018

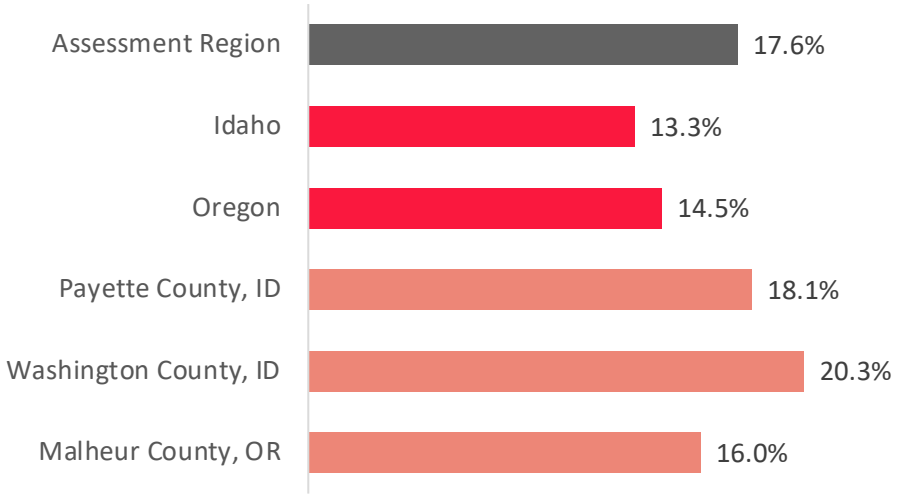


DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Individuals with Disabilities

In 2018, almost one in five residents of the Assessment Region had a disability, more than the state rates in Idaho and Oregon (Figure 9). When asked what their specific challenges were, the most highly selected concerns were vision, mobility, and hearing (Table 3).

Figure 9: Percentage of Population with a Disability, 2018



Note: This indicator is compared to the lowest state average.
DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Table 3: Survey Respondents Disability Status

Difficulty with any of the following* (n=71)	n	%
Vision	29	40.8
Hearing	22	31.0
Mobility	23	32.4
Cognitive functioning	16	22.5
Independent living	4	5.6
Other	8	11.3

*Respondents were permitted to select more than one option, so percentages do not sum to 100%
Saint Alphonsus Health System & United Way of Treasure Valley 2020 Community Survey

Built Environment

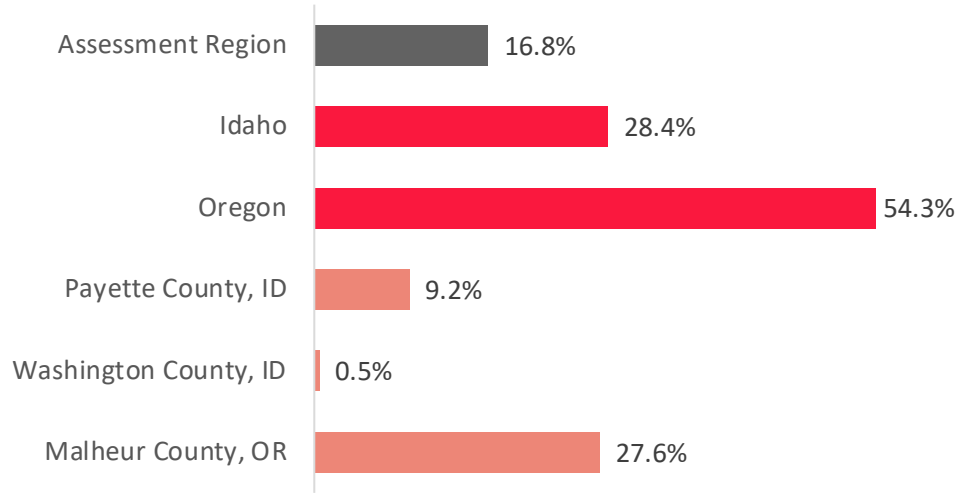
The Centers for Disease Control (CDC) defines the built environment as the man-made structures where we live and work which include homes, buildings, streets, sidewalks, and parks or other open spaces. The built environment can affect an individual and the community's health in a number of ways. For example, the walkability of a community can affect how physically active people are, which is important for mental well-being and can reduce the risk of morbidity or mortality from cardiovascular disease, Type II diabetes, osteoporosis, and some forms of cancer.[2] Additionally, the walkability and bikability of the community can contribute to whether individuals and families have the ability to get to food retail outlets, jobs, and social services that they need due to limited access to personal vehicles and/or public transportation.

Assessment participants shared their disappointment in the built environment of their communities. Participants believed their communities were not walkable because there are many streets without sidewalks. Others believed the few parks that exist were uninviting, and one participant even called them "scary." Participants also mentioned that there are very limited trails and walkways in their community. ACS data supports participants' perception of the built environment. In the Assessment Region in 2013, only about 17% of the population lived within half a mile of a park, varying greatly across the region (Figure 10). Less than one percent of Washington County residents lived within ½ mile of a park, whereas more than one in four residents of Malheur County lived near a park. However, much of the difference could be due to the more rural makeup of Washington County as compared with Malheur County.

"Right now, kids will stay away from parks because parents are concerned that they may find a sharp-needle."

[2] https://bmjopen.bmj.com/content/3/1/e002482

Figure 10: Percent of Population Within 1/2 Mile of a Park, 2013

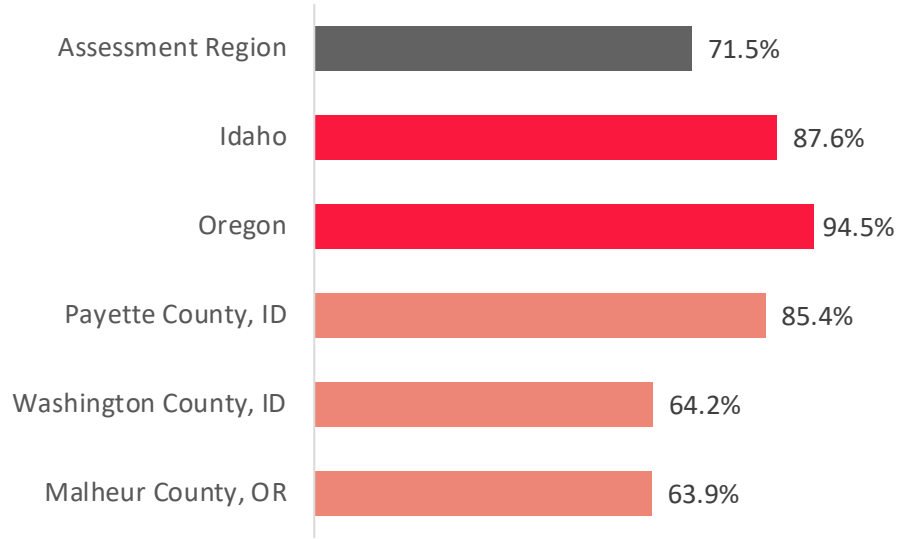


DATA SOURCE: US Census Bureau, Decennial Census, ESRI Map Gallery, as cited by Trinity Health Data Hub, 2013

In 2018, broadband internet access was variable across the region, ranging from 64% in Malheur County to 85% in Payette County, but lower than the Idaho and Oregon state rates (Figure 11). This data substantiates assessment participants' frustration with the internet connection in the Assessment Region. Participants said that low internet speed was one reason why new businesses, such as technology corporations, would not move to the Assessment Region.

"The lack of technological infrastructure, poor internet connections, etc. keeps other businesses from relocating here. The infrastructure cannot handle the volume of data traffic as it is now. There is land available, but not technology. It is difficult for people to do some of the higher tech jobs here when they do not have access."

Figure 11: Percent Households with Broadband Access to DL Speeds Greater than 25MBP, 2018



DATA SOURCE: National Broadband Map, as cited by Trinity Health Data Hub, June 2018

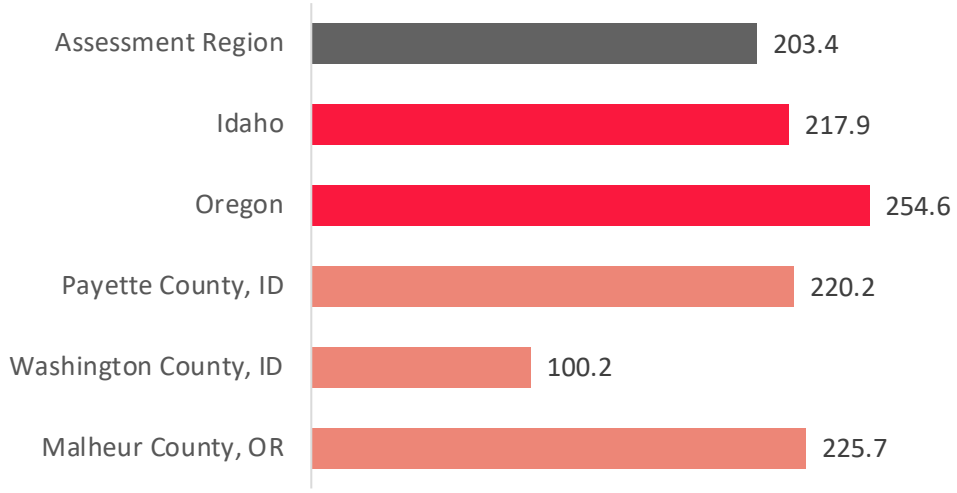
Social Environment

Public perceptions of safety are also an important part of the social environment. If people don't feel safe in their communities, they are less likely to participate in social events and gatherings, leading to feelings of social isolation, and they are less likely to use community resources. Residents were asked to rank topics under the category of 'Personal and Public Safety' from 'not a concern' to 'high concern' on the community survey. Drug trafficking was ranked as a high concern by 54.4% of survey respondents, and human trafficking was ranked as a high concern by 49.5% of survey respondents. However, most participants believed that the community is safe and the people in the community are close with one another; describing the community as "close-knit" and "family oriented." Community members seemed to be very willing to help each other whenever a problem arises. Some residents wish there were more recreational activities such as art and theater shows. Residents did note there is a recreational district in Malheur County that was recently revamped and offers some activities for community members.

"The community takes care of each other. If there's a house fire the whole community comes together."

Overall, crime rates are fairly low in Idaho and Oregon. In 2002, the violent crime rate in the Assessment Region was 203.4 crimes for every 100,000 people, which ranged from 100.2 per 100,000 in Washington County to 225.7 per 100,000 in Malheur County.

Figure 12: Violent Crime Rate Per 100,000 population, 2020

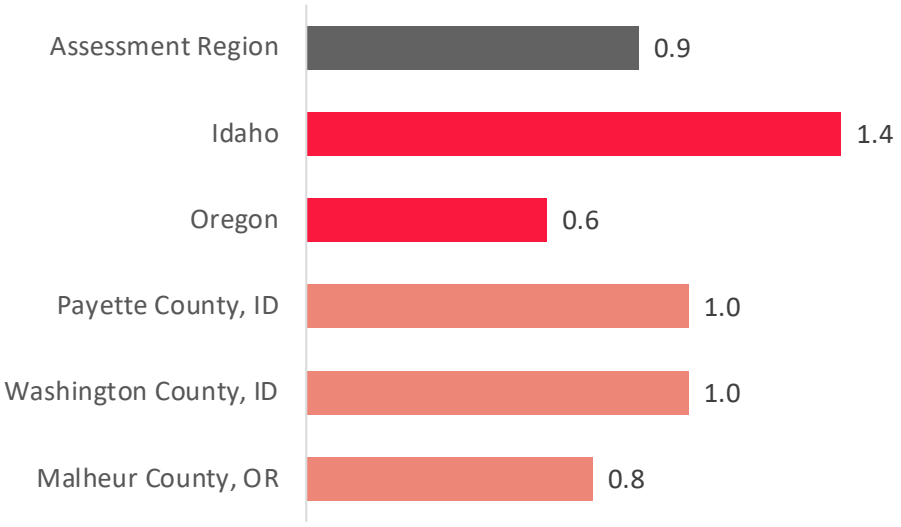


DATA SOURCE: Federal Bureau of Investigation, FBI Uniform Crime Reports. Additional analysis by the National Archive of Criminal Justice Data. Accessed via the Inter-university Consortium for Political and Social Research. 2020. Source geography: County

Natural Environment

Good air quality is important to community health. Poor air quality can worsen health issues like asthma and allergies and can impact heart health stroke risk. Outdoor air quality is impacted by things like smoke, smog and other emissions into the air. The Ontario region has good air quality overall (Figure 13). In the Assessment Region in 2012, approximately 0.9 days exceeded emissions of particulate matter. These data support residents' perception of good air quality.

Figure 13: Number of Days Exceeding Emission Standards of Air Quality Particulate Matter, 2012



DATA SOURCE: Centers for Disease Control and Prevention, National Environmental Public Health Tracking Network, as cited by Trinity Health Data Hub, 2012

KEY FINDINGS

Financial Stability

Poverty and unemployment are linked to health.[3] An individual's employment and income level directly impacts their ability to afford access to healthcare, healthy food, and housing, all of which influence myriad health outcomes. For individuals that are employed, it is more than just having a job that affects health. The number of hours they work and the wage they earn impacts the level of economic stability that their job affords. This is especially relevant for individuals who find themselves part of the working poor, individuals who meet the definition of being in the labor force but their income level falls below the poverty line.[4] Individuals who are unemployed or underemployed experience higher rates of depression, stress, and stress-related conditions, such as stroke, heart attack, heart disease, arthritis.[5]

When examining inequalities in financial stability, research from the Pew Research Center reveals that women earned 85% of what men earned in 2018.[6] This would mean that women would have to work 39 more days on average to earn the same income as men.[6] Furthermore, when examining racial inequities, "the difference in median household incomes between White and Black Americans has grown from about $23,800 in 1970 to roughly $33,000 in 2018" according to research from the Pew Research Center.[7]

Economic Status

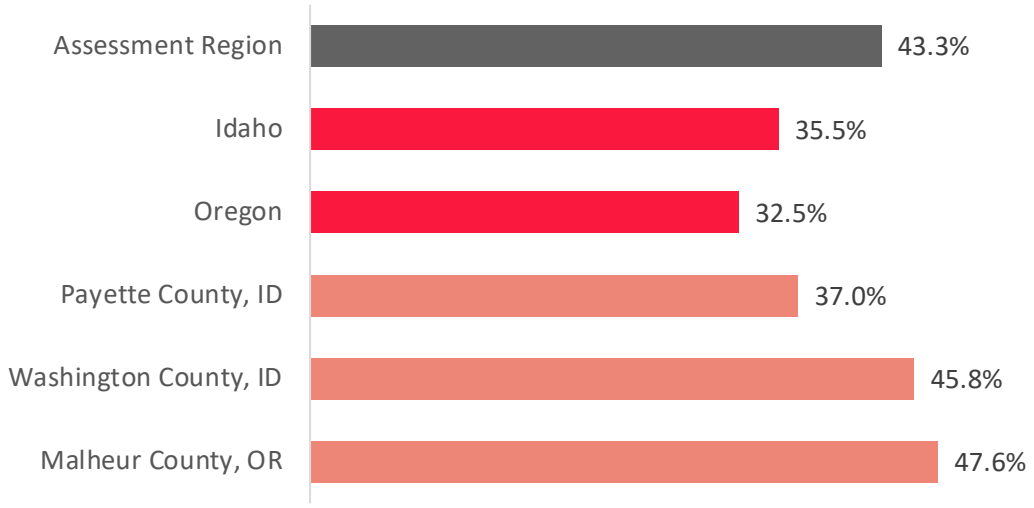
The U.S. federal poverty level (FPL) is a measure of income issued every year to determine eligibility for certain programs and benefits. While FPL is a useful indicator of individuals' and households' ability to meet basic needs, it is not adjusted for region-specific variables nor does it capture the full picture of financial stability. Many individuals and families that live above the FPL are employed but still struggle financially. They make too much to qualify for public assistance programs or benefits, but not enough to make ends meet financially. As a result, they are often unable to afford necessities such as housing, food, healthcare, and transportation and/or are one paycheck or disaster away from losing these things. In 2018, the percent of population at or below the 200% Federal Poverty Level (FPL) ranged from 37% in Payette County to almost 48% in Malheur County (Figure 14). This was higher than 35% in Idaho and 32% in Oregon. ACS income data substantiates assessment participants perception of high levels of poverty within the Assessment Region, especially in Malheur County. Assessment participants often said Malheur county was the poorest county in Oregon and that there are many "working poor" that are struggling to make ends meet. Participants perceived poverty in the area as the "biggest public health crisis" community members are facing.

"Families feel trapped in a poverty circle. They cannot afford to go back to school to gain more skills because they are not able to afford childcare. They would need to work more hours that are not available just to meet their daily needs."

"People cannot afford food or rent. A two-parent household with each parent working 40 hours per week is still not making it financially."

[3] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: What the patterns tell us. American Journal of Public Health. 2010; 100: S186-S196.
[4] Bureau of Labor Statistics. A profile of the working poor, 2016. BLS Reports. Available at: https://www.bls.gov/opub/reports/working-poor/2016/home.htm Accessed on: October 30, 2018.
[5] Robert Wood Johnson Foundation. How Does Employment – or Unemployment – Affect Health? Health Policy Snapshot Issue Brief. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360 Accessed: October 30, 2018.
[6] Graf, N., Brown, A., & Patten, E. The narrowing, but persistent, gender gap in pay. Pew Research Center. 2019
[7] Schaeffer, K. 6 facts about economic inequality in the U.S. Pew Research Center. 2020

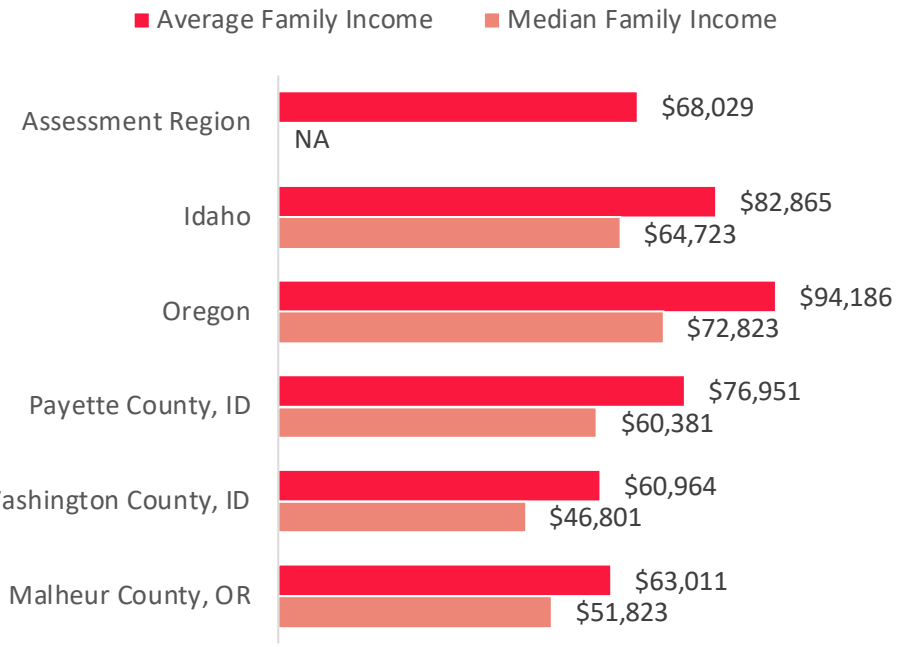
Figure 14: Percent of Population with Income At Or Below 200% FPL, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

In the Assessment Region in 2018, the average family income was $68,029, which was well below the statewide average family incomes of $82,865 in Idaho and $94,186 in Oregon (Figure 15). Among the Assessment Region, median family income, or middle of the range of family incomes, showed fairly wide variability between Malheur and Payette Counties. As with the average family income, the median family income in Idaho and Oregon overall was higher than those in the counties in the Assessment Region.

Figure 15: Average and Median Family Income, 2018

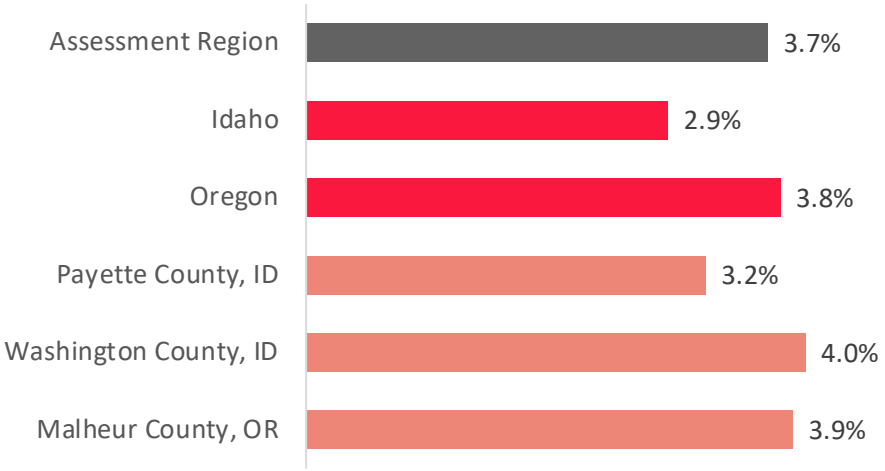


DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Wages, Income, Employment

In 2020, unemployment in the Assessment Region was 3.7% prior to the Coronavirus outbreak, slightly higher than Idaho rate and slightly lower than Oregon (Figure 16). Despite relatively low unemployment, assessment participants indicated that it is a challenge for community members to make a living in the area, given the limited jobs available and the low pay for those opportunities that do exist. Participants shared how people in the community want to better themselves by learning a new skill or going back to school, but it is hard because many people are living paycheck to paycheck.

