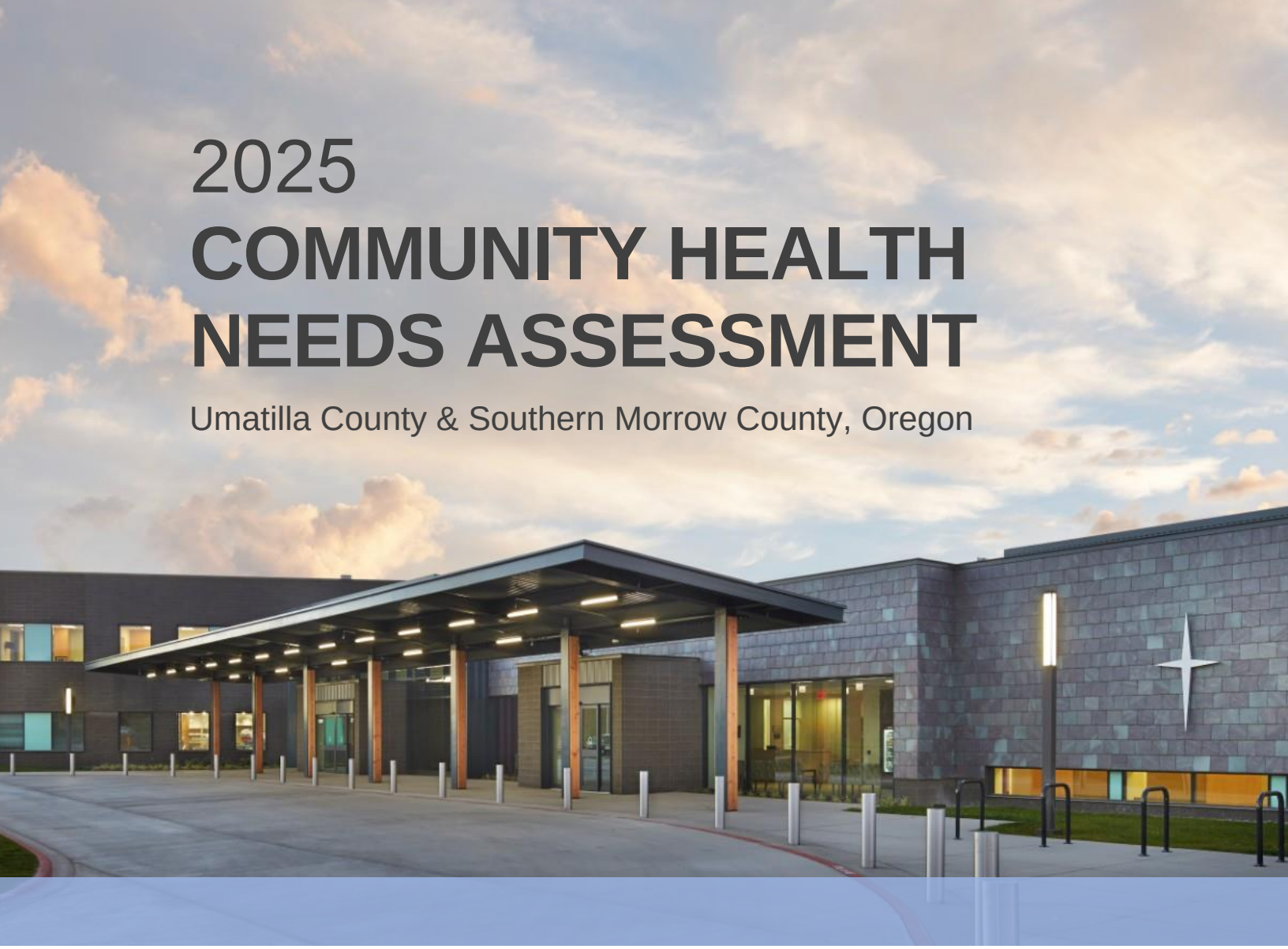

2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Umatilla County & Southern Morrow County, Oregon

Sponsored by

CHI St. Anthony Hospital™
A member of CommonSpirit

Adopted May 2025

2024-0463-02

Prepared by
www.PRCExcellence.com

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INTRODUCTION

EXECUTIVE SUMMARY

CHNA Purpose

The purpose of this Community Health Needs Assessment (CHNA) is to identify and prioritize significant health needs in the community served by CHI St. Anthony Hospital. The priorities identified in this report help to guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with other organizations that share a mission to improve health. This CHNA report meets requirements of the Patient Protection and Affordable Care Act that not-for-profit hospitals conduct a community health needs assessment at least once every three years.

CommonSpirit Health Commitment & Mission

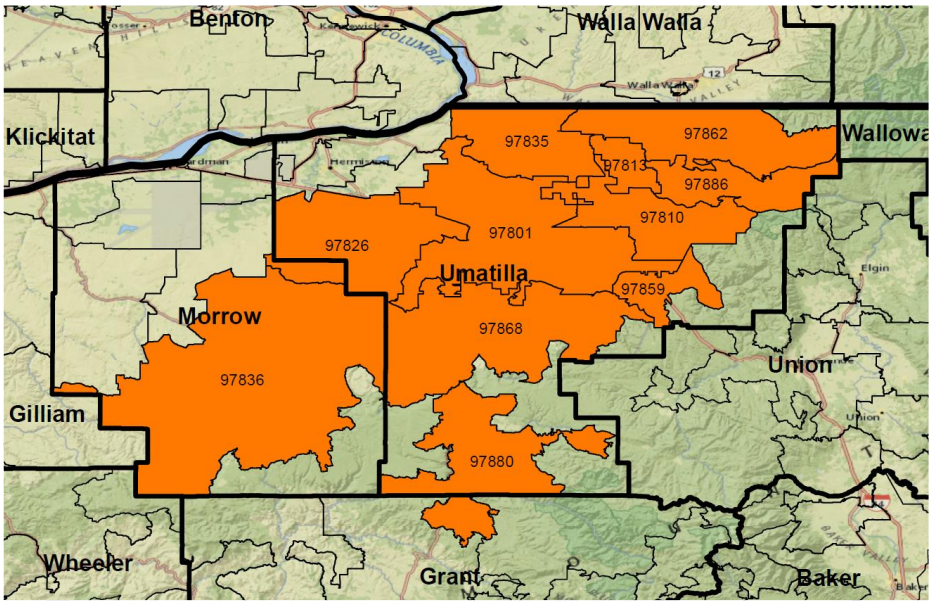
The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

CHNA Collaborators

This assessment was conducted on behalf of CHI St. Anthony Hospital by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Community Definition

The study area for this assessment (referred to as the "Total Service Area" in this report) is defined as each of these residential ZIP Codes in Umatilla County and southern Morrow County in Oregon: 97801, 97810, 97813, 97826, 97835, 97836, 97859, 97862, 97868, 97880, and 97886. This community definition, determined based on the ZIP Codes of residence of recent patients of CHI St. Anthony Hospital, is illustrated in the following map.



Assessment Process & Methods

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

Primary Data Collection. Primary data represent the most current information provided in this assessment. The PRC Community Health Survey provides an aggregate snapshot of the health experience, behaviors, and needs of residents in the community. The PRC Online Key Informant Survey allows key community leaders and providers in the area an opportunity to give extensive qualitative input about what they see as the most pressing issues in the populations they serve.

Secondary Data Collection. Secondary data provide information from existing data sets (e.g., public health records, census data, etc.) that complement the primary research findings.

Identifying & Prioritizing Significant Health Needs

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

Prioritization of the health needs was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

This process yielded the following prioritized list of community health needs:

1. **BEHAVIORAL HEALTH** ► Key informants identified both *Mental Health* and *Substance Use* as top concerns in the community. Existing data revealed a high suicide mortality rate, as well as a high cirrhosis/liver disease mortality. Survey findings revealed needs related to seeking professional help.
2. **CANCER** ► Key informants identified this as a top concern. Cancer is a leading cause of death in the community and existing data revealed a particularly high colorectal cancer mortality rate.
3. **TOBACCO USE** ► Key informants identified this as a top concern in the community. Use of vaping products has increased significantly in recent years.
4. **NUTRITION, PHYSICAL ACTIVITY & WEIGHT** ► This was a top concern among the surveyed key informants. Existing data revealed needs relative to access to healthy food and fitness/recreational facilities. Survey findings revealed worsening food insecurity, relatively few residents meeting physical activity guidelines, and a relatively high prevalence of overweight/obesity.
5. **DIABETES** ► The local diabetes mortality rate is high in comparison to state and national rates.

Other health needs identified in this assessment include:

- Infant Health & Family Planning
- Disabling Conditions
- Access to Health Care Services
- Injury & Violence
- Respiratory Disease

Resources Potentially Available to Meet Significant Health Needs

Measures and resources (such as programs, organizations, and facilities in the community) potentially available to address the significant health needs were identified by key informants giving input to this process. While not exhaustive, this list — which includes dozens of potential resources — draws on the experiences and wide knowledge base of those directly serving our community.

Report Adoption, Availability & Comments

This CHNA report was adopted by the St. Anthony Hospital Board of Trustees in May 2025.

The report is widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at St. Anthony Hospital's Community Health Office. Written comments on this report can be submitted to St. Anthony Hospital, Attn: Community Health, 2801 St. Anthony Way, Pendleton, Oregon 97801, or by e-mail to SAHPendleton@commonspirit.org.

IRS FORM 990, SCHEDULE H COMPLIANCE

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

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	9
Part V Section B Line 3b Demographics of the community	29
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	118
Part V Section B Line 3d How data was obtained	7
Part V Section B Line 3e The significant health needs of the community	14
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	24
Part V Section B Line 3h The process for consulting with persons representing the community's interests	10
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	124

ASSESSMENT PROCESS & METHODS

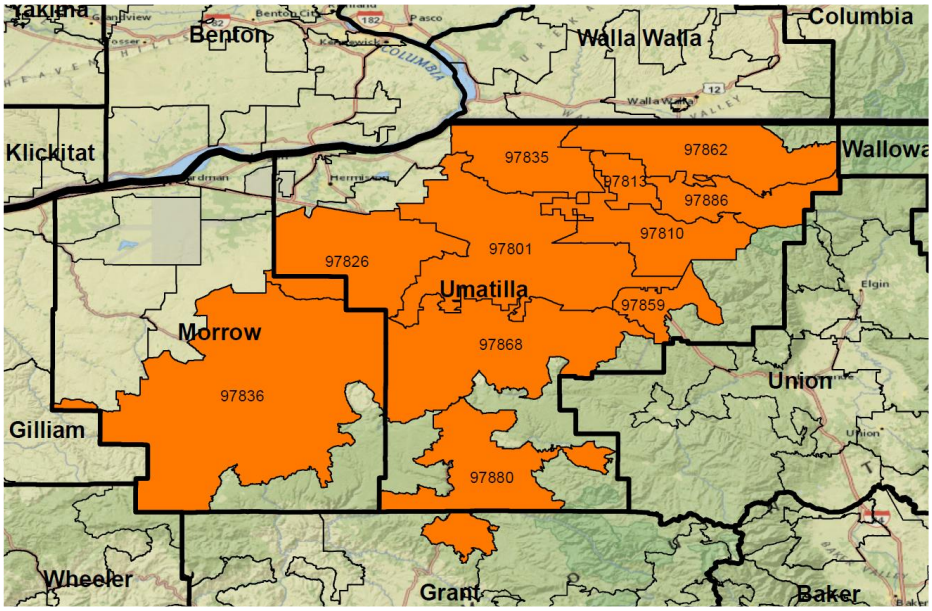
PRC Community Health Survey

Survey Instrument

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

Community Definition

The study area for this assessment (referred to as the "Total Service Area" in this report) is defined as the following residential ZIP Codes comprising the CHI St. Anthony Hospital service area in Umatilla County and southern Morrow County in Oregon: 97801, 97810, 97813, 97826, 97835, 97836, 97859, 97862, 97868, 97880, and 97886. This community definition, determined based on the ZIP Codes of residence of recent patients of CHI St. Anthony Hospital, is illustrated in the following map.



Sample Approach & Design

A precise and carefully implemented methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

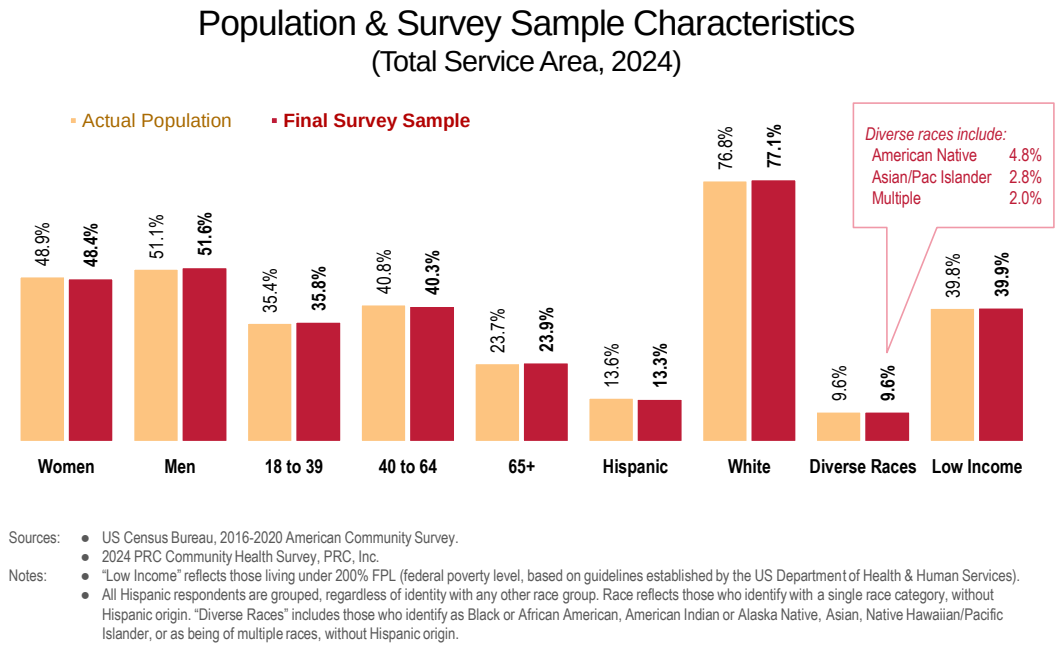
The sample design used for this effort consisted of a random sample of 201 individuals age 18 and older in the Total Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Total Service Area as a whole. All administration of the surveys, data collection, and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 201 respondents is ±6.9% at the 95 percent confidence level.

Sample Characteristics

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data are gathered, respondents are examined by key demographic characteristics (namely sex, age, race, ethnicity, and poverty status), and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses might contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics might have been slightly oversampled, might contribute the same weight as 0.9 respondents.

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



Sources:
- US Census Bureau, 2016-2020 American Community Survey.
- 2024 PRC Community Health Survey, PRC, Inc.

Notes:
- "Low Income" reflects those living under 200% FPL (federal poverty level, based on guidelines established by the US Department of Health & Human Services).
- All Hispanic respondents are grouped, regardless of identity with any other race group. Race reflects those who identify with a single race category, without Hispanic origin. "Diverse Races" includes those who identify as Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian/Pacific Islander, or as being of multiple races, without Hispanic origin.

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

Online Key Informant Survey

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented in October 2024 as part of this process. A list of recommended participants was provided by CHI St. Anthony Hospital; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 54 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	5
Public Health Representatives	4
Other Health Providers	19
Social Services Providers	16
Other Community Leaders	10

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. These populations include people with autism, children in foster care, those with development delays, people with disabilities, older residents, Hispanic residents, those without homes, those who are immigrants or refugees, LGBTQ+ people, residents who live in low-income households, those who rely on Medicare/Medicaid, migrant workers, Native American people, pregnant women, rural residents, those with language barriers, people with behavioral health issues, those with substance use issues, residents who are undocumented, those who are uneducated/undereducated, those who are unemployed/underemployed, people without insurance, veterans, and victims of domestic abuse.

Final participation included representatives of the organizations outlined below.

- Advantage Dental
- CAPECO
- Cason's Place
- Creating Conquerors
- Desire for Healing
- Doulas Latinas International
- Euvalcree
- Greater Oregon Behavioral Health Inc
- Helix School District
- Hermiston School District
- Horizon Project, Inc.
- Intermountain Educational Service District
- Milton Freewater School District
- Moda Health
- Oregon Child Development Coalition
- Oregon Department of Human Services
- Oregon State Police
- Oregon Washington Health Network
- Pendleton School District
- Pioneer Relief Nursery
- St. Anthony Hospital
- Umatilla County
- Umatilla County Developmental Disabilities Program
- Umatilla County Public Health
- Umatilla Morrow County Head Start
- WIC
- Yakima Valley Farm Workers Clinic
- Yellowhawk Tribal Health Center

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

Public Health, Vital Statistics & Other Data

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

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

Note that secondary data reflect Umatilla County data.

Benchmark Comparisons

Trending

A similar survey was administered in the Total Service Area in 2021 by PRC on behalf of CHI St. Anthony Hospital. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

Oregon Data

State-level findings are provided where available as an additional benchmark against which to compare local findings. For survey indicators, these are taken from the most recently published data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS). For other indicators, these draw from vital statistics, census, and other existing data sources.

National Data

National survey data, which are also provided in comparison charts, are taken from the *2023 PRC National Health Survey*; these data may be generalized to the US population with a high degree of confidence. National-level findings (from various existing resources) are also provided for comparison of secondary data indicators.

Healthy People 2030 Objectives

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

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

Determining Significance

Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level), using question-specific samples and response rates. For the purpose of this report, "significance" of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

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

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, LGBTQ+ residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — while included in the overall findings, might not be individually identifiable or might not comprise a large-enough sample for independent analyses.

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

Public Comment

CHI St. Anthony Hospital invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received.

SUMMARY OF FINDINGS

Summary Tables: Comparison With Benchmark Data

Reading the Summary Tables

In the following tables, Total Service Area results are shown in the larger, gray column.

The columns to the right of the Total Service Area column provide trending, as well as comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the Total Service Area compares favorably (🌞), unfavorably (🌺), or comparably (🌤) to these external data.

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

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

TREND SUMMARY
(Current vs. Baseline Data)

SURVEY DATA INDICATORS:
Trends for survey-derived indicators represent significant changes since 2021. Note that survey data reflect the ZIP Code-defined Total Service Area.

OTHER (SECONDARY) DATA INDICATORS:
Trends for other indicators (e.g., public health data) represent point-to-point changes between the most current reporting period and the earliest presented in this report (typically representing the span of roughly a decade). Local secondary data reflect Umatilla County data.

SOCIAL DETERMINANTS	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Linguistically Isolated Population (Percent)	2.6 [Umatilla County]	2.3	3.9		
Population in Poverty (Percent)	11.7 [Umatilla County]	11.9	12.5	8.0	
Children in Poverty (Percent)	13.7 [Umatilla County]	13.5	16.7	8.0	
No High School Diploma (Age 25+, Percent)	15.5 [Umatilla County]	8.5	10.9		
Unemployment Rate (Age 16+, Percent)	3.7 [Umatilla County]	3.9	3.9		8.7
% Unable to Pay Cash for a $400 Emergency Expense	23.7		34.0		21.2
% Worry/Stress Over Rent/Mortgage in Past Year	24.6		45.8		20.7
% Unhealthy/Unsafe Housing Conditions	11.1		16.4		10.4
Population With Low Food Access (Percent)	30.5 [Umatilla County]	17.0	22.2		
% Food Insecure	30.1		43.3		18.4
		better	similar	worse	

OVERALL HEALTH	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
% "Fair/Poor" Overall Health	20.9	17.7	15.7		18.1
		better	similar	worse	

ACCESS TO HEALTH CARE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS			
		vs. OR	vs. US	vs. HP2030	TREND
% [Age 18-64] Lack Health Insurance	**7.2**	7.1	8.1	7.6	6.1
% Difficulty Accessing Health Care in Past Year (Composite)	**47.3**		52.5		47.9
% Cost Prevented Physician Visit in Past Year	**12.4**	9.1	21.6		9.3
% Cost Prevented Getting Prescription in Past Year	**10.2**		20.2		11.4
% Difficulty Getting Appointment in Past Year	**29.3**		33.4		29.5
% Inconvenient Hrs Prevented Dr Visit in Past Year	**18.2**		22.9		19.7
% Difficulty Finding Physician in Past Year	**15.7**		22.0		19.6
% Transportation Hindered Dr Visit in Past Year	**10.1**		18.3		6.6
% Language/Culture Prevented Care in Past Year	**0.3**		5.0		1.1
% Stretched Prescription to Save Cost in Past Year	**13.8**		19.4		15.1
% Difficulty Getting Child's Health Care in Past Year	**2.4**		11.1		5.5
Primary Care Doctors per 100,000	**62.4** [Umatilla County]	130.9	116.2		
% Have a Specific Source of Ongoing Care	**69.8**		69.9	84.0	79.6
% Routine Checkup in Past Year	**62.9**	72.6	65.3		63.3
% [Child 0-17] Routine Checkup in Past Year	**89.9**		77.5		82.6
% Two or More ER Visits in Past Year	**9.2**		15.6		12.8

ACCESS TO HEALTH CARE SERVICES (continued)	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
% Rate Local Health Care "Fair/Poor"	26.4		11.5		22.8

better similar worse

CANCER	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Cancer Deaths per 100,000 (Age-Adjusted)	153.8 [Umatilla County]	147.1	146.5	122.7	181.1
Lung Cancer Deaths per 100,000 (Age-Adjusted)	30.9 [Umatilla County]	31.6	33.4	25.1	
Female Breast Cancer Deaths per 100,000 (Age-Adjusted)	16.8 [Umatilla County]	18.9	19.4	15.3	
Prostate Cancer Deaths per 100,000 (Age-Adjusted)	14.1 [Umatilla County]	19.7	18.5	16.9	
Colorectal Cancer Deaths per 100,000 (Age-Adjusted)	17.7 [Umatilla County]	12.3	13.1	8.9	
Cancer Incidence per 100,000	377.3 [Umatilla County]	419.2	442.3		
Lung Cancer Incidence per 100,000	44.3 [Umatilla County]	49.1	54.0		
Female Breast Cancer Incidence per 100,000	115.6 [Umatilla County]	128.8	127.0		
Prostate Cancer Incidence per 100,000	89.0 [Umatilla County]	94.4	110.5		
Colorectal Cancer Incidence per 100,000	37.3 [Umatilla County]	32.8	36.5		
% Cancer	7.7	13.1	7.4		10.3
% [Women 50-74] Breast Cancer Screening	83.4	78.0	64.0	80.5	76.0

CANCER (continued)	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
% [Women 21-65] Cervical Cancer Screening	71.6		75.4	84.3	66.2
% [Age 45-75] Colorectal Cancer Screening	69.8	70.0	71.5	74.4	79.0
		better	similar	worse	

DIABETES	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Diabetes Deaths per 100,000 (Age-Adjusted)	30.7 [Umatilla County]	23.4	22.6		30.7
% Diabetes/High Blood Sugar	13.4	10.3	12.8		13.0
% Borderline/Pre-Diabetes	10.8		15.0		13.8
Kidney Disease Deaths per 100,000 (Age-Adjusted)	9.8 [Umatilla County]	7.4	12.8		9.7
		better	similar	worse	

DISABLING CONDITIONS	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
% 3+ Chronic Conditions	31.5		38.0		43.5
% Activity Limitations	30.1		27.5		31.2
% High-Impact Chronic Pain	24.4		19.6	6.4	24.0
Alzheimer's Disease Deaths per 100,000 (Age-Adjusted)	44.1 [Umatilla County]	36.6	30.9		26.9
% Caregiver to a Friend/Family Member	21.1		22.8		30.1
		better	similar	worse	

HEART DISEASE & STROKE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Heart Disease Deaths per 100,000 (Age-Adjusted)	**145.9** [Umatilla County]	131.1	164.4	127.4	145.1
% Heart Disease	**7.5**	7.2	10.3		9.2
Stroke Deaths per 100,000 (Age-Adjusted)	**33.3** [Umatilla County]	39.3	37.6	33.4	41.7
% Stroke	**3.1**	3.9	5.4		2.2
% High Blood Pressure	**37.5**	30.9	40.4	42.6	40.3
% High Cholesterol	**26.0**		32.4		37.4
% 1+ Cardiovascular Risk Factor	**86.7**		87.8		86.6
		better	similar	worse	

INFANT HEALTH & FAMILY PLANNING	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Teen Births per 1,000 Females 15-19	**26.5** [Umatilla County]	12.4	16.6		
Low Birthweight (Percent of Births)	**6.4** [Umatilla County]	6.7	8.3		
Infant Deaths per 1,000 Births	**6.4** [Umatilla County]	4.4	5.6	5.0	
% [Parents] Use Physical Discipline on Child	**10.8**				20.8
		better	similar	worse	