Figure 16: Unemployment Rate, 2020



DATA SOURCE: US Department of Labor, Bureau of Labor Statistics. 2020 - March. Source geography: County

Furthermore, community members discussed the difference in wages between Oregon and Idaho. Minimum wage in Oregon ($11.50 for non-urban areas such as Ontario effective July 2020) is $4 more than the minimum wage in Idaho ($7.25). Participants spoke about how it was not uncommon to see people living in Idaho but working in Oregon because the difference in wages is so great. One participant shared, "people are working full time jobs and are still having trouble paying for their expenses." Participants believed the majority of jobs available are either agricultural or "non-professional" (not requiring a college degree), which limits the types of professions that community members are able to enter.

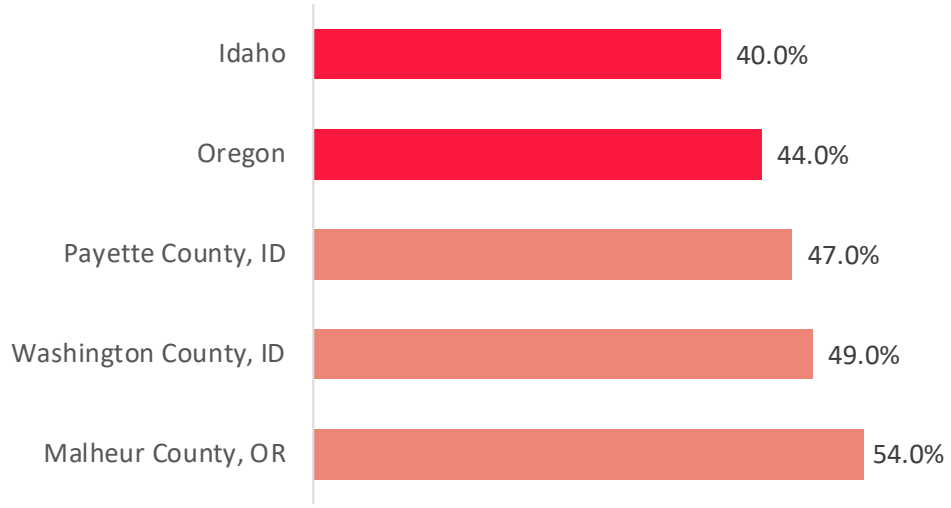
"Outside of agriculture, the youth of the community are leaving and not returning. A whole generation is leaving to get a great college education and cannot return, because there are not jobs for them. We can only hire so many teachers, and mechanics in the community."

Meeting Basic Needs

To meet basic needs, individuals and families need a certain amount of money to afford food, housing, child care, healthcare, and transportation to school and work. ALICE, a United Way acronym that stands for Asset Limited, Income Constrained, Employed, represents the growing number of individuals and families who are working, but are unable to afford the basic necessities listed above. This tells an alarming story about the experience of residents in the Ontario region. Almost one in two people across the area are making too much to qualify for many subsidies, but not enough to make ends meet. Among the Assessment Region in 2018, the percentage of the population who are ALICE or in poverty ranged from 47% in Payette County to 54% in Malheur County. This was substantially higher than in both Idaho and Oregon (Figure 17). According to the 2016 ALICE Report, a family of four in Malheur County would need to make a

combined annual income of $57, 348 per year to meet a basic survival budget, which is 19% higher than the 2018 annual median family income in Malheur County seen in Figure 15.

Figure 17. Percent of Population Asset Limited, Income Constrained, Employed (ALICE) or in Poverty, 2018



DATA SOURCE: ALICE: A Study of Financial Hardship in Idaho and Oregon; United Way ALICE Project. 2020. Source Geography: County

Since 1981, the U.S. Department of Housing and Urban Development has deemed households that spend more than 30% of their income on rent or mortgage payments to be "cost-burdened." Such households are considered to have insufficient income for other essential expenses such as food, transportation, and healthcare. According to data from the National Low Income Housing Coalition, in Payette County in 2018 among extremely low-income households, approximately 26% were cost burdened (spending 30-50% of income on housing) and 62% were severely cost burdened (spending more than 50% of income on housing). Among very low-income Payette County households, approximately 49% were cost burdened and 14% were severely cost burdened. Among low income households, 47% were cost burdened. In Washington County in 2018, among extremely low-income households, approximately 28% were cost burdened, 67% were severely cost burdened. Among very low-income Washington County households, approximately 47% were cost burdened and 29% were severely cost burdened. Among low income households, approximately 30% were cost burdened and 9% were severely cost burdened.

Almost half of community survey respondents believed cost of living is a top five health issue for themselves and their family. Assessment participants also felt that cost of living was a major issue for the community. Participants often talked about how people were struggling with money for rent/housing, medical expenses, food, transportation, and childcare. Focus group participants spoke about how financial stress was one of the biggest stressors in the community. When asked why cost of living was so high, participants spoke about how housing expenses were higher as of late. Participants believed the cost to rent/own a home has dramatically increased over time.

"Financial stress is one of the biggest stressors we see."

Food Security

A nutritious diet is essential to prevent heart disease, cancer, and obesity, the most common causes of death. Diets high in sugar, fat, and sodium and low in fruits, vegetables, and whole grains are commonplace in the U.S. Improving the dietary habits of children and adults is critical to improving community health. Some residents experience food insecurity, meaning they do not have enough food in their homes due to a lack of resources. In the Assessment Region in 2017, approximately 13% of the population – 1 in 8 people – was food insecure, which was similar to the food

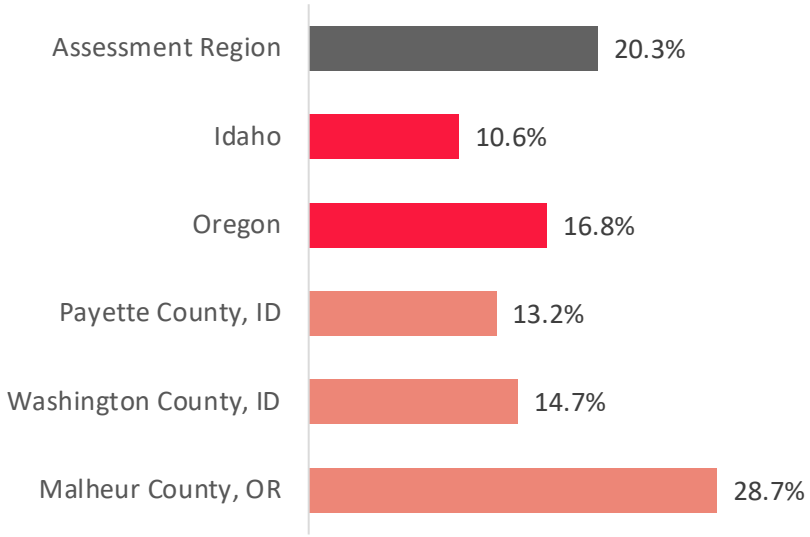
insecure populations in Idaho and Oregon. Assessment participants had mixed views about the level of food insecurity in the Assessment Region. Some believed food insecurity is not as much of a problem as it was in the past because more resources have been made available locally. Participants named programs that have been created to address food insecurity such as the garden at Love Inc. Others believed food insecurity is still a major problem in the community. Some towns only have one grocery store and sometimes the food available there is too expensive for community members to afford. For example, assessment participants shared that there was only one grocery store in Fruitland and that the grocery store in Payette was too expensive for some individuals and families.

"There is a lot of food insecurity. Patients know what to do but do not have fruits vegetables available or that they can afford."

"There's an abundance of food, farming, and no food insecurity. You just need to know who to contact."

In 2018, the percent of population receiving Supplemental Nutrition Assistance Program, or SNAP, benefits ranged from almost 15% in Washington County to nearly 29% in Malheur County, which was much higher than Idaho overall at 11% and Oregon at 17%.

Figure 18: Percent of Population Receiving SNAP Benefits, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

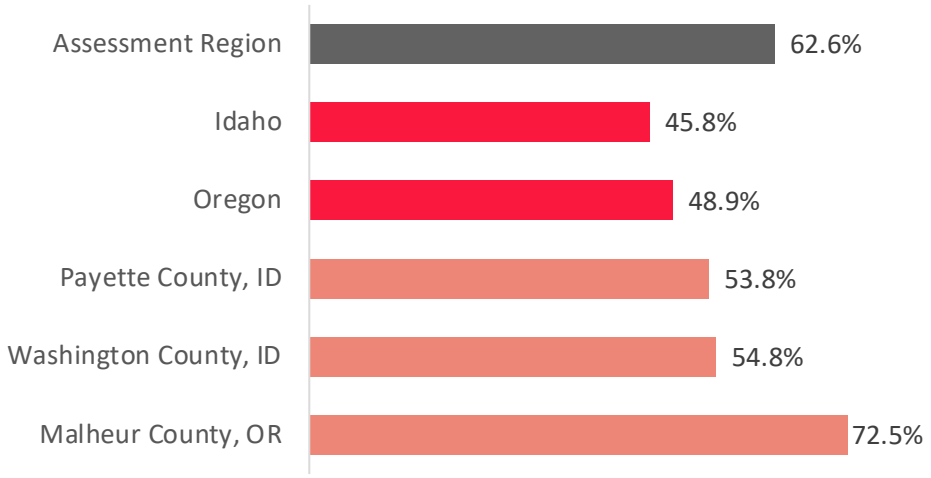
Food insecurity affects both adults and children, but it is particularly dangerous for children whose physical, social, emotional, and cognitive development are at risk. School-based food programs help students to stay focused and ready to learn and contribute to important health and academic outcomes such as obesity prevention and improved attendance and test scores.[8]

Schools play an important role in the hunger safety net by providing free meals to students from families with incomes less than 135% of the FPL and reduced-priced meals ($0.30 for breakfast and $0.40 for lunch) to those between 135%

[8] M. L. Anderson, J. Gallagher & E. R. Ritchie. *School Lunch Quality and Academic Performance.* National Bureau of Economic Research, March 2017. http://www.nber.org/papers/w23218

and ≤185% of the FPL. In the Assessment Region overall during the 2016-2017 school year, approximately 63% of children were eligible for free and/or reduced-price lunch, ranging from 54% in Payette County to 73% in Malheur County. This was higher than the 46% in Idaho and 49% in Oregon.

Figure 19: Children Eligible Free and/or Reduced-Price Lunch, 2016-2017



Data Source: National Center for Education Statistics, as cited by Trinity Health Data Hub, 2016-2017

Existing resources and assets include, but are not limited to:

- Eastern Oregon Border Economic Development Region Board
- Euvalcree
- Familias en Acción
- Four Rivers Welcome Center
- Local Churches
- Love Inc
- Malheur Poverty to Prosperity
- Oregon Food Bank
- Oregon State University and University of Idaho Extension
- Nyssa Community Food Pantry
- Payette and Washington County Community Health Action Teams
- Senior Centers
- Vale Community Coalition
- Western Idaho Community Action Partnership
- Western Treasure Valley Community Food Systems Assessment and Work Groups

Housing

Affordability, quality, and stability are important characteristics that directly impact an individual's ability to access safe and healthy housing.[9] Unstable housing and homelessness can lead to stress, isolation, chronic disease (e.g., asthma), substance use, mental health issues, and violence.[10] For those with housing, the affordability and quality of housing

[9] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.
[10] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.

impact health and well-being. Housing is often a household's single greatest expense. The cost of housing directly impacts an individual's ability to afford housing, as well as how much money they can use towards healthcare, food, child care, and transportation.[11] While housing itself is an important factor in an individual's health, it can also be a cost burden and result in compromises to health in other areas – i.e. not purchasing prescription medications – due to cost. High housing-related costs place a disproportionate economic burden on low-income families in particular, as demonstrated by one study which found that low-income people with difficulty paying rent, mortgage, or utility bills were less likely to have a usual source of medical care, and were more likely to postpone treatment and use the emergency room for treatment.[12] Additionally, research has shown that children who live in areas with greater housing instability are more likely to have worse health outcomes, more behavioral problems, and lower school performance.[13]

The quality of housing includes everything from the structure of the housing unit itself to the built environment around it. Indoor exposure to lead paint, secondhand smoke, and mold are all pollutants that can cause negative health outcomes. The location of housing also has broad health implications – from access to employment that provides health insurance, green spaces for physical activity, healthy food, and accessible transportation.

Furthermore, when examining inequities in housing and homelessness, research shows us that most racial groups of color make up a larger share of the homeless population than they do the general population.[14] For example, according to data collected in 2017 by the US Department of Housing and Urban Development, African Americans makeup 13% of the general population but more than 40% of the homeless population.[14] The rate at which people of color are experiencing homelessness is also far greater than that of Whites.[14] Native Hawaiians and Pacific Islanders have the highest rate at 93.8 individuals experiencing homelessness per 10,000 population compared to 10.4 per 10,000 for Whites.[14] Lastly, youth that identify as LGBTQIA+ are at greater risk for homelessness.[15]

Housing Quality

Due to a limited rental market with few affordable vacancies, people with the lowest incomes may be forced to rent substandard housing that exposes them to health and safety risks such as vermin, mold, water leaks, and inadequate heating or cooling systems. More than half of the community survey respondents reported that they did not have any of the listed problems in their homes , however bug infestations and inadequate heat were the issues most frequently identified (Figure 20). Comparatively, assessment participants believed the more affordable housing options in the Assessment Region are older homes and apartments of poor quality. Residents often referred to these homes as "run-down" or "substandard." Assessment participants shared in focus groups that they believed that the reasons for the abundance of low-quality homes include lack of attention/responsiveness of landlords, lack of new housing development, and homeowners not having enough money to maintain their house due to competing costs.

"The housing that is available to us, if we can afford it, is not up to code. There are problems with wiring, plumbing, mold, pests, etc. and landlords don't care. People will still pay to stay there just to be housed."

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[11] Maqbool N, Viveiros J, and Ault M. The Impacts of Affordable Housing on Health: A Research Summary. Center for Housing Policy. 2015.

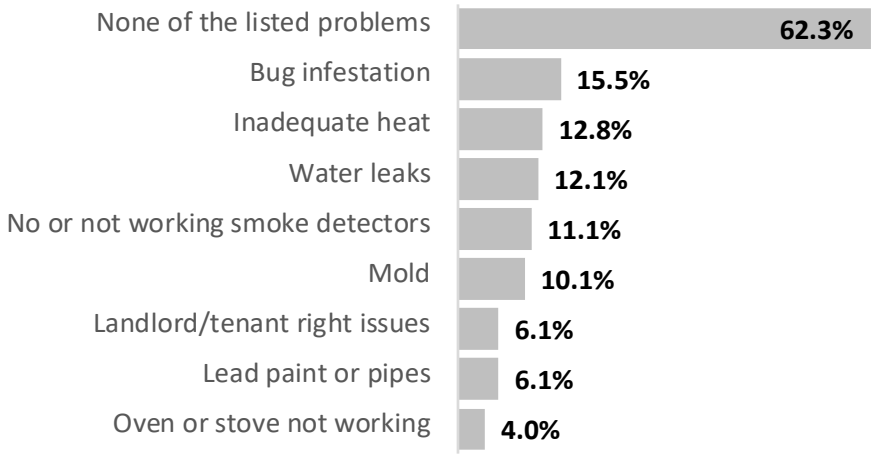
[12] Jelleyman T. and Spencer N. Residential Mobility in Childhood and Health Outcomes: A Systemic Review, J Epidemiol Community Health, 62(7): 584-92, 2008.

[13] Jelleyman T. and Spencer N. Residential Mobility in Childhood and Health Outcomes: A Systemic Review, J Epidemiol Community Health, 62(7): 584-92, 2008.

[14] National Alliance to End Homelessness. Racial Inequalities in Homelessness, by the Numbers. 2017 Annual Homeless Assessment Report to Congress, Part 1. Available at: https://endhomelessness.org/resource/racial-inequalities-homelessness-numbers/. Accessed on February 20 , 2020

[15] Franklin, S., Lane, A., & Franklin, S. Ending LGBT Health Inequities. Stanford Social Innovation Review. 2016

Figure 20: Reported Problems With The Place The Respondent Lives (n=297)*



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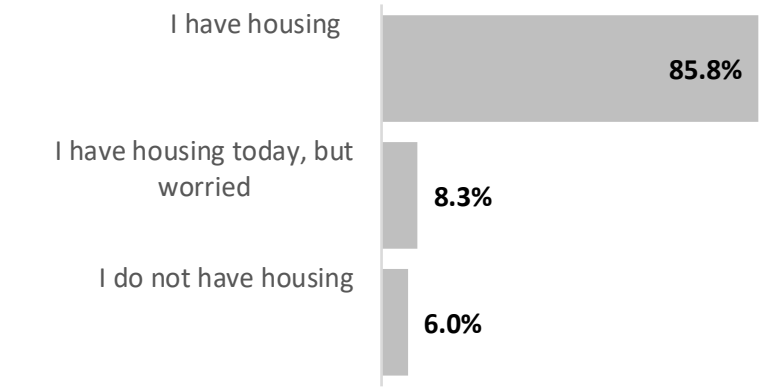
Housing Availability

Community survey results show that almost 60% of survey respondents believed that affordable housing is a top five health issue for the community. While most respondents have housing, almost one in ten reported that they have housing today but are worried about maintaining it in the future, and 6% reported having no housing at all. In 2018 in Payette County, there were approximately 18 affordable and available units for every 100 people who had extremely low income (<30% Area Median Income, or AMI), approximately 74 available units for every 100 people with very low income (30-50% AMI), and approximately 106 units for every 100 people with low income (50-80% AMI). These data support assessment participants perception of a lack of affordable housing options for very low-income individuals and families.

"There is not a housing inventory at all even for individuals and families who have a decent income. People are forced to rent or buy in Idaho because there is no stock in Ontario proper."

Figure 21: Respondent Housing Situation At The Time of the Survey (n=302)



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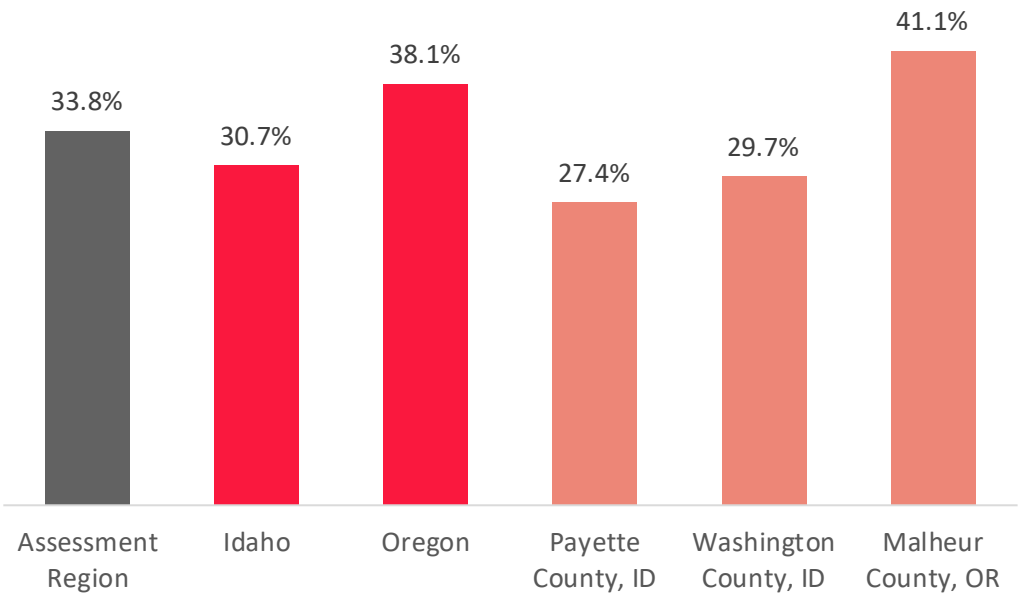
In 2018, approximately one third of the housing units in the Assessment Region were renter occupied (Figure 22). Renter-occupancy ranged from 27% in Payette County to 41% in Malheur County. In Idaho, approximately 31% of housing units were renter-occupied and in Oregon, approximately 38% were renter-occupied.

Figure 22: Percentage of Housing Units Renter-Occupied, 2018

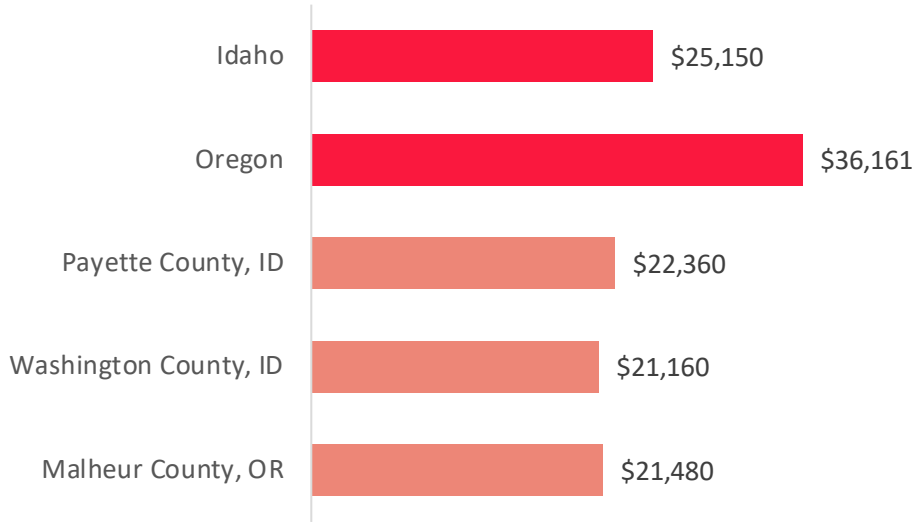


DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as cited by Trinity Health Data Hub, 2014-2018

Data from the National Low Income Housing Coalition reveals that the annual income needed to afford a 1 bedroom rental in the Assessment Region ranged from $21,160 in Washington County to $22,360 in Payette County, which was lower than the $25,150 needed in Idaho overall and $36,161 needed in Oregon overall (Figure 23).