INJURY & VIOLENCE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	**54.7** [Umatilla County]	47.2	51.6	43.2	45.8
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	**16.8** [Umatilla County]	11.1	11.4	10.1	
[65+] Fall-Related Deaths per 100,000 (Age-Adjusted)	**84.4** [Umatilla County]	104.1	67.1	63.4	
Homicide Deaths per 100,000 (Age-Adjusted)	**5.4** [Umatilla County]	2.9	5.9	5.5	
Violent Crimes per 100,000	**259.8** [Umatilla County]	265.8	416.0		
% Victim of Violent Crime in Past 5 Years	**5.0**		7.0		2.6
% Victim of Intimate Partner Violence	**11.2**		20.3		21.7
		better	similar	worse	

MENTAL HEALTH	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
% "Fair/Poor" Mental Health	**18.1**		24.4		26.4
% Diagnosed Depression	**25.2**	24.0	30.8		26.4
% Symptoms of Chronic Depression	**40.5**		46.7		39.2
% Typical Day Is "Extremely/Very" Stressful	**11.0**		21.1		18.4
Suicide Deaths per 100,000 (Age-Adjusted)	**18.7** [Umatilla County]	19.2	13.9	12.8	14.1
% Suicide Ideation	**5.8**				10.1

MENTAL HEALTH (continued)	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Mental Health Providers per 100,000	440.8 [Umatilla County]	561.9	311.0		
% Receiving Mental Health Treatment	19.2		21.9		19.7
% Unable to Get Mental Health Services in Past Year	7.4		13.2		8.2
		better	similar	worse	

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
% "Very/Somewhat" Difficult to Buy Fresh Produce	29.4		30.0		23.2
% No Leisure-Time Physical Activity	23.0	19.0	30.2	21.8	25.0
% Meet Physical Activity Guidelines	21.5	24.9	30.3	29.7	19.3
Recreation/Fitness Facilities per 100,000	7.5 [Umatilla County]	12.6	12.3		
% Overweight (BMI 25+)	75.4	66.9	63.3		73.8
% Obese (BMI 30+)	42.6	30.9	33.9	36.0	46.7
		better	similar	worse	

ORAL HEALTH	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
% Have Dental Insurance	72.9		72.7	75.0	79.2
% Dental Visit in Past Year	60.1	66.2	56.5	45.0	63.9
		better	similar	worse	

RESPIRATORY DISEASE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Lung Disease Deaths per 100,000 (Age-Adjusted)	**47.2** [Umatilla County]	36.0	38.1		46.9
Pneumonia/Influenza Deaths per 100,000 (Age-Adjusted)	**12.9** [Umatilla County]	8.8	13.4		11.0
% Asthma	**12.7**	11.5	17.9		19.5
% [Child 0-17] Asthma	**10.5**		16.7		11.5
% COPD (Lung Disease)	**6.8**	6.6	11.0		6.7
		better	similar	worse	

SEXUAL HEALTH	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
HIV Prevalence per 100,000	**115.5** [Umatilla County]	206.5	386.6		
Chlamydia Incidence per 100,000	**374.0** [Umatilla County]	365.7	495.0		
Gonorrhea Incidence per 100,000	**128.8** [Umatilla County]	129.6	194.4		
		better	similar	worse	

SUBSTANCE USE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
Alcohol-Induced Deaths per 100,000 (Age-Adjusted)	**9.7** [Umatilla County]	14.0	11.9		
Cirrhosis/Liver Disease Deaths per 100,000 (Age-Adjusted)	**19.6** [Umatilla County]	12.4	12.5	10.9	
% Excessive Drinking	**17.9**	20.1	34.3		20.8
Unintentional Drug-Induced Deaths per 100,000 (Age-Adjusted)	**8.9** [Umatilla County]	11.3	19.9		
% Used an Illicit Drug in Past Month	**2.8**		8.4		0.7
% Used a Prescription Opioid in Past Year	**15.0**		15.1		18.5
% Ever Sought Help for Alcohol or Drug Problem	**2.7**		6.8		7.7
		better	similar	worse	

TOBACCO USE	Total Service Area	TOTAL SERVICE AREA vs. BENCHMARKS vs. OR	vs. US	vs. HP2030	TREND
% Smoke Cigarettes	**16.9**	12.4	23.9	6.1	
% Someone Smokes at Home	**8.9**		17.7		
% Use Smokeless Tobacco	**10.4**				
% Use Vaping Products	**10.5**	6.9	18.5		3.3
		better	similar	worse	

Prioritized Description of Significant Community Health Needs

Identification of Significant Health Needs

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

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

Community Feedback on Prioritization

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey. In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

PRIORITIZED LIST OF SIGNIFICANT HEALTH NEEDS		
Priority	Significant Health Need	Key Supporting Evidence
1	BEHAVIORAL HEALTH	▪ Suicide Deaths ▪ Cirrhosis/Liver Disease Deaths ▪ Sought Help for Alcohol/Drug Issues ▪ Key Informants: *Mental Health* ranked as a top concern. ▪ Key Informants: *Substance Use* ranked as a top concern.
2	CANCER	▪ Leading Cause of Death ▪ Colorectal Cancer Deaths ▪ Key Informants: *Cancer* ranked as a top concern.
3	TOBACCO USE	▪ Use of Vaping Products
4	NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Food Insecurity ▪ Low Food Access ▪ Meeting Physical Activity Guidelines ▪ Access to Recreation/Fitness Facilities ▪ Overweight & Obesity [Adults] ▪ Key Informants: *Nutrition, Physical Activity and Weight* ranked as a top concern.
5	DIABETES	▪ Diabetes Deaths

Other health needs identified in this assessment include:

- Infant Health & Family Planning
- Disabling Conditions
- Access to Health Care Services
- Injury & Violence
- Respiratory Disease

Hospital Implementation Strategy

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

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

COMMUNITY DESCRIPTION

DEMOGRAPHIC SUMMARY

The Total Service Area, the focus of this Community Health Needs Assessment, is predominantly associated with Umatilla County, which encompasses 3,215.45 square miles and houses a total population of 79,904 residents, according to latest census estimates.

The county is predominantly urban. Note the following demographic makeup of our community.

Core Demographic Summary

	Umatilla County
Urbanization	76.2% Urban
Total Population Size	79,904
Race & Ethnicity	
Hispanic	28.1%
White	76.3%
American Indian or Alaska Native	3.2%
Asian	0.9%
Black	0.8%
Native Hawaiian/Pacific Islander	0.1%
Median Household Income	$70,322
Percent of Population Living in Poverty (Below 100% FPL)	11.7%
Unemployment Rate (September 2024)	3.7%
Percent of People Age 5 and Older Who are Non-English Speaking	2.6%
Percent of People Without Health Insurance	11.1%
Percent of People with Medicaid	28.1%
Health Professional Shortage Area	Primary Care, Dental, Mental Health
Medically Underserved Areas/Populations	Yes
Number of Other Hospitals Serving the Community	None

DATA CHARTS & KEY INFORMANT INPUT

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

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

SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

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

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

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

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

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

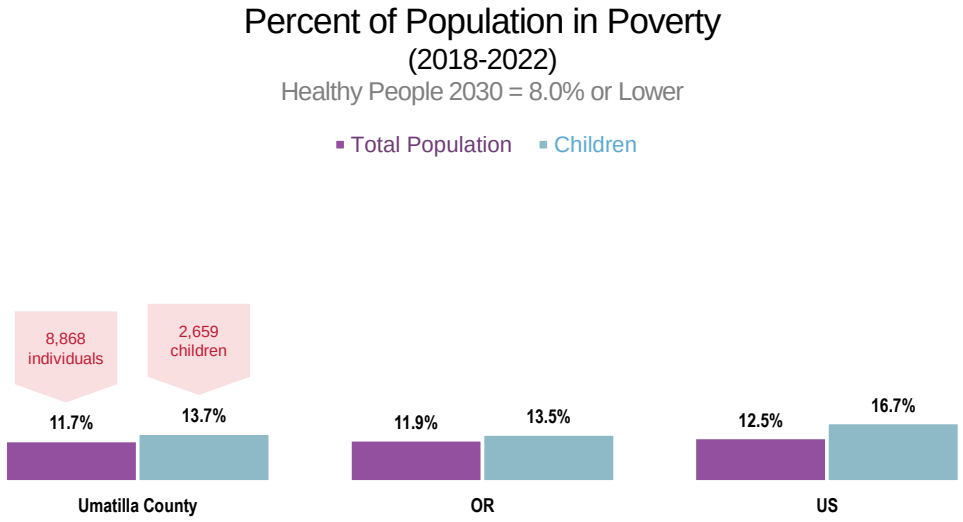
– Healthy People 2030 (https://health.gov/healthypeople)

Income & Poverty

Poverty

Poverty is considered a key driver of health status because it creates barriers to accessing health services, healthy food, and other necessities that contribute to health status.

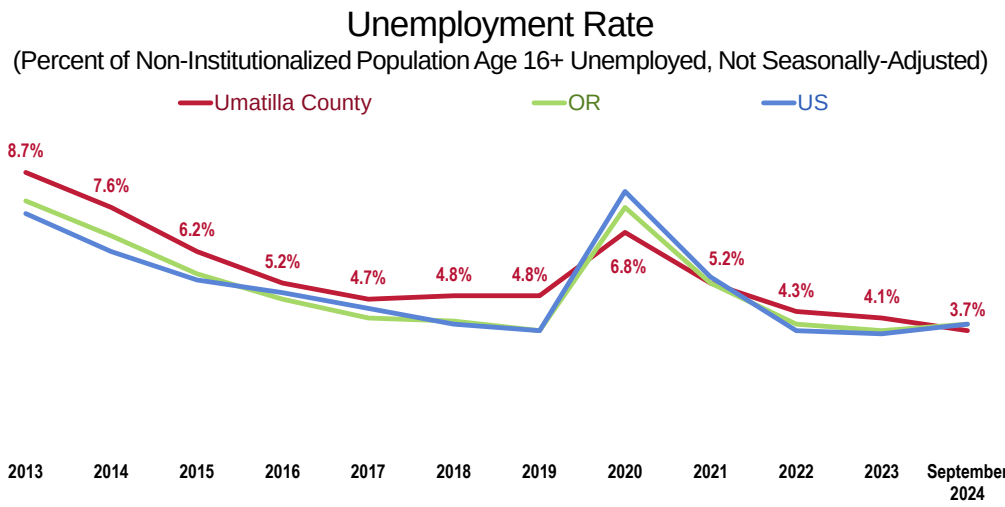
The following chart outlines the proportion of our population below the federal poverty threshold in comparison to state and national proportions. [COUNTY-LEVEL DATA]



Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Employment

Note the following trends in unemployment data derived from the US Department of Labor. [COUNTY-LEVEL DATA]



Sources:
- US Department of Labor, Bureau of Labor Statistics.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

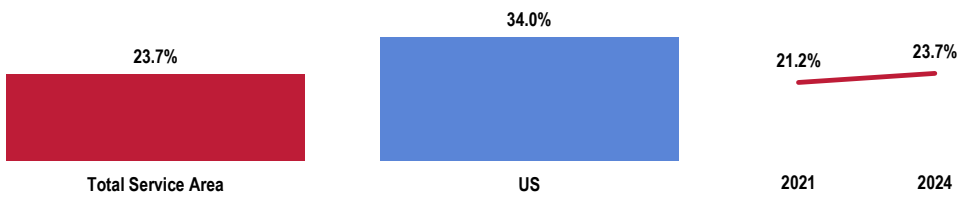
Financial Resilience

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

The following charts detail "no" responses in the Total Service Area in comparison to benchmark data, as well as by basic demographic characteristics (such as gender, age groupings, and income [based on poverty status]).

Do Not Have Cash on Hand to Cover a $400 Emergency Expense

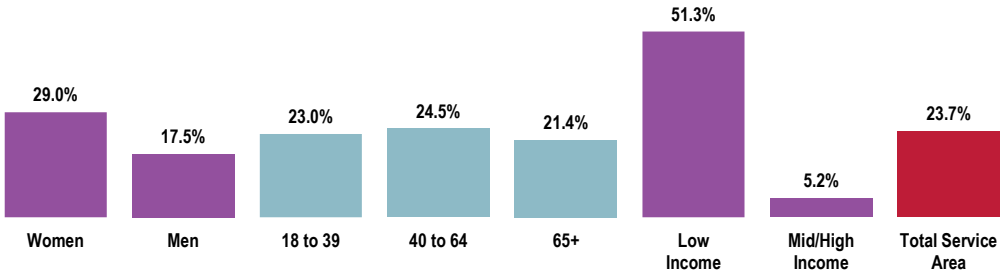
Total Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

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

Do Not Have Cash on Hand to Cover a $400 Emergency Expense
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 53]
- 2023 PRC National Health Survey, PRC, Inc.

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

INCOME & RACE/ETHNICITY

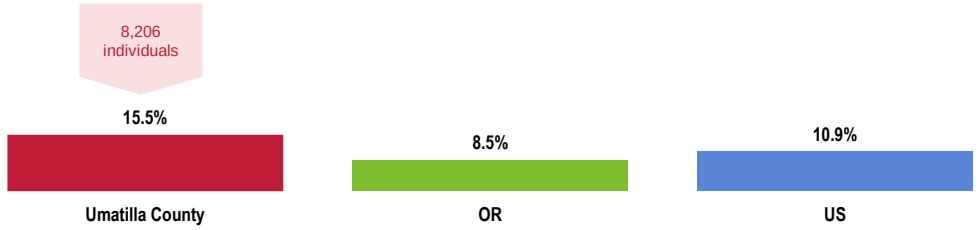
INCOME ► Income categories used to segment survey data in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2022 guidelines place the poverty threshold for a family of four at $27,750 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

RACE & ETHNICITY ► While the survey data are representative of the full racial and ethnic makeup of the population, samples were not of sufficient size for independent analysis by race and/or ethnicity.

Education

Education levels are reflected in the proportion of our population without a high school diploma. This indicator is relevant because educational attainment is linked to positive health outcomes. [COUNTY-LEVEL DATA]

Population With No High School Diploma
(Adults Age 25 and Older; 2018-2022)



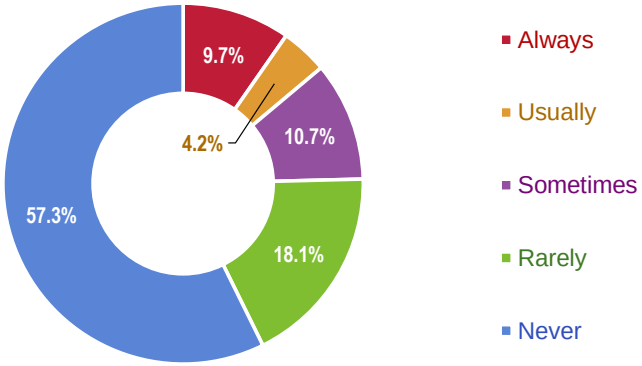
Sources:
- US Census Bureau American Community Survey, 5-year estimates.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

Housing

Housing Insecurity

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

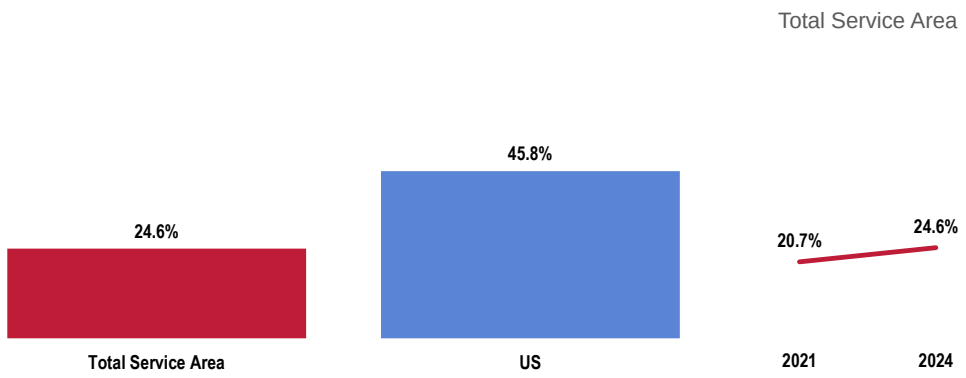
Frequency of Worry or Stress About Paying Rent or Mortgage in the Past Year
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 56]

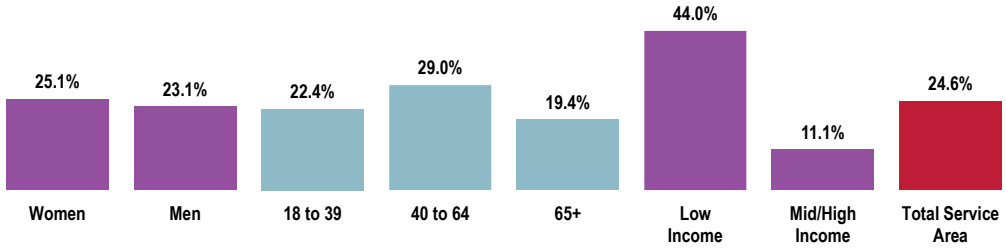
Notes:
- Asked of all respondents.

Always/Usually/Sometimes Worry About Paying Rent or Mortgage



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Always/Usually/Sometimes Worry About Paying Rent or Mortgage
(Total Service Area, 2024)



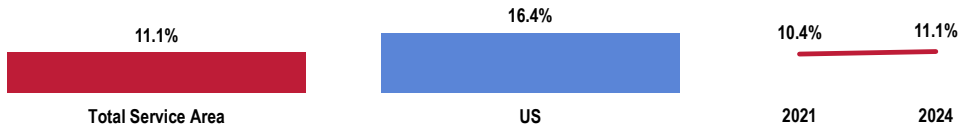
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 56]
Notes: ● Asked of all respondents.

Unhealthy or Unsafe Housing

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

Unhealthy or Unsafe Housing Conditions in the Past Year

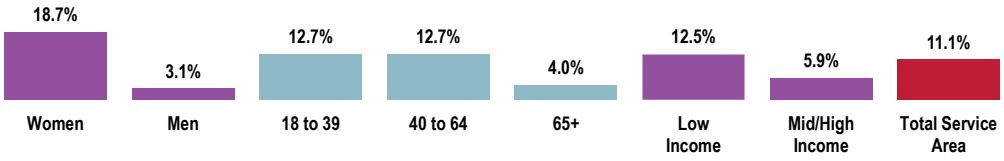
Total Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 55]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Unhealthy or Unsafe Housing Conditions in the Past Year
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 55]

Notes:
- Asked of all respondents.
- Includes respondents who say they experienced ongoing problems in their current home with water leaks, rodents, insects, mold, or other housing conditions that might make living there unhealthy or unsafe.

Food Insecurity

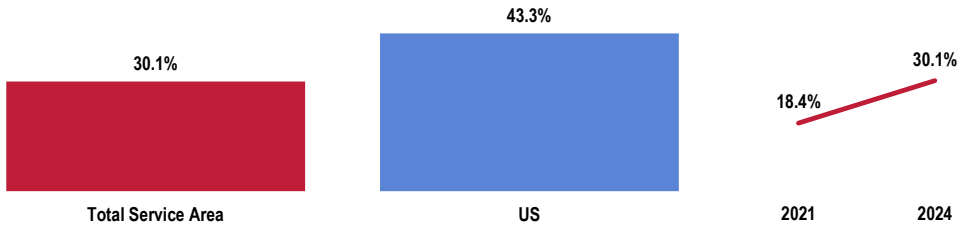
PRC SURVEY ► "Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was 'often true,' 'sometimes true,' or 'never true' for you in the past 12 months.

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

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

Food Insecure

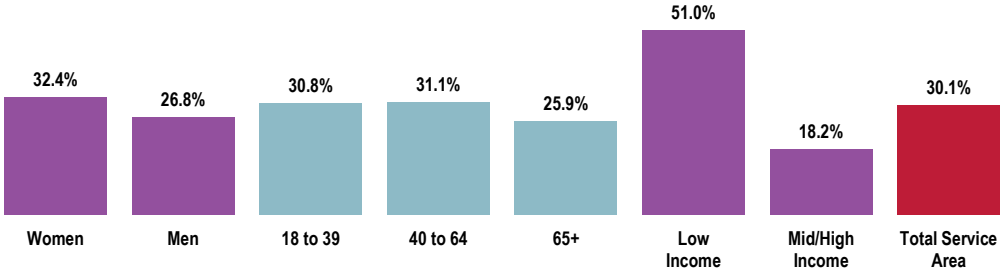
Total Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 98]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Food Insecure
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 98]

Notes:
- Asked of all respondents.
- Includes adults who A) ran out of food at least once in the past year and/or B) worried about running out of food in the past year.

Social Vulnerability Index

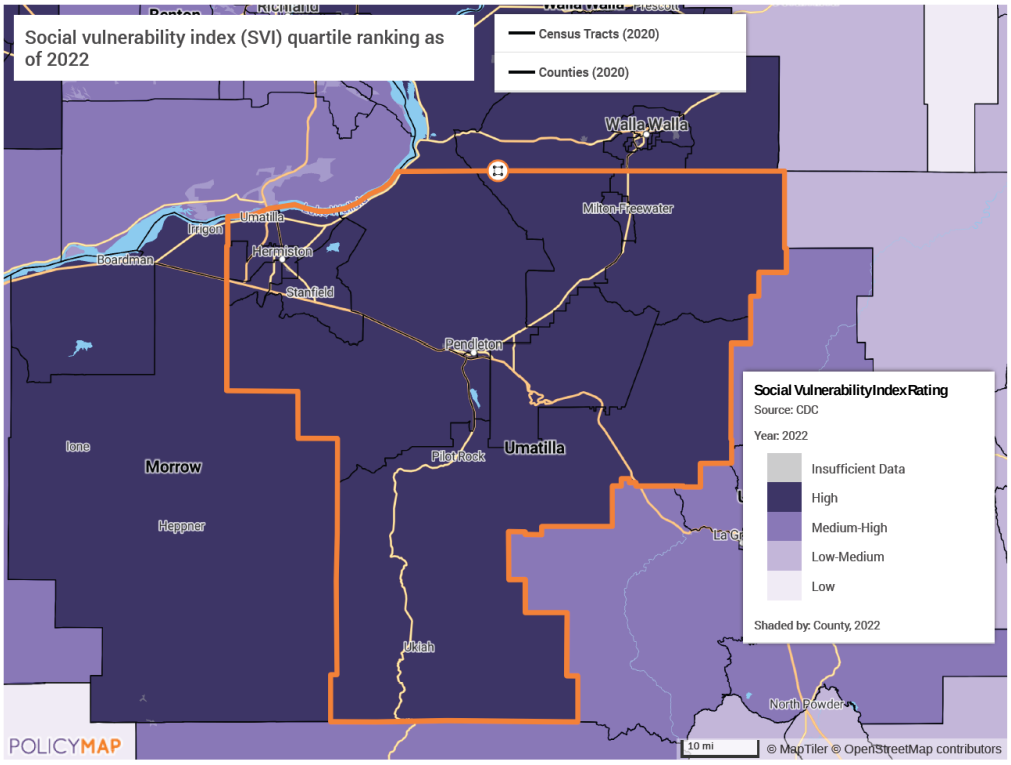
Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. Such stresses include natural or human-caused disasters, or disease outbreaks. Reducing social vulnerability can decrease both human suffering and economic loss.

The CDC/ATSDR Social Vulnerability Index (CDC/ATSDR SVI) uses 16 US census variables to help local officials identify communities that may need support before, during, or after disasters.

The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

The social vulnerability index is a measure of the degree of social vulnerability in counties and neighborhoods across the United States, where a higher score indicates higher vulnerability.

The following illustrates those census tracts in Umatilla County and neighboring areas with the highest social vulnerability.