In order to be able to afford rent for a 1-bedroom apartment, a person living in Payette County would have needed to work 59 hours at minimum wage, or 34 hours at the average renter's wage. A person living in Washington County would have needed to work 56 hours at minimum wage, or 40 hours at the average renter's wage to afford rent for a 1-bedroom unit. Lastly, a person living in Malheur County would have needed to work 51 hours at minimum wage or 47 hours at the average renter's wage to afford rent for a 1-bedroom unit. This supports assessment participants statements about having to work extra hours or more than one job in order to keep up with housing costs.

Figure 23: Annual Income Needed to Afford 1 Bedroom Rental, 2018



DATA SOURCE: National Low-Income Housing Coalition, Out of Reach Idaho and Oregon, 2018

One issue that assessment participants brought up several times was how the current housing and land use laws and policies in Oregon made it hard to turn farmland to into land that could be used for housing. Residents also stated that there were fewer building permits given out in Malheur County compared to other neighboring counties in Idaho. which also affected the availability of affordable housing in the Assessment Region.

"Planning and zoning are overregulated by the state which makes land development difficult. You have to have 80 acres to build a house on exclusive farm use zoned land."

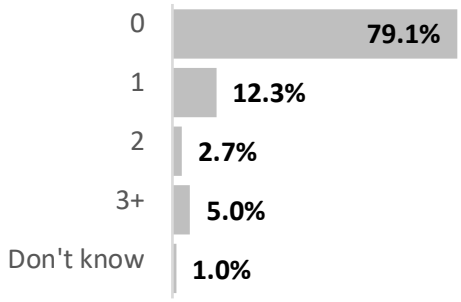
Homelessness

Community survey results show that 45.3% of survey respondents believed that homelessness is a top five health issue for their community. Community survey respondents were also asked to report the number of times they had moved in the past 12 months, which is sometimes a risk factor or precursor to homelessness. While most respondents had not moved at all in the past 12 months, more than one in ten reported moving once in the past year (12.3%) (Figure 24). Additionally, assessment participants shared that there has been a growing number of people experiencing housing insecurity coming to the Assessment Region from Boise and the surrounding areas, because the cost of housing is cheaper in the Assessment Region and wages are higher. There are some in the community who perceived these new residents moving into the area as a "drain on the community" because they felt that they are using community resources but not contributing anything back. Community members were also concerned that there is not an overnight shelter in Ontario or the surrounding region. The nearest overnight shelter is nearly 30 miles away in Nampa, Idaho. There is only one day shelter in the area that has limited hours of operation. Key stakeholders also thought there were not enough services for people experiencing homelessness to keep up with the current demand. It was mentioned that the resources that do exist focus on "daily survival" and not future success.

"When we're sleeping unsheltered, it's hard to do much more than try to stay fed, warm, safe, which is not achievable currently. We are suffering. We are grateful that there are people thinking of us and doing something about it like New Hope, but it isn't enough."

"Homelessness in general is a big concern in the community, with no overnight shelter, a homeless community that was displaced from their encampments near the river, because of department of health concerns, now have nowhere to sleep."

Figure 24: Number of Times The Respondent Has Moved In The Past 12 Months (n=301)



Saint Alphonsus Health System & United Way of Treasure Valley 2020 Community Survey

Existing resources and assets include, but are not limited to:

- Community in Action
- Eastern Oregon Border Development Region Board
- New Hope Day Shelter
- Project Dove

Transportation

Transportation affects multiple aspects of an individual's health. It affects physical activity, injury levels, respiratory related illnesses, and healthcare access.[16] Sidewalks and bike trails in communities can encourage physical activity. Each additional hour spent in a car per day increases the likelihood of obesity while each added kilometer walked per day reduces risk of obesity.[16] The way roads are designed can affect the incidence of motor vehicle, pedestrian, and bicyclist injuries. Increasing the availability of public transit can decrease traffic congestion and air pollution that can lead to respiratory and heart disease.[16] Transportation barriers also lead to rescheduled or missed appointments, delayed care, and missed or delayed medication use.[17]

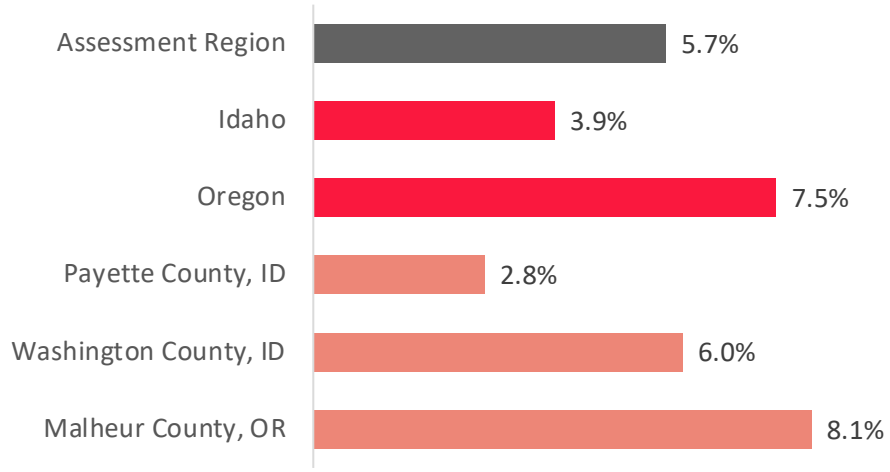
Vehicle Availability

In 2018, approximately 5.7% of households in the Assessment Region did not have access to a motor vehicle. This ranged from 2.2% in Payette County up to 8.9% in Malheur County (Figure 25). Focus group participants stated that it was hard to get around the area without a car because of the limited availability of public transportation. Participants also spoke about the added expenses of maintaining a car (gas, repair costs, etc.) being a barrier to owning a car.

[16] Centers for Disease Control and Prevention. Transportation and Health. Available at: https://www.cdc.gov/healthyplaces/healthtopics/transportation/default.htm. Accessed on February 20, 2020.

[17] Syed ST, Gerber BS, Sharp LK. Traveling towards disease: transportation barriers to healthcare access. J Community Health. 2013;38(5):976–993.

Figure 25: Percent of Households with No Motor Vehicle, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Public Transportation

Availability of public transportation was ranked as the top transportation concern among almost 35% of community survey participants. Focus group and key informant interview participants talked about the very limited public transportation that was offered in the region, stating the only available form of public transportation is a bus system which often only stops at bus stops hourly. Some buses do not run daily which limits transportation options for residents further. Residents even stated that it is an "all day process" to try and take the bus to and from certain locations. According to assessment participants, the state of Oregon has allotted funding to address the transportation issue, but it has not reached the Ontario region yet. In Idaho, lack of federal and state funding has been cited as the cause for the poor public transportation system.

"There is little public transportation, especially across the river and back. If you get dropped off somewhere at 8 a.m. you won't get picked up until 5 p.m."

Access to Services

Focus group and key informant interview participants spoke about how the lack of transportation options affected their access to medical and social services. Those with insurance sometimes have options to arrange medical transportation, but the reliability of these services vary. Residents also shared how they had to travel several miles, or even to other communities, to access services that are not available in the area (specialty care, dentistry, etc.). They stated that making those appointments had been an issue due to the lack of transportation options. Residents that do have a car are sometimes unable to make appointments because they are too sick to drive themselves.

"Lack of transportation is lack of medical attention which then makes health conditions worse."

Existing resources and assets include, but are not limited to:

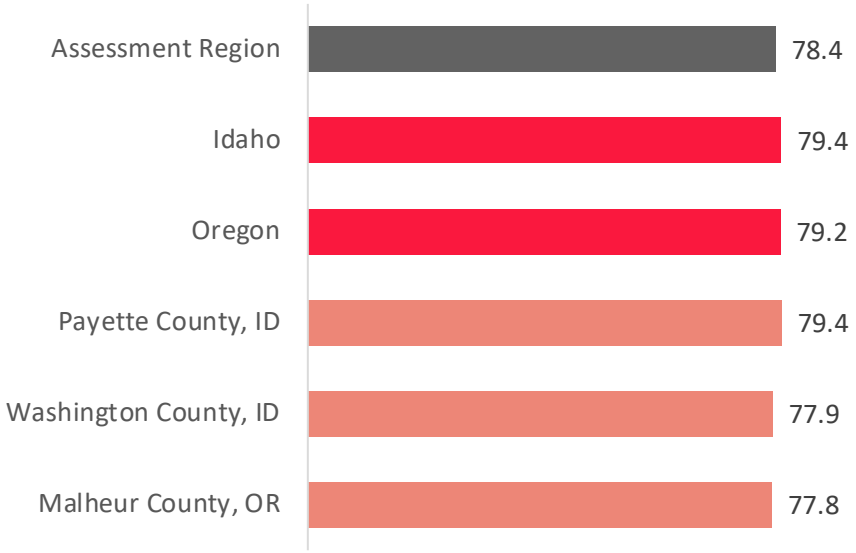
- Angel Wings
- Local Bus Routes
- Malheur Council on Aging and Community Services
- SRT-Malheur Express

Health

There is strong evidence characterizing the social influencers (e.g. financial stability, housing, education) and their relationship to health. While other sections of the report speak specifically to those upstream influencers, the following section details the downstream health and well-being of residents in the Ontario region. From both statistics and stories, the top health concerns identified were access to affordable healthcare and mental health and well-being.

One measure for overall health status is the life expectancy of the residents in a community. Zip code has become more predictive of people's health and life expectancy than their genetic code, meaning where they live impacts their health. The life expectancy of residents of Idaho, Oregon, and the Ontario region are fairly similar (Figure 26).

Figure 26: Life Expectancy at Birth, 2010-2015



Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2007-10. Source geography: County

Access to Healthcare

Healthcare access refers to how easily an individual can obtain medical services to achieve the best health outcomes and can affect one's physical, social, and mental health as well as quality of life.[18] Healthcare access has three main components: coverage (insurance), services (access to services is dependent mostly on having ongoing care such as a primary care physician), and timeliness (ability to obtain healthcare quickly after a need is recognized).[18] People that are uninsured are more likely to have poor health status, be diagnosed later for a disease, and die prematurely.[18] Those who access services more frequently through a primary care physician have an increased likelihood of receiving appropriate care and lowered mortality from all causes.[18] Delays in care can lead to increased emotional distress, complications, and hospitalizations.[18]

When examining inequities in access to care, according to data from the Center of American Progress, LGBTQIA+ individuals are more likely to lack health insurance, delay medical care, visit emergency rooms for treatment, and

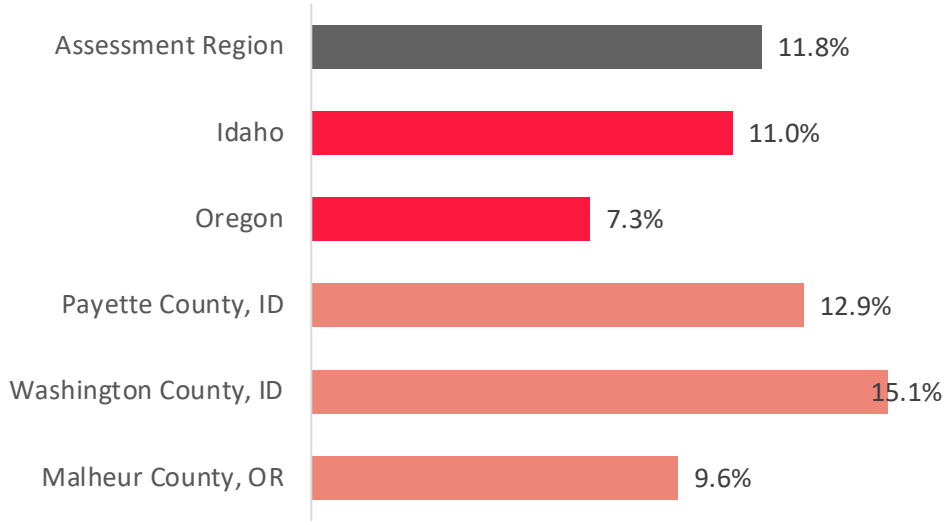
[18] Healthy People 2020. Access to Health Services. Fact Sheet. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services.

encounter prejudice from health-care providers.[19] Among nonelderly adults, Hispanic and Latino residents face greater barriers to accessing healthcare than Whites and are less likely to be insured.[20]

Community survey respondents most frequently selected cost of services (46.5%), insurance problems/lack of coverage/not enough coverage (35.5%), and long waits for appointments (34.6%) as issues that have ever made it more difficult for them to get the health or social services needed. Though about one third of survey respondents identified insurance coverage as a barrier, in 2018according to data from the American Community Survey, the percentage of the population without insurance ranged from 10% in Malheur County to a high of 15% in Washington County; this was higher than the Idaho and Oregon statewide uninsured populations (Figure 27).

One issue that assessment participants mentioned in focus groups was the limited coverage that came with Medicaid for those who were able to even qualify for Medicaid. Participants shared that many people have no insurance because they did not qualify. Assessment participants also shared that community members with Medicaid still had to pay for needed medical services and expensive prescription medications out of pocket because insurance did not cover it. It should be noted that eligibility, reimbursement qualifications and rates vary greatly between Oregon and Idaho. Medicaid expansion was only made available to Idaho residents in January 2020.

Figure 27: Total Population Uninsured, 2018



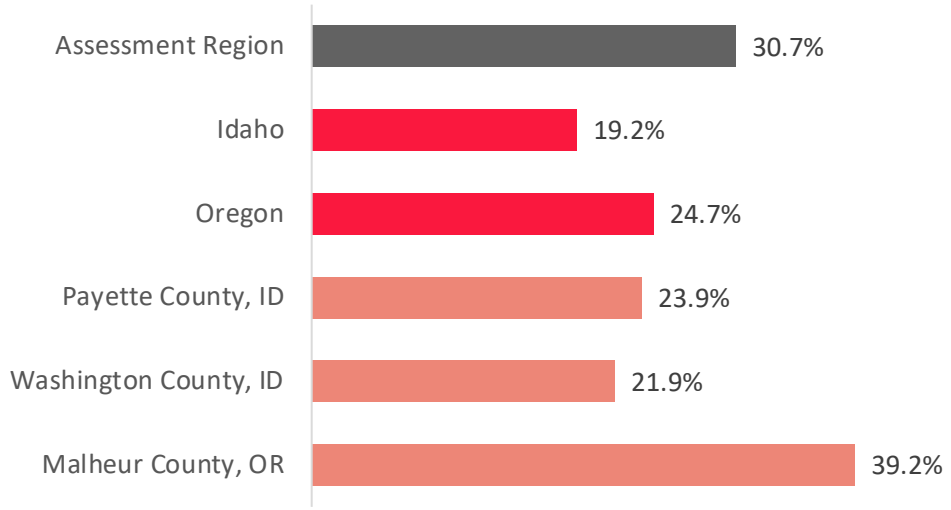
DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Within the Assessment Region in 2018, the percentage of the insured population receiving Medicaid ranged from 22% in Washington County to 39% in Malheur County. Though focus group participants often talked about issues with insurance, participants believed that Idaho's Medicaid expansion will allow more people to obtain insurance coverage.

[19] Laura E. Durso, Kellan Baker, and Andrew Cray, LGBT Communities and the Affordable Care Act: Findings from a National Survey, Washington, D.C.: Center for American Progress, 2014. Jeff Krehely, How to Close the LGBT

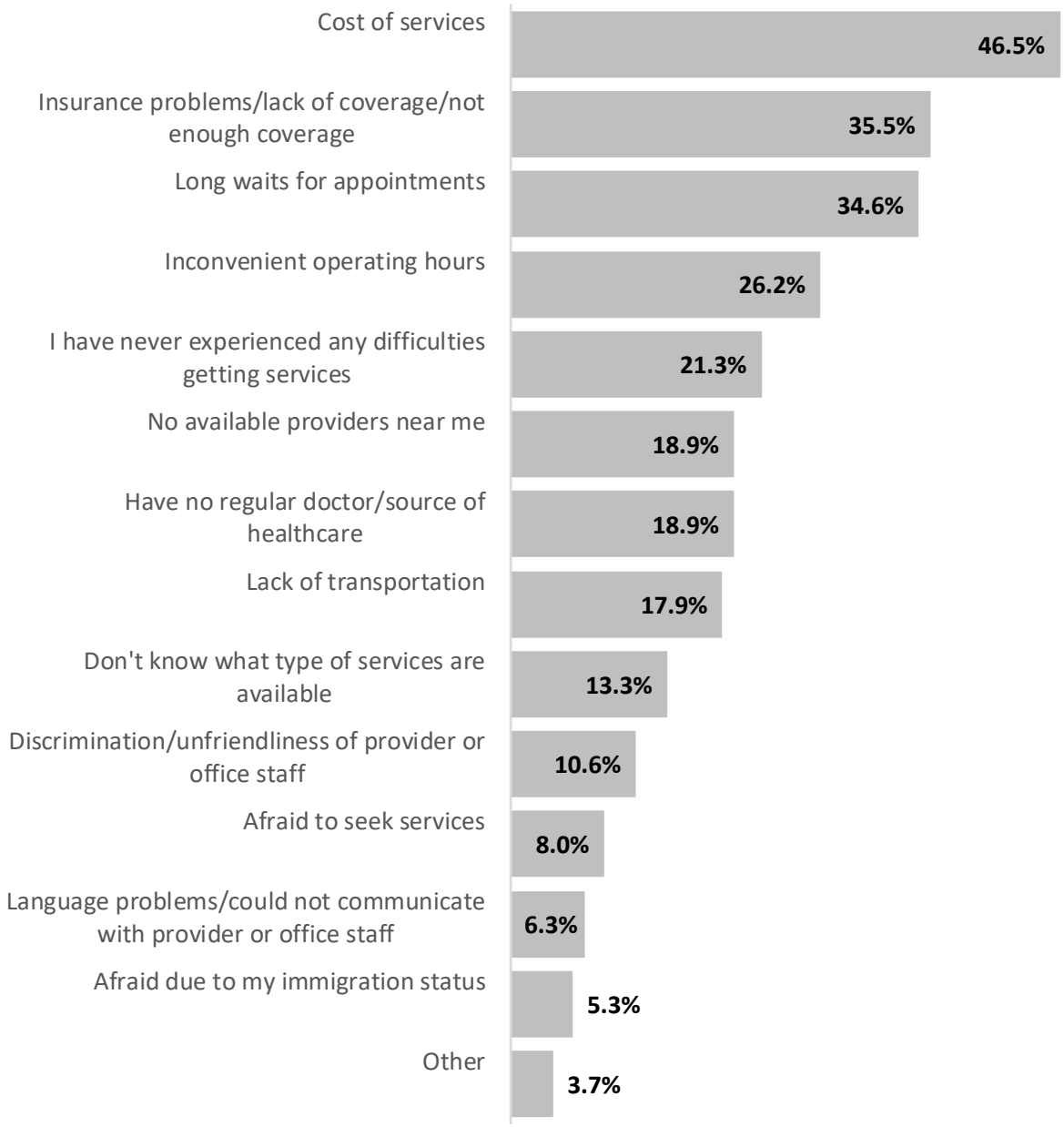
[20] Kaiser Family Foundation. Health and Healthcare for Hispanics in the United States. Fact Sheet. Available at: https://www.kff.org/infographic/health-and-health-care-for-hispanics-in-the-united-states/. Accessed on February 28, 2020

Figure 28: Percentage of Insured Population Receiving Medicaid, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Figure 29: Issues That Have Ever Made It More Difficult For The Respondent To Get The Health Or Social Services Needed (n=301)*



*Respondents were permitted to select more than one option, so percentages do not sum to 100%
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Assessment participants conveyed that while some services are available within the service area, there were also several barriers to accessing them. One barrier that was mentioned several times was language. Refugees and other immigrants have not been able to access services because of the limited translation services in the Assessment Region even though approximately one fifth of the population speaks a language other than English. Participants also described a "service

gap." When community members were receiving services, such as SNAP, sometimes their financial situation improved slightly which caused them to be "priced out" of that service which they still may need.

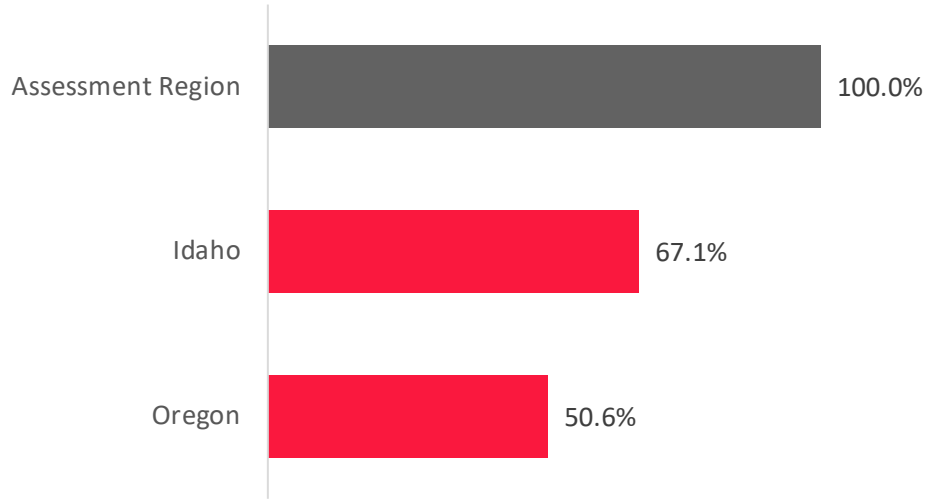
"If you make too much, you lose benefits, such as healthcare. I know some people who quit their jobs just to keep their benefits."

Participants also shared some frustrations around resource communication and navigation in the area. Participants felt as if the resources that are available in the community are not communicated to them, and even if a resource was known, individuals do not know how to navigate that specific resource. Community members expressed a desire for more Community Health Workers to help with resource navigation and a resource directory that lists all the resources and services available in the area.

In 2019, the entire population in the Assessment Region was living in a health professional shortage area; this was higher than the 67.1% in Idaho and 50.6% of population in Oregon (Figure 30). In the Assessment Region in 2014, the number of primary care physicians available for 100,000 people ranged widely from 23 in Malheur County to approximately 68 in Washington County (Figure 31). These data confirm assessment participants perception of a low number of healthcare providers, especially specialists, in the Assessment Region.

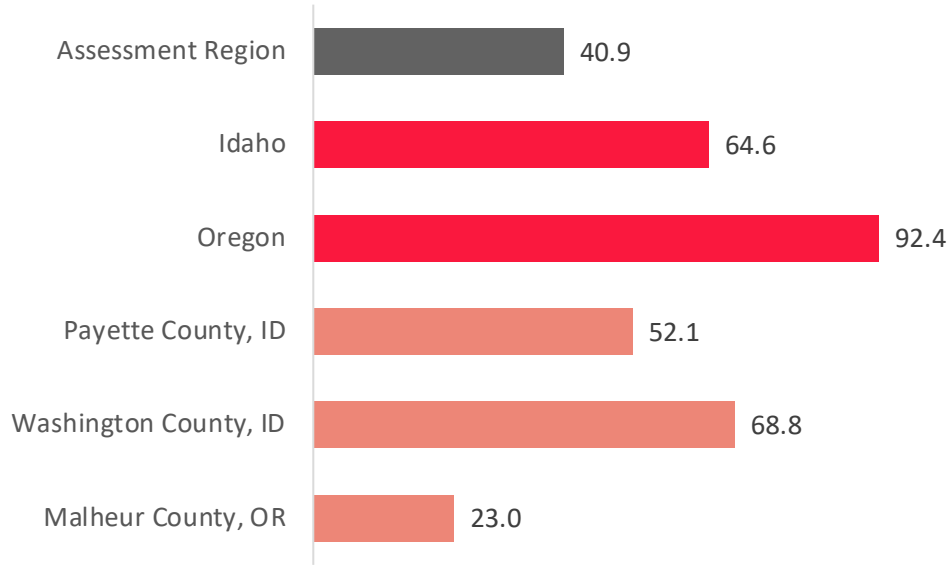
"Many people have no insurance, struggle to find resources, and lack access to case management."

Figure 30: Population in a Health Professional Shortage Area, 2019



DATA SOURCE: US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administrations cited by Trinity Health Data Hub, February 2019

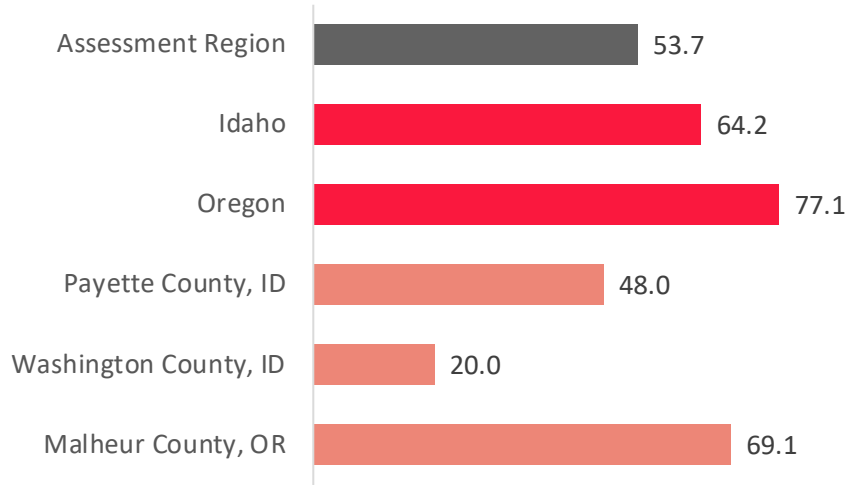
Figure 31: Primary Care Physicians Per 100,000 Population, 2014



DATA SOURCE: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, as cited by Trinity Health Data Hub, 2014

In the Assessment Region in 2015, the number of dentists available for every 100,000 people ranged from 20 in Washington County to about 70 in Malheur County (Figure 32). In the region overall, there were fewer dentists per capita than in the Idaho and Oregon. This echoes what was heard in focus groups regarding difficulty finding and receiving dental care.

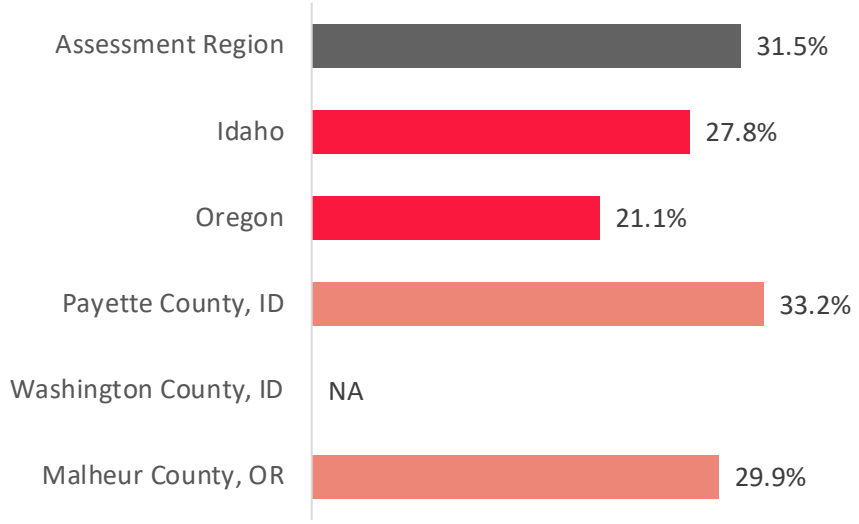
Figure 32. Dentists Per 100,000 Population, 2015



DATA SOURCE: U.S. Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, as cited by Trinity Health Data Hub, 2015

Approximately 19% of community survey respondents reported that they had no regular doctor or source of healthcare. Additionally, according to data from the CDC, approximately one third of the population in the Assessment Region did not have regular doctor in 2012; this was higher than both Idaho and Oregon (Figure 33). In 2015, approximately 58% of the adult population in Idaho and 61% of adults in Oregon had a routine checkup in the past year (Figure 34).

Figure 33: Percentage of Adults Without A Regular Doctor, 2012



DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, additional data analysis by CARES, as cited by Trinity Health Hub, 2011-2012

Figure 34: Percent of Adults with Routine Checkup In The Past Year, 2015

DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, accessed via the 500 Cities Data Portal, as cited by Trinity Health Hub, 2015

Existing resources and assets include, but are not limited to:

- Angel Wings
- Community in Action
- Familias en Acción
- Four Rivers Welcome Center
- Idaho Community Action Network
- Lifeways Behavioral Health
- Malheur County Health Department
- Payette County Community Health Action Team
- Saint Alphonsus Health System

- Southwest District Health
- Valley Family Health
- Washington County Community Health Action Team
- Western Idaho Community Action Partnership

Behavioral Health- Mental Health and Substance Use

Mental health is an important part of one's overall health and well-being. Mental illness is one of the most common health conditions with one in five Americans experiencing a mental illness in any given year, and more than 50% of people in the United States predicted to be diagnosed with a mental illness at some point in their lifetime.[21,22] Those most at risk for developing a mental illness are individuals who experience an early adverse childhood event, those with chemical imbalances in the brain, those who use recreational drugs, and those in isolation.[23] Mental health conditions, such as depression, increase the risk of for physical health problem including stroke, Type II diabetes, and heart disease.[24] Chronic conditions can also increase the risk for a person to develop a mental illness.[24]

Inequities in stress and mental health illness exist for certain populations. LGBTQIA+ individuals are at a higher risk of developing a mental illness. According to the American Psychology Association, "Blacks, Latinos, American Indians/Alaska Natives and Asian Americans are over-represented in populations that are particularly at risk for mental health disorders."[25]

Substance use disorders are also a critical public health issue that affects not only the individual, but also have serious direct and indirect impacts on families, communities, and society as whole. The causes of substance use disorders are multi-faceted and include biological, social, and environmental factors.[26] Trauma and adverse childhood experiences increase the chances of substance use and addiction.[27] Individuals with substance use disorders can experience negative health and social outcomes including higher rates of infectious disease (HIV, hepatitis), cancer, mental illness, domestic violence, crime, financial hardship, housing instability and homelessness, child-abuse, and overdose.[28] Illicit drug use, along with existing and emerging alcohol and marijuana use, strains resources from law enforcement to social and health services.

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[21] Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry. 2007;6(3):168-176.
[22] Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. Rockville, MD: Center for Behavioral Health Statistics and Quality. Substance Abuse and Mental Health Services Administration. 2016.
[23] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, Severity, and Comorbidity of Twelve-month DSM-IV Disorders in the National Comorbidity Survey Replication (NCS-R). Archives of general psychiatry. 2005;62(6):617-627. doi:10.1001/archpsyc.62.6.617.Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2016). Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. Rockville, MD.
[24] World Health Organization, Geneva, Switzerland. Strengthening Mental Health Promotion External. Fact sheet no. 220.
[25] American Psychology Association. Healthcare Reform: Disparities in Mental Health Status and Mental Healthcare. Available at: https://www.apa.org/advocacy/health-disparities/health-care-reform.pdf. Accessed: February 20, 2020

[26] US Department of Health and Human Services, Office of the Surgeon General. Facing Addiction in America The Surgeon General's Report on Alcohol, Drugs, and Health. 2016.
[27] Felitti VJ, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study. American Journal of Preventative Medicine. 1998; 14(4): 245-258.
[28] US Department of Health and Human Services, Office of the Surgeon General. Facing Addiction in America The Surgeon General's Report on Alcohol, Drugs, and Health. 2016.

Mental Health and Wellbeing

Mental health includes emotional, psychological, and social well-being. It affects how people think, feel, and act. It also helps determine how people handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood.[29] There are numerous risk factors or influencers of mental illness, including genetics, stressful life situations, social isolation, and chronic health conditions.[30]

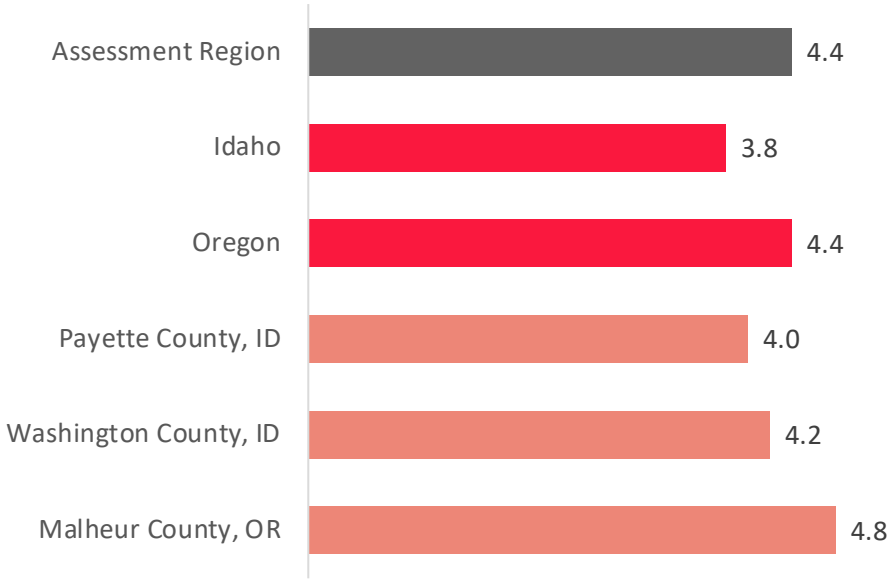
Table 4: **Lack of Social or Emotional Support, by Total Service Area, Idaho, Oregon, Payette Co., Washington Co., Malheur Co., 2006-2012**

	Estimated Population Without Adequate Social/Emotional Support	Crude %
Assessment Region	8,524	18.1
Idaho	184,689	16.4
Oregon	446,505	15.2
Payette County, ID	3,559	22.4
Washington County, ID	1,547	20.1
Malheur County, OR	3,418	14.7

DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the Health Indicators Warehouse. US Department of Health & Human Services, Health Indicators Warehouse. 2006-12.

In the Assessment Region overall in 2017, adults aged 20 and over reported having on average 4.4 poor mental health days in a month; this was slightly higher than the 3.8 days in Idaho and 4.4days in Oregon (Figure 35).

Figure 35: Poor Mental Health Days of Adults aged 20 and over, 2017



DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings. 2020. Source geography: County

[29] https://www.mentalhealth.gov/basics/what-is-mental-health
[30] https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968

Community survey respondents were concerned about mental health; 44% listed mental health and stress as a top five health issue in their community. Mental health was a major concern for interview and focus group participants as well. There were mental health concerns for the whole population regardless of age, race, education, or socioeconomic status. Stress came from different sources, but financial stress seemed to be the major cause of mental health problems in the community that participants identified. Participants also shared their thoughts about the current crisis intervention system in the region. Currently, there are no facilities in the Assessment Region to care for people in crisis. Participants said their two options for treatment are either the ER or a number of facilities that are several miles outside the Assessment Region. Community members identifying as LGBTQIA+ also shared in interviews that they were concerned with providers' ability to treat LGBTQIA+ patients.

"Families and individuals feel hopeless with economic situation and the lack of mental health available. They feel stuck fighting internal and exterior stressors and begin to shut down. This creates the symptoms – violence, increased drug addiction and more stress on the systems."

"Lifeways has a monopoly on behavioral health and have no skill with LGBT+ counselling. Suicide attempts will most likely board in the ED unless there is insurance. IF insurance is inadequate or runs out, patients discharged whether appropriate or not."

Table 5: Reported Mental Health Status, Assessment Region

Mental Health and Stress	Not a Concern		Slight Concern		Moderate Concern		High Concern		I Don't Know	
	N	%	N	%	N	%	N	%	N	%
Mental health and stress among veterans (n=286)	16	5.6	16	5.6	60	21	**171**	**59.8**	23	8
Mental health and stress among middle and high school aged youth (n=288)	19	6.6	19	6.6	66	22.9	**165**	**57.3**	19	6.6
Suicide (n=284)	22	7.7	24	8.5	52	18.3	**165**	**58.1**	21	7.4
Mental health and stress among low-income families and individuals (n=289)	24	8.3	28	9.7	60	20.8	**165**	**57.1**	12	4.2
Mental health and stress among homeless (n=289)	26	9	28	9.7	53	18.3	**165**	**57.1**	17	5.9
Real or perceived stigma associated with seeking mental healthcare (n=283)	26	9.2	22	7.8	22	7.8	**146**	**51.6**	17	6
Ability to get mental healthcare services (n=288)	45	15.6	20	6.9	72	25	**141**	**49**	10	3.5
Mental health and stress among immigrants (n=287)	37	12.9	32	11.1	73	25.4	**118**	**41.1**	27	9.4

Saint Alphonsus Health System & United Way of Treasure Valley 2020 Community Survey

Youth suicide has become a public health crisis in Idaho and Oregon. In Oregon, it is the second leading cause of death for youth ages 10-24. Depression, suicide ideation, and suicide attempts are on the rise among Oregon 8th and 11th graders surveyed, with steady increases from 2015 to 2019.

Table 6. Depression and Suicide, 8th and 11th Graders, Oregon, 2015-2019

	2015		2017		2019	
	8th Grade	11th Grade	8th Grade	11th Grade	8th Grade	11th Grade
Depressive Symptoms	26.7	29.0	30.1	32.2	31.5	36.3
Suicide Ideation	16.2	16.3	16.9	18.2	19.9	18.6
Suicide Attempts	8.2	6.2	8.7	6.8	10.4	7.4

DATA SOURCE: Oregon Healthy Teen Survey, 2019

Idaho is also consistently among the states with the highest suicide rates in the nation. In 2017, Idaho had the fifth highest suicide rate in the U.S., with a rate of 22.9 deaths for every 100,000 people; that is 58% higher than the national average. Suicide is the second leading cause of death for Idaho residents ages 15-34 and for males up to age 44. The 2019 Idaho Youth Risk Behavior Surveillance Survey showed that almost 22% of Idaho high school students had ever thought about committing suicide, and 10% of students had tried committing suicide during the past year.[31] Another 39% of Idaho students reported feeling sad or hopeless for two weeks or more during the past 12 months, while 32% of Oregon 8th graders and 42% of Oregon 11th graders reported the same.[32]

Looking at data on suicide completions among the total population, the Assessment Region experiences a similar rate to Idaho and Oregon overall.

Table 7. Suicide, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2013-2017

	Avg Annual Deaths	Crude Death Rate per 100,000 Pop
Assessment Region	11	20.6
Idaho	346	20.9
Oregon	768	19.0
Payette County, ID	5	22.7
Washington County, ID	no data	no data
Malheur County, OR	6	19.1

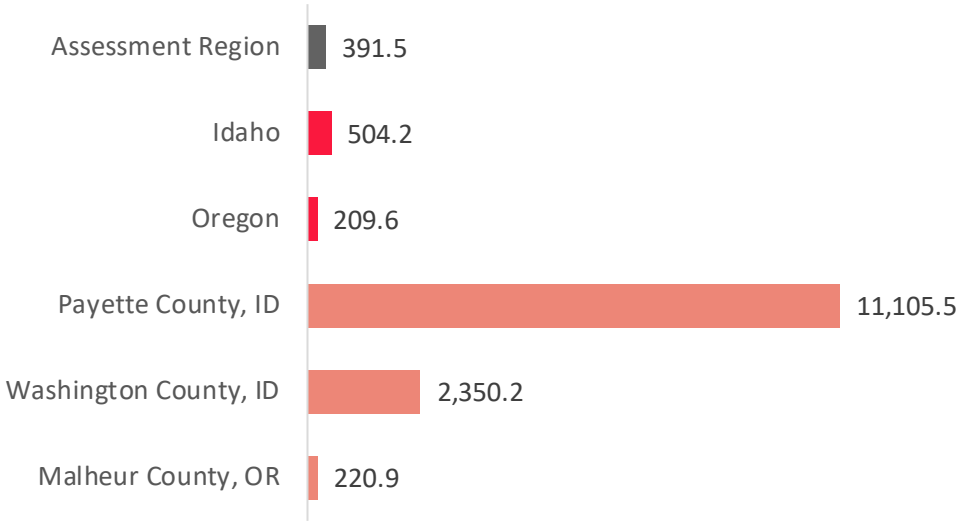
DATA SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, Accessed via CDC WONDER, as cited by Trinity Health Data Hub, 2013-2017

In the Assessment Region overall in 2017, there was 1 mental health provider for every 392 people; this ranged widely from 1 mental health provider for every 221 people in Malheur County to 1 for every 11,105 people in Payette County. Focus group participants frequently brought up issues with accessing mental health services due to the lack of providers, which is evident in Payette and Washington County. A lack of options also deters residents because they believed they may run into someone they know while trying to access care and fear being stigmatized.

[31] https://www.sde.idaho.gov/student-engagement/school-health/files/youth/Youth-Risk-Behavior-Survey-Results-2019.pdf

[32] https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Documents/2019/2019%20State%20of%20Oregon%20Profile%20Report.pdf

Figure 36: Ratio of Mental Health Providers (1 provider for x persons), 2017



DATA SOURCE: University of Wisconsin Population Health Institute, County Health Rankings, as cited by Trinity Health Data Hub, 2017

Substance Use

Substance use was selected as top five health concern for the community by 42% of community survey respondents. In the category of Substance Use, methamphetamine use had the highest percentage of respondents that marked that as a high concern for the community (70.0%). Focus group and key informant interview participants expressed their concerns around the use of different substances in the community.

In 2014, the state of Oregon legalized the recreational use of marijuana, though cities could restrict use in their communities. In November 2018, Ontario residents passed a ballot initiative to lift the ban in the city. Assessment participants had mixed views about the legal marijuana industry. Some participants thought that legalization would cause people to get addicted to marijuana, especially youth. There were concerns that both youth and adults were traveling from Idaho to Oregon in order to get marijuana. Others were happy about the taxes that the industry generated for the county. Lastly, community members also had concerns about other substance use in the community such as methamphetamine, opiates, and alcohol.