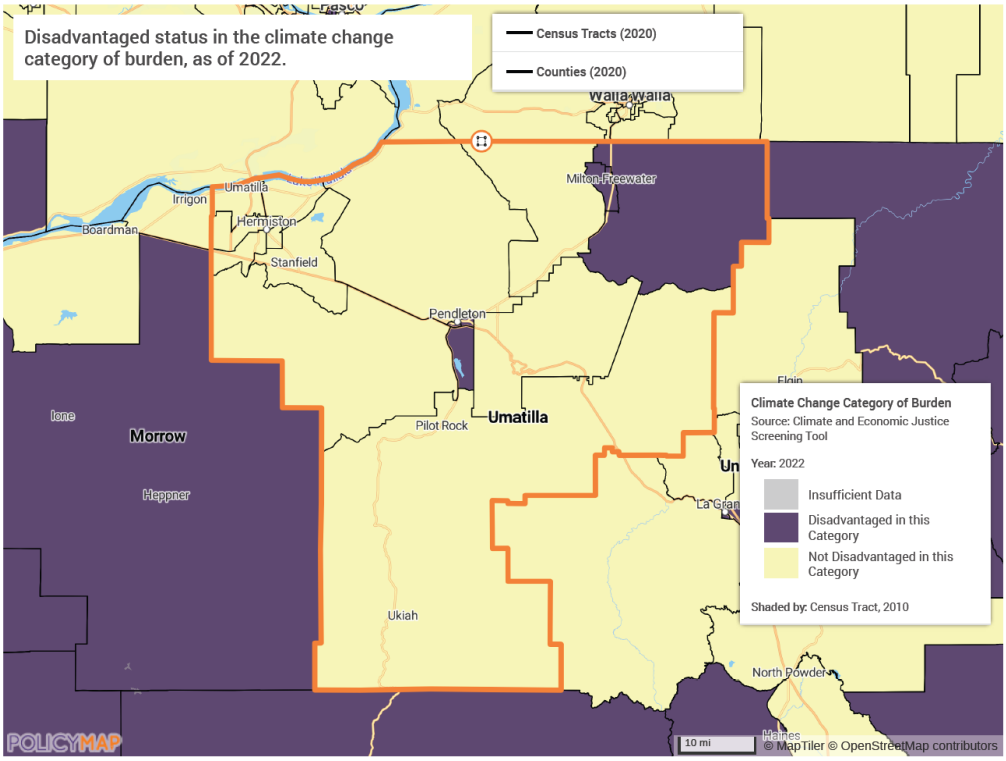
Source: Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention (CDC). Accessed via PolicyMap.

Climate Change Burden

The Climate and Economic Justice Screening Tool (CEJST) was developed by the Council on Environmental Quality to identify disadvantaged communities that face burdens across eight categories: climate change, energy, health, housing, legacy pollution, transportation, water and wastewater, and workforce development. CEJST combines a number of publicly available national datasets to identify disadvantaged communities.

Census tracts are considered disadvantaged if they meet the thresholds for at least one of the CEJST categories of burden or if they are on land within the boundaries of Federally Recognized Tribes. Meeting one of the CEJST categories of burden requires that a tract be at or above specified thresholds for one or more environmental, climate, housing, health or other burdens and be at or above the threshold for an associated socioeconomic burden (e.g., low income or low educational attainment). Additionally, a census tract that is completely surrounded by disadvantaged communities and is at or above the 50th percentile for low income is also considered disadvantaged.

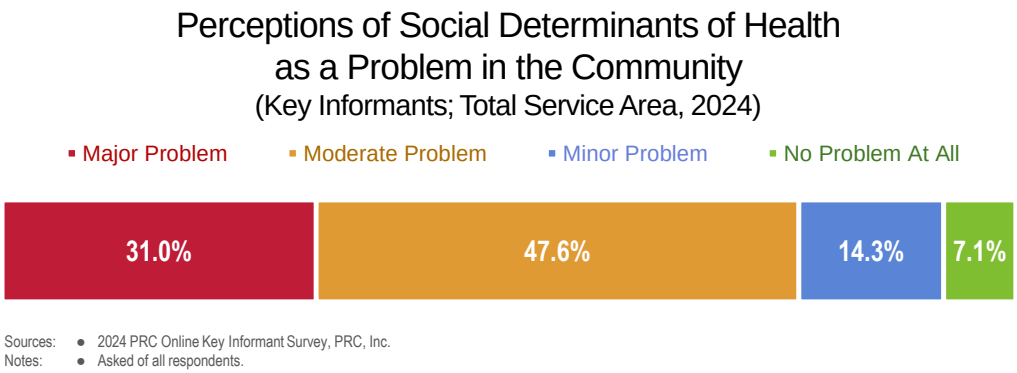
The following illustrates those census tracts in Umatilla County and neighboring areas with the highest burden relative to climate change.



Source: Council on Environmental Quality, Climate and Economic Justice Screening Tool (CEJST). Accessed via PolicyMap.

Key Informant Input: Social Determinants of Health

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



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

Housing

> Lack of affordable housing and resources for those experiencing homelessness. History of racism in the community especially toward tribal populations. – Other Health Provider
>
> There is lack of affordable housing. Rents are exceeding the cost of house payments in Umatilla County and wages are low. High truancy rates, as parents aren't sending their children to school and a lot of times it is due to the parents in active addiction, so they don't care. This is going to exacerbate the generational poverty cycle when children grow up not learning to read and end up unable to find a living wage working as an adult. We have more children now with severe mental health issues due to bullying than ever. Elementary students smoking and drinking. Middle school students sexually active and having babies. People becoming parents who don't know how to parent and failing to teach their child how to deal with life. – Social Services Provider
>
> It has been demonstrated that a person's health can be impacted significantly when they are experiencing challenges surrounding their health, housing, income, education, environment and/or discrimination. In our community there is not enough affordable housing, leaving many without adequate housing. Barriers to higher income jobs are often experienced thus leaving individual left to take lower paying jobs as they may not have access or financial means for higher educational opportunities. Discrimination is felt/experienced based on race, ethnic background, familial background, language. – Other Health Provider
>
> Lack of affordable housing and increased cost of living. Increased visibility of homeless population. Climate change, wildfires etc. – Social Services Provider
>
> Housing. Full stop. Affordability and availability. – Social Services Provider
>
> The cost of housing is high, there are not enough affordable housing options, lack of adequate transportation between communities, poverty, chronic stressors of living in poverty, access to quality childcare and parenting skills. – Community Leader
>
> Housing as a whole could be the root and solution to the issue here. There is still discrimination here with language access, immigration status that can make it easy to exclude certain people however that does not make it right. With limited access, and many times no education earned in the US, these people are prone to being taken advantage of or just not know of local resources that could serve them. – Social Services Provider
>
> Because there are no housing resources for people who struggle with homelessness. There also is no housing that is affordable even for the working population because rent is insanely high and the minimum wage is super low. There has and always will be a stigma in Umatilla County towards lower poverty populations, houselessness, a person struggling with substance use disorder, and mental health. If anything is "wrong" with you, you are not meant to be in the world. – Other Health Provider
>
> I am hearing from older adults about the lack of affordable housing for them that is ADA as they age out of their homes. – Social Services Provider
>
> Housing is a major issue in some areas of Umatilla County. Finding adequate housing for convicted felons and persons with evictions and past due utility bills is extremely difficult. The waiting lists are long for families with small children. – Social Services Provider

> Housing for seniors is terrible, they wait on lists, stay at Promised Inn for max 90 days and then no housing opens, and they have nowhere to go. They can't afford Sunridge or assisted living, they can't get into senior living because of waitlists. Their SSI is too high to qualify for EOCCO, so they don't purchase supplements and then don't seek the care they need because of copays. – Physician
>
> Lack of low-income housing. Wait list is years long for low income housing. – Other Health Provider
>
> This area is very low income, not enough affordable housing, prices on just about everything is up. Many in the area are underserved populations. – Social Services Provider

Vulnerable Populations

> We are located within a few miles of an Indian reservation, we have a low income level for our area and we have a bad meth drug problem. – Other Health Provider
>
> We are a borderland community with the CTUIR. This community experiences continued challenges related to the historical and generational trauma of colonization. – Community Leader
>
> With all the information we have shared, it is possible to understand how, where and for how long the Social Determinants of Health are a very complex issue among Latino-Hispanic and Indigenous populations of Eastern Oregon. – Other Health Provider

Access to Care/Services

> Limited resources, housing, increased population, migration. – Social Services Provider
>
> To put it simply the needs in our community has more needs than resources. There is not a single determinant of health that I don't see having significant need in our community. – Social Services Provider

Lifestyle

> Income, drug use, cultural practices, distances to care facilities, affordable housing, price of fuel, price of groceries. – Physician

Addiction

> Addiction to substances and technology that prevents people from working and caring for themselves and children. Lack of affordable housing is significant, though there has been progress made in availability in our area, these are still quite expensive. – Community Leader

Follow Up/Support

> We live in a rural, underserved area due to lack of CBO options providing comprehensive wraparound support. – Other Health Provider

Homelessness

> There is a huge increase in homeless in our area! Not only locals but being bussed in and dropped off. This is increasing homelessness but also drug addiction and violence in our area. – Other Health Provider

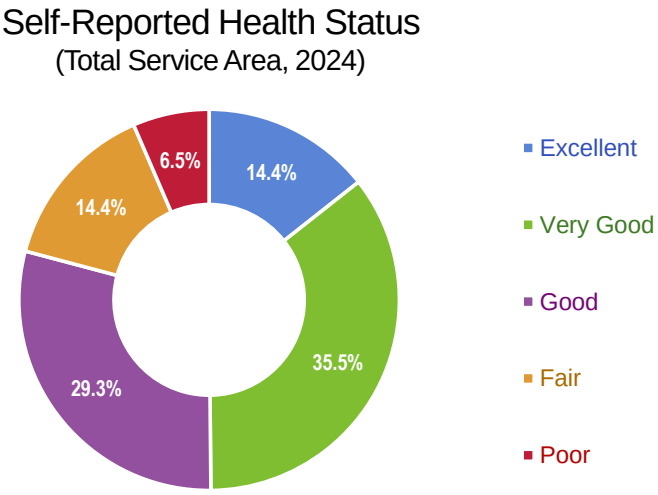
Inflation

> Inflation. No one can afford anything. – Physician

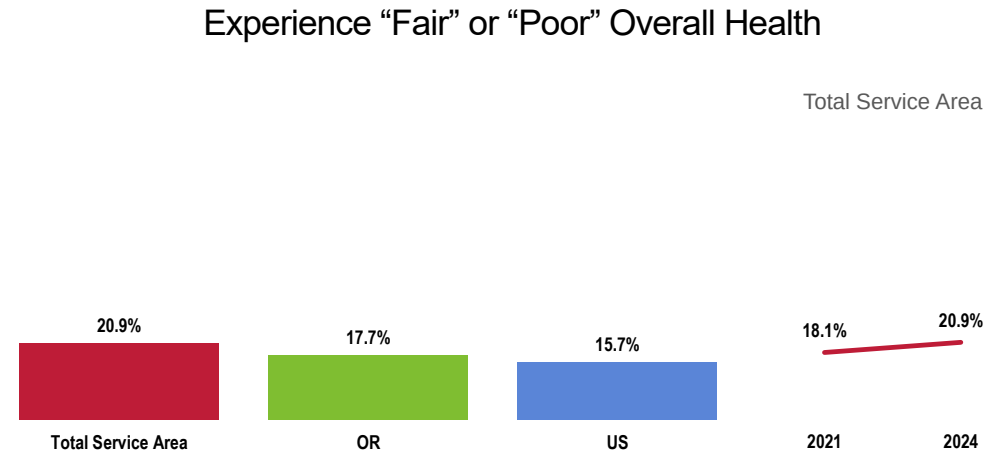
HEALTH STATUS

Overall Health

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

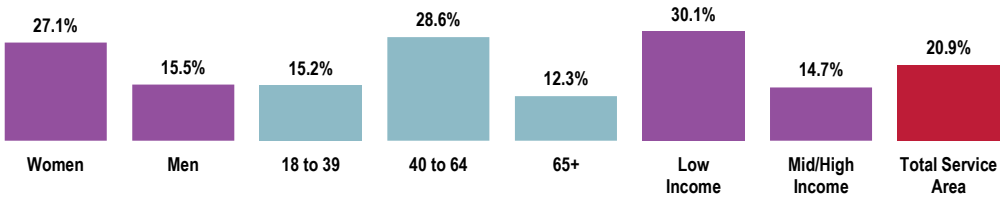


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: ● Asked of all respondents.



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
● Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Overall Health
(Total Service Area, 2024)



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 4]
Notes: • Asked of all respondents.

Mental Health

ABOUT MENTAL HEALTH & MENTAL DISORDERS

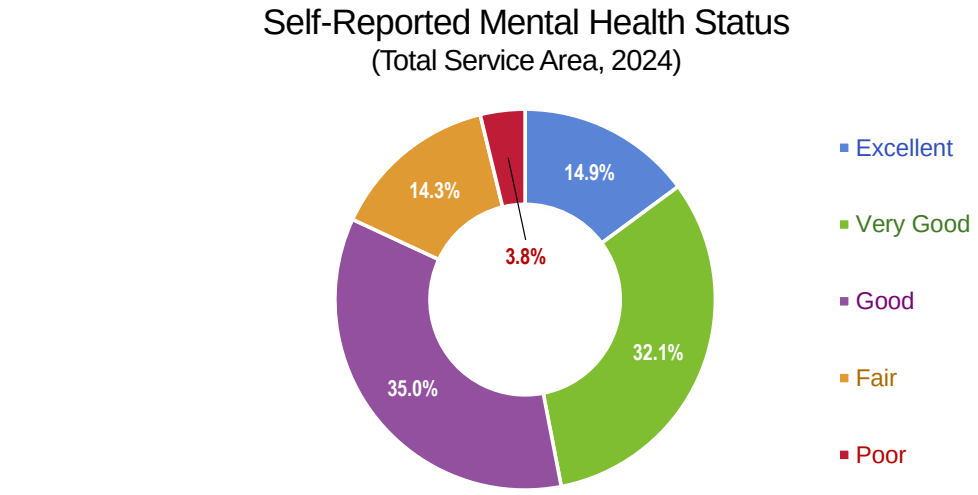
About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental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

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

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

Mental Health Status

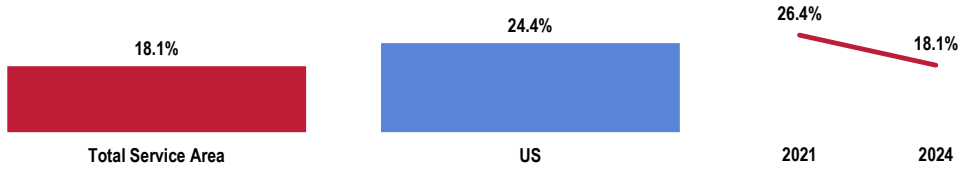
PRC SURVEY ► "Now thinking about your mental health, which includes stress, depression, and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
Notes: ● Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

Total Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 77]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Depression

Diagnosed Depression

PRC SURVEY ► “Has a doctor, nurse, or other health professional ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

Have Been Diagnosed With a Depressive Disorder

Total Service Area

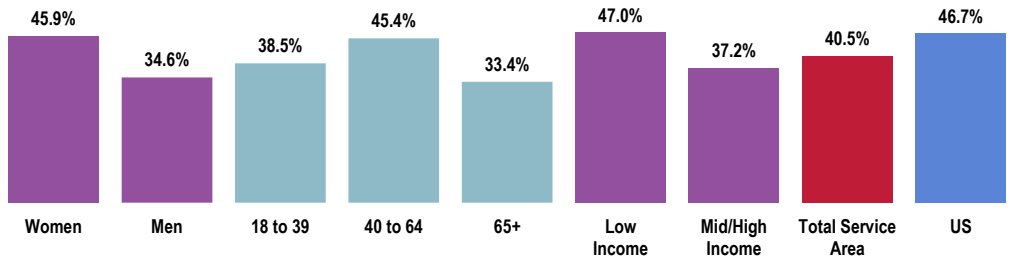
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 80]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Depressive disorders include depression, major depression, dysthymia, or minor depression.

Symptoms of Chronic Depression

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

Have Experienced Symptoms of Chronic Depression
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 78]
- 2023 PRC National Health Survey, PRC, Inc.

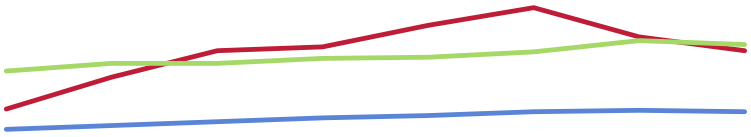
Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population. [COUNTY-LEVEL DATA]

Refer to "Leading Causes of Death" for an explanation of the use of age-adjusting for these rates.

Suicide: Age-Adjusted Mortality Trends
(Annual Average Deaths per 100,000 Population)
Healthy People 2030 = 12.8 or Lower

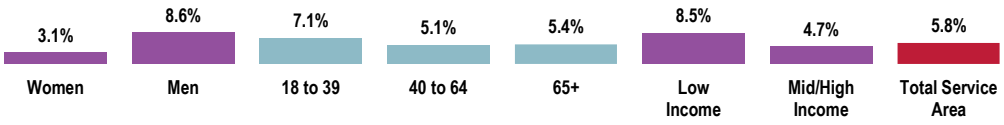


	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	14.1	16.6	18.7	19.0	20.7	22.1	19.8	18.7
OR	17.1	17.7	17.7	18.1	18.2	18.6	19.5	19.2
US	12.5	12.8	13.1	13.4	13.6	13.9	14.0	13.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

PRC SURVEY ▶ "Has there been a time in the past 12 months when you thought of taking your own life?"

Suicide Ideation
(Total Service Area, 2024)



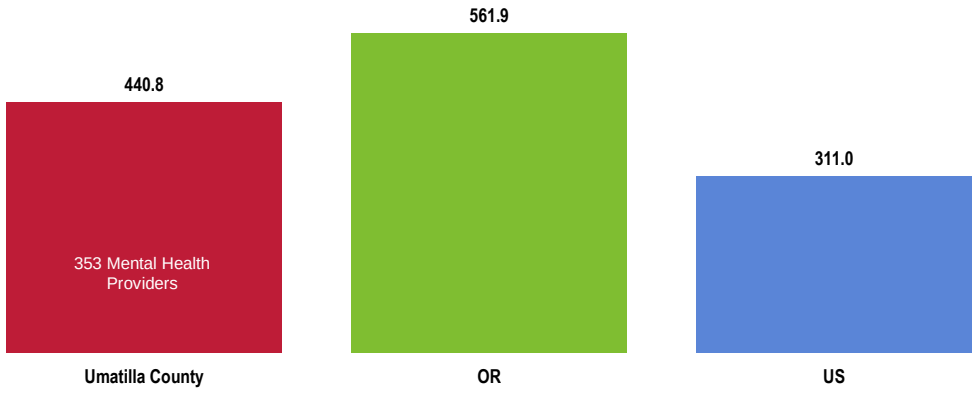
Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 304]
Notes: ● Asked of all respondents.

Mental Health Treatment

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

Note that this indicator only reflects providers practicing within the study area and residents within the study area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

Number of Mental Health Providers per 100,000 Population
(2024)

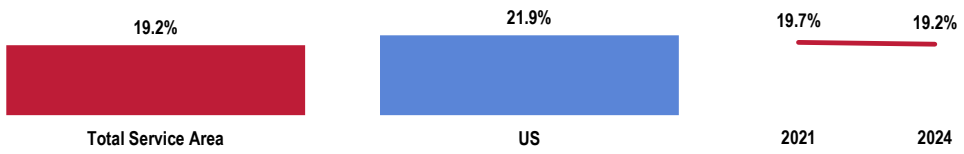


Sources: ● Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
● Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).
Notes: ● This indicator reports the rate of the county population to the number of mental health providers, including psychiatrists, psychologists, clinical social workers, and counselors that specialize in mental health care.

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

Currently Receiving Mental Health Treatment

Total Service Area



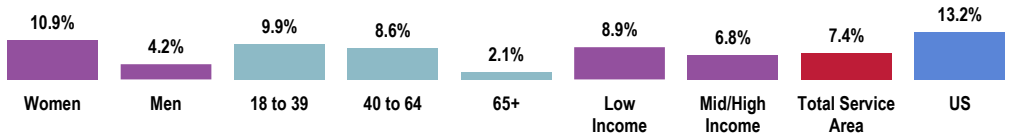
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 81]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes those now taking medication or otherwise receiving treatment for any type of mental health condition or emotional problem.

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

Unable to Get Mental Health Services When Needed in the Past Year

(Total Service Area, 2024)

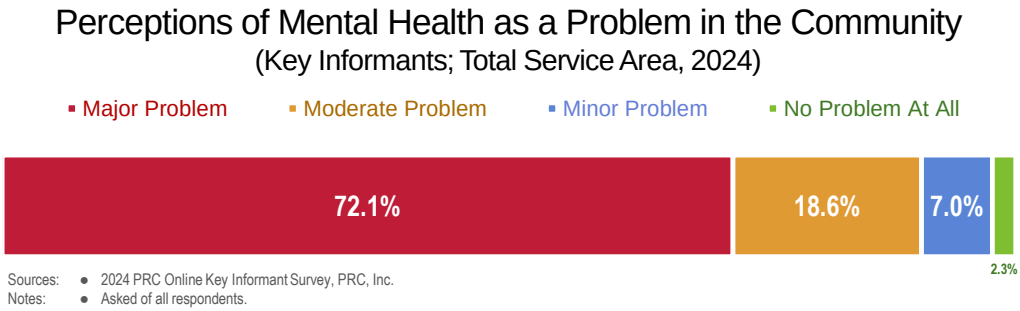


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 82]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Key Informant Input: Mental Health

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



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

Access to Care/Services

> Mental health is a national epidemic. The local issue is the lack of services. Services are again after-the-fact services and there is little time for preventative services. There are limited people with the correct alphabet soup behind their names to diagnose and provide high-end treatments. – Community Leader
>
> Access to mental health providers. – Social Services Provider
>
> To get in to see specialists. The biggest challenge is the lack of mental health resources, especially those that are appropriate for children and teens. Long wait times for suicidal youth and others in mental crisis. Lack of inpatient treatment options for mental health. Parents, families, schools all need these critical resources to be able to function properly. – Community Leader
>
> Access to mental health care can be challenging. Patients are subject to long wait times to receive the necessary services/assessments that they need. For some patients, by the time they receive services the immediate need is no longer prevalent. – Other Health Provider
>
> Access to meaningful services. There is a lack of providers throughout eastern Oregon. Of those serving the area, some only offer virtual services, which not everyone wants to participate in. – Social Services Provider
>
> Access to care. It is at least six months before someone can obtain an appointment/assessment. People have nowhere to go. – Social Services Provider
>
> The ability to get seen for an assessment in a timely manner. And then, when you do get seen, the care you receive is not trauma-informed. – Other Health Provider
>
> The biggest issues are i9s, lack of access to culturally and linguistically (both and not with interpreters!) mental health care. Then, lack of access to even basic mental health care. Then, feelings of discrimination against immigrants and refugees – their employers might have them removed from their jobs even if they seek out basic mental health support. Lastly, used to be a taboo among Latino-Hispanic and Indigenous communities – however, that has been overcome because of the need, it is getting huge, including the need for youth/young adults is growing. – Other Health Provider
>
> Getting access to the type of provider they need that takes their insurance, or the cost if you pay out of pocket. Finding someone who specializes in child psychology. Having the resources to manage daily mental health concerns. – Community Leader
>
> We have severe mental health problems in our community and not enough resources. There are huge waitlists to begin services and once you get in you are lucky to be seen once per month which is not enough to manage much less treat a mental illness. Clinicians are required to carry unmanageable caseloads that makes it impossible to provide the level of care they wish they could and that their clients need. Children are struggling more and more with mental health and schools are not equipped to handle the issues arising. Statewide there are very few resources available for inpatient care. People in our area must travel hours to get to any facility. – Social Services Provider
>
> Access to care, Asmts, ISSP, care, and following care recommendations. – Other Health Provider
>
> Receiving acute interventions when not in "full crisis", but are in a heightened level of concern with managing their anxiety or mental health issues. Often these patients have to wait weeks before they are able to see a provider. By then, they are in a full crisis and are being held in the emergency room. Also, a concern for bed space for patients who need inpatient treatment. These patients spend days in the emergency department which is often not a therapeutic environment that is equipped at meeting their needs. – Other Health Provider
>
> Extreme lack of access to mental health care, especially pediatric mental health care. – Other Health Provider

Access to timely and adequate care. Barriers like stigma, some don't seek help for fear of judgment, financial challenges, long wait times for services, and some don't recognize the symptoms. Managing mental health also requires ongoing care, support networks, and lifestyle adjustments, which can be difficult for some either for lack of resources or family support. – Other Health Provider

Lack of resources, over capacity, drugs, lack of housing, no permanent resources beyond crisis help. Even then there is not enough help for those who are even in crisis. – Other Health Provider

People experiencing mental health crises are limited to an on-call service and long waits for clinicians. – Social Services Provider

Timely access to care. – Physician

Access to a mental health provider. – Other Health Provider

Access to care, continuity of care. – Physician

Not enough resources to treat and house persons with mental health issues. – Community Leader

Lack of resources, lack of providers, lack of inpatient or respite facilities. Difficult state laws. – Other Health Provider