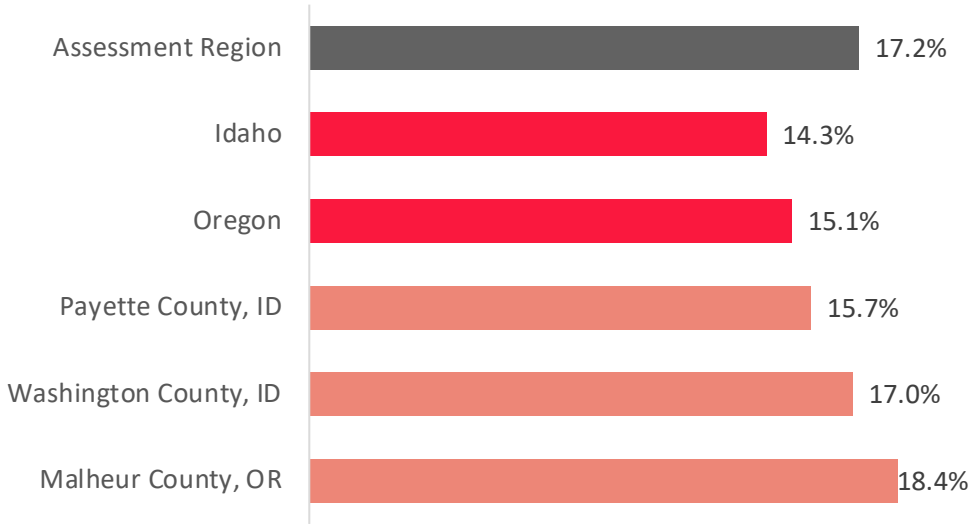
"Our youth using marijuana and other drugs, will change our education system. There are many more people now who will say they've used drugs."

"Malheur county is the poorest in the state, but Ontario is getting a lot of money in taxes for the marijuana services."

In the Assessment Region in 2016, approximately 17.2% of adults were current smokers, which ranged from 15.7% of adults in Payette County to 18.4% in Malheur County (Figure 37).

In 2014, the Assessment Region, the average expenditures for tobacco was $813 or 1.8% of annual food-at-home expenditures; in Idaho it was $845 or 1.8% of expenditures and in Oregon, it was $789 or 1.6% of expenditures.

Figure 37: Current Adult Smokers, 2016



DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Accessed via County Health Rankings, as cited by Trinity Health Data Hub, 2016

Vaping was mentioned as a substance of particular concern among youth in the Ontario region, as well as across the Treasure Valley. Students who vape or use e-cigarettes are more likely to become tobacco users within four years than those who don't.[33] In 2019, 17% of Oregon 8th grade students and 34% of 11th grade students had ever used a vape or e-cigarette with mint, fruit, coffee, candy or other flavors.[34] An additional 8.2% of 8th grade and 8.9% of 11th grade students said they would probably or definitely smoke an e-cigarette one of their best friends asked them to. In Idaho, 48% of high school students reported they had ever used an electronic vapor product at least once.[35]

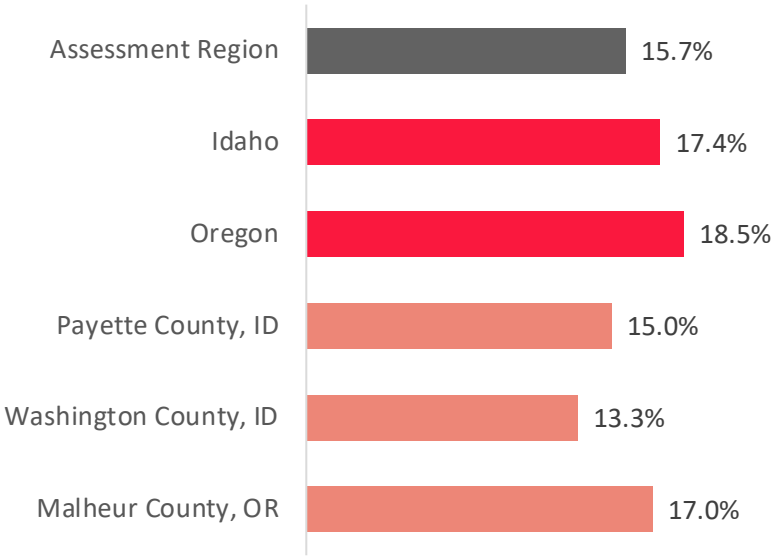
Residents in the Ontario region were less likely to report excessive drinking, as compared with Idaho and Oregon state rates. In 2016, approximately 16% of adults in the Assessment Region reported excessively drinking, ranging from 13.3% adults in Washington County to 17.0% adults in Malheur County (Figure 38).

[33] Centers for Disease Control and Prevention. *Electronic Nicotine Delivery Systems Key Facts.* [Online]: http://www.cdc.gov/tobacco/stateandcommunity/pdfs/ends-key-facts2019.pdf.

[34] https://www.oregon.gov/oha/PH/BIRTHDEATHCERTIFICATES/SURVEYS/OREGONHEALTHYTEENS/Documents/2019/2019%20State%20of%20Oregon%20Profile%20Report.pdf

[35] https://www.sde.idaho.gov/student-engagement/school-health/files/youth/Youth-Risk-Behavior-Survey-Results-2019.pdf

Figure 38: Percent of Adults Reporting Excessively Drinking, 2016



DATA SOURCE: University of Wisconsin Population Health Institute, County Health Rankings, as cited by Trinity Health Data Hub, 2016

Existing assets and resources include, but are not limited to:

- Familias en Acción
- Greater Oregon Behavioral Health, Inc.
- Lifeways Behavioral Health
- Malheur County Courthouse
- Malheur County Public Health
- Oregon Department of Human Services
- Saint Alphonsus Health System
- Southwest District Health
- Valley Family Health

Chronic Disease

According to the CDC, chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States.[36] In 2017, chronic diseases accounted for 90% of the nation's $3.5 trillion annual healthcare expenditure.[36] Six in ten adults in the U.S have a chronic disease and four in ten adults have two or more.[36] Major risk factors for chronic diseases include excessive alcohol use, poor nutrition, lack of physical activity, and tobacco use.[36]

Nutrition and Exercise

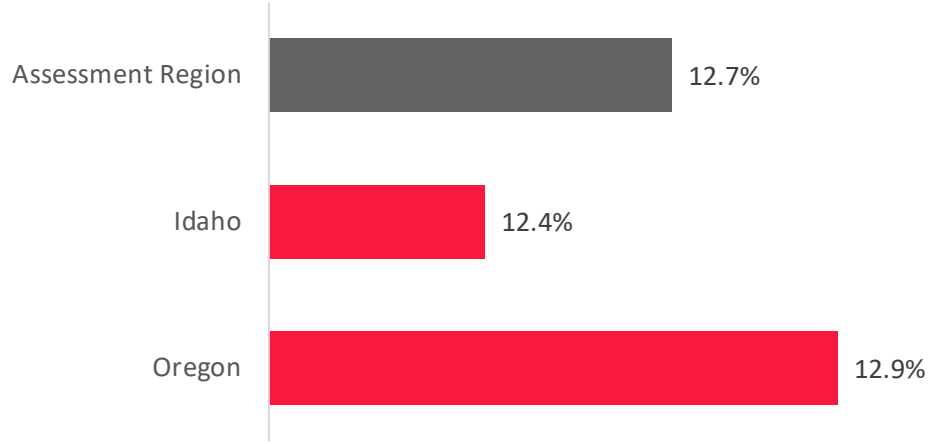
In 2014, 12.7% of the food-at-home expenditures of the population in the Assessment Region was spent on fruits and vegetables; this was similar to Idaho and Oregon rates (Figure 39). The average annual expenditures for soda in the Assessment Region was $251, which was 4.3% of total food-at-home expenditures; in Idaho it was $260 per year or 4.4% of expenditures and in Oregon, it was $248 per year or 4.2% of expenditures (Figure 40). Focus group and key informant interview participants spoke about the abundance of unhealthy food options in the Assessment Region, which could be

[36] Centers for Disease Control and Prevention. Health and Economic Cost of Chronic Diseases. Available at: https://www.cdc.gov/chronicdisease/about/costs/index.htm. Accessed on February 20, 2020.

why so few at home expenditures were spent on fruits and vegetables. Some also believed there is a lack of knowledge in the community on how to make healthy meals.

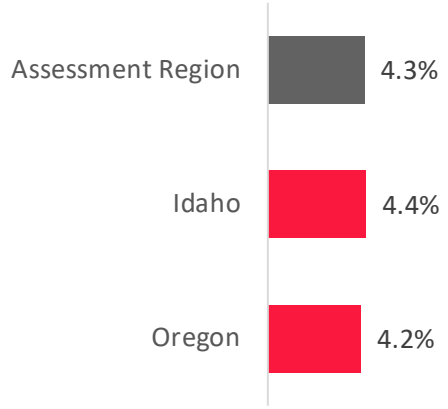
"There a lack of healthy food options when eating out. Everything is greasy food in all town restaurants."

Figure 39: Fruit and Vegetable Expenditures, 2014



DATA SOURCE: Nielsen SiteReports as cited by Trinity Health Data Hub, 2014

Figure 40: Soda Expenditures, 2014



DATA SOURCE: Nielsen SiteReports, as cited by Trinity Health Data Hub, 2014

Reinforcing what was heard in focus groups about healthy food availability, the data in Table 8 indicate a high rate of fast food establishments in Washington and Malheur Counties.

Table 8. Fast Food Restaurants, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2016

	# of Establishments	Rate per 100,000 Pop
Assessment Region	36	56.1
Idaho	1,083	69.1
Oregon	2,932	76.5
Payette County, ID	9	39.8
Washington County, ID	7	68.6
Malheur County, OR	20	63.9

DATA SOURCE: US Census Bureau, County Business Patterns, Additional data analysis by CARES, as cited by Trinity Health Data Hub, 2016

Further, there are six census tracts in the Assessment Region that are categorized as food deserts. Thus, over 27,000 residents have limited access to buy healthy, affordable food.

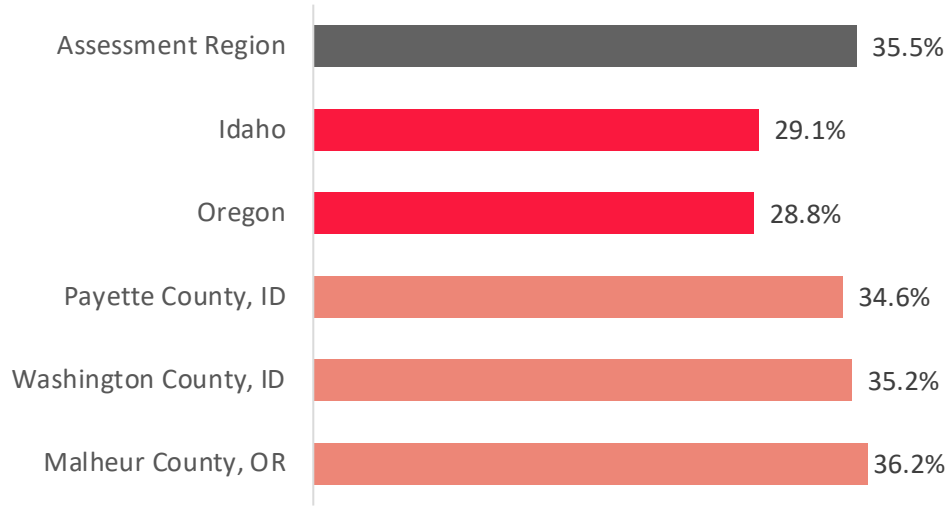
Table 9. Food Desert Census Tracts, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2015

	Number of Food Desert Census Tracts	Population in Food Desert Census Tracts
Assessment Region	6	27,633
Idaho	157	902,851
Oregon	294	1,517,679
Payette County, ID	3	14,653
Washington County, ID	1	1,655
Malheur County, OR	2	11,325

DATA SOURCE: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas. 2015.

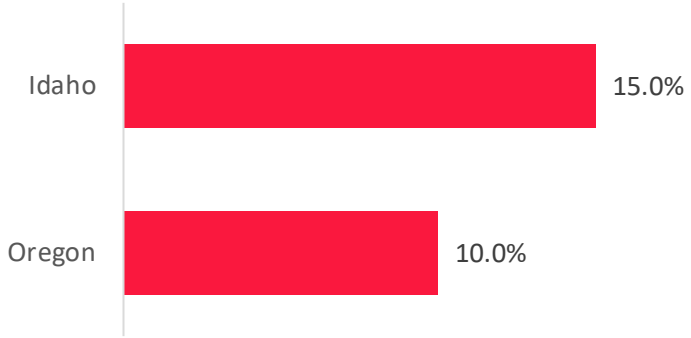
In 2016, approximately 36% of adults in the Assessment Region reported being obese, which was greater than both the Idaho and Oregon percentages (Figure 41). Among youth aged 10-17 years in 2016, approximately 15% in Idaho and 10% in Oregon reported being obese (Figure 42).

Figure 41: Adult Obesity (BMI >30), 2016



DATA SOURCE: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, as cited by Trinity Health Data Hub, 2016

Figure 42: Youth Obesity Among 10-17 Year-Olds, 2016



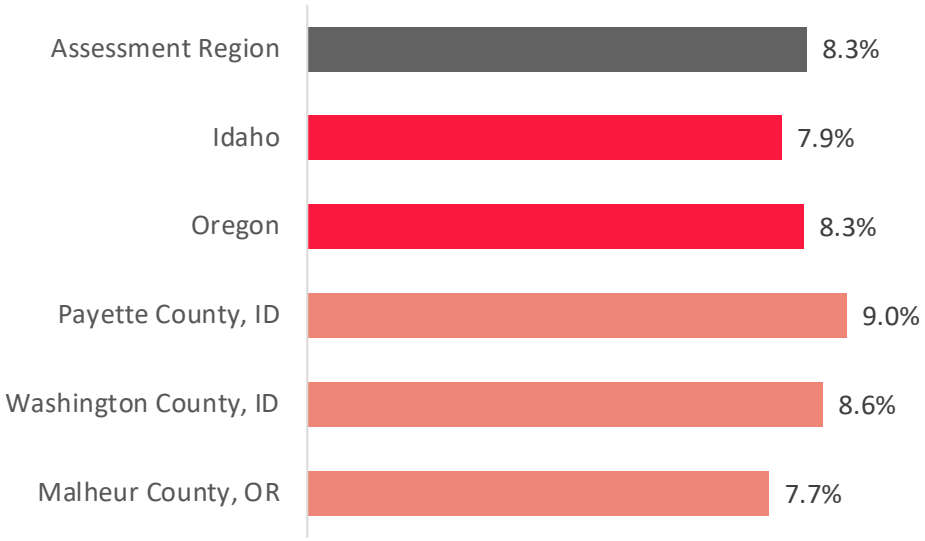
DATA SOURCE: Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, as cited by Trinity Health Data Hub, 2016

Cancer and Diabetes

In 2016, approximately 8.3% of the population in the Assessment Region had diabetes, ranging from 7.7% of the population in Malheur County to 9.0% in Payette County (Figure 43). Diabetes and cancer were the most mentioned chronic diseases in focus groups and interviews. Concerns around these diseases were mostly about accessing specialty care, which participants thought was lacking in the Assessment Region. Another big concern around these services was paying for treatment, especially medication cost.

"There's a growing need with aging population. Cancer is the last straw. Leaves people in financial ruin, and everything is hard. Taps into many resources – food, $, utilities, rent/mortgage assistance, case management, all resources are impacted."

Figure 43: Percent Adults with Diabetes, 2016

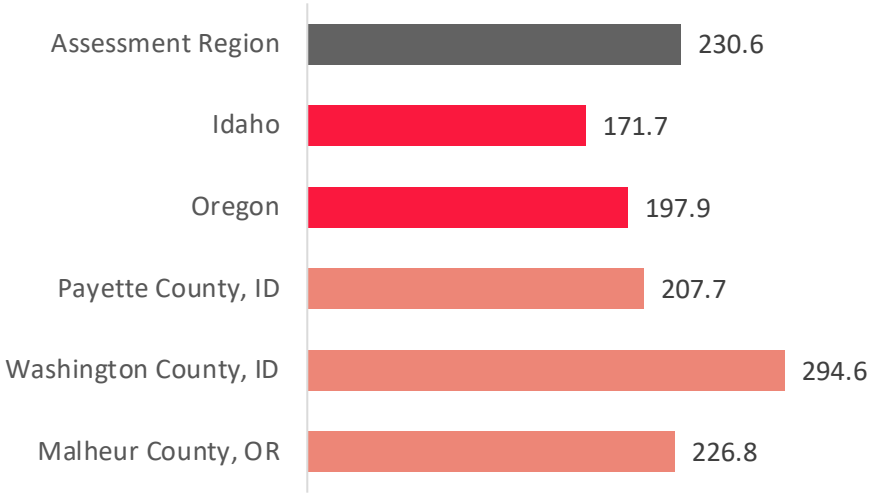


DATA SOURCE: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, as cited by Trinity Health Data Hub, 2016

Over the 2013-2017 period, the number of people dying from cancer was 203.6 for every 100,000 people, which was higher than Idaho rate of 171.7 and Oregon rate of 197.9. Washington County has the highest rates of death from cancer than the other counties in the area, which could be associated with their higher percentage of older adults as well.

Additional information on chronic diseases such as high blood pressure, heart diseases, etc. can be found in APPENDIX E: ADDITIONAL FINDINGS.

Figure 44: Crude Cancer Mortality Rate per 100,000, 2013-2017



DATA SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, accessed via CDC WONDER, as cited by Trinity Health Data Hub, 2013-2017

Existing assets and resources include, but are not limited to:

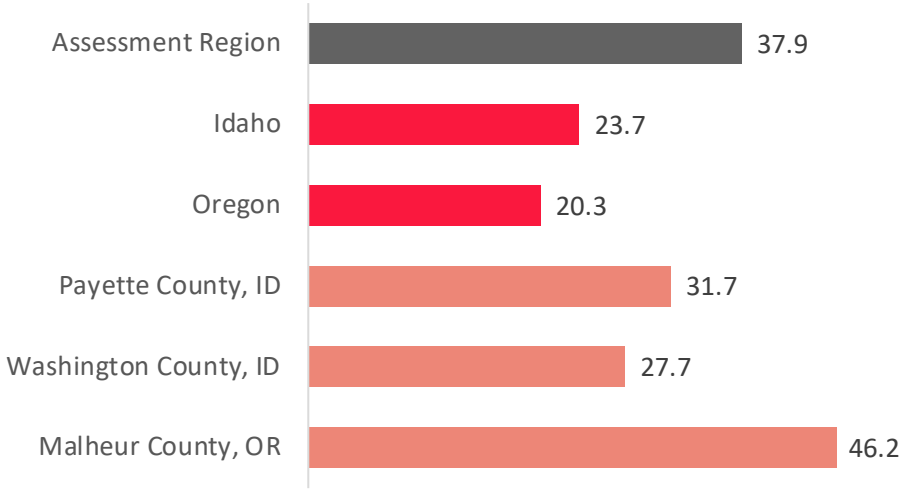
- Angel Wings
- Council on Aging
- Familias en Acción
- Malheur County Aging and Community Services
- Malheur County Health Department
- Malheur Memorial
- Southwest District Health

Sexual Health

The World Health Organization defines sexual health as a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Many things can affect sexual health such as age, stage of life, sexual experiences, culture, religious beliefs, experience of sexual trauma or abuse, comfort with your body, stress, and general physical and mental health.[37] In turn, changes in sexual health, such as acquiring a sexually transmitted infection (STI) or experiencing sexual trauma, can lead to changes in physical and mental health such as stress, bruising, depression, anxiety, genital discomfort, and cardiovascular issues.[38] Furthermore, when examining inequities in sexual health outcomes for different populations, people who identify as LGBTQIA+, specifically men who have sex with men, have a higher chance of contracting STIs such as syphilis and HIV.[38]

During the 2011-2017 period, teen birth rates per 100,000 population ranged from 27.7 in Washington County to 46.2 in Malheur County. The teen birth rate in the Assessment Region overall, at 37.9 per 100,000 population was higher than both Idaho and Oregon state percentages (Figure 45). The relatively high teen birth rates in the Assessment Region support key stakeholders' concerns over teen pregnancy that was discussed in focus groups.

Figure 45: Teen Birth Rate per 100,000 population, 2011-2017



DATA SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, accessed via County Health Rankings, as cited by Trinity Health Data Hub, 2011-2017

[37] Journal of Midwifery & Women's Health. Sexual Health and Sexual Problems. (2018), 63: 249-250.
[38] Centers for Disease Control. Sexual Health. Available at: https://www.cdc.gov/sexualhealth/Default.html. Accessed on February 20, 2020.

Participants also discussed a need for more places to get education on sexual health. Participants felt as if there was "nowhere to get good information on sexual health." Participants also shared that there was nowhere in the area that provided Pre-exposure Prophylaxis (PrEP), Post-exposure Prophylaxis (PEP), or Hormone Replacement Therapy (HRT). Boise was the closest location to get these medications/treatments. Finally, some participants believe there is stigma around using birth control and that comprehensive sex education should be taught in schools. According to one participant, there was is requirement to teach sex education in schools, but it is not currently happening.

"There is no PrEP, PEP, or HRT available in Ontario. If you are raped, you have to go to Boise for Sexual Assault Nurse Examiner (SANE) examiner and/or PEP."

Existing assets and resources include, but are not limited to:

- Malheur County Health Department
- Project Dove
- Southwest District Health Department

Education

Education influences health outcomes from the individual to population level. As one of the strongest predictors of health, the more education an individual has, the more likely they are to live a longer and healthier life.[39] During childhood, when a child is engaged in the education system not only are they learning, but they also have access to support systems and resources that can impact health, such as breakfast and lunch programs. Research shows that there are certain levels of education that are defining points, for example increased mortality risk drops at high school graduation.[40] While education beyond high school continues to improve health outcomes, having a credential and skill set that opens the door to benefits, i.e. a job, shows the role education plays in many factors that impact health outcomes. Adults continue to be impacted by their educational attainment, as more education is associated with access to more, and better paying, job opportunities. This link between education, employment and income drives much of an individual's ability to achieve economic stability and the positive health outcomes that result from access to housing, food, and healthcare.[41]

There are numerous inequities that exist within the current education system offered in the U.S. A study done by the Department of Education revealed that 45% of high-poverty schools received less state and local funding than was typical for other schools in their district.[42] In 2017, the high school graduation rate for White students in the United States was 89% while the graduation rate for Black and Latino students was 78% and 80% respectively.[43] American Indians had the worst graduation rate at 72%.[43] Furthermore, national data show a disturbing trend for students called the "school to prison pipeline" where students, mostly of color, are funneled out of schools and into juvenile and

[39] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us. American Journal of Public Health. 2010; 100: S186-S196.
[40] Zimmerman EB, Woolf SH, and Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html
[41] Zimmerman EB, Woolf SH, and Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html
[42] Heurer, R., Stullich, S. Comparability of State and Local Expenditures Among Schools Within Districts: A Report from the Study of School-Level Expenditures. U.S Department of Education. 2011
[43] U.S. Department of Education: Office of Elementary and Secondary Education. Consolidated State Performance Report. 2017.

criminal justice systems either directly or indirectly.[44] This makes it critical for communities to support funding and policy opportunities to support early childhood education, K-12 schools, and post-secondary education opportunities such as Treasure Valley Community College and others.

Child Care and Early Childhood Education

The first six years of a child's life are vital for a child's development and future success. Therefore, supporting children and families by assuring access to high quality and affordable early learning and child care environments key to having a healthy community. A child care desert is an area with more than three children for every one available slot in a child care program. In Idaho, 49% of the population lives in a child care desert, and in Oregon, 69% live in a child care desert.[45] All of the counties within the Assessment Region are considered child care deserts. In the Assessment Region in 2018, approximately 36% of children aged 3-4 years old were enrolled in programs, which was similar to Idaho at 34% and Oregon at 45% (Figure 35).

Access to high quality early childhood education is critical for long term educational as well as social-emotional benefits for children and their parents. In the Assessment Region overall in 201, there were approximately 13 Head Start programs for every 100,000 people, which ranged from approximately 6 for every 100,000 in Payette County to approximately 17 in both Washington and Malheur Counties (Figure 36). Because Head Start programs only serve families meeting certain eligibility requirements, assessment participants believed there are not enough child care or early childhood education programs present in the Assessment Region to serve everyone. Participants felt as if the current programs were either not affordable or had income guidelines that community members did not meet. Residents think there are low number of programs because of the regulations to become a child care facility, such as fingerprinting for child care workers, which can be costly and burdensome. Residents also desired more child care hours for parents working varying shifts throughout the day. Community members explained how older children have needed to help with child care of younger siblings because there were no other options.

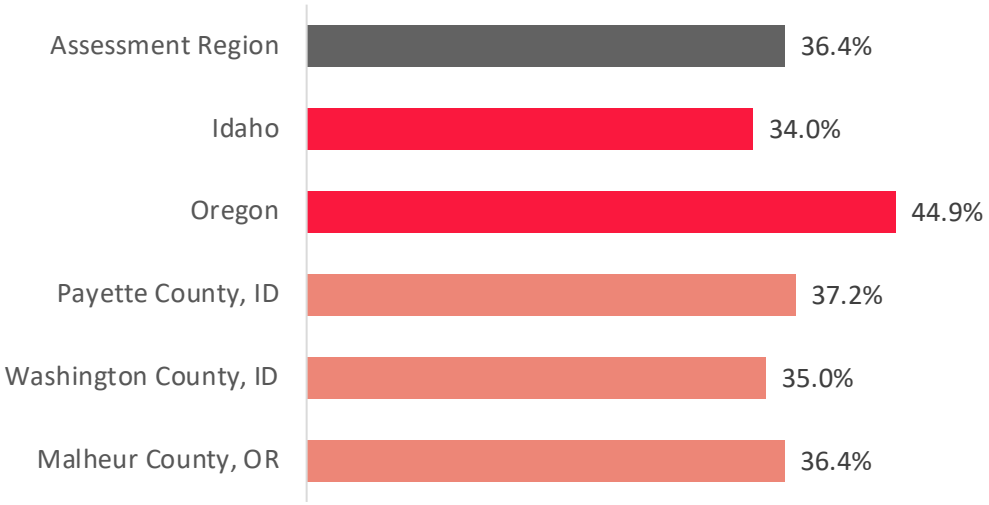
"We mostly have subsidized childcare facilities, which are only available for people under certain income guidelines. There are not enough pre-school providers to meet the demands. Providers faced with overwhelming regulations and training costs are no longer providing childcare."

"Pre-school access is lacking. Pre-schools are full and have long waiting lists."

[44] Wald, Johanna, and Daniel J. Losen. Defining and redirecting a school-to-prison pipeline: New directions for youth development 2003.99 (2003): 9-15.

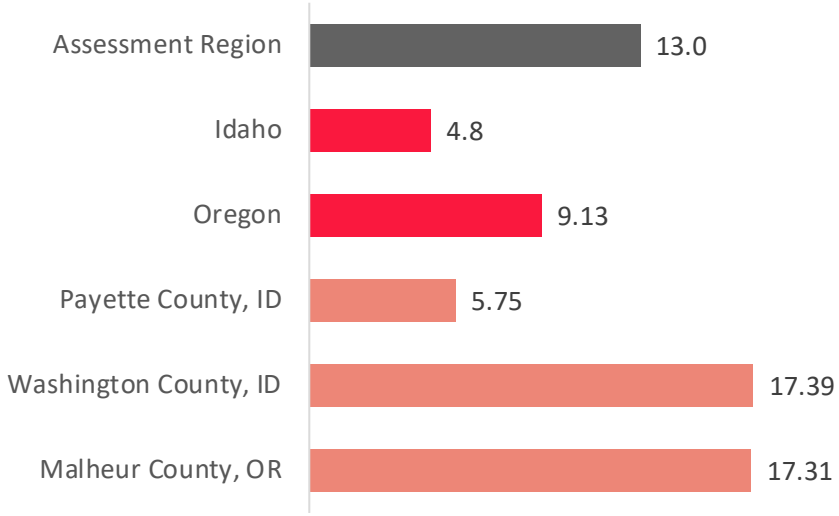
[45] https://health.oregonstate.edu/sites/health.oregonstate.edu/files/early-learners/pdf/oregon-child-care-deserts-01-29-2019.pdf

Figure 46: Percent of 3-4 Year-Olds Enrolled in Programs, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Figure 47: Number of Head Start Programs Per 100,000 Population, 2017

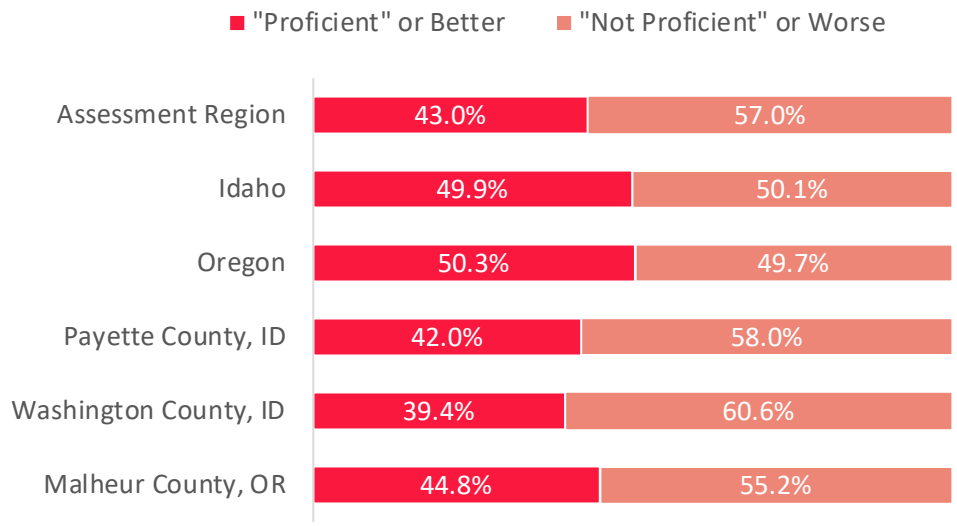


DATA SOURCE: US Department of Health & Human Services, Administration for Children and Families, as cited by Trinity Health Data Hub, 2019

K-12 Education

Just as early learning opportunities are critical building blocks for the young child, a high-quality K-12 education is key to developing essential knowledge and skills in children and teens that they can carry into their adult lives. This learning begins in elementary school where students develop fundamental skills in reading and math. In the Assessment Region in 2018, approximately 43% of students in 4th grade scored 'proficient' or better in their measures of reading proficiency.

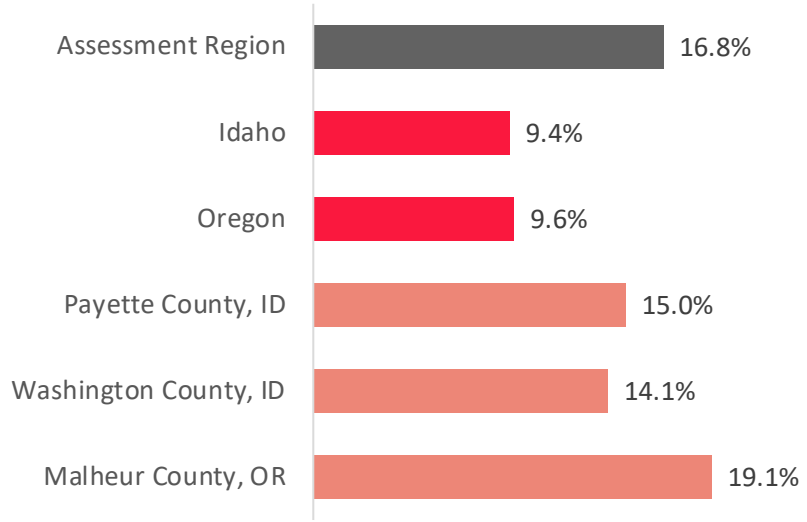
Figure 48: Student Reading Proficiency (4th Grade), 2018



DATA SOURCE: US Department of Education, EDFacts, accessed via DATA.GOV, as cited by Trinity Health Data Hub, 2017-2018

High school graduation has also been shown to be predictive of lifelong earning potential as well as improved health outcomes. In the Assessment Region in 2018, approximately 17% of the population over the age of 25 did not have a high school diploma, ranging from 15% in Payette County to 19% in Malheur County; in Idaho and Oregon overall approximately 9-10% of the population over 25 did not have a high school diploma (Figure 49). The high rates of adults over 25 without a high school diploma in the Assessment Region aligns with assessment participant's stated perceptions.

Figure 49: Percent of Population Aged 25 and over with No High School Diploma, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Residents had mixed views about the school systems in the Assessment Region. Some believed the school systems were great and provided quality education. Others believed that the education that students received from county to county was different.

"Education seems to be different in each county but seems accessible for most. It's better than it was in the past, with improved graduation rates in some locations."

A majority of community survey respondents ranked mental health and stress among middle and high school aged youth as a high concern (57.3%). Focus group and interview participants also felt that mental health issues for students were not being addressed in schools, but they should be. Some schools seem to have received funding to address mental health, but others have not. Participants also highlighted other issues that students may face, such as homelessness and food insecurity as barriers to their success.

"Payette did not have a football team because of drug issues, mental health problems, didn't have enough kids to form a team after drug testing and grades review."

"Schools are not equipped on the counseling side to find out what is going on with kids and refer them to further mental health services."

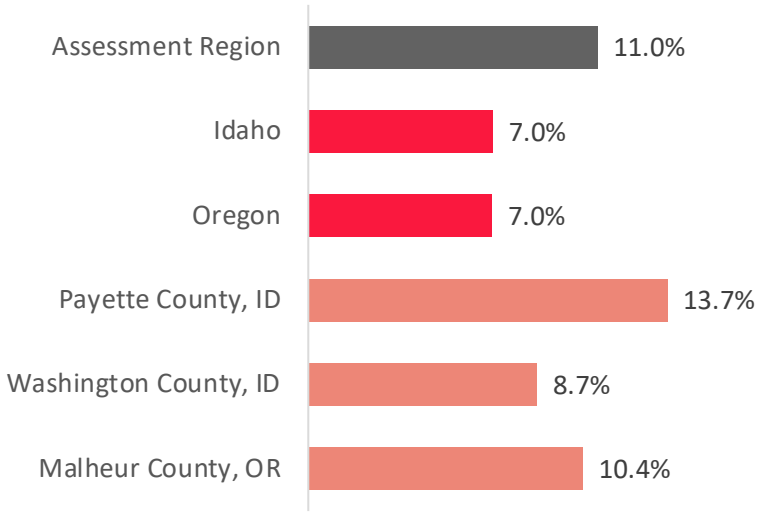
Opportunities Beyond High School

Post-secondary education can look different for each person. It can include college, university, community college, trade school, seminary, technical institute, or any other facility offering a certificate or degree. Focus group and interview participants believed there are opportunities beyond high school in the region, such as post-secondary education at the Treasure Valley Community College but had a desire for more options. Participants emphasized the need for a range of post-secondary education options. They believed most of the individuals living in the Assessment Region do not have an education past high school, which makes it less likely for families to move up in socioeconomic status.

"Post-secondary education is a need – trades, certifications, adult education is needed. We need a better-trained workforce. The local college doesn't seem to provide the answer to the need in the workforce."

In 2018, in the Assessment Region, approximately 11% of the population aged 16-19 was not in school and not employed, which ranged from nearly 10% in Malheur County to almost 14% in Payette County, and was higher than in Idaho and Oregon.

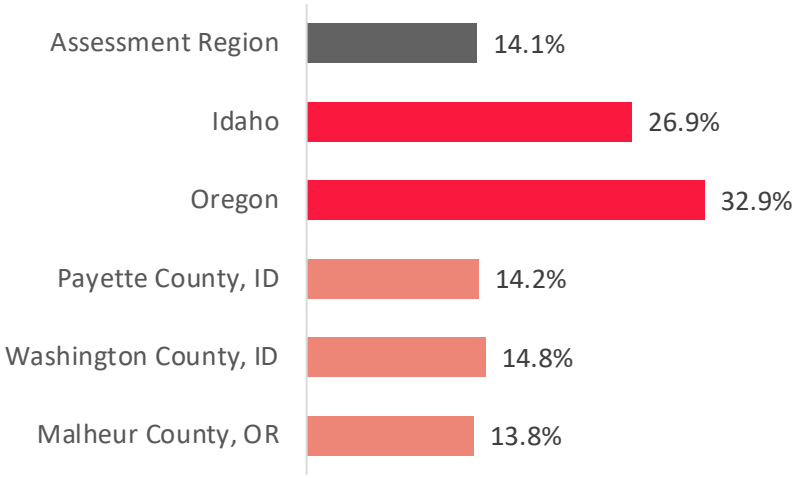
Figure 50: Young People Not in School and Not Working, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

In the Assessment Region in 2018, approximately 14% of the population over 25 years of age had a bachelor's degree or higher; this was lower than both Idaho at 27% and Oregon at 33%.

Figure 51: Percent of Population Aged 25 and over with a Bachelor's Degree or Higher, 2018



DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Existing assets and resources include, but are not limited to:

- Boys and Girls Club
- Cradle to Career
- Eastern Oregon Border Economic Development Region Board
- Giggles & Grace Early Learning Center
- Head Start
- Malheur County Child Development Center
- Oregon Child Development Coalition
- Treasure Valley Community College
- Western Idaho Community Action Partnership
- YMCA

VISION FOR THE FUTURE

As part of the interview and focus group discussion process, participants were asked to provide a "vision for the future" in their community. Participants were asked to name things they would like to see in their community regardless of realistic they would be to implement. Participants had a desire to improve the following: housing, transportation, wages, access to services, the built environment, employment opportunities, mental health, the education system, funding for services, opportunities for education beyond high school, childcare.

Specifically, some things participants mentioned were increasing access to specialty and behavioral healthcare, providing more affordable housing options, improving housing conditions, improving walkability, renovating parks, attracting more employers, increasing minimum wage especially in Idaho, providing more options for public transportation, providing more options for childcare and preschool that are affordable, hiring more community health workers, and providing mental healthcare in schools.

APPENDIX A. FOCUS GROUP DISCUSSION GUIDE

Goals of the focus groups:

- To identify the perceived health needs and assets in [REGION]
- To gain an understanding of people's barriers to health and how these barriers can be addressed
- To identify areas of opportunity to address needs

[NOTE: THE QUESTIONS IN THE FOCUS GROUP GUIDE ARE INTENDED TO SERVE AS A GUIDE, BUT NOT A SCRIPT.]

[NOTE: GUIDE WILL BE TAILORED FOR EACH GROUP.]

I. BACKGROUND (5-10 MINUTES)

- Welcome everyone. My name is _____, and I work for _____.

- We're going to be having a focus group today. Has anyone here been part of a focus group before? You are here because we want to hear your opinions. I want everyone to know there are no right or wrong answers during our discussion. We want to know your opinions, and those opinions might differ. This is fine. Please feel free to share your opinions, both positive and negative.

- The [CLIENT] is conducting a community needs assessment to gain a greater understanding of the issues facing residents, how those needs are currently being addressed, and where there are opportunities to address these needs in the future. We want to hear from you about all the things that can affect the health of a community, which can include not just healthcare but also other things related to where people live, work, and play. The information you provide is a valuable part of this assessment and improving health in the community.

- As you can see, I have a colleague with me today, [NAME], who is taking notes during our discussion. She works with me on this project. I want to give you my full attention, so they are helping me out by taking notes during the group and they do not want to distract from our discussion.

- [NOTE AUDIOTAPING IF APPLICABLE] Just in case we miss something in our note-taking, we are also audio-taping the groups tonight. We are conducting several of these discussion groups around the area, and we want to make sure we capture everyone's opinions. After all of the groups are done, we will be writing a summary report of the general opinions that have come up. In that report, I might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In our report, nothing you say here will be connected to your name.

- You might also notice that I have a stack of papers here. I have a lot of questions that I'd like to ask you tonight. I want to let you know that so if it seems like I cut a conversation a little short to move on to the next question, please don't be offended. I just want to make sure we cover a number of different topics during our discussion tonight.

- Lastly, please turn off your cell phones or at least put them on silent or vibrate mode. The group will last only about 45-60 minutes. If you need to go to the restroom during the discussion, please feel free to leave, but we'd appreciate it if you would go one at a time.

- Any questions before we begin our introductions and discussion?

II. INTRODUCTION AND WARM-UP (5-10 MINUTES)

1. Now, first let's spend a little time getting to know one another. Let's go around the table and introduce ourselves. Please tell me: 1) Your first name; 2) what community you live in. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY PERCEPTIONS (20-30 MINUTES)

2. Today, we're going to be talking a lot about the community that you live in. How would you describe your community?

    a. If someone was thinking about moving into your community, what would you say are some of its biggest strengths or the most positive things about it? [PROBE ON COMMUNITY AND ORGANIZATIONAL ASSETS/STRENGTHS]

3. What are some of the biggest problems or concerns in your community? [PROBE ON ISSUES IF NEEDED – transportation, affordable housing; education; childcare; financial stress; food security; violence; employment, etc.]

    a. How have these issues affected your community?

    b. Just thinking about day-to-day life –working, getting your kids to school, things like that – what are some of the challenges or struggles you deal with on a day-to-day basis?

4. What do you think are the most pressing health concerns in your community? [PROBE ON SPECIFIC ISSUES IF NEEDED, E.G. CHRONIC DISEASES/CONDITIONS, MENTAL HEALTH, SUBSTANCE USE, ETC.; ENSURE ADEQUATE DISCUSSION TIME; PROBE ON HEALTHCARE ACCESS IF MENTIONED]

        i. How have these health issues affected your community? [PROBE FOR SPECIFICS]

5. Thinking about health and wellness in general, what helps keep you healthy?

a. What makes it easier to be healthy in your community?

    i. What supports your health and wellness?

b. What makes it harder to be healthy in your community?

IV. PERCEPTIONS OF SERVICE ENVIRONMENT (15 minutes)

6. Let's talk about a few of the issues you mentioned. [SELECT TOP CONCERNS, HEALTH AND 1-2 OTHERS] What programs, services, and policies are you aware of in the community that currently focus on these issues?

    a. What's missing? What programs, services, or policies are currently not available that you think should be?

    b. What do you think the community should do to address these issues? [PROBE SPECIFICALLY ON WHAT THAT WOULD LOOK LIKE AND WHO WOULD BE INVOLVED TO MAKE THAT HAPPEN]

V. VISION OF COMMUNITY (5 minutes)

7. I'd like you to think ahead about the future of your community. When you think about the community 3 years from now, what would you like to see? What is your vision for the future?

    a. What do you think needs to happen in the community to make this vision a reality?

VI. CLOSING (5 MINUTES)

Thank you so much for your time and sharing your opinions. Before we end the discussion, is there anything that you wanted to add that you didn't get a chance to bring up earlier?