There is very limited care for mental health and no treatment centers locally. PTs become housed in the Emergency Departments for safety until the appropriate care becomes available. Usually miles away. – Other Health Provider

Lack of quality services, lack of inpatient beds. Patients put into emergency rooms instead of taken to jail when it's appropriate. – Other Health Provider

Lack of Providers

Lack of qualified counselors. – Community Leader

Shortage of providers. – Other Health Provider

There are no local psychiatrists or therapists just counseling. And this is even very limited and have a long wait list. – Social Services Provider

Lack of Behavioral Health clinicians /therapists and medication prescribers in the area. Long wait times to establish care. – Other Health Provider

Pendleton lacks an adequate amount of providers and facilities for mental health services. – Community Leader

Lack of mental health providers especially those who are able to provide culturally appropriate MH services. Long wait times for appointments and between appointments. Fragmented system- people with mental health issues being incarcerated and being released and going back to same lifestyle (cycle). – Social Services Provider

Very limited availability of counselors and mental health prescribers. – Physician

No psychiatrists in the area. – Physician

Lack of qualified mental health care professionals that can prescribe medication. Finding a provider that takes state insurance has been a problem. – Social Services Provider

Denial/Stigma

Stigma, limited access, limited secondary factors to maintain healthy habits. – Other Health Provider

The culture in the community makes it stigmatizing to have mental health issues. – Social Services Provider

Aging Population

Loneliness and social isolation in older adults can significantly impact their health, increasing the risk of various physical and mental health issues like heart disease, depression, cognitive decline, weakened immune system, anxiety, and even premature death; essentially, a lack of social connection can be detrimental to overall well-being and quality of life in older individuals. – Social Services Provider

For older adults who have some of the highest percentage of those living with depression, access to mental health resources is limited because of number of providers who will take Medicare. That means at least a fifth of the population in Umatilla County has limited access to mental health providers. – Social Services Provider

Cell Phone/Technology Addiction

Cell phones and technology addiction among youth and adults. This issue effects parenting and the mental and emotional health of our children and everyone. This new challenge is not being talked about enough. – Community Leader

Access to Care for Medicaid Patients

For the Medicaid population, it is getting an assessment done. Our CMHP is understaffed and wait times are long. Lack of providers for medication management. – Social Services Provider

Due to COVID-19

> There has been such a huge increase in mental health issues especially since COVID, it is really disturbing. And due to this there is a huge increase in homeless population in our area as well. – Other Health Provider

Lifestyle

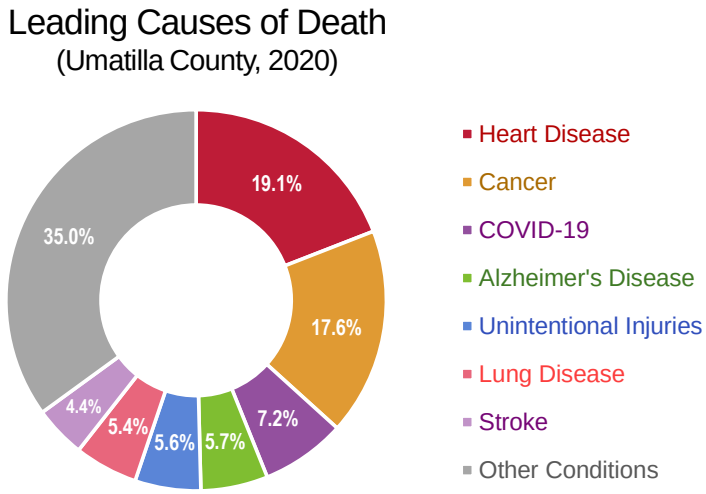
> Using it as an excuse to do whatever they want without consequences. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

Leading Causes of Death

Distribution of Deaths by Cause

The following outlines leading causes of death in the community. [COUNTY-LEVEL DATA]



Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
Notes: ● Lung disease includes deaths classified as chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

AGE-ADJUSTED DEATH RATES

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

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

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

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

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death. [COUNTY-LEVEL DATA]

Age-Adjusted Death Rates for Selected Causes

(2018-2020 Deaths per 100,000 Population)

	Umatilla County	OR	US	Healthy People 2030
Cancers (Malignant Neoplasms)	153.8	147.1	146.5	122.7
Heart Disease	145.9	131.1	164.4	127.4*
Falls [Age 65+]	84.4	104.1	67.1	63.4
Unintentional Injuries	54.7	47.2	51.6	43.2
Lung Disease (Chronic Lower Respiratory Disease)	47.2	36.0	38.1	—
Alzheimer's Disease	44.1	36.6	30.9	—
Stroke (Cerebrovascular Disease)	33.3	39.3	37.6	33.4
Diabetes	30.7	23.4	22.6	—
Cirrhosis/Liver Disease	19.6	12.4	12.5	10.9
Suicide	18.7	19.2	13.9	12.8
Motor Vehicle Deaths	16.8	11.1	11.4	10.1
Pneumonia/Influenza	12.9	8.8	13.4	—
Kidney Disease	9.8	7.4	12.8	—
Alcohol-Induced Deaths	9.7	14.0	11.9	—
Unintentional Drug-Induced Deaths	8.9	11.3	19.9	—
Homicide [2011-2020]	5.4	2.9	5.9	5.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Note:
- *The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cardiovascular Disease

ABOUT HEART DISEASE & STROKE

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

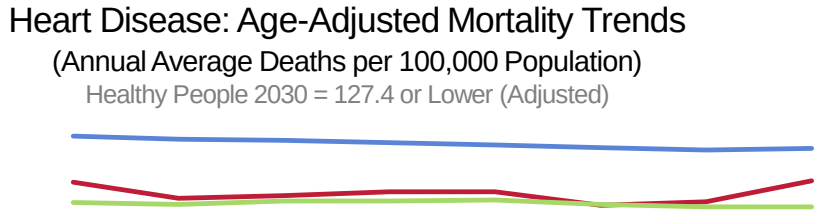
In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they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

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

Age-Adjusted Heart Disease & Stroke Deaths

The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community. [COUNTY-LEVEL DATA]

The greatest share of cardiovascular deaths is attributed to heart disease.



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	145.1	136.0	137.5	139.6	139.7	132.0	134.1	145.9
OR	133.6	132.5	134.4	134.4	135.0	132.5	131.1	131.1
US	171.3	169.6	168.9	167.5	166.3	164.7	163.4	164.4

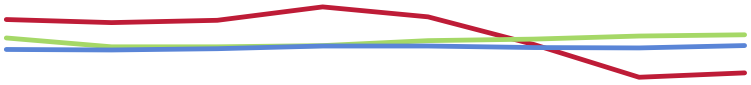
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- The Healthy People 2030 coronary heart disease target is adjusted here to account for all diseases of the heart.

Stroke: Age-Adjusted Mortality Trends

(Annual Average Deaths per 100,000 Population)

Healthy People 2030 = 33.4 or Lower



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	41.7	41.2	41.6	43.7	42.1	37.8	32.6	33.3
OR	38.8	37.4	37.4	37.6	38.4	38.6	39.1	39.3
US	37.0	36.9	37.1	37.5	37.5	37.3	37.2	37.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Prevalence of Heart Disease & Stroke

PRC SURVEY ► "Have you ever suffered from or been diagnosed with heart disease, including heart attack or myocardial infarction, angina, or coronary heart disease?"

Prevalence of Heart Disease

Total Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 22]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

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

PRC SURVEY ► "Have you ever suffered from or been diagnosed with a stroke?"

Prevalence of Stroke

Total Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 23]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cardiovascular Risk Factors

Blood Pressure & Cholesterol

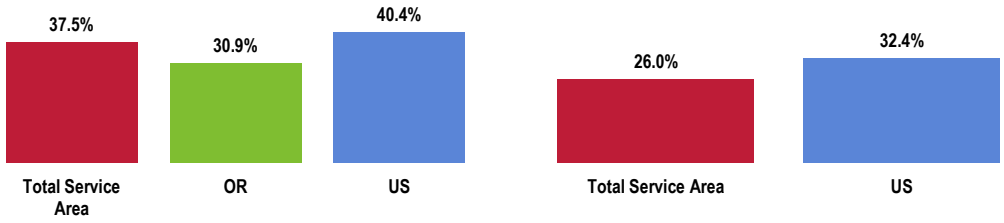
PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?"

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

Prevalence of High Blood Pressure

Healthy People 2030 = 42.6% or Lower

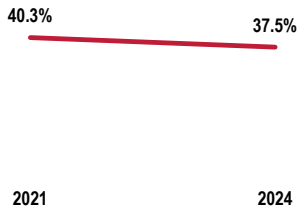
Prevalence of High Blood Cholesterol



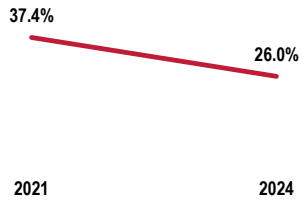
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Prevalence of
High Blood Pressure
(Total Service Area)
Healthy People 2030 = 42.6% or Lower



Prevalence of
High Blood Cholesterol
(Total Service Area)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 29-30]
● US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: ● Asked of all respondents.

Total Cardiovascular Risk

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

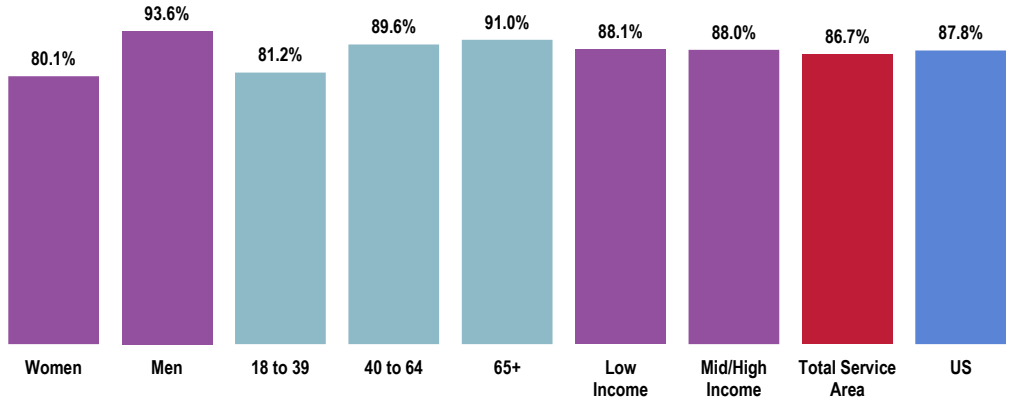
- High Blood Pressure
- High Blood Cholesterol
- Cigarette Smoking
- Physical Inactivity
- Overweight/Obesity

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

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

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

Exhibit One or More Cardiovascular Risks or Behaviors
(Total Service Area, 2024)



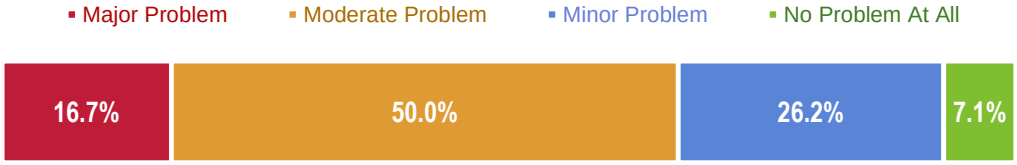
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 100]
- 2023 PRC National Health Survey, PRC, Inc.

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

Key Informant Input: Heart Disease & Stroke

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

Perceptions of Heart Disease & Stroke as a Problem in the Community
(Key Informants; Total Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Access to Care/Services

> We have no providers to treat these types of patients. People must travel to Walla Walla or Tri Cities to receive treatment. Transportation is a barrier for some patients, especially those on Medicare. I believe some people who need these types of treatments don't receive them due to transportation barriers. – Social Services Provider
>
> The people we know who have heart disease are having to drive an hour or more out of town to receive guidance and treatment. – Community Leader
>
> There are no resources for individuals. If they have a heart problem or stroke, they are taken to a hospital hours away and continual care is often managed by doctors out of the area. There are limited resources for nutrition and exercise. The cost of healthy foods keeps going up and the resources miss populations of people who have needs. – Social Services Provider

Obesity

> Have seen an increase in strokes and heart disease possibly due to obesity. – Community Leader
>
> We have a lot of overweight people in the communities and heart disease and diabetes go together often. – Social Services Provider

Vulnerable Populations

> It is well known and registered regarding to Social Determinants of Health & Equity (SDH-E) as a huge issue among Latino-Hispanic and Indigenous populations in Eastern Oregon. Housing, health care, health prevention, education opportunities, risk of being homeless, and proper jobs among others. Besides have been living for a long time with other pre-issues of heart disease such as hypertension – even young people and diabetes too! Issues regarding lack of formal documentation prevent many getting better jobs and treatments for prevention. Pregnant mothers, who might not be diagnosed in early stages of pregnancy or there are possible issues with their babies might been going with these issues longer than to prevent a death. – Other Health Provider

Diagnosis/Treatment

> These are major problems because of the lack of early treatment and diagnosis, due to long waitlists to see a doctor. – Social Services Provider

Environmental Contributors

> There is a large influx of patients who have heart disease and stroke in our area. Possibly due to environmental stressors or due to diet. – Other Health Provider

Incidence/Prevalence

> Heart disease and stroke are regular factors in worsening conditions for OPI consumers and their moving to APD services. – Social Services Provider

Cancer

ABOUT CANCER

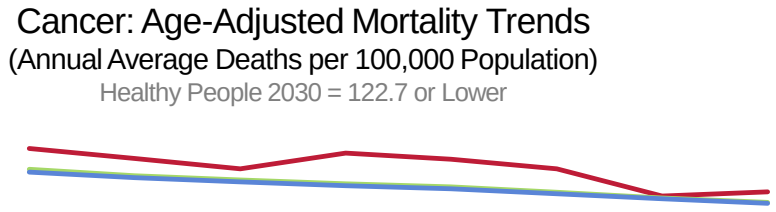
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are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

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

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

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types). [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	181.1	174.8	168.2	178.1	174.4	168.3	151.1	153.8
OR	168.0	163.9	161.3	158.8	156.8	153.6	149.9	147.1
US	166.2	162.7	160.1	157.6	155.6	152.5	149.3	146.5

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Lung cancer is by far the leading cause of cancer deaths. [COUNTY-LEVEL DATA]

Age-Adjusted Cancer Death Rates by Site
(2018-2020 Annual Average Deaths per 100,000 Population)

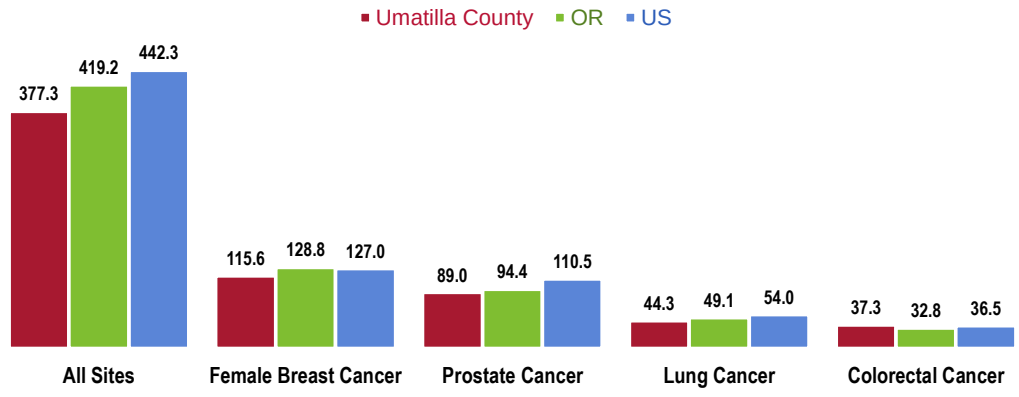
	Umatilla County	OR	US	HP2030
ALL CANCERS	153.8	147.1	146.5	122.7
Lung Cancer	30.9	31.6	33.4	25.1
Colorectal Cancer	17.7	12.3	13.1	8.9
Female Breast Cancer	16.8	18.9	19.4	15.3
Prostate Cancer	14.1	19.7	18.5	16.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. It is usually expressed as cases per 100,000 population per year. [COUNTY-LEVEL DATA]

Cancer Incidence Rates by Site
(Annual Average Incidence per 100,000 Population, 2016-2020)

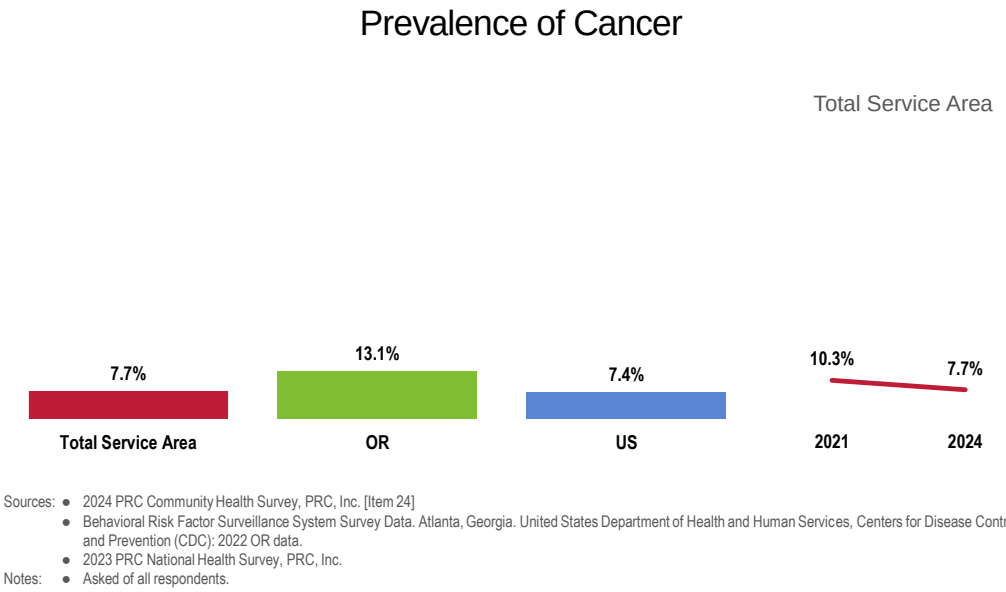


Sources:
- National Cancer Institute, State Cancer Profiles.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the ncidence rate (cases per 100,000 population per year) of cancers.

Prevalence of Cancer

PRC SURVEY ► "Have you ever suffered from or been diagnosed with cancer?"



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 24]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 45 years and continuing until age 75 years.

– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.

Screening levels in the community were measured in the PRC Community Health Survey relative to the following cancer sites:

Breast Cancer Screening

PRC SURVEY ► "A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?"

Breast cancer screening is calculated here among women age 50 to 74 who indicate mammography within the past 2 years.

Cervical Cancer Screening

PRC SURVEY ► "A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?"

[If Pap test in the past five years] **"HPV, or the human papillomavirus, is a common infection that can cause several types of cancer. When you received your last Pap test, were you screened for HPV?"**

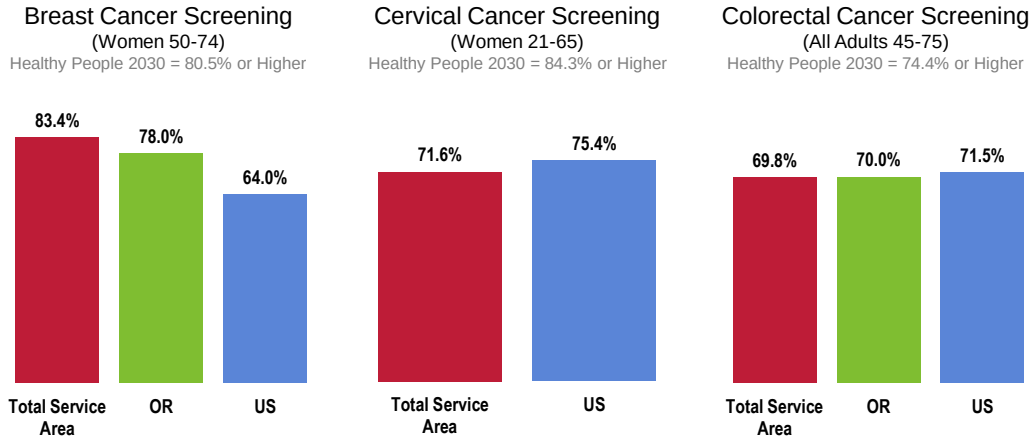
"Appropriate cervical cancer screening" includes Pap smear testing (cervical cytology) every three years in women age 21 to 29 and Pap smear testing and/or HPV testing every 5 years in women age 30 to 65.

Colorectal Cancer Screening

PRC SURVEY ► "Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?"

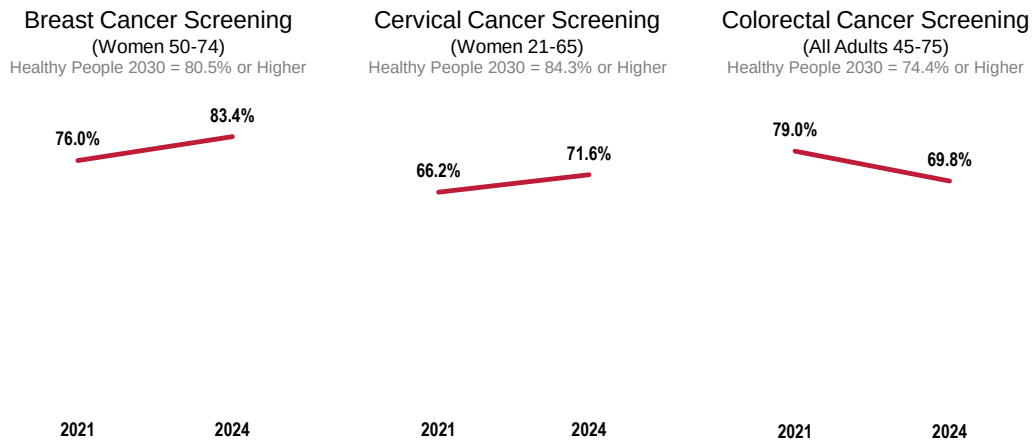
PRC SURVEY ► "A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?"

"Appropriate colorectal cancer screening" includes adults age 45 to 75 with a fecal occult blood test within the past year and/or lower endoscopy (sigmoidoscopy or colonoscopy) within the past 10 years.



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that state and national data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

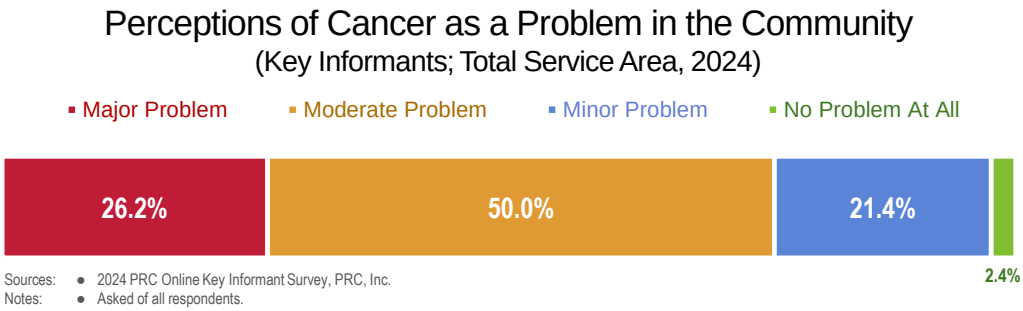


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 101-103]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Each indicator is shown among the gender and/or age group specified.
- Note that trend data for colorectal cancer screening reflect the age group (50 to 75) of the previous recommendation.