I want to thank you again for your time. And we'd like to express our thanks to you. [DISTRIBUTE STIPENDS AND HAVE RECEIPT FORMS SIGNED].

As I mentioned before, we are conducting these groups around the [REGION], and we're also talking to people who work at organizations. After all this is over, we're going to be writing up a report. [CLIENT] will post this report on their website.

Thank you again. Your feedback is greatly valuable, and we greatly appreciate your time and thank you for sharing your opinion.

APPENDIX B. KEY INFORMANT INTERVIEW DISCUSSION GUIDE

Goals of the Key Informant Interview

- To gather perceptions of the health strengths and needs of [REGION]
- To identify health-related gaps, challenges, and assets
- To explore opportunities for addressing community health needs more effectively

[NOTE: QUESTIONS FOR THE INTERVIEW GUIDE ARE INTENDED TO SERVE AS A GUIDE, NOT A SCRIPT.]

BACKGROUND (5 minutes)

- Hi, my name is _____ and I am with _____.

- As you may know, the [CLIENT] is conducting a community needs assessment to gain a greater understanding of the issues of [REGION], how those needs are being addressed, and whether there might be opportunities to address these issues more effectively.

    - As part of this process, we are conducting interviews with leaders in the community and focus groups with residents and other stakeholders to understand different people's perspectives on these issues. We greatly appreciate your feedback, insight, and honesty. We are also gathering quantitative data on a wide range of community and health issues.

- Our interview will last about 45 – 60 minutes. After all of the interview and focus group discussions are completed, we will be writing a summary report of the general themes that have emerged during the discussions. This report will be public, but we will not include any names or identifying information in that report. All names and responses will remain confidential. Nothing sensitive that you say here will be connected to directly to you in our report.

- Do you have any questions before we begin our introductions and discussion?

THEIR AGENCY / ORGANIZATION (5 minutes)

SKIP THIS SECTION FOR ELECTED OFFICIALS

8. Can you tell me a bit about your organization/agency? [TAILOR PROBES DEPENDING ON AGENCY]

a. [PROBE ON ORGANIZATION: What is your organization's mission/services? What communities do you work in? Who are the main clients/audiences?]

    i. What are some of the biggest challenges your organization faces in conducting your work in the community?

b. Do you currently partner with any other organizations or institutions in any of your work?

COMMUNITY ISSUES (10 minutes)

9. How would you describe the community served by your organization/ that you serve as [INSERT TITLE]?

    a. What do you consider to be the community's strongest assets/strengths?

    b. What are some of its biggest concerns/issues in general? What challenges do residents face in their day-to-day lives? [PROBE ON: transportation; affordable housing; education; childcare; financial stress; food security; violence; employment]

        i. What populations (geography, age, race, gender, income/education, etc.) do you see as being most affected by these issues?

TOP ISSUES (10 minutes)

10. What do you think are the most pressing <u>health/education/housing/education/economic/transportation [MODERATOR SELECT HEALTH AND MOST APPLICABLE TOPIC FOR EACH INTERVIEWEE]</u> concerns in the community? Why? [PROBE ON SPECIFICS]

    [MODERATOR INSTRUCTIONS: AFTER PARTICIPANTS TALK ABOUT DIFFERENT ISSUES, SELECT THE TOP 3 AND ASK THE FOLLOWING SERIES OF QUESTIONS FOR <u>EACH</u> ISSUE.]

    a. How has [HEALTH ISSUE] affected the/ your community? [PROBE FOR DETAILS: IN WHAT WAY? CAN YOU PROVIDE SOME EXAMPLES?]

    b. Who do you consider to be the populations in the community most vulnerable or at risk for [THIS CONDITION / ISSUE]?

    c. From your experience, what are peoples' biggest challenges to addressing [THIS ISSUE]?

i. [PROBE: Barriers to accessing medical care, barriers to accessing preventive services or programs, barriers to receiving information on these issues, etc.]

PROGRAM / SERVICE ENVIRONMENT (10 minutes)

11. Let's talk about a few of the issues you mentioned previously. [SELECT TOP CONCERNS] What programs, services, or policies are you aware of in the community that address some of these issues? [PROBE FOR SPECIFICS]

    a. In your opinion, how effective have these programs, services, or policies been at addressing these issues? Why?

        i. How coordinated are these programs or services, if at all?

    b. Where are the gaps? What program, services, or policies are currently not available that you think should be?

    c. What do you think needs to be done to address these issues?

        i. Do you see opportunities currently out there that can be seized upon to address these issues? For example, are there some "low hanging fruit" – current collaborations or initiatives that can be strengthened or expanded?

12. [IF HEALTH NOT YET MENTIONED/DISCUSSED] What do you see as the strengths of the health services in your community? What do you see as its limitations?

    a. What challenges do residents in your community face in accessing health services? [PROBE IN DEPTH FOR BARRIERS TO CARE: LACK OF TRANSPORTION, INSURANCE ISSUES, LANGUAGE BARRIERS, CHILD CARE, ETC.]

        i. You mentioned [NAME BARRIER] as something that makes it difficult for residents to get health services. What do you think needs to happen in your community to help residents overcome or address this challenge? [REPEAT FOR OTHER BARRIERS]

VISION OF THE FUTURE (10 minutes)

13. I'd like you to think ahead about the future of your community. When you think about the community 3-5 years from now, what would you like to see? What is your vision for the future?

    a. What is your vision specifically related to people's <u>health</u> in the community?

        i. What do you think needs to happen in the community to make this vision a reality?

        ii. Who should be involved in this effort?

CLOSING (2 minutes)

Thank you so much for your time. That's it for my questions. Is there anything else that you would like to mention that we didn't discuss today?

As I mentioned before, we are conducting discussions all around the region. After collecting all the data and completing these interviews, we're going to be writing up a report which will be posted on the UWTV website.

Thank you again. Have a good afternoon.

APPENDIX C. SURVEY INSTRUMENT

[CLIENT] is conducting a community assessment to better understand the needs of [REGION] community members. The assessment will inform future regional community improvement activities.

We are asking community members to give us your thoughts and suggestions about concerns and services in [REGION] by completing this survey by [DATE]. All responses are completely anonymous. There are no right or wrong answers; it's your opinion that matters!

You can complete this survey online at: [LINK]

Or return it by mail to: [LINK]

Your input is valuable and we appreciate your participation!

---

1. **What county do you live in?**

☐ Ada
☐ Canyon
☐ Elmore
☐ Gem
☐ Malheur
☐ Owyhee
☐ Other _____

2. **Are you a health or social service provider?**

☐ Yes
☐ No

3. **Please select <u>THE TOP HEALTH ISSUES</u> that have the largest impact on you and/or your family, and your community as a whole.**

(Please select <u>up to 5</u> issues under "you/your family" and <u>up to 5</u> issues under "your community." You can select the same or different issues.)

	YOU AND/OR YOUR FAMILY	YOUR COMMUNITY
Access to contraceptives (birth control)	☐	☐
Affordable childcare	☐	☐
Affordable housing	☐	☐
Aging health concerns (Alzheimer's, arthritis, dementia, falls, etc.)	☐	☐
Air quality	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Cost of living (e.g., housing, child care, groceries, etc.)	☐	☐
Dental/oral health	☐	☐
Diabetes	☐	☐
Disabilities (including lack of services for individuals with disabilities)	☐	☐
Education	☐	☐
Getting healthcare (transportation, health insurance, cost, etc.)	☐	☐
Heart disease/ heart attacks	☐	☐
High blood pressure/hypertension	☐	☐

Homelessness	☐	☐
Infectious/contagious diseases (tuberculosis, pneumonia, flu, etc.)	☐	☐
Mental health and stress	☐	☐
Obesity/ overweight	☐	☐
Physical activity opportunities	☐	☐
Public safety	☐	☐
Sexually transmitted infections (STIs) (Chlamydia, Gonorrhea, etc.)	☐	☐
Smoking	☐	☐
Substance Use (alcohol, marijuana, heroin, meth, etc.)	☐	☐
Teenage pregnancy	☐	☐
Transportation (e.g. schedules, cost, accessibility)	☐	☐
Other (please specify): _____	☐	☐

4. Have any of these issues ever made it more difficult for you to get the health or social services that you needed? (Check all that apply.)

- ☐ Lack of transportation
- ☐ Have no regular doctor/source of healthcare
- ☐ Cost of services
- ☐ Inconvenient operating hours
- ☐ Insurance problems/lack of coverage/not enough coverage
- ☐ Language problems/could not communicate with provider or office staff
- ☐ Discrimination/unfriendliness of provider or office staff
- ☐ Afraid to seek services
- ☐ Afraid due to my immigration status
- ☐ Don't know what type of services are available
- ☐ No available providers near me
- ☐ Long waits for appointments
- ☐ I have never experienced any difficulties getting services
- ☐ Other (please specify): _____

5. Which of the following health and social services are currently <u>lacking</u> in your community? (Please select all that apply.)

- ☐ Services for older adults
- ☐ Services for people with disabilities
- ☐ Services for veterans
- ☐ Services for new immigrants
- ☐ Services for youth (including out of school time)
- ☐ Educational support services (including language services)
- ☐ Transportation services
- ☐ Affordable housing
- ☐ Affordable child care services
- ☐ Substance use services
- ☐ Mental healthcare services
- ☐ Healthcare services (including primary care, specialty care, hospital services)
- ☐ Oral healthcare services
- ☐ Exercise and physical activity opportunities
- ☐ Employment services (including job training and readiness)
- ☐ Financial assistance services
- ☐ Housing services (including services for the

homeless or housing insecure)
- ☐ Food services (including food stamps, food pantries, nutrition education and support)
- ☐ Family Planning Services (including birth control and pregnancy counseling services)
- ☐ I don't know
- ☐ Other (please specify): _____

6. How many times have you moved in the past 12 months?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3+
- ☐ Don't know
- ☐ Prefer not to answer

7. Think about the place you live. Do you have problems with any of the following? (check all that apply)

- ☐ Bug infestation
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ No or not working smoke detectors
- ☐ Water leaks
- ☐ Landlord/tenant rights issues
- ☐ None of the above

8. What is your housing situation today?

- ☐ I do not have housing (I am staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
- ☐ I have housing today, but I am worried about losing housing in the future.
- ☐ I have housing

9. The following questions ask you to rate your concern for specific community issues. Please indicate how high of a concern each of the following topics are to you as a community member in [REGION].

Cost of Living	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Availability of healthy, affordable food options Availability of internet access	☐	☐	☐	☐	☐
Availability of jobs	☐	☐	☐	☐	☐
Cost of child care (e.g., in-home, center based, or after school care)	☐	☐	☐	☐	☐
Cost of utilities (e.g., heat, electricity, water, etc.)	☐	☐	☐	☐	☐
Housing costs and issues associated with home ownership (e.g., mortgage payments, property taxes)	☐	☐	☐	☐	☐
Housing costs and issues associated with renting (e.g., rent payments, evictions, housing conditions)	☐	☐	☐	☐	☐
Prescription Drug Costs	☐	☐	☐	☐	☐
Support for low-income families and individuals	☐	☐	☐	☐	☐

Wages	☐	☐	☐	☐	☐

Mental Health and Stress	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Ability to get mental healthcare services (e.g., affordable, timely, proximity, etc.)	☐	☐	☐	☐	☐
Mental health and stress among homeless	☐	☐	☐	☐	☐
Mental health and stress among immigrants	☐	☐	☐	☐	☐
Mental health and stress among low-income families and individuals	☐	☐	☐	☐	☐
Mental health and stress among middle and high school aged youth	☐	☐	☐	☐	☐
Mental health and stress among veterans	☐	☐	☐	☐	☐
Real or perceived stigma associated with seeking mental healthcare	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐

Transportation	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Accessibility of transportation	☐	☐	☐	☐	☐
Availability of public transportation (e.g., regional bus)	☐	☐	☐	☐	☐
Cost of transportation	☐	☐	☐	☐	☐
Length of commute	☐	☐	☐	☐	☐
Motor vehicle safety	☐	☐	☐	☐	☐
Pedestrian or bike safety	☐	☐	☐	☐	☐
Transportation to activities other than work (e.g., grocery shopping, medical appointments, etc.)	☐	☐	☐	☐	☐
Transportation to work or school	☐	☐	☐	☐	☐

Substance Use	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know

Ability to get substance use services (e.g., affordable, timely, proximity, etc.)	☐	☐	☐	☐	☐
Alcohol use among adults	☐	☐	☐	☐	☐
Alcohol use among youth	☐	☐	☐	☐	☐
Drug use among youth (including misuse of prescriptions, use of other illicit drugs)	☐	☐	☐	☐	☐
Marijuana use among youth	☐	☐	☐	☐	☐
Methamphetamine use	☐	☐	☐	☐	☐
Opioid use (e.g., prescription pain killers, heroin, etc.)	☐	☐	☐	☐	☐
Other substance use	☐	☐	☐	☐	☐
Real or perceived stigma associated with seeking substance use services	☐	☐	☐	☐	☐
Recreational marijuana use among adults	☐	☐	☐	☐	☐
Tobacco use among adults	☐	☐	☐	☐	☐
Tobacco use among youth (including vaping and e-cigarettes)	☐	☐	☐	☐	☐

Personal and Public Safety	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Adequate law enforcement system	☐	☐	☐	☐	☐
Domestic Abuse	☐	☐	☐	☐	☐
Drug trafficking	☐	☐	☐	☐	☐
Human trafficking	☐	☐	☐	☐	☐
Neighborhood safety	☐	☐	☐	☐	☐
Property crime	☐	☐	☐	☐	☐
Sexual assault or rape	☐	☐	☐	☐	☐
Sexual harassment	☐	☐	☐	☐	☐
Violent crime	☐	☐	☐	☐	☐

10. Are there any other issues of concern – not listed previously – that are of high concern to you as [REGION] community member?

☐ No
☐ Yes, please specify: _____

The following items are related to your own demographic characteristics. We are asking these questions in order to make sure this survey has reached all population groups that live in [REGION]. Your input is valuable and we appreciate your response to these questions!

11. What's your zip code? _____

12. How old are you?

☐ Under 18 years old
☐ 18-24 years old
☐ 25-34 years old
☐ 35-44 years old
☐ 45-64 years old
☐ 65+ years old

13. What is your gender?

☐ Male
☐ Female
☐ Other (please specify) _____

14. What is your sexual orientation?

☐ Heterosexual/straight
☐ Gay or Lesbian
☐ Bisexual
☐ Other (please specify) _____

15. How would you describe your ethnic/racial background? (Please check all that apply.)

☐ African American or Black
☐ American Indian or Alaskan Native
☐ Asian
☐ Hispanic/Latino(a)
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other (please specify) _____

16. What language do you speak most often at home? (Please choose one.)

☐ English
☐ Spanish
☐ Other (please specify) _____

17. What is the highest level of education that you have completed?

☐ Less than high school
☐ High school graduate or GED
☐ Some college
☐ Associate or technical degree/certification
☐ College graduate
☐ Graduate or professional degree

18. What is your household income?

☐ Less than $25,000
☐ $25,000 to $49,999
☐ $50,000 to $74,999
☐ $75,000 to $99,999
☐ $100,000 or more

19. Have you or someone in your family experienced housing insecurity or homelessness in the last 12 months?

☐ Yes

☐ No

20. How long have you lived in [REGION]?

☐ Less than one year
☐ At least 1 year but less than 5 years
☐ At least 5 years but less than 10 years
☐ At least 10 years but less than 15 years
☐ At least 15 years but less than 20 years
☐ 20 years or more

21. Do you have difficulty with any of the following? (Please check all that apply.)

- ☐ Hearing (deafness or severe hearing impairment)
- ☐ Vision (blindness or severe vision impairment)
- ☐ Mobility (walking, climbing stairs)
- ☐ Cognitive Functioning (concentrating, remembering, making decisions)
- ☐ Independent Living (dressing, bathing)
- ☐ Other (please write): _____

APPENDIX D. SURVEY DEMOGRAPHICS AND ADDITIONAL DATA

Survey participant demographic data

Measure	n	%
County (n=318)		
Malheur	193	60.7
Payette	92	28.9
Washington	33	10.4
Zip code (n=270)		
83610	2	0.7
83617	1	0.4
83619	30	11.1
83645	1	0.4
83655	10	3.7
83661	37	13.7
83672	21	7.8
97901	2	0.7
97910	1	0.4
97913	28	10.4
97914	119	44.1
97916	1	0.4
97918	17	6.3
Health or social service provider (n=318)		
Yes	116	36.5
No	202	63.5
Age (n=286)		
18-24	13	4.5
25-34	50	17.5
35-44	81	28.3
45-64	120	42.0
65+	22	7.7
Gender (n=288)		
Female	229	79.5
Male	57	19.8
Other	2	0.7
Sexual orientation (n=268)		
Heterosexual/straight	258	96.3
Lesbian/gay/bisexual	10	3.7
Ethnic/racial background* (n=286)		
African American or Black	7	2.4
American Indian or Alaskan Native	7	2.4
Asian	2	0.7

Measure	n	%
Hispanic/Latino(a)	80	28.0
White	194	67.8
Other	12	4.2
Language of Survey (n=318)		
English	310	97.5
Spanish	7	2.2
Swahili	1	0.3
Language most spoken at home (n=286)		
English	250	87.4
Spanish	28	9.8
Other	8	2.8
Highest level of education completed (n=286)		
Less than high school	18	6.3
High school graduate or GED	35	12.2
Some college	65	22.7
Associate or technical degree/certification	53	18.5
College graduate	64	22.4
Graduate or professional degree	51	17.8
Household income (n=283)		
Less than $25,000	63	22.3
$25,000 to $49,999	78	27.6
$50,000 to $74,999	71	25.1
$75,000 to $99,999	34	12.0
$100,000 or more	37	13.1
Experience of housing insecurity or homelessness by participant or a family member in the past 12 months (n=286)		
Yes	73	25.5
No	213	74.5
Length of time lived in this region (n=285)		
Less than one year	12	4.2
At least 1 year but less than 5 years	31	10.9
At least 5 years but less than 10 years	34	11.9
At least 10 years but less than 15 years	22	7.7
At least 15 years but less than 20 years	28	9.8
20 years or more	158	55.4
Difficulty with any of the following* (n=71)		
Vision	29	40.8
Hearing	22	31.0
Mobility	23	32.4
Cognitive functioning	16	22.5
Independent living	4	5.6
Other	8	11.3

*Respondents were permitted to select more than one option, so percentages do not sum to 100%

Respondent rating of their concern for specific community issues

	Not a concern		Slight concern		Moderate concern		**High Concern**		I don't know	
Issue	n	%	n	%	n	%	**n**	**%**	n	%
Cost of Living										
Housing costs and issues associated with renting (n=287)	48	16.7	28	9.8	49	17.1	**149**	**51.9**	13	4.5
Housing costs and issues associated with home ownership (n=290)	35	12.1	42	14.5	69	23.8	**137**	**47.2**	7	2.4
Cost of child care (n=282)	45	16.0	27	9.6	60	21.3	**136**	**48.2**	14	5.0
Support for low-income families and individuals (n=291)	36	12.4	35	12.0	89	30.6	**120**	**41.2**	11	3.8
Cost of utilities (n=287)	31	10.8	44	15.3	87	30.3	**119**	**41.5**	6	2.1
Wages (n=281)	30	10.7	34	12.1	89	31.7	**115**	**40.9**	13	4.6
Prescription drug costs (n=287)	52	18.1	39	13.6	69	24.0	**115**	**40.1**	12	4.2
Availability of jobs (n=284)	51	18.0	37	13.0	86	30.3	**108**	**38.0**	2	0.7
Availability of healthy, affordable food options (n=291)	62	21.3	44	15.1	82	28.2	**98**	**33.7**	5	1.7
Availability of internet access (n=286)	128	44.8	60	21.0	62	21.7	**29**	**10.1**	7	2.4
Mental Health and Stress										
Mental health and stress among veterans (n=286)	16	5.6	16	5.6	60	21.0	**171**	**59.8**	23	8.0
Mental health and stress among middle and high school aged youth (n=288)	19	6.6	19	6.6	66	22.9	**165**	**57.3**	19	6.6
Suicide (n=284)	22	7.7	24	8.5	52	18.3	**165**	**58.1**	21	7.4
Mental health and stress among low-income families and individuals (n=289)	24	8.3	28	9.7	60	20.8	**165**	**57.1**	12	4.2
Mental health and stress among homeless (n=289)	26	9.0	28	9.7	53	18.3	**165**	**57.1**	17	5.9
Real or perceived stigma associated with seeking mental healthcare (n=283)	26	9.2	22	7.8	22	7.8	**146**	**51.6**	17	6.0
Ability to get mental healthcare services (n=288)	45	15.6	20	6.9	72	25.0	**141**	**49.0**	10	3.5
Mental health and stress among immigrants (n=287)	37	12.9	32	11.1	73	25.4	**118**	**41.1**	27	9.4
Transportation										
Availability of public transportation (n=287)	41	14.3	47	16.4	89	31.0	**100**	**34.8**	10	3.5
Accessibility of transportation (n=288)	45	15.6	49	17.0	89	30.9	**97**	**33.7**	8	2.8
Cost of transportation (n=289)	42	14.5	59	20.4	88	30.4	**78**	**27.0**	22	7.6
Transportation to activities other than work (n=289)	57	19.7	49	17.0	92	31.8	**75**	**26.0**	16	5.5
Transportation to work or school (n=284)	55	19.4	63	22.2	81	28.5	**69**	**24.3**	16	5.6
Pedestrian or bike safety (n=282)	61	21.6	66	23.4	73	25.9	**67**	**23.8**	15	5.3
Length of commute (n=285)	78	27.4	65	22.8	66	23.2	**57**	**20.0**	19	6.7
Motor vehicle safety (n=284)	75	26.4	77	27.1	75	26.4	**38**	**13.4**	19	6.7
Substance Use										

Methamphetamine use (n=283)	12	4.2	23	8.1	37	13.1	**198**	**70.0**	13	4.6
Drug use among youth (n=283)	17	6.0	19	6.7	43	15.2	**192**	**67.8**	12	4.2
Opioid use (n=279)	15	5.4	23	8.2	44	15.8	**182**	**65.2**	15	5.4
Marijuana use among youth (n=285)	22	7.7	22	7.7	52	18.2	**178**	**62.5**	11	3.9
Tobacco use among youth (n=281)	16	5.7	28	10.0	60	21.4	**166**	**59.1**	11	3.9
Alcohol use among youth (n=278)	18	6.5	34	12.2	63	22.7	**150**	**54.0**	13	4.7
Other substance use (n=276)	21	7.6	27	9.8	52	18.8	**145**	**52.5**	31	11.2
Real or perceived stigma associated with seeking substance use services (n=274)	31	11.3	41	15.0	58	21.2	**121**	**44.2**	23	8.4
Recreational marijuana use among adults (n=281)	49	17.4	51	18.1	50	17.8	**120**	**42.7**	11	3.9
Ability to get substance use services (n=277)	35	12.6	25	9.0	81	29.2	**110**	**39.7**	26	9.4
Alcohol use among adults (n=281)	19	6.8	56	19.9	95	33.8	**98**	**34.9**	13	4.6
Tobacco use among adults (n=279)	44	15.8	58	20.8	75	26.9	**92**	**33.0**	10	3.6
Personal and Public Safety										
Drug trafficking (n=281)	17	6.0	31	11.0	65	23.1	**153**	**54.4**	15	5.3
Human trafficking (n=279)	23	8.2	37	13.3	62	22.2	**138**	**49.5**	19	6.8
Violent crime (n=280)	28	10.0	43	45.4	70	25.0	**124**	**44.3**	15	5.4
Domestic Abuse (n=282)	24	8.5	35	12.4	93	33.0	**115**	**40.8**	15	5.3
Sexual assault or rape (n=279)	29	10.4	46	16.5	68	24.4	**110**	**39.4**	26	9.3
Neighborhood safety (n=282)	28	9.9	59	20.9	78	27.7	**108**	**38.3**	9	3.2
Property crime (n=277)	19	6.9	74	26.7	74	26.7	**97**	**35.0**	13	4.7
Sexual harassment (n=279)	35	12.5	49	17.6	82	29.4	**92**	**33.0**	21	7.5
Adequate law enforcement system (n=280)	38	13.6	56	20.0	85	30.4	**89**	**31.8**	12	4.3

APPENDIX E: ADDITIONAL FINDINGS

Community Demographics

Appendix Table 1: Percent of Population Under 18 and 65+ years, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2013-2017

	Total Population	Under 18		65+ years	
		n	%	n	%
Assessment Region	63,256	16,245	25.7%	11,086	17.5%
Idaho	1,657,375	434,611	26.2%	242,449	14.6%
Oregon	4,025,127	864,247	21.5%	655,089	16.3%
Payette County, ID	22,839	6,176	27.0%	3,859	16.9%
Washington County, ID	9,996	2,338	23.4%	2,366	23.7%
Malheur County, OR	30,421	7,731	25.4%	4,861	16.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as cited by Trinity Health Data Hub, 2013-2017

Appendix Table 2: Foreign Born Population, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2014-2018

	Total Population	Foreign Born		Naturalized US Citizens		Without Citizenship	
	2013-2017	n	%	n	%	n	%
Assessment Region	63,497	5,207	8.2%	1,272	2.0%	3,935	6.2%
Idaho	1,687,809	100,996	6.0%	39,721	2.4%	61,275	3.6%
Oregon	4,081,943	405,821	9.94%	177,406	4.3%	228,412	5.6%
Payette County, ID	23,041	1560	6.77%	370	1.6%	1,190	5.2%
Washington County, ID	10,025	639	6.37%	123	1.2%	516	5.1%
Malheur County, OR	30,431	3008	9.88%	779	2.6%	2,229	7.3%

DATA SOURCE: U.S. Census Bureau, American Community Survey 5-Year Estimates, as cited by Trinity Health Data Hub, 2013-2017

Appendix Table 3: Racial Diversity (Theil Index)

	Diversity Index

Assessment Region	no data	
Idaho		0.14
Oregon		0.16
Payette County, ID		0.04
Washington County, ID		0.10
Malheur County, OR		0.14

DATA SOURCE: US Census Bureau, Decennial Census, as analyzed by University of Missouri Center for Applied Research and Engagement Systems, as cited by Trinity Health Data Hub, 2010

Appendix Table 4: Population Geographic Mobility (In Migration), by Assessment Region, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2014-2018

	n	%
Assessment Region	5,751	9.2%
Idaho	134,733	8.1%
Oregon	315,029	7.8%
Payette County, ID	1,951	8.6%
Washington County, ID	704	7.1%
Malheur County, OR	3,096	10.3%

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Social influencers of health

Appendix Table 5: Food Insecurity Rate, by Assessment Region, Idaho, Oregon, Payette County, Washington County, Malheur County, 2017

	n	%
Assessment Region	7,900	12.5%
Idaho	210,420	12.3%
Oregon	510,080	12.3%
Payette County, ID	2,700	11.8%

Washington County, ID	1,260	12.6%
Malheur County, OR	3,940	13.0%

DATA SOURCE: Feeding America, as cited by Trinity Health Data Hub, 2017

Appendix Table 6: GINI Index, by Assessment Region, Idaho, Oregon, Payette County, Washington County, Malheur County, 2014-18

	GINI Index Value
Assessment Region	no data
Idaho	0.45
Oregon	0.46
Payette County, ID	0.43
Washington County, ID	0.44
Malheur County, OR	0.45

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Appendix Table 7: Population Under Age 18 At or Below 200% FPL, by Total Service Area, Idaho, Oregon, Payette County, Washington County, Malheur County, 2014-2018'

	n	%
Assessment Region	8,813	55.5%
Idaho	192,293	44.4%
Oregon	345,720	40.7%
Payette County, ID	2,695	45.4%
Washington County, ID	1,357	57.9%
Malheur County, OR	4,761	62.7%

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Appendix Table 8: Opportunity Index, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co

	OI Score
Assessment Region	no data
Idaho	50.8
Oregon	55.4

Payette County, ID	44.0
Washington County, ID	no data
Malheur County, OR	44.1

Data Source: Opportunity Nation

Appendix Table 9: Access to Recreation and Fitness Facilities, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2016

	# of Establishments	Rate per 100,000 Pop
Assessment Region	3	4.7
Idaho	158	10.1
Oregon	473	12.35
Payette County, ID	0	0
Washington County, ID	1	9.81
Malheur County, OR	2	6.39

DATA SOURCE: US Census Bureau, County Business Patterns, additional data analysis by CARES, as cited by Trinity Health Data Hub, 2016

Appendix Table 10: Student Chronic Absenteeism, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2014-2018

	n	Rate per 100,000 Pop
Assessment Region	1,640	14.3
Idaho	37,759	12.8
Oregon	134,339	23.4
Payette County, ID	493	11.5
Washington County, ID	136	7.6
Malheur County, OR	1,011	18.9

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Appendix Table 11: Overcrowded Housing, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2014-2018

	# of Units	%
Assessment Region	1,156	5.5%
Idaho	16,227	2.8%
Oregon	52,336	3.7%
Payette County, ID	491	6.0%
Washington County, ID	109	3.0%
Malheur County, OR	556	5.9%

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Appendix Table 12: Substandard Housing, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2014-2018

	#	%
Assessment Region	7,096	31.0%
Idaho	173,968	28.1%
Oregon	565,172	35.5%
Payette County, ID	2,391	27.3%
Washington County, ID	1,348	33.6%
Malheur County, OR	3,357	33.1%

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Appendix Table 13: Owner Occupied Housing, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2014-2018

	# of Units	%
Assessment Region	22,924	66.2%
Idaho	618,331	69.3%
Oregon	985,523	61.9%

Payette County, ID	6,368	72.6%
Washington County, ID	2,824	70.3%
Malheur County, OR	5,974	58.9%

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Appendix Table 14: Population Using Public Transit for Commute to Work, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2014-2018

	#	%
Assessment Region	43	0.2%
Idaho	5,418	0.7%
Oregon	85,300	4.5%
Payette County, ID	11	0.1%
Washington County, ID	0	0.0%
Malheur County, OR	32	0.3%

DATA SOURCE: US Census Bureau, American Community Survey. 2014-18. Source geography: Tract

Appendix Table 15: ALICE State Survival Budget, Idaho, 2018

	Single Adult	2 Adults, 1 Infant, 1 Preschooler
Childcare	N/A	1,010
Food	279	846
Healthcare	171	727
Housing	542	761
Misc.	161	480
Tech	55	75
Transportation	325	794
Tax	240	589
Total Monthly	1,773	5,282
Total Annual	21,276	63,384
Wage	10.64	31.69

DATA SOURCE: ALICE: A Study of Financial Hardship in Idaho and Oregon; United Way ALICE Project. 2020. Source Geography: State

Appendix Table 16: ALICE State Survival Budget, Oregon, 2018

	Single Adult	2 Adults, 1 Infant, 1 Preschooler
Childcare	N/A	1,147
Food	294	890
Healthcare	156	803
Housing	678	970
Misc.	192	574
Tech	55	75
Transportation	356	824
Tax	384	1,031
Total Monthly	2,115	6,314
Total Annual	25,380	75,768
Wage	12.69	37.88

DATA SOURCE: ALICE: A Study of Financial Hardship in Idaho and Oregon; United Way ALICE Project. 2020. Source Geography: State

Appendix Table 17: Population Potentially Exposed to Unsafe Drinking Water, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2012-2013

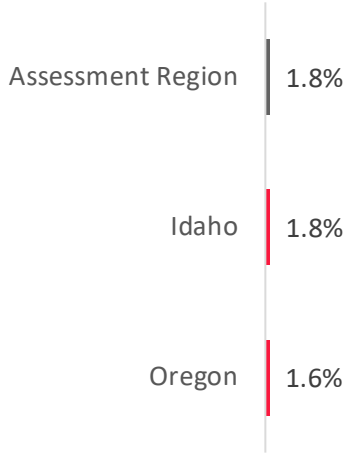
	n	%
Assessment Region	10,712	51.6%
Idaho	103,618	9.0%
Oregon	374,423	11.5%
Payette County, ID	5,317	38.5%
Washington County, ID	0	0.0%
Malheur County, OR	5,395	31.9%

DATA SOURCE: University of Wisconsin Population Health Institute, County Health Rankings, as cited by Trinity Health Data Hub, 2012-2013

Appendix Figure 1: Alcohol Expenditures, 2014

DATA SOURCE: Nielsen SiteReports, as cited by Trintiy Health Data Hub, 2014

Appendix Figure 2: Tobacco Expenditures, 2014



DATA SOURCE: Nielsen SiteReports, as cited by Trinity Health Data Hub, 2014

Healthcare Services and Access

Appendix Table 18: Population of Uninsured Adults, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2018

	With Medical Insurance	Percentage	Without Medical Insurance	Percentage
	n	%	n	%
Assessment Region	26,887	82.5%	5,715	17.5%
Idaho	844,968	83.7%	164,491	16.3%
Oregon	2,272,498	89.8%	258,354	10.2%
Payette County, ID	10,554	81.6%	2,384	18.4%
Washington County, ID	4,061	77.9%	1,151	22.1%
Malheur County, OR	12,272	84.9%	2,177	15.1%

DATA SOURCE: US Census Bureau, Small Area Health Insurance Estimates. 2018. Source geography: County

Appendix Table 19: Population of Uninsured Children Under Age 19, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2018

	With Medical Insurance	Percentage	Without Medical Insurance	Percentage
	n	%	n	%
Assessment Region	15,654	94.3%	938	5.7%
Idaho	435,291	93.9%	28,091	6.1%
Oregon	871,987	96.6%	30,334	3.4%
Payette County, ID	5,907	93.3%	424	6.7%
Washington County, ID	2,154	91.8%	192	8.2%
Malheur County, OR	7,593	98.9%	323	4.1%

DATA SOURCE: US Census Bureau, Small Area Health Insurance Estimates. 2018. Source geography: County

Appendix Table 12: 30 Day Hospital Readmissions among Medicare Beneficiaries, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co

	Rate
Assessment Region	6.9

Idaho	12.5
Oregon	13.7
Payette County, ID	no data
Washington County, ID	no data
Malheur County, OR	12.2

DATA SOURCE: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Healthcare, as cited by Trinity Health Data Hub.

Appendix Table 20: Preventable Hospital Events among Medicare Part A Enrollees, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2015

	Ambulatory Care Sensitive Condition Hospital Discharges	Ambulatory Care Sensitive Condition Discharge Rate
Assessment Region	235	40.1
Idaho	3,744	32.3
Oregon	8,564	33.9
Payette County, ID	66	38.6
Washington County, ID	38	35.7
Malheur County, OR	130	42.6

DATA SOURCE: Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Healthcare, as cited by Trinity Health Data Hub, 2015

Chronic Diseases and Related Risk Factors

Appendix Table 21: Adults with Heart Disease, by Assessment Region, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2011-2012

	n	%
Assessment Region	1,985	4.9%
Idaho	43,695	3.9%
Oregon	122,426	4.1%

Payette County, ID	937	4.8%
Washington County, ID	no data	no data
Malheur County, OR	1,048	5.0%

DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, as analyzed by CARES, as cited by Trinity Health Data Hub, 2011-2012

Appendix Table 22: Adults with High Blood Pressure, by Assessment Region, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2006-2012

	n	%
Assessment Region	11,202	23.8%
Idaho	296,178	26.3%
Oregon	754,946	25.7%
Payette County, ID	3,978	24.7%
Washington County, ID	2,039	26.5%
Malheur County, OR	5,185	22.3%

DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Accessed via the Health Indicators Warehouse, as cited by Trinity Health Data Hub, 2006-2012

Appendix Table 23: Adults with High Cholesterol, by Assessment Region, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2011-2012

	n	%
Assessment Region	9,582	36.6%
Idaho	305,436	38.7%
Oregon	853,961	38.4%
Payette County, ID	5,872	42.1%
Washington County, ID	no data	no data
Malheur County, OR	3,710	30.3%

DATA SOURCE: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, as analyzed by CARES, as cited by Trinity Health Data Hub, 2011-2012

Appendix Table 24: Colon and Rectum Cancer Incidence, by Assessment Region, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2012-2016

	New Cases, Annual Avg	Incidence per 100,000 Pop
Assessment Region	32	42.9
Idaho	633	35.5
Oregon	7,642	34.4
Payette County, ID	13	51.0
Washington County, ID	6	42.6
Malheur County, OR	13	37.2

DATA SOURCE: State Cancer Profiles, as cited by Trinity Health Data, 2012-2016

Maternal and Child Health

Appendix Table 25: Children Ever Breastfed, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2017

	Number Total Pop	% Total Pop	Number of SNAP-Ed Pop	% SNAP-Ed Pop
Assessment Region	no data	no data	no data	no data
Idaho	143,083	95.0%	64,488	99.0%
Oregon	258,603	91.0%	84,507	83.0%
Payette County, ID	no data	no data	no data	no data
Washington County, ID	no data	no data	no data	no data
Malheur County, OR	no data	no data	no data	no data

DATA SOURCE: Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, Additional data analysis by CARES, as cited by Trinity Health Data Hub, 2017

Appendix Table 26: Children Exclusively Breastfed, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2017

	n	%
Assessment Region	no data	no data

Idaho	10,084	7.0%
Oregon	17,425	6.0%
Payette County, ID	no data	no data
Washington County, ID	no data	no data
Malheur County, OR	no data	no data

DATA SOURCE: Child and Adolescent Health Measurement Initiative, National Survey of Children's Health, Additional data analysis by CARES, as cited by Trinity Health Data Hub, 2017

Appendix Table 27: Infant Mortality, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2006-2010

	Infant Births	Infant Deaths	Infant Mortality Rate
Assessment Region	4,695	21.0	4.5
Idaho	121,630	730.0	6.0
Oregon	240,190	1249	5.2
Payette County, ID	1,700	13	7.6
Washington County, ID	605	1	1.6
Malheur County, OR	2,390	7	2.9

DATA SOURCE: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File as cited by Trinity Health Data Hub, 2006-2010

Appendix Table 28: Prenatal Care, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2007-2010

	Mothers Starting Prenatal Care in 1st Trimester	Mothers with Late or No Prenatal Care	Prenatal Care Not Reported	% of Mothers with Late or No Prenatal Care
Assessment Region	no data	no data	no data	no data
Idaho	68,371	27,291	1,441	28.1%
Oregon	101,912	38,546	50,688	20.2%
Payette County, ID	5,317	39	no data	no data
Washington County, ID	0	0	no data	no data
Malheur County, OR	5,395	32	no data	no data

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research. 2007-10.

Appendix Table 29: Low Birth Weight (under 2500g), by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2006-2012

	n	%
Assessment Region	436	6.7%
Idaho	10,756	6.5%
Oregon	20243	6.1%
Payette County, ID	159	6.8%
Washington County, ID	58	6.6%
Malheur County, OR	219	6.6%

DATA SOURCE: US Department of Health & Human Services, Health Indicators Warehouse, National Vital Statistics System, Accessed via CDC WONDER, as cited by Trinity Health Data Hub, 2006-2012

Mortality

Appendix Table 30: Coronary Heart Disease, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2013-2017

	Avg Annual Deaths	Crude Death Rate per 100,000 Pop
Assessment Region	87	136.9
Idaho	1,528	92.0
Oregon	3,413	84.6
Payette County, ID	30	130.0
Washington County, ID	14	135.3
Malheur County, OR	43	142.6

DATA SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, Accessed via CDC WONDER, as cited by Trinity Health Data Hub, 2013-2017

Appendix Table 31: Drug Poisoning, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2012-2016

	Avg Annual Deaths	Crude Death Rate per 100,000 Pop

Assessment Region	9	16.5
Idaho	212	13.0
Oregon	496	12.4
Payette County, ID	6	24.6
Washington County, ID	no data	no data
Malheur County, OR	3	10.5

DATA SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, Accessed via CDC WONDER, as cited by Trinity Health Data Hub, 2013-2017

Appendix Table 32: Lung Disease, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2013-2017

	Avg Annual Deaths	Crude Death Rate per 100,000 Pop
Assessment Region	45	71.3
Idaho	852	51.3
Oregon	2,054	50.9
Payette County, ID	19	82.0
Washington County, ID	7	71.7
Malheur County, OR	19	63.1

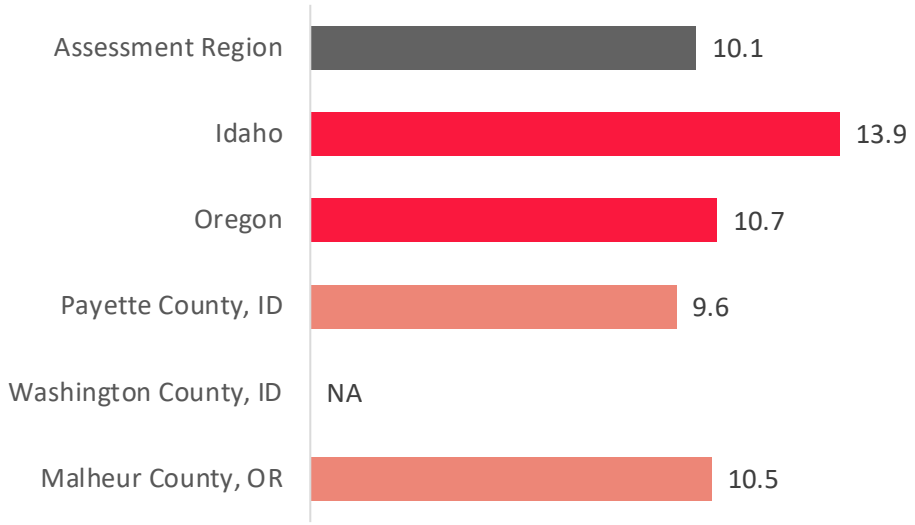
DATA SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, Accessed via CDC WONDER, as cited by Trinity Health Data Hub, 2013-2017

Appendix Table 33: Premature Death, by Total Service Area, Idaho, Oregon, Payette Co, Washington Co, Malheur Co, 2015-2017

	Total Premature Deaths	Total Years of Potential Life Lost
Assessment Region	805	13,353.0
Idaho	17,383	297,753.0
Oregon	46,337	697,214.0
Payette County, ID	287	4,982.0
Washington County, ID	121	1,497.0
Malheur County, OR	397	6,903.0

DATA SOURCE: University of Wisconsin Population Health Institute, County Health Rankings, as cited by Trinity Health Data Hub, 2015-2017

Appendix Figure 352: Crude Motor Vehicle Crash Mortality Rate per 100,000, 2013-2017



DATA SOURCE: Centers for Disease Control and Prevention, National Vital Statistics System, Accessed via CDC WONDER, as cited by Trinity Health Data Hub, 2013-2017