Key Informant Input: Cancer

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



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Incidence/Prevalence

> Cancer is a significant problem in our community because it affects millions of lives each year, causing significant physical, emotional, and financial burdens. Early detection and treatment can be challenging due to limited healthcare access for some, while others face high costs for care they can't afford. – Other Health Provider
>
> There is a large influx of patients who have cancer in our area. – Other Health Provider
>
> I see people every day of all ages being diagnosed with cancer. I do not have data, but especially in our small communities, it seems like if you were to run a statistical analysis, it would be a very large percentage per capita. The amount of young people being diagnosed and dying of cancer seems to be growing exponentially. There are limited resources for diagnosis and treatment and many people end up many hours away from home to seek services. – Social Services Provider

Access to Care/Services

> Available resources. – Other Health Provider
>
> So many people are receiving diagnosis of cancer and have the services and supports are not enough to meet the need. – Social Services Provider
>
> Cancer care means in most cases treatment outside the region. This is an added cost and barrier for patients and families. Each time we have an added barrier we see a higher death rate. – Community Leader

Awareness/Education

> Cancer is a disease not well learned and let alone discussed among our communities. There are major issues about accessing health care prevention as true means for preventing cancer. – Other Health Provider

Diagnosis/Treatment

> Cancer is a problem because of the access to early diagnosis. People are put on waiting lists to receive treatment and see a doctor. This can be up to six months long, which is too long with cancer. – Social Services Provider

Prevention/Screenings

> In the last 6 months our team has seen an increase in persons who are diagnosed in late-stage cancer with metastasis. At the time of diagnosis, it is too late for treatment, and they have been sent straight into hospice. They either had no care or limited care (ER or urgent care visits) during the pandemic and a poor history of well health exams, cancer screenings or routine labs. Routine cancer screenings have significantly declined when compared to pre-pandemic vs post-pandemic. – Public Health Representative

Respiratory Disease

ABOUT RESPIRATORY DISEASE

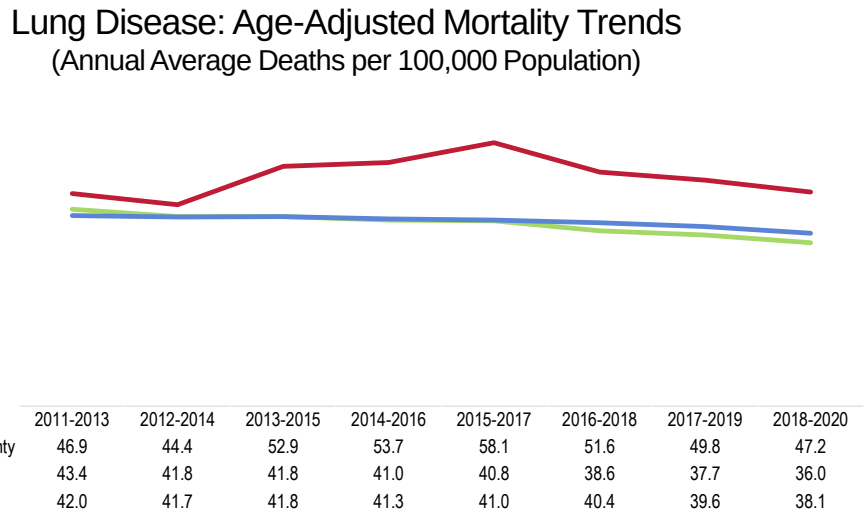
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million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

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

Age-Adjusted Respiratory Disease Deaths

Lung Disease

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



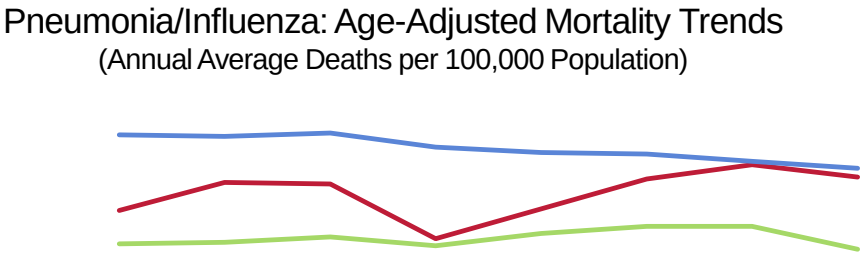
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	46.9	44.4	52.9	53.7	58.1	51.6	49.8	47.2
OR	43.4	41.8	41.8	41.0	40.8	38.6	37.7	36.0
US	42.0	41.7	41.8	41.3	41.0	40.4	39.6	38.1

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.

Notes:
- Here, lung disease reflects chronic lower respiratory disease (CLRD) deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Pneumonia/Influenza

Pneumonia and influenza mortality is illustrated here. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	11.0	12.6	12.5	9.4	11.1	12.8	13.6	12.9
OR	9.1	9.2	9.5	9.0	9.7	10.1	10.1	8.8
US	15.3	15.2	15.4	14.6	14.3	14.2	13.8	13.4

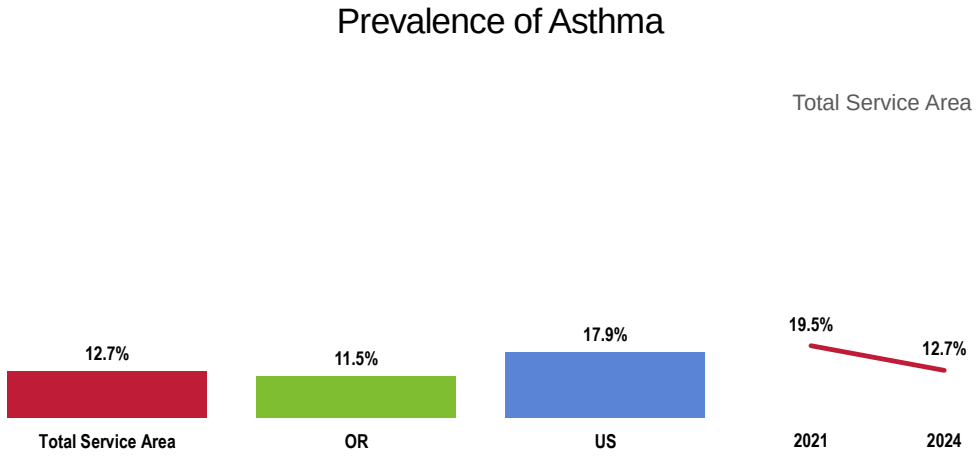
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Respiratory Disease

Asthma

PRC SURVEY ► "Do you currently have asthma?"



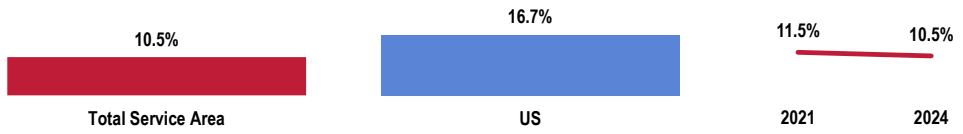
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 26]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

PRC SURVEY ► "Has a doctor, nurse, or other health professional ever told you that this child had asthma?"

Prevalence of Asthma in Children
(Children 0-17)

Total Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 92]
- 2023 PRC National Health Survey, PRC, Inc.

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

Chronic Obstructive Pulmonary Disease (COPD)

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

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

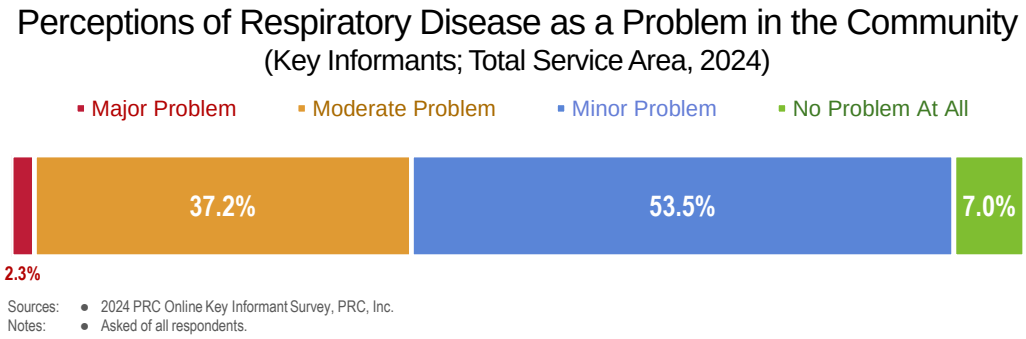
Total Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 21]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- Includes conditions such as chronic bronchitis and emphysema.

Key Informant Input: Respiratory Disease

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



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

COVID-19

> Respiratory diseases have grown significantly with and during the COVID-19 pandemic. Beyond that, the "long COVID" has brought an extra burden over our communities who might have gotten COVID-19 more than once – either because of age (children and or over 65) and because our communities live in multigenerational families with 5-6 to 10-12 people in each house or apartment. Besides, the RSV has grown after COVID-19 and the most affected are the vulnerable communities such as Latino-Hispanic and Indigenous who might not have access to health care, hardness to drive to doctor appointments, and other issues. – Other Health Provider

Environmental Contributors

> Many persons have asthma, and I think some of it is caused from the chemicals used in farming and agriculture. Many pesticides are being used and they are in the air we breathe. Umatilla Chemical Depot, Hanford. – Social Services Provider

Access to Care/Services

> There are limited resources for respiratory therapists. Most people have to travel out of state. – Social Services Provider

Injury & Violence

ABOUT INJURY & VIOLENCE

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

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

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

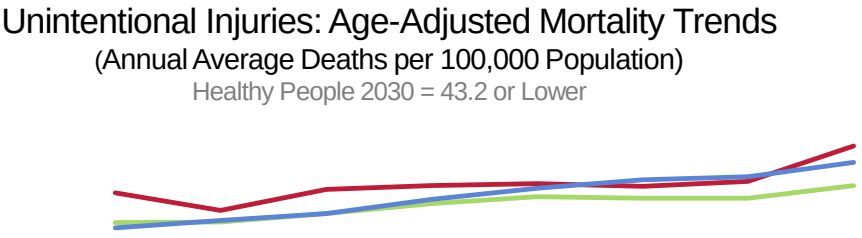
Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

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

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the area. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	45.8	42.5	46.5	47.2	47.6	47.1	48.0	54.7
OR	40.2	40.3	41.9	43.8	45.1	44.8	44.8	47.2
US	39.2	40.6	41.9	44.6	46.7	48.3	48.9	51.6

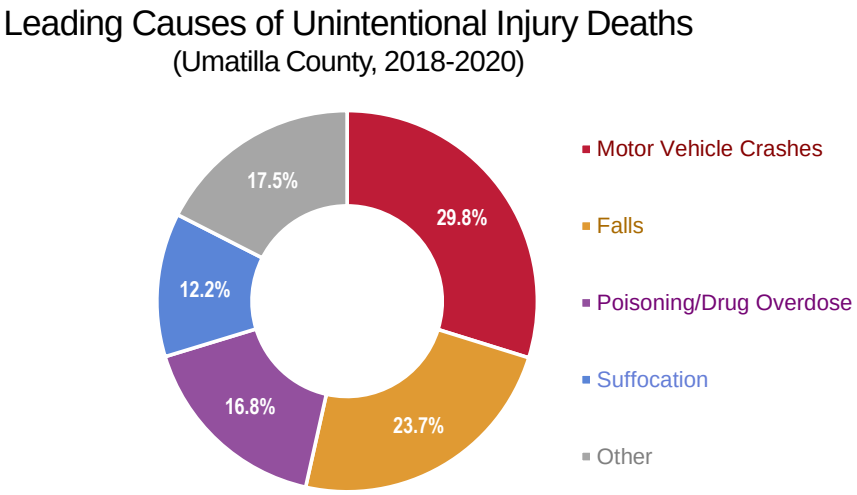
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Leading Causes of Unintentional Injury Deaths

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

The following outlines leading causes of accidental death in the area. [COUNTY-LEVEL DATA]



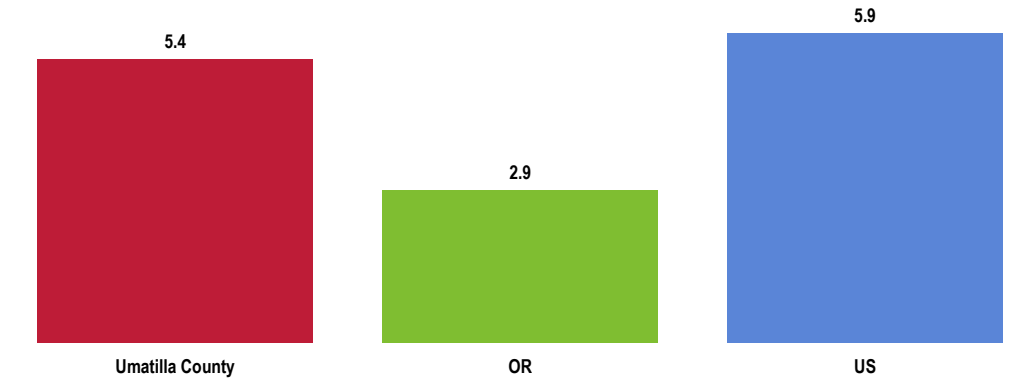
Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.

Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.

Age-adjusted mortality attributed to homicide is shown in the following chart. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted 2E-DATE.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

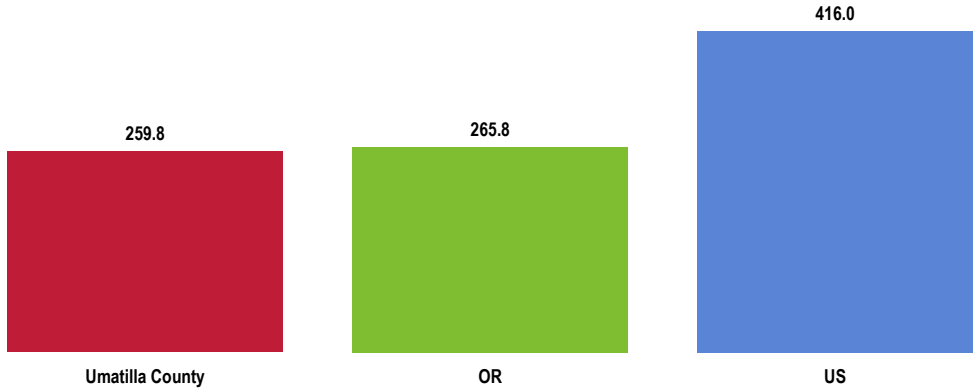
Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent Crime

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

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

Violent Crime Rate
(Reported Offenses per 100,000 Population, 2015-2017)



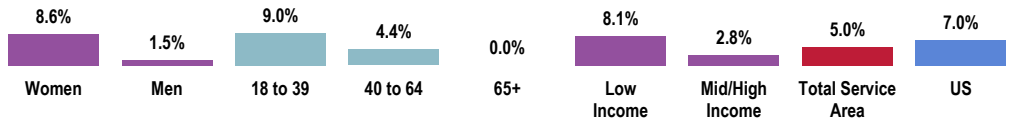
Sources:
- Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

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

Violent Crime Experience

PRC SURVEY ► "Thinking about your own personal safety, have you been the victim of a violent crime in your area in the past 5 years?"

Victim of a Violent Crime in the Past Five Years
(Total Service Area, 2024)



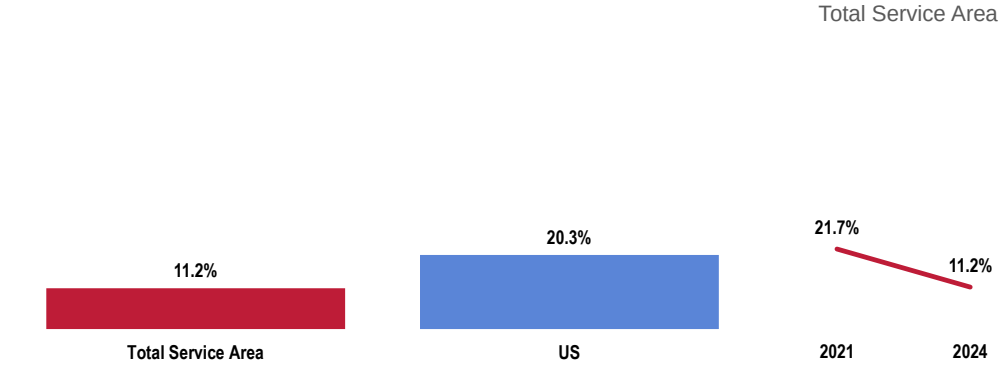
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 32]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

Intimate Partner Violence

PRC SURVEY ► "The next question is about violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?"

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

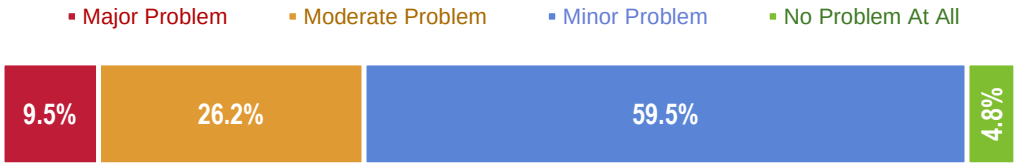


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 33]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Injury & Violence

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

Perceptions of Injury & Violence as a Problem in the Community
(Key Informants; Total Service Area, 2024)



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Access to Care/Services

> Injury and violence are problems due to the lack of wraparound resources. – Social Services Provider
>
> There are limited services available and in most cases, you are sent to Portland or Spokane. This is so common that most people carry LifeFlight coverage, and they have added more transportation stations. Our medical facilities have turned in to triage centers. – Community Leader

Gang Violence

> There is a lot of gang activity and with that brings violence. – Social Services Provider
>
> I believe due to increase in gang activity as well as substance abuse this is leading to a major increase in violence. – Other Health Provider

Alcohol/Drug Use

> The amount of criminal, drug, and mental health issues in our community drive up violence and injury. We also have always struggled with alcohol related injury and violence. – Social Services Provider

Diabetes

ABOUT DIABETES

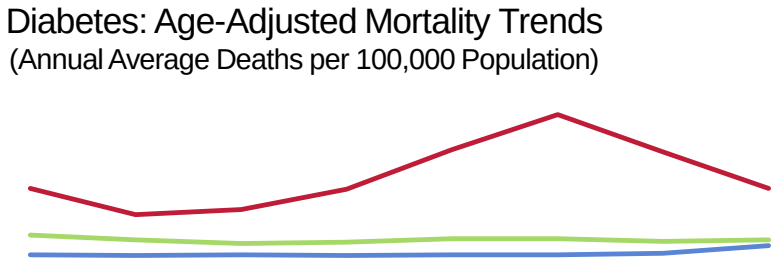
More than 30 million people in the United States have diabetes, and it's the seventh leading cause of death. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

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

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

Age-Adjusted Diabetes Deaths

Age-adjusted diabetes mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]



	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	30.7	27.0	27.7	30.6	36.2	41.2	35.9	30.7
OR	24.1	23.4	22.9	23.1	23.6	23.6	23.2	23.4
US	21.3	21.2	21.3	21.2	21.3	21.3	21.5	22.6

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Prevalence of Diabetes

PRC SURVEY ► "Have you ever been told by a doctor, nurse, or other health professional that you have diabetes, not counting diabetes only occurring during pregnancy?"

PRC SURVEY ► "Other than during pregnancy, have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes?"

Prevalence of Diabetes

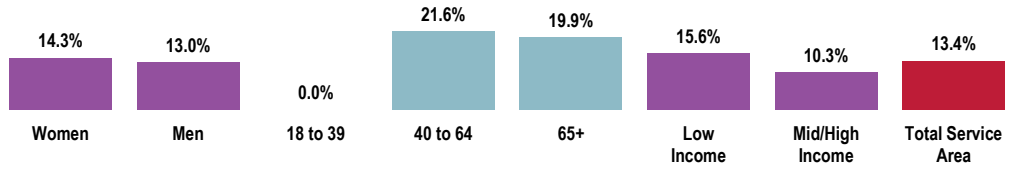
Another 10.8% of adults have been diagnosed with "pre-diabetes" or "borderline" diabetes.

Total Service Area

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 106]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Prevalence of Diabetes
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 106]

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

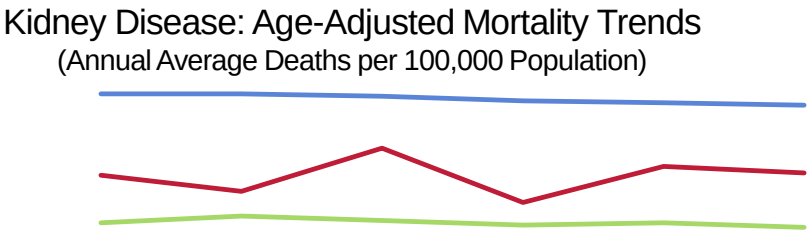
Age-Adjusted Kidney Disease Deaths

ABOUT KIDNEY DISEASE & DIABETES

Chronic kidney disease (CKD) is common in people with diabetes. Approximately one in three adults with diabetes has CKD. Both type 1 and type 2 diabetes can cause kidney disease. CKD often develops slowly and with few symptoms. Many people don't realize they have CKD until it's advanced and they need dialysis (a treatment that filters the blood) or a kidney transplant to survive.

– Centers for Disease Control and Prevention (CDC)
https://www.cdc.gov/diabetes/managing/diabetes-kidney-disease.html

Age-adjusted kidney disease mortality for the area is shown in the following chart. [COUNTY-LEVEL DATA]

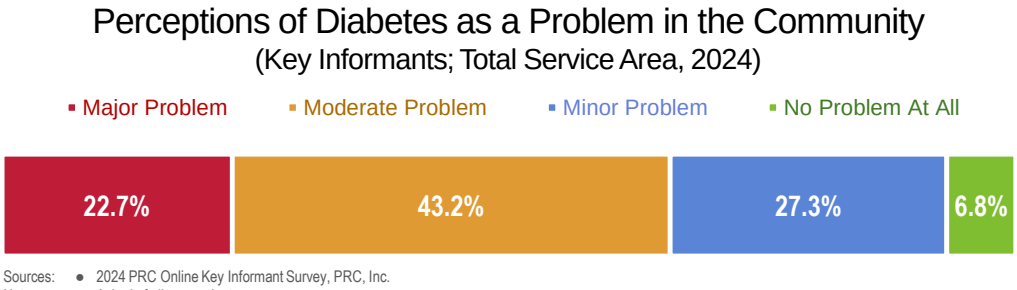


	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	9.7	9.0	10.9	8.5	10.1	9.8
OR	7.6	7.9	7.7	7.5	7.6	7.4
US	13.3	13.3	13.2	13.0	12.9	12.8

Sources: ● CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.
Notes: ● Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
● Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Key Informant Input: Diabetes

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



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Awareness/Education

> Education in prevention and treatment. – Social Services Provider
>
> Many people do not understand how to holistically address diabetes. The may understand how to measure their blood sugar, but not what foods will cause their blood sugar to spike. I recently heard someone say “I've had diabetes for 15 years and I just learned that I should see an endocrinologist.” – Other Health Provider
>
> Education in which people understand their diabetes and take it seriously. – Community Leader
>
> Access to education and healthy food. Affordability of dietician and medications. – Physician
>
> The lack of understanding of how it affects the body as a whole. – Other Health Provider
>
> Understanding what a nutritious meal is. Affordability of nutritious food. The link between exercise, BMI, food quality, and diabetes. – Social Services Provider

Access to Care/Services

> Access to care and following care recommendations. – Other Health Provider
>
> Access to care and social/environmental conditions that support management of the disease. Also equitable access to prevention education. – Public Health Representative
>
> Limited resources for getting and staying active. – Community Leader

Lack of Providers

> There are not many endocrinologists available in our area. We have one in our immediate area that takes most insurance, otherwise folks will have to travel out of the area to seek help. – Other Health Provider
>
> Lack of primary care, cost of insulin and supplies. – Other Health Provider
>
> No access to an endocrinologist in Pendleton and only one in Hermiston. PCPs are trying to manage diabetes but do a poor job of it. Talking with an endocrinologist you learn about diabetes and why doing certain things is important. Such as why you take a short-term insulin before meals and a long-term insulin before bed. Why it is important to have a consistent blood sugar reading. What exactly is A1C and why is it so important to maintain it at a certain level. PCPs do a poor job of explaining the why. – Social Services Provider

Diet & Exercise

> Diet & exercise. Fear, medications, food insecurity, access to healthy foods, knowledge of healthy food. It starts with the school system lunches which establishes eating patterns for children as they grow to young adults. Please look at their menu. Also local food pantries! Do providers know how to counsel person receiving commodities or food boxes or buying food with SNAP benefits? Persons living in low income situations have voiced how they feel a healthy diet is out of reach because it is expensive, and they don't know how to cook with all the fruits, veggies or whole wheat products. Exercise: if they feel like they can't win they won't do it. Exercise options need to be done in a playful way, not just gym. Fear: Alot of folks voice how they’re afraid to die of amputation complications. Medications: They make them feel horrible and little or no support. CHWs can help give support. Also need options besides just meds. – Public Health Representative
>
> Poor understanding of nutrition and not enough resources for physical activity in the community—no public pool where exercise classes and swim lessons can be taught. Few safe areas for walking—the Riverwalk and even some neighborhoods in town have many vagrants with addiction and mental health issues. – Community Leader

Disease Management

> Managing their blood sugar levels consistently. Many face difficulty accessing affordable healthcare, medication, and education on the disease. Also, the possible complications, heart disease, kidney failure, and liver damage, adds emotional and physical strain to people living with diabetes. – Other Health Provider
>
> The biggest challenge would be in managing their own secondary traits of health risk management, maintenance, regular activity. The lack of community programs that bring people together affect their ability to get out and stay healthy. – Other Health Provider

Language

> In fact, Doulas Latinas International is a Recognized CDC Diabetes Prevention Program with three Spanish native’s lifestyle coaches certified in Umatilla and Morrow counties. However, the communities of Hispanic-Latino and Indigenous people need to work too many hours every day, and weekends, to get their needs met. Only when the winter comes, and snow, some of them might be able to get connected with our certified Spanish Doulas Latinas Lifestyle Coaches and 2024 Spanish Cohorts – one already finished; and the Cohort #2 in planned to begin in November/24 through 2025.That includes farmworkers/pregnant mothers who might be at risk already without knowing or not being able to take care of themselves and their babies properly, begging for three good and nutritious meals every day. – Other Health Provider
>
> Education in home language. – Social Services Provider

Denial/Stigma

> There is a huge problem with stigma and discrimination around the topic of diabetes. Many people find it difficult to find the support they need because of these factors. Many of the medical providers seem under informed about current research and understanding of the disease. There are no providers in the area equipped to manage pediatric cases and few who actually manage adults. People must go hours from home to get the care they need. Pharmacies are understaffed and are forced to serve too many people due to pharmacy closures. This creates problems with getting supplies on time. Pharmacies also frequently have supply chain issues. The availability of facilities and programs for exercise and nutrition are limited. The RAC is not well maintained and very expensive making exercise options inaccessible. – Social Services Provider

Nutrition

> Increased poor nutrition has caused an increase in both adult and youth diabetes. Care is not available in our region which is easy to access. – Community Leader

Access to Affordable Healthy Food

> Following recommendations based on lack of cheap food options. – Physician

Affordable Medications/Supplies

> Access to low cost medications, including GLPs and blood sugar monitors. – Physician

Obesity

> We have a huge obesity problem in our community. – Other Health Provider

Prevention/Screenings

> Preventative care. – Community Leader

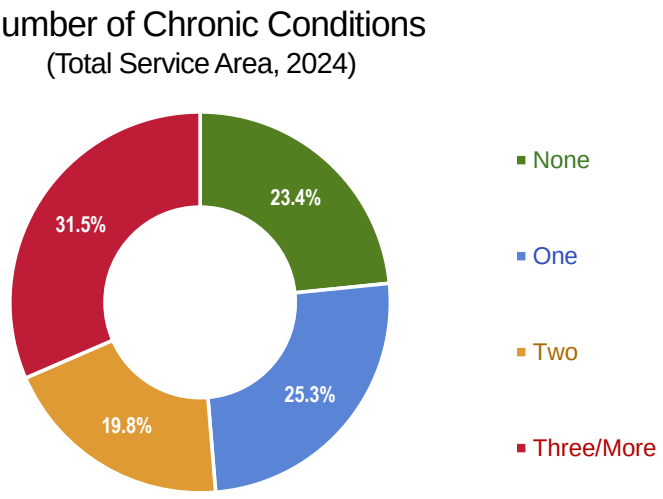
Disabling Conditions

Multiple Chronic Conditions

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

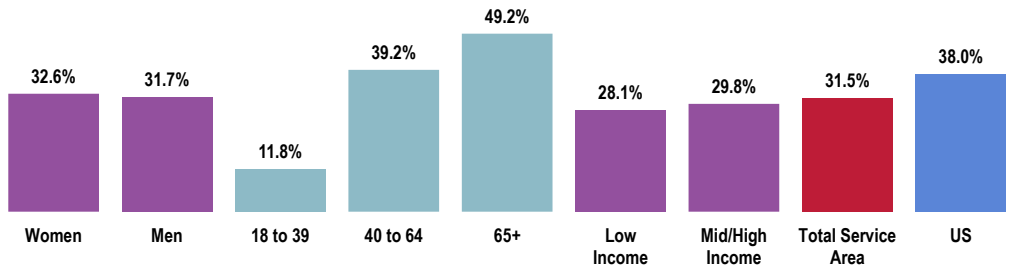
For the purposes of this assessment, chronic conditions include:

- Asthma
- Cancer
- Chronic pain
- Diabetes
- Diagnosed depression
- Heart disease
- High blood cholesterol
- High blood pressure
- Lung disease
- Obesity
- Stroke



Sources: 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
Notes: Asked of all respondents.
In this case, chronic conditions include asthma, cancer, chronic pain, diabetes, diagnosed depression, heart disease, high blood cholesterol, high blood pressure, lung disease, obesity, and stroke.

Have Three or More Chronic Conditions
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 107]
- 2023 PRC National Health Survey, PRC, Inc.

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

Activity Limitations

ABOUT DISABILITY & HEALTH

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

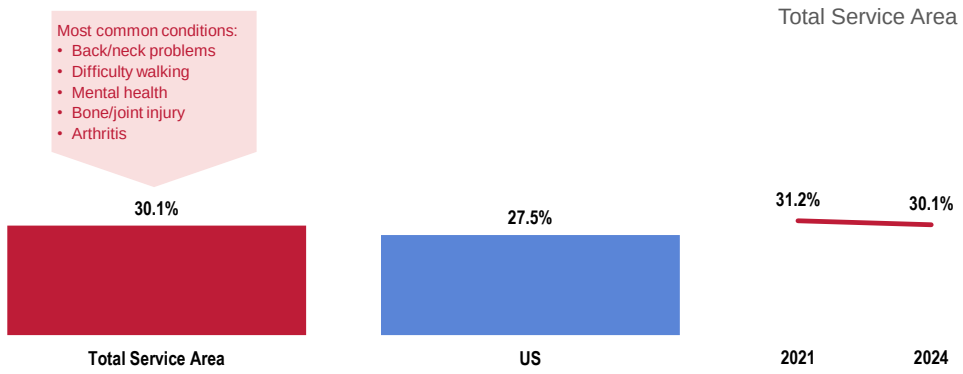
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life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

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

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

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

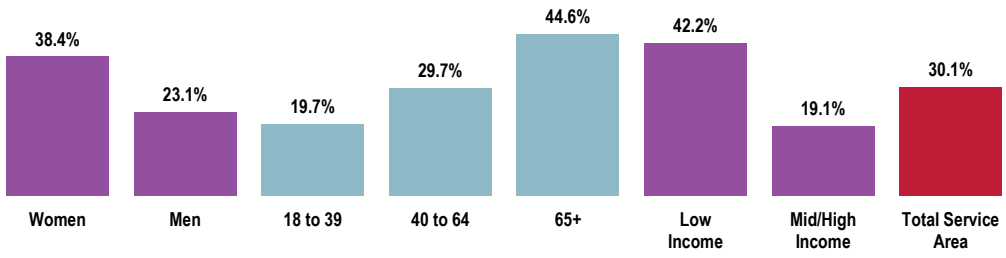
Limited in Activities in Some Way Due to a Physical, Mental, or Emotional Problem



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Items 83-84]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

(Total Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 83]
Notes: ● Asked of all respondents.

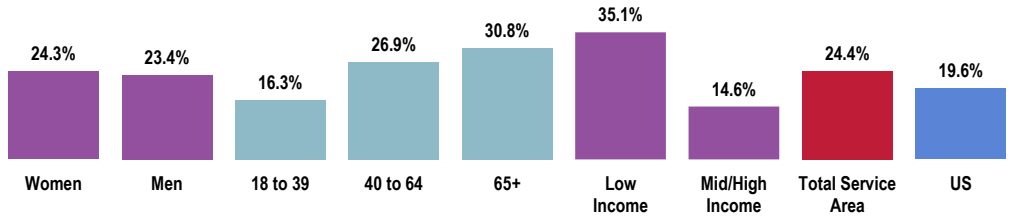
High-Impact Chronic Pain

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

Experience High-Impact Chronic Pain

(Total Service Area, 2024)

Healthy People 2030 = 6.4% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 31]
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Alzheimer's Disease

ABOUT DEMENTIA

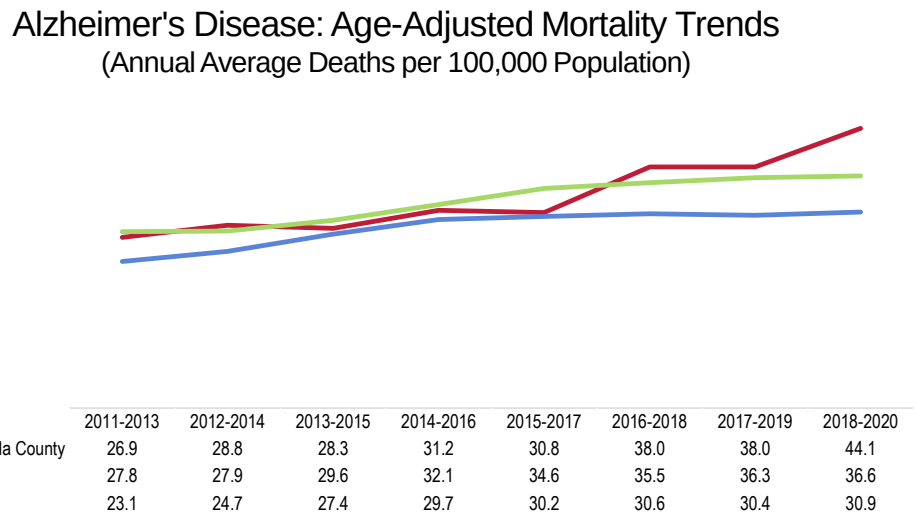
Alzheimer's disease is the most common cause of dementia… . Dementia refers to a group of symptoms that cause problems with memory, thinking, and behavior. People with dementia are more likely to be hospitalized, and dementia is linked to high health care costs.

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

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

Age-Adjusted Alzheimer's Disease Deaths

Age-adjusted Alzheimer's disease mortality is outlined in the following chart. [COUNTY-LEVEL DATA]



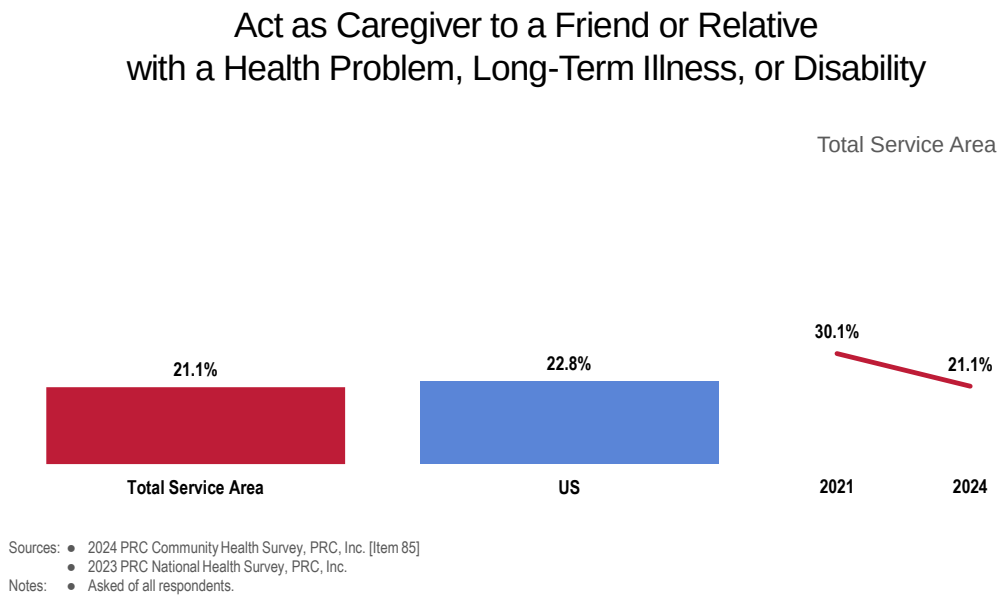
	2011-2013	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019	2018-2020
Umatilla County	26.9	28.8	28.3	31.2	30.8	38.0	38.0	44.1
OR	27.8	27.9	29.6	32.1	34.6	35.5	36.3	36.6
US	23.1	24.7	27.4	29.7	30.2	30.6	30.4	30.9

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Caregiving

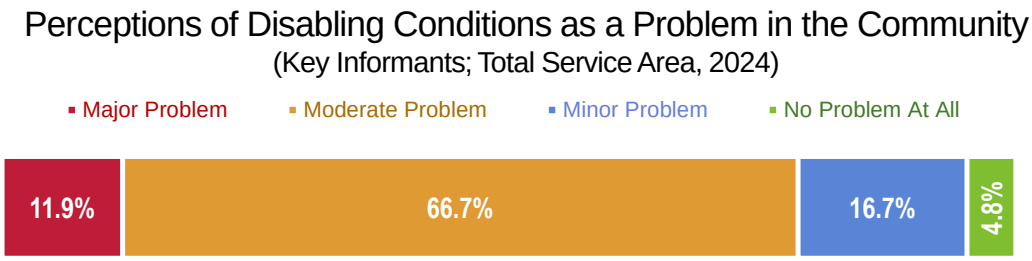
PRC SURVEY ► "People may provide regular care or assistance to a friend or family member who has a health problem, long-term illness, or disability. During the past 30 days, did you provide any such care or assistance to a friend or family member?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 85]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Disabling Conditions

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



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Access to Care/Services

> There are limited resources available for these issues. Many public spaces that say they are ADA accessible are not. Recently I noticed that older curb cuts for wheelchair access have a large lip that a manual wheelchair cannot go over without assistance. I noticed a restaurant with ADA stall but the hallway to access the restroom was too narrow to get a wheelchair down. We don't have a pain clinic locally to assist people with chronic pain. Vision services for Medicaid clients are minimal and take months to get an appointment. – Social Services Provider
>
> We just don't have a lot of resources for this issue, so many times we will refer them to the same reference and they will run out of funds faster. And then eliminates that resource until they receive more funding. – Social Services Provider

Built Environment

> Our community is built on hills and getting around with a physical disability is much more difficult. – Social Services Provider
>
> Our county is not age-friendly or dementia-friendly. In Pendleton there is no place for older adults with disabilities to gather for meals, have a place to bring their loved ones living with dementia for social engagement or respite. – Social Services Provider

Aging Population

> We have an aging population and are losing resources for connection like the Pendleton Senior Center. Many of the diseases of concern in our community will lead to disabilities, and it seems that those who are not yet disabled would not know where to go if they experienced a disabling event. Equitable access to services is also an issue, and I'm not sure all organizations have the resources to effectively serve people with disabling conditions. – Public Health Representative

Incidence/Prevalence

> It is a curious thing. CAPECO administers Oregon Project Independence. In Umatilla and Morrow counties, the physical needs of consumers are considerably higher than in our western counties. Across the service area, chronic pain, dementia, and activity limiting illness are concerns, with limited supports available (this is not news, but there is a critical shortage of home care workers, even for those eligible for services). – Social Services Provider

Access to Care for Uninsured/Underinsured

> Many people seem to lack the insurance or access to local reliable health care for a variety of disabling conditions. – Community Leader

Impact on Quality of Life

> Disabling conditions negate healthy progress towards a health community. – Other Health Provider

Nutrition

> I believe that lack of overall good nutrition and environmental exposures are leading to the majority of the conditions as a whole. – Other Health Provider

BIRTHS & PARENTING

ABOUT INFANT HEALTH

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

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

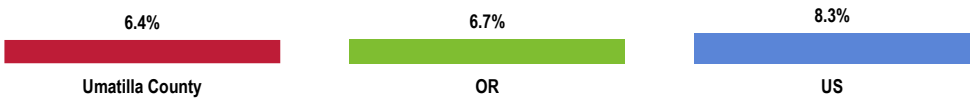
– Healthy People 2030 (https://health.gov/healthypeople)

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. [COUNTY-LEVEL DATA]

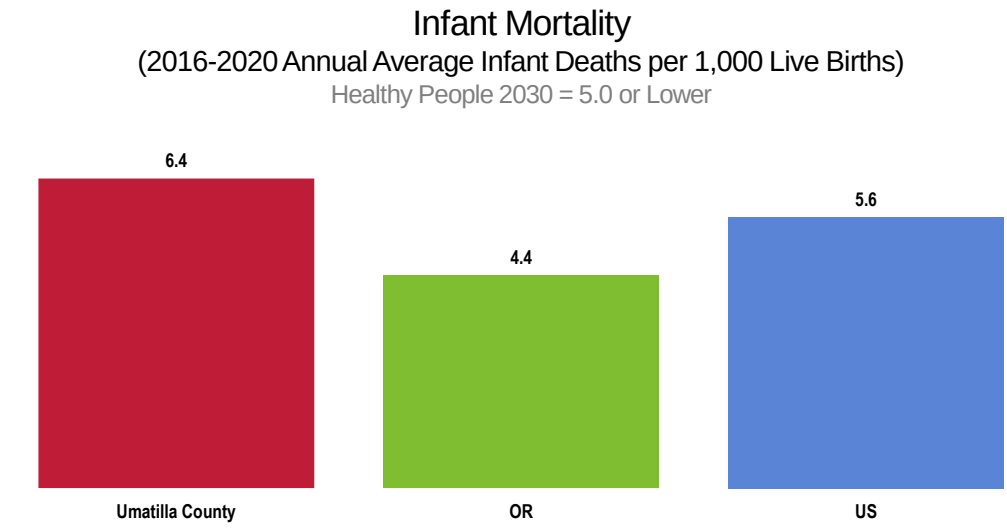
Low-Weight Births
(Percent of Live Births, 2016-2022)



Sources: ● University of Wisconsin Population Health Institute, County Health Rankings.
Note: ● This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. High infant mortality can highlight broader issues relating to health care access and maternal/child health. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, National Center for Health Statistics, Division of Vital Statistics. Data extracted December 2024.
- Centers for Disease Control and Prevention, National Center for Health Statistics.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- This indicator reports deaths of children under 1 year old per 1,000 live births.

Family Planning

ABOUT FAMILY PLANNING

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

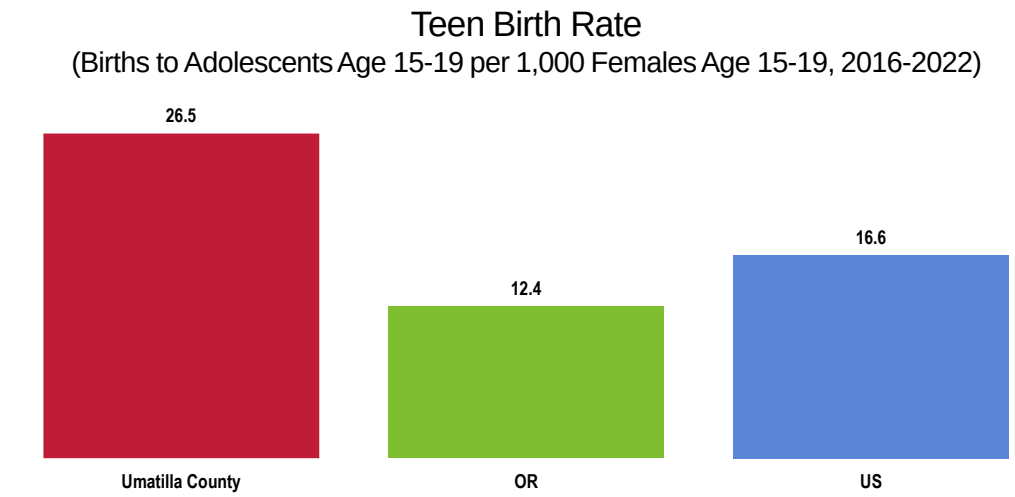
Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy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

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

Births to Adolescent Mothers

Here, teen births include births to women age 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.

The following chart outlines local teen births, compared to the state and nation. In many cases, teen parents have unique health and social needs. High rates of teen pregnancy might also indicate a prevalence of unsafe sexual behavior. [COUNTY-LEVEL DATA]

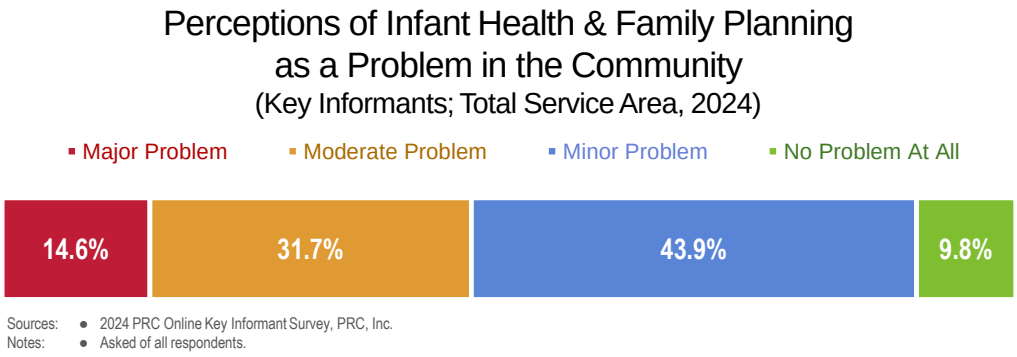


Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

Notes:
- This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19.

Key Informant Input: Infant Health & Family Planning

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



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

Lack of Providers

> Lack of access to maternal health providers. Very few in our area. – Community Leader
>
> Limited number of pediatricians and OB/GYN's in the local area. – Other Health Provider
>
> There are not enough providers to meet the needs of the population. Issues with cost associated with fertility issues as well as distance from treatment. The type of treatment and services available are also severely impacted by the moral stance of the institution regardless of what is legal or in people's best interest. We also have a culture with significant issues of historical and family trauma that create difficulties in healthy pregnancy, birth, and infancy. – Social Services Provider

Access to Care/Services

> Infant health and family planning are major problems because of the lack of family planning facilities and doctors. – Social Services Provider
>
> Currently, providers are limited, and becoming more inaccessible to families. Particularly families without access to supports. – Social Services Provider

Lifestyle

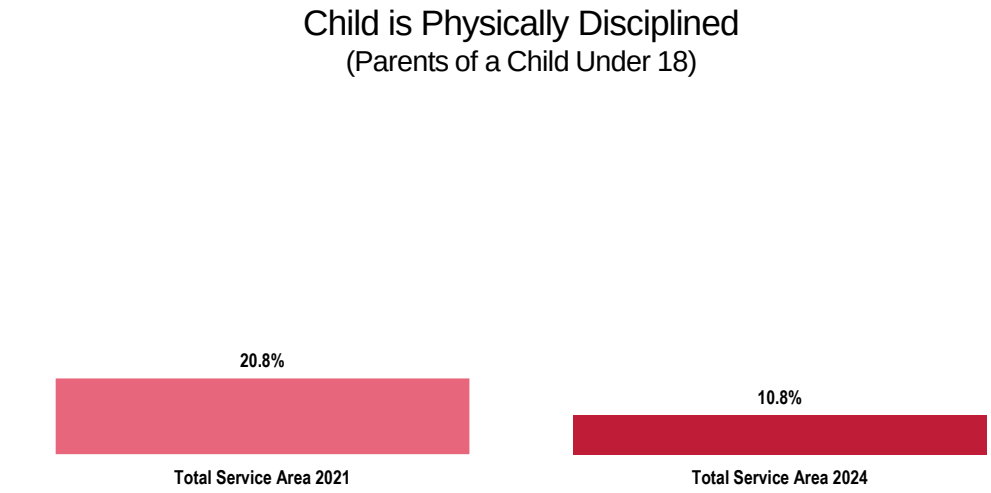
> I believe families or individuals really want to be good parents, but there are so many issues that surround our community. It is hard to be able to care for infants when many cannot care for themselves properly. – Social Services Provider

Young Parents

> Too many young people are having kids without stable SDOH-E factors. – Other Health Provider

Physical Discipline of Children

PRC SURVEY ► "Do you ever use physical discipline on this child, such as spanking, washing out his or her mouth, etc.?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 308]
Notes: ● Asked of all respondents with a child under 18 at home.

MODIFIABLE HEALTH RISKS

Nutrition

ABOUT NUTRITION & HEALTHY EATING

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

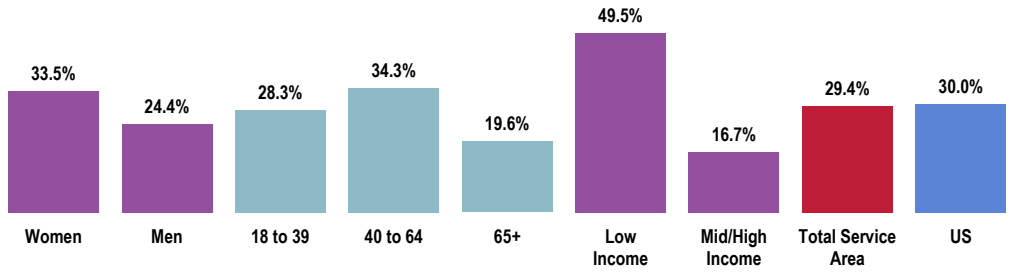
Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

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

Access to Fresh Produce

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

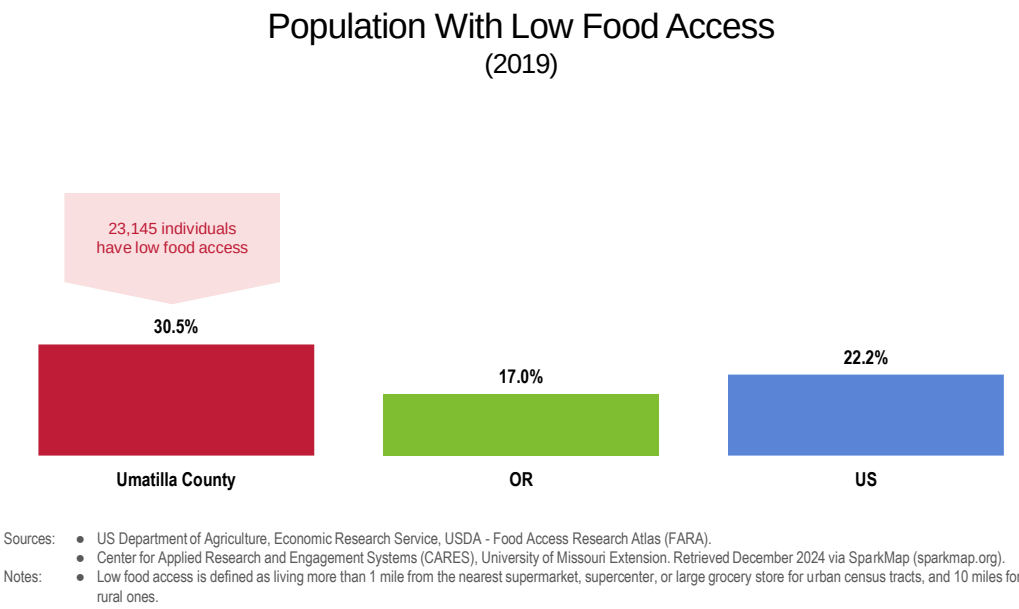
Find It "Very" or "Somewhat"
Difficult to Buy Affordable Fresh Produce
(Total Service Area, 2024)



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 66]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Low Food Access

Low food access is defined as living more than one mile from the nearest supermarket, supercenter, or large grocery store in urban areas (10 miles in rural areas). This related chart is based on US Department of Agriculture data. [COUNTY-LEVEL DATA]



Sources:
- US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

Notes:
- Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.

Physical Activity

ABOUT PHYSICAL ACTIVITY

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

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

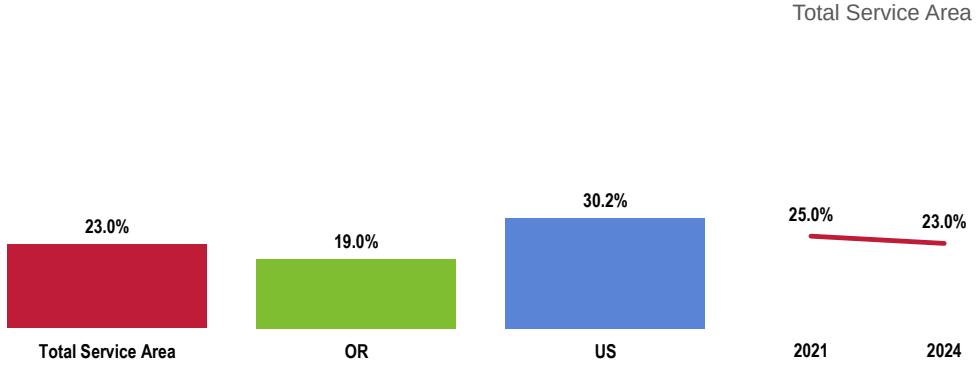
– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

PRC SURVEY ► "During the past month, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?"

No Leisure-Time Physical Activity in the Past Month

Healthy People 2030 = 21.8% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 69]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Meeting Physical Activity Recommendations

ADULTS: RECOMMENDED LEVELS OF PHYSICAL ACTIVITY

"Meeting physical activity recommendations" includes adequate levels of both aerobic and strengthening activity:

- **Aerobic activity** is at least 150 minutes per week of light-to-moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- **Strengthening activity** is at least 2 sessions per week of exercise designed to strengthen muscles.

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

To measure physical activity frequency, duration and intensity, respondents were asked:

PRC SURVEY ► "During the past month, what type of physical activity or exercise did you spend the most time doing?"

PRC SURVEY ► "And during the past month, how many times per week or per month did you take part in this activity?"

PRC SURVEY ► "And when you took part in this activity, for how many minutes or hours did you usually keep at it?"

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes. Respondents were also asked about strengthening exercises:

PRC SURVEY ► "During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands."

Meets Physical Activity Recommendations

(Total Service Area, 2024)

Healthy People 2030 = 29.7% or Higher

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 110]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week (or an equivalent combination of moderate and vigorous-intensity activity) *and* who also report doing physical activities specifically designed to strengthen muscles at least twice per week.

Weight Status

ABOUT OVERWEIGHT & OBESITY

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

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

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

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

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

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

Adult Weight Status

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

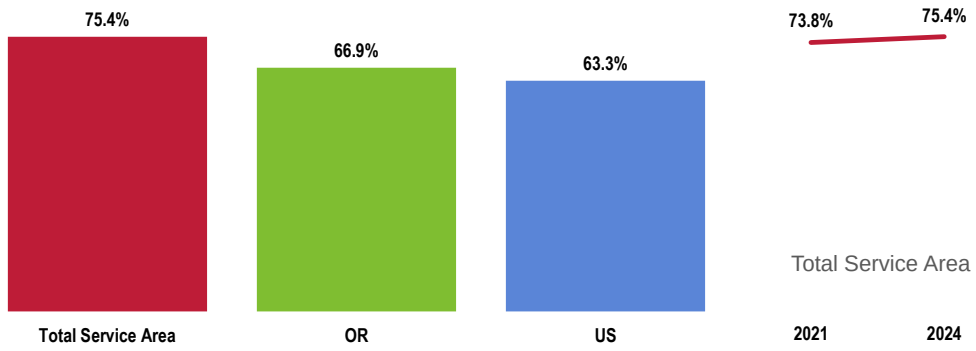
Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September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

PRC SURVEY ► "About how much do you weigh without shoes?"

PRC SURVEY ► "About how tall are you without shoes?"

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

Prevalence of Total Overweight (Overweight and Obese)

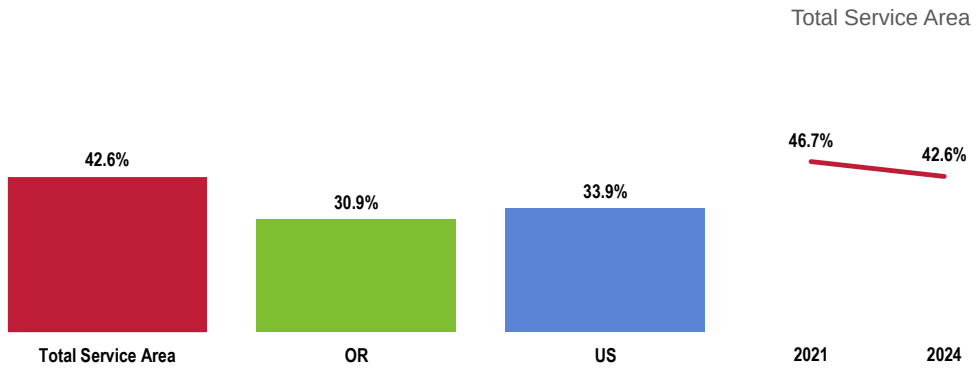


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

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

Prevalence of Obesity

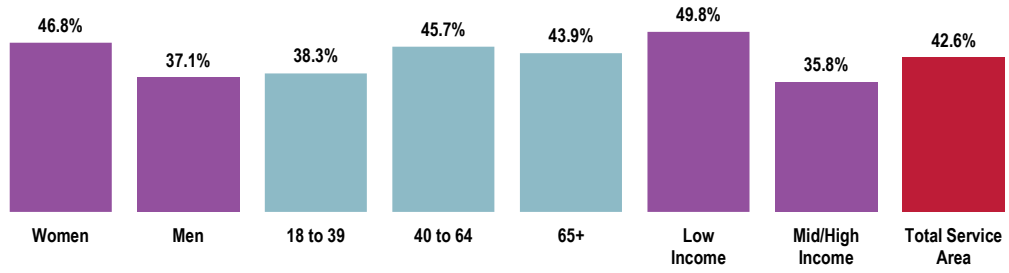
Healthy People 2030 = 36.0% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Prevalence of Obesity
(Total Service Area, 2024)
Healthy People 2030 = 36.0% or Lower



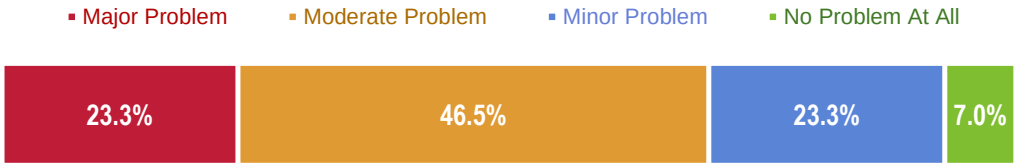
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 112]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

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

Key Informant Input: Nutrition, Physical Activity & Weight

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

Perceptions of Nutrition, Physical Activity & Weight as a Problem in the Community
(Key Informants; Total Service Area, 2024)



Sources:
- 2024 PRC Online Key Informant Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

Access to Affordable Healthy Food

> Foods that are higher in nutritional value are more expensive. – Physician
>
> Lack of access to good and nutritious food, or at least 3 basic meals every day. Housing or lack of good places for their housing – hard on physical activity – places where our community live are multigenerational houses/ apartments with more than 5 to 10-12 people. They are in general places not easily accessible for physical activities. Discrimination against – people that might go to existing parks – might not feel comfortable and welcome even when they bring their children together. Weight: the combination of both, lack to access to good and nutritious 3 meals per day, and lack of places for physical activities. – Other Health Provider
>
> The cost of healthy food is so high. It is cheaper to buy fast food than groceries from the store. The income limit for food stamps is so low that people who still would benefit from assistance can't qualify. They also can't work more due to the ERDC income limit being lower for qualifying than food stamps, it doesn't make sense. Child care is ridiculously high. There also is not an affordable gym with child care. – Other Health Provider
>
> The overall cost of food and busy live makes it hard for people to see they can plan for healthy meals for themselves and/or their family. People are lazy and tired and don't get out and get their bodies moving as they should. – Other Health Provider

> Access to and the affordability of nutritious food. Poor diet and excess weight lead to fatigue and lethargy, fatigue and lethargy lead to increased weight. Increased weight makes it more likely someone will experience an injury, or have a worse injury, from a fall or other incident. – Social Services Provider

Awareness/Education

> Access to education, dietician, healthy food sources, limited income. – Physician
>
> Education, access and finances to health eating and nutrition. Long working hours. – Social Services Provider

Obesity

> General overall increase in obesity rates post COVID, athletic club pool is closed, lack of quality indoor workout facilities. – Other Health Provider
>
> There is an increase in obesity in the last number of years in Eastern Oregon. We have access to great food but it is so expensive to eat healthy so I think people are turning to food that is unhealthy so their dollar can go further. – Other Health Provider

Lack of Specialists

> There are no specialists available in the area. Treatment for these problems is stipulated and insurance will not cover it in many situations. Food costs are exponential, and people can't afford to eat healthy food and the idea of what is healthy has become somewhat convoluted. Weather and safety concerns with rising homeless and drug populations and lack of mental health make use of outdoor spaces for exercise difficult. Indoor facilities are poorly maintained, have limited hours, and are very expensive for what is available. People need support with these issues. It is very hard to do it alone. – Social Services Provider

Environmental Contributors

> Society is struggling. It is difficult to make good choices. It is very hot in summer and very cold in winter to work out, outside. Safety for women to workout, outside when it is dark. Cost of eating healthy as well as costs of workout facilities. – Community Leader

Income/Poverty

> Poverty limits access to healthy food. School systems food choices are not healthy. More options for physical fitness would help. Indoor tracks, affordable gyms, curves, weight watchers and organized programs. Classes for aerobics, Zumba, tai chi that you can just pay for one class and not require gym membership. More community sponsored walks and runs. – Physician

Affordable Care/Services

> Lack of affordable options, transportation shortage. Financial constraints and only one gym and one old facility. – Other Health Provider

Built Environment

> There are limited indoor gyms and zero pools. Dieticians and nutritionists have long waits for people to access care. – Social Services Provider

Lifestyle

> In my opinion, these stem from unhealthy diets and a lack of physical activity. Emotional and social barriers can also complicate weight management. – Other Health Provider

Substance Use

ABOUT DRUG & ALCOHOL USE

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

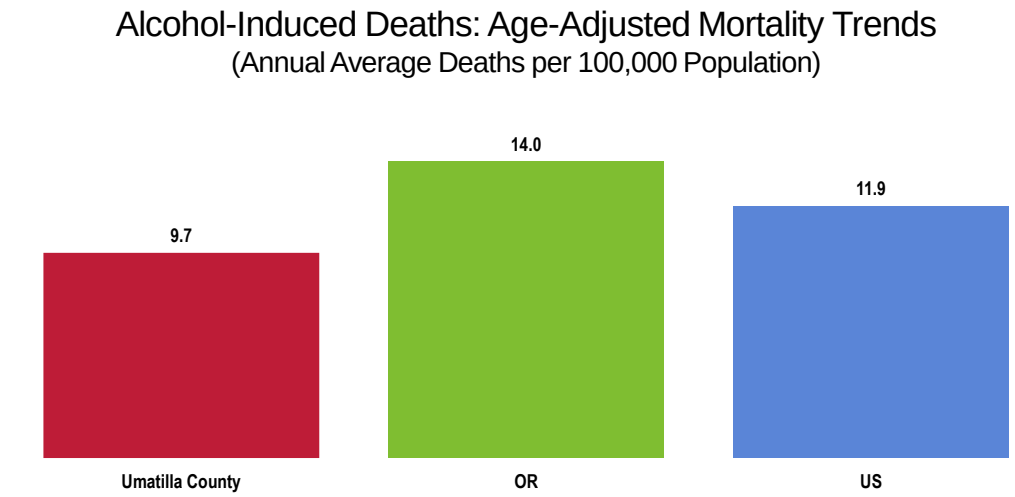
Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

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

Alcohol

Age-Adjusted Alcohol-Induced Deaths

The following chart outlines age-adjusted, alcohol-induced mortality in the area. [COUNTY-LEVEL DATA]



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Excessive Drinking

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

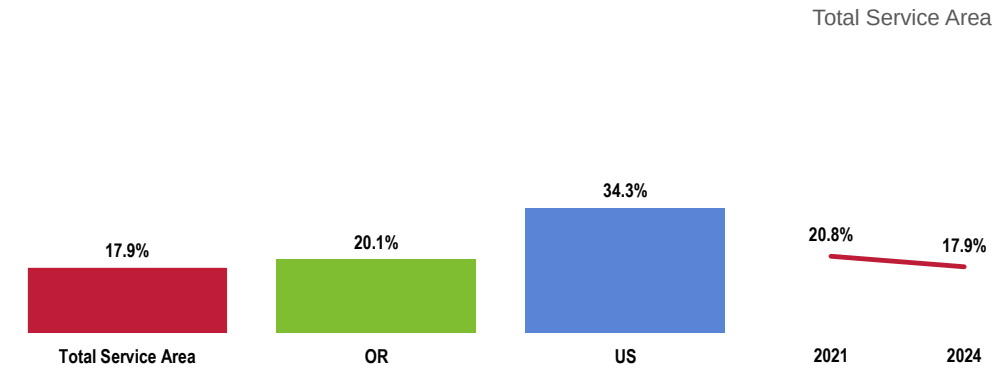
PRC SURVEY ► "On the day(s) when you drank, about how many drinks did you have on average?"

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

Excessive drinking includes heavy and/or binge drinkers:

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

Engage in Excessive Drinking



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 116]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

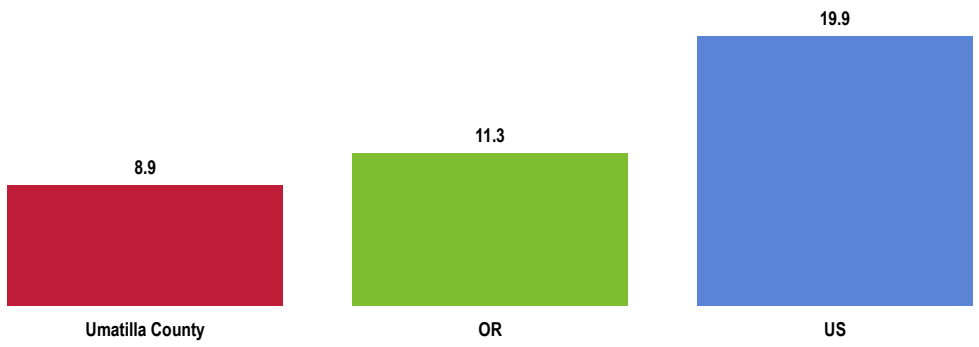
Notes:
- Asked of all respondents.
- Excessive drinking reflects the percentage of persons age 18 years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) OR who drank 5 or more drinks during a single occasion (for men) or 4 or more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

Drugs

Age-Adjusted Unintentional Drug-Induced Deaths

Unintentional drug-induced deaths include all deaths, other than suicide, for which drugs are an underlying cause. A "drug" includes illicit or street drugs (e.g., heroin and cocaine), as well as legal prescription and over-the-counter drugs; alcohol is not included. The following chart outlines local age-adjusted mortality for unintentional drug-induced deaths. [COUNTY-LEVEL DATA]

Unintentional Drug-Induced Deaths: Age-Adjusted Mortality
(2016-2020 Annual Average Deaths per 100,000 Population)



Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted December 2024.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

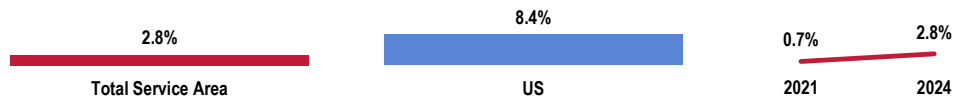
Illicit Drug Use

Note: As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that actual illicit drug use in the community is likely higher.

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

Illicit Drug Use in the Past Month

Total Service Area



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 40]
- 2023 PRC National Health Survey, PRC, Inc.

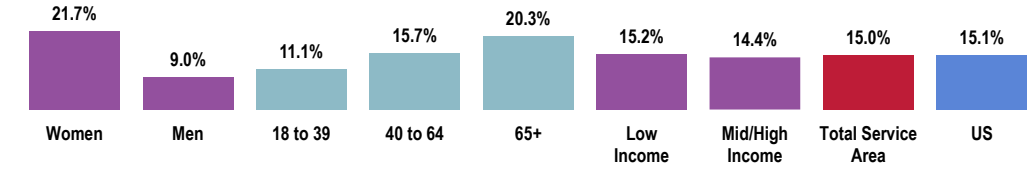
Notes:
- Asked of all respondents.

Use of Prescription Opioids

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

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

Used a Prescription Opioid in the Past Year
(Total Service Area, 2024)

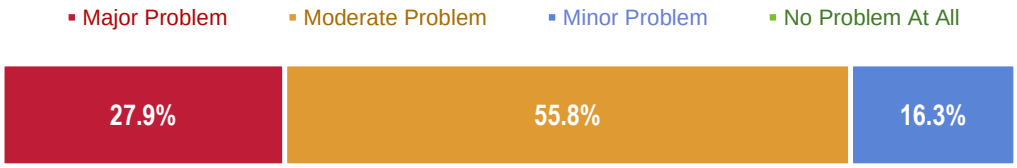


Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 41]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Key Informant Input: Substance Use

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

Perceptions of Substance Use as a Problem in the Community
(Key Informants; Total Service Area, 2024)



Sources: ● 2024 PRC Online Key Informant Survey, PRC, Inc.
Notes: ● Asked of all respondents.

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

Access to Care/Services

> Not enough resources for inpatient rehab. – Social Services Provider
>
> Care facility. Many rehab centers are very full or just don't have the capacity to care for certain patients. – Social Services Provider
>
> Outpatient treatment centers. – Other Health Provider
>
> No resources. There are only 4 treatment centers in this part of Oregon and 4 if not more in Portland alone. We have increasing numbers of addicts and homeless and a whole city complaining about it but they don't want to do anything to help or deal with the problem. – Other Health Provider

> There are not enough services and there is too much stigma. – Social Services Provider
>
> Again, potential long wait times for appointments/assessments. Few choices. – Other Health Provider
>
> Access to timely services and residential treatment. – Other Health Provider
>
> Access to care (Asmts, ISSP, TX) and following TX recommendations. Staffing shortage, increased access to trg, increase pay to retain qualified professional in the SUD field. Need additional prevention, education, outreach, early intervention, Withdrawal Mgt, OP TX, OBOT, MAT, IOP TX, Residential TX, and IP TX. Need additional youth specific TX such as IOP. – Other Health Provider
>
> Getting into a program, finding care for your children, being ready to enter treatment. – Community Leader

Denial/Stigma

> Stigma, limited resources. – Other Health Provider
>
> Stigma, financial challenges and lack of awareness. Fear of judgment. Rural areas face long wait times and transportation barriers. – Other Health Provider

Diagnosis/Treatment

> Buprenorphine prescribers, counseling, safe needle exchange, Narcan access. – Physician
>
> The pain clinics do not allow patients to use THC. So they continue to use illegal sources and continue to use THC. Alcohol resources are limited when people need help. When there is motivation to stop drinking, timing is everything, and they have to wait months to get into outpatient therapy. Too many patients, not enough resources: they need help making and getting to appointments, help with accountability. – Physician

Easy Access

> There are more drug dealers than people trying to keep people off drugs. Because of things like poor family structures and mental health, people will self-medicate to excess. – Community Leader
>
> Drugs are readily available. They are easier to obtain than rehabilitation for them. With the mental health issues it explodes the drug problems. – Other Health Provider

Lack of Providers

> Lack of workers for these facilities and lack of rooms available due to such a large number needing the program. – Other Health Provider
>
> Short staffing at providers, CCS, OWhN, EOCIL, etc. – Social Services Provider

Prevention/Screenings

> Youth treatment and prevention. – Community Leader
>
> A big barrier is a lack of health prevention programs, that are also culturally and linguistically specific focused on those issues. That also includes for treatment, lack of culturally and linguistically specific (native born, trained and certified people) for counseling and at once, with the expertise in some populations such as young/teenagers and pregnant mothers/teens. – Other Health Provider

Homelessness

> Homelessness, mental health, lack of all services in general. Lack of harm reduction focused programs, too many programs with requirements for individuals to seek them out and be off of substances first. Affordability and funding to our area. – Other Health Provider

Willingness to Seek Help

> Abusers not wanting to get help. – Community Leader

Family Support

> Lack of social support at the level of the core family/friends. – Physician

Government/Policy

> The use of alcohol in excess, up until just recently you could use drugs in public. – Social Services Provider

Social Norms/Community Attitude

> Public acceptance of alcohol overconsumption and addiction. – Community Leader

Tobacco Use

ABOUT TOBACCO USE

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

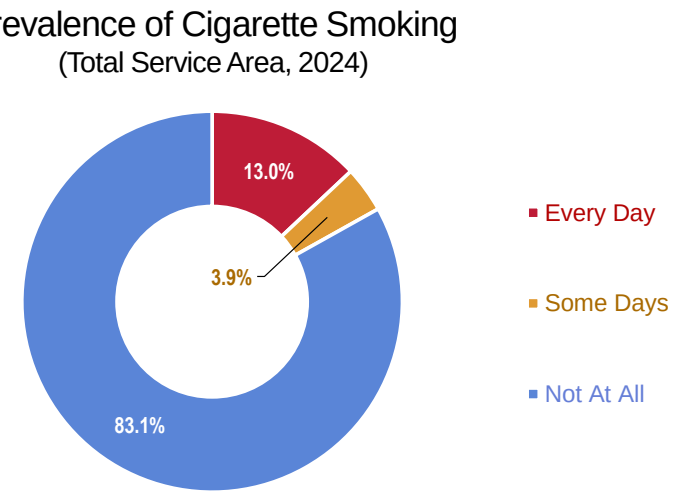
Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including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

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

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

Cigarette Smoking

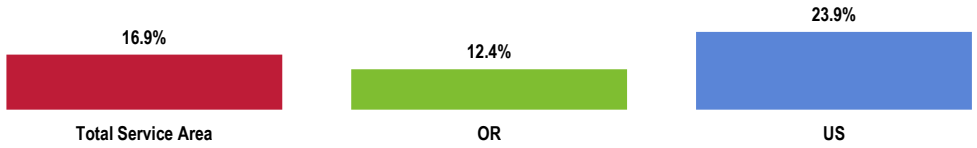
PRC SURVEY ► "Do you currently smoke cigarettes every day, some days, or not at all?"
("Currently Smoke Cigarettes" includes those smoking "every day" or on "some days.")



Sources: • 2024 PRC Community Health Survey, PRC, Inc. [Item 34]
Notes: • Asked of all respondents.

Currently Smoke Cigarettes

Healthy People 2030 = 6.1% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 34-35]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

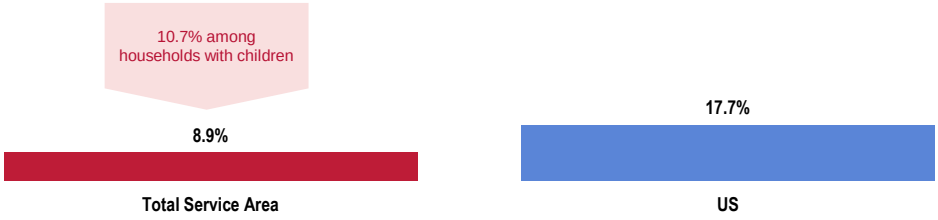
Notes:
- Asked of all respondents.
- Current smoking Includes those who smoke cigarettes every day or on some days.

Environmental Tobacco Smoke

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

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

Member of Household Smokes at Home



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 34-35]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.
- A member of the household has smoked cigarettes, cigars, or pipes anywhere in the home an average of 4+ days per week.

Use of Vaping Products

PRC SURVEY ► "Electronic vaping products, such as electronic cigarettes, are battery-operated devices that simulate traditional cigarette smoking but do not involve the burning of tobacco. Do you currently use electronic vaping products, such as electronic cigarettes, every day, some days, or not at all?"

("Currently Use Vaping Products" includes use "every day" or on "some days.")

Currently Use Vaping Products
(Total Service Area, 2024)

Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 36]
- 2023 PRC National Health Survey, PRC, Inc.
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.

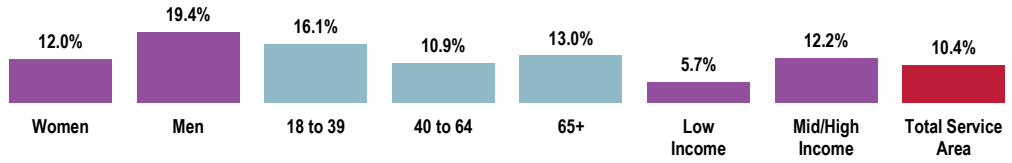
Notes:
- Asked of all respondents.
- Includes those who use vaping products every day or on some days.

Use of Smokeless Tobacco

PRC SURVEY ► "Do you currently use smokeless tobacco products, such as chewing tobacco, snuff, snus, or dissolvable tobacco every day, some days, or not at all?"

("Currently Use Smokeless Tobacco" includes use "every day" or on "some days.")

Currently Use Smokeless Tobacco
(Total Service Area, 2024)

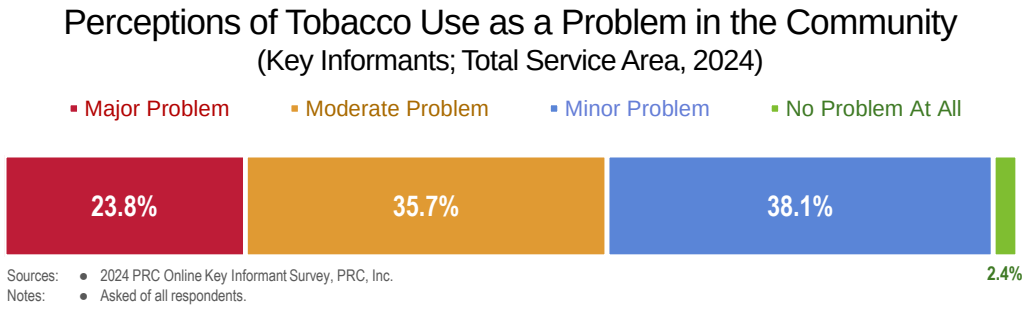


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 301]

Notes:
- Asked of all respondents.
- Includes chewing tobacco, snuff, snus, or dissolvable tobacco.

Key Informant Input: Tobacco Use

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



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

E-Cigarettes

> Lots of people vaping. – Other Health Provider
>
> Smoking/vaping is popular among youth and young adults. Volume of users and related health risks and problems. – Other Health Provider
>
> They are finding vapes in elementary schools more than they are in middle or high school. – Other Health Provider
>
> Vaping is at an all-time high and pouches of tobacco like Zyn are as well. They are easy for youth to get ahold of and they have pleasant smells so often adults are unaware that it is even happening or being used. – Other Health Provider
>
> Vaping is rampant. – Community Leader
>
> Vaping. A significant number of young people, underage, as well as adults are vaping as an alternative to smoking cigarettes. Looking at it as a safer option, also more accepted. The risks are not fully known. – Other Health Provider

Incidence/Prevalence

> We have higher rates of use than the state average, there is a lot of tobacco present in the community. In stores and sponsorship of events. – Community Leader
>
> I think tobacco use and vaping in particular is a major problem. – Other Health Provider
>
> There is nowhere in our community that you can go and not see tobacco use. Schools are reporting kids using vape in school in forms that are harder and harder to catch. There is such a strong belief that there is no problem with these projects. We also have a high percentage of people who use chewing tobacco. – Social Services Provider

Impact on Quality of Life

> It's a determinant of poor health and we have a larger population of elders smoking in our community than young kids. We need to change the conversation around inhalants. – Other Health Provider

Smokeless Tobacco

> Smoking is addressed via various campaigns, however, smokeless tobacco, chew, has not been adequately addressed. I think chew and vaping are huge issues in Umatilla County. – Social Services Provider

Vulnerable Populations

> Latino-Hispanic & Indigenous young populations are the biggest target of the big industry for commercial tobacco use. University of Southern California has conducted studies for the past 10 years and recently, that has proven that in fact, our communities are the highest target, followed by Black communities. Children of 6 years old already see and buy candies at stores that resemble tobacco. If their parents/family already use tobacco at their homes the issues are natural to raise. Schools have become the biggest target: middle and high school students are there in the open wide world to experiment all those tobacco-related products. – Other Health Provider

Sexual Health

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

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

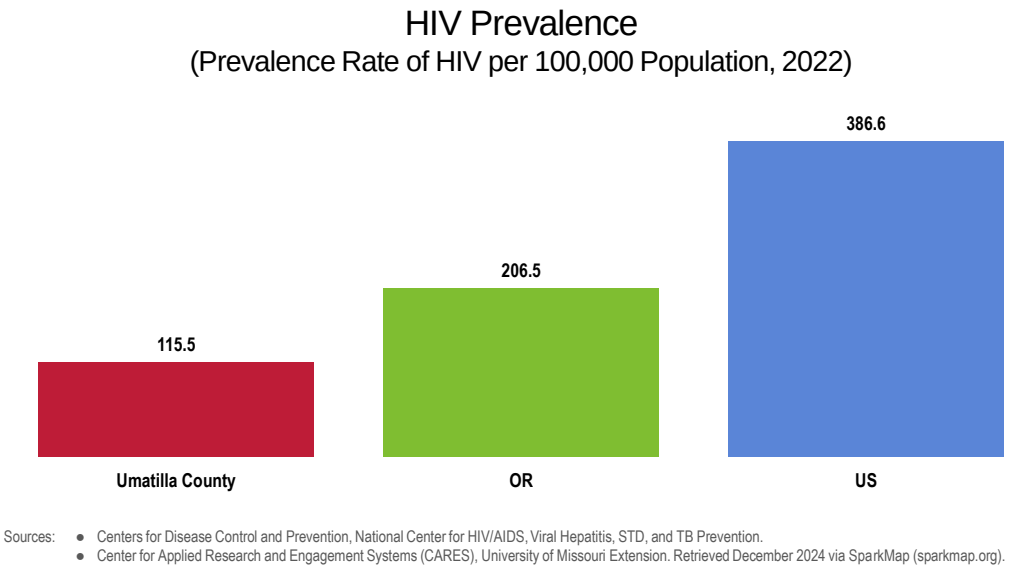
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV.

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

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

HIV

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the area. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

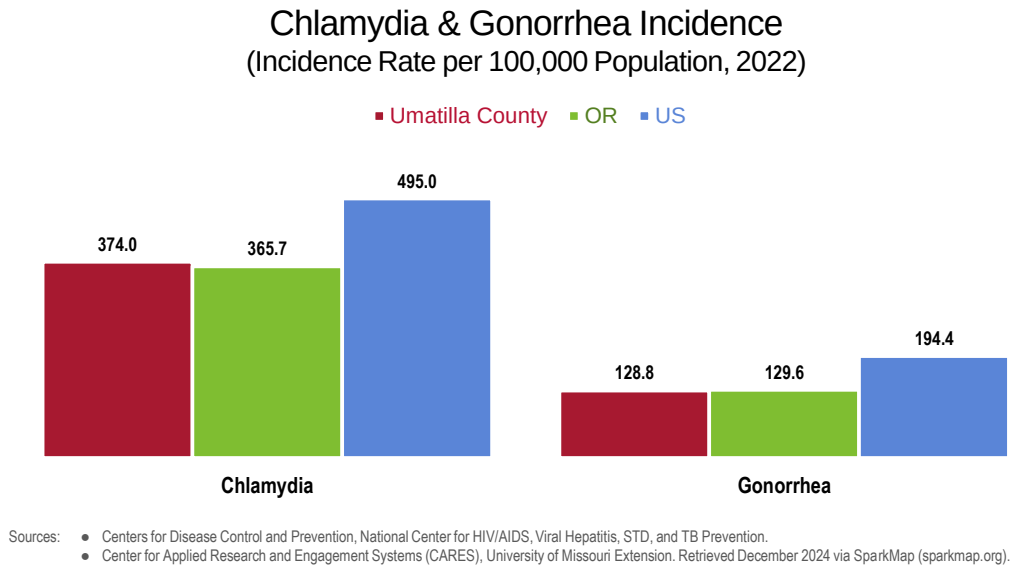
Chlamydia

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

Gonorrhea

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

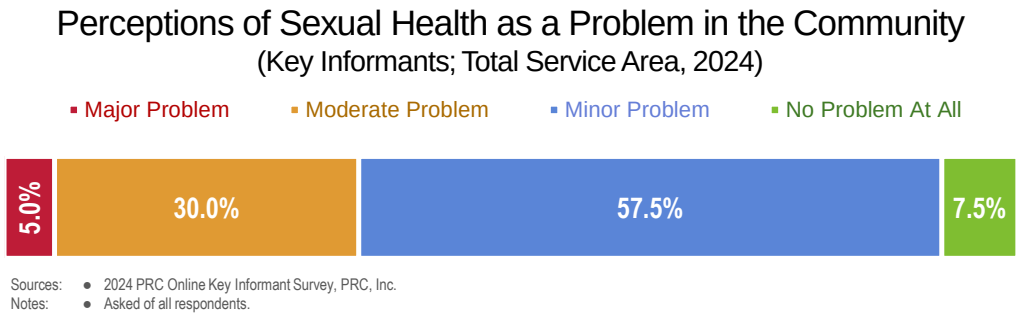
The following chart outlines local incidence for these STIs. [COUNTY-LEVEL DATA]



Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

Key Informant Input: Sexual Health

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



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

Incidence/Prevalence

> Data that I recently saw showed an increase in STIs in this and surrounding areas. – Social Services Provider
>
> STIs, namely syphilis, have been on the rise in Umatilla County. I am less familiar with this issue, but it has been mentioned by our CMO and public health teams. – Other Health Provider
>
> Sexual health has always been a concern among our communities in Eastern Oregon. Farmworkers tend to not look at these issues as they also have hardness to get or access to health care. More concerning at this moment is the congenital syphilis which has increased enormously in Oregon, and even harder in Eastern Oregon (data shared by the Umatilla County Health at the EOCCO Summit in Pendleton, this month). – Other Health Provider

Denial/Stigma

> Sexual health is very stigmatized in our area, making it difficult to get accurate information and treatment. We have high drug rates which are strongly correlated with high STD rates. We often rank among the top counties in Oregon for STD rates. – Social Services Provider

Co-Occurrences

> Drugs are a major problem and I think sexual health goes along with that. – Social Services Provider

ACCESS TO HEALTH CARE

ABOUT HEALTH CARE ACCESS

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

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

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

Lack of Health Insurance Coverage

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

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

PRC SURVEY ► "Do you have any government-assisted health care coverage, such as Medicare, Medicaid, or VA/military benefits?"

PRC SURVEY ► "Do you currently have: health insurance you get through your own or someone else's employer or union; health insurance you purchase yourself or get through a health insurance exchange website; or, you do not have health insurance and pay entirely on your own?"

Lack of Health Care Insurance Coverage

(Adults 18-64)

Healthy People 2030 = 7.6% or Lower

Total Service Area

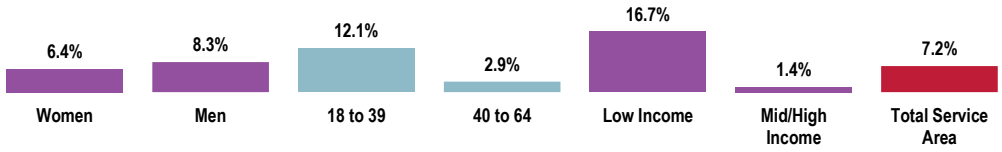
Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Lack of Health Care Insurance Coverage

(Adults 18-64; Total Service Area, 2024)

Healthy People 2030 = 7.6% or Lower



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 117]
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Reflects respondents age 18 to 64.

Difficulties Accessing Health Care

Barriers to Health Care Access

To better understand health care access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

PRC SURVEY ► "Was there a time in the past 12 months when you needed medical care but had difficulty finding a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you had difficulty getting an appointment to see a doctor?"

PRC SURVEY ► "Was there a time in the past 12 months when you needed to see a doctor but could not because of the cost?"

PRC SURVEY ► "Was there a time in the past 12 months when a lack of transportation made it difficult or prevented you from seeing a doctor or making a medical appointment?"

PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor because the office hours were not convenient?"

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

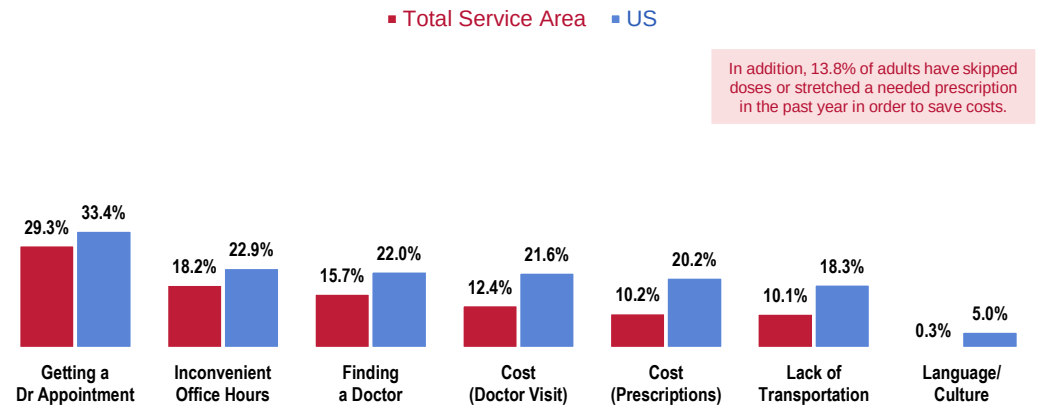
PRC SURVEY ► "Was there a time in the past 12 months when you were not able to see a doctor due to language or cultural differences?"

Also:

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

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

Barriers to Access Have Prevented Medical Care in the Past Year

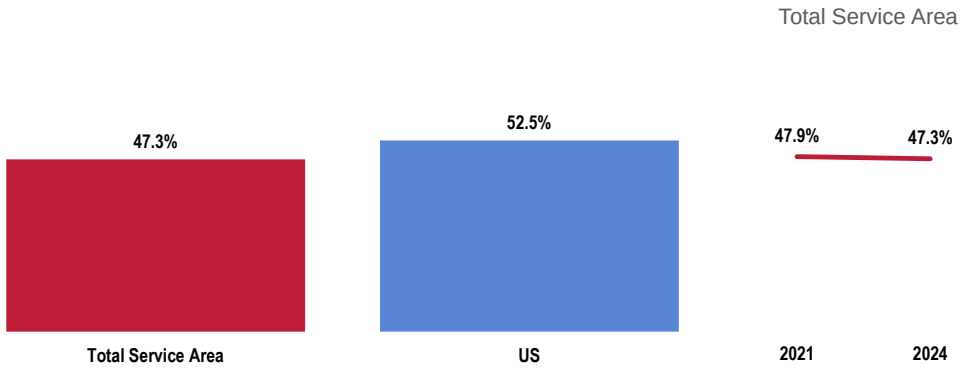


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Items 6-13]
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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

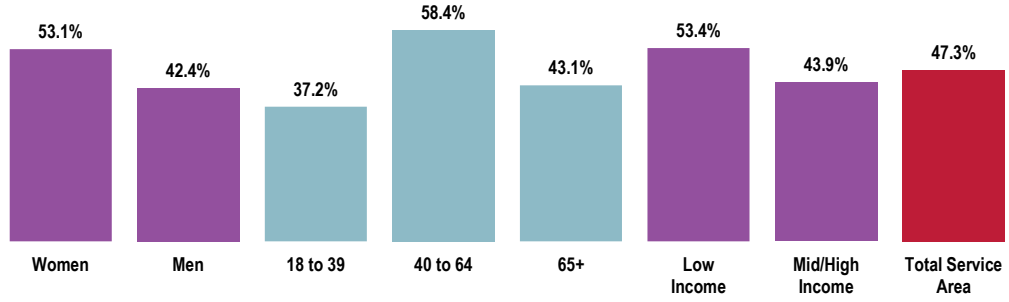
Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 119]
- 2023 PRC National Health Survey, PRC, Inc.

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

Experienced Difficulties or Delays of Some Kind in Receiving Needed Health Care in the Past Year
(Total Service Area, 2024)



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 119]

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

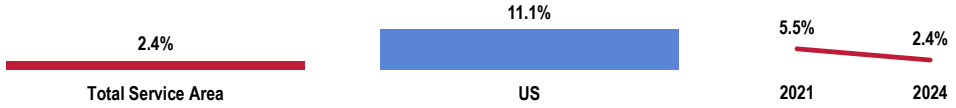
Accessing Health Care for Children

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

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

Had Trouble Obtaining Medical Care for Child in the Past Year
(Children 0-17)

Total Service Area

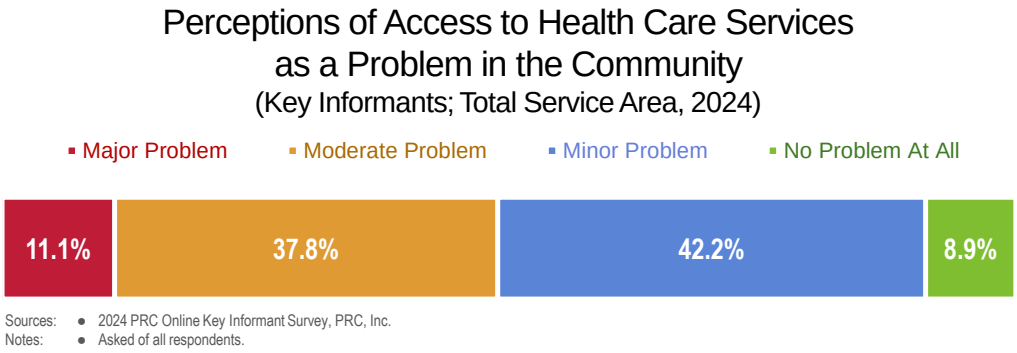


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 90]
- 2023 PRC National Health Survey, PRC, Inc.

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

Key Informant Input: Access to Health Care Services

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



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

Lack of Providers

> There seems to be a lack of qualified experts in most of the health care service areas. – Community Leader
>
> Limited providers or availability to see patients, specialty care being the largest deficit. – Other Health Provider
>
> In Morrow County there are very limited providers with subpar services/access to care which is pushing patients and staff to Umatilla County. There is poor access and availability to specialty care, socioeconomic supports and mental health support across both counties. – Physician
>
> Lack of providers taking new patients. – Physician
>
> Not enough health care providers in the area, both primary care physicians and specialists. Not enough pediatricians. – Physician
>
> Lack of providers/mistrust/lack of communication between patient and provider. – Public Health Representative
>
> Not enough primary care providers and long wait times to get into specialists. The biggest challenge is lack of mental health resources, especially those that are appropriate for children and teens. Long wait times for suicidal youth and others in mental crisis. Lack of inpatient treatment options for mental health. Parents, families, school all need these critical resources to be able to function properly. – Community Leader
>
> Lack of providers with the ability to diagnose for autism. Lack of providers to see high risk kids who need health care but need something more. – Social Services Provider
>
> Lack of primary care, appointments to establish care are often months out. Lack of medical specialists. Lack of quality mental health services. – Other Health Provider
>
> There are a limited number of PCPs. When patients get established with one they often have to flex over to Urgent Care for acute care needs because the PCP is booked out. People with multiple chronic conditions, especially uncontrolled chronic conditions, are given a PCP as their insurance dictates but then are sent out to a specialist (nephrology, cardiology, infectious disease, endocrinology, oncology, physiatry, neurology, etc.). When multiple providers are involved patients get confused on which provider is managing what. On multiple occasions I have witnessed the PCP and the specialists NOT communicating and the patient's care is compromised with delayed imaging, delayed labs and duplicated medications. Other barriers that affect health care are the lack of transportation, mandating the use of the My Chart apps (elders really struggle with the technology). – Public Health Representative
>
> Availability of providers, quick access to primary care providers visits. – Social Services Provider
>
> Wait times for local providers and availability to specialty care which requires going to Tri-Cities, Portland, etc. – Other Health Provider
>
> People with a health problem, even if they are insured, have a very long waiting time to be seen. And their health problem is not resolved by a family doctor, nor is it referred to a specialist. A problem shared by many hospital users. – Public Health Representative
>
> There is a huge lack of providers. Almost every provider has a huge waitlist. If a problem is suspected, it takes weeks to months and in some cases years to get a diagnosis. Then treatment frequently must take place hours away. Even people who have access to a provider have limited quality of services because of appointment availability and the fact that insurance gets to dictate what treatment you receive rather than your doctor unless you can afford to pay out of pocket. We have Medicaid but if you don't qualify for Medicaid the plans on the market place are still expensive and offer very poor coverage. The urgent care doesn't have capacity to see the number of people who need care each day. – Social Services Provider

Access to Care/Services

> In Milton-Freewater, there are no medical services for a town of 7,000 and a community of over 10,000. Services are available in neighboring towns that are out of state and pose an issue for those with and without insurance. This causes minor medical issues to become major medical issues. Mental healthcare is non-existent for those who don't have state insurance. I have had people quit their jobs to go on state insurance to access mental health and medical healthcare. Milton-Freewater is a community that is used by the rest of the county for our demographics to get grants and state services then is not included in the services provided. I challenge you to prove me wrong. – Community Leader
>
> People who need a higher level of care and require someone to take care of them can't get in anywhere. – Other Health Provider
>
> Access to mental health resources. – Community Leader
>
> The ability to access specialized healthcare and the lack of availability. Also, the lack of partnership and advocacy when it comes to understanding resources and navigating complex medical systems. – Other Health Provider

Transportation

> Lack of wheelchair transportation services for those who do not qualify for Medicaid. – Other Health Provider
>
> There is very little public transportation in these areas and then there seems to be a lack of providers also. – Social Services Provider

Vulnerable Populations

> Despite the advancement for the uses of OHP Oregon Health Plan we do still have many families, in particular farm workers, without health insurance. Or Immigrants or pregnant mothers who does not know about OHP eligibility; or many that already are enrolled have difficulties to access a primary care or take too long to get doctor and/or nurse appointment. The lack of cultural awareness among health care providers is a biggest challenge for our Latino-Hispanic and Indigenous communities. – Other Health Provider

Gender Affirming Care

> Gender-affirming care. What types of non-invasive, outpatient treatments are available. Most patients are traveling to Portland when there may be some services that can be administered closer to home. – Other Health Provider

Access to Therapies

> Patients with developmental issues (autism or other delays) have minimal resources for diagnosis, treatment, PT OT Speech therapies, in-home therapies, vocational options. We rely on their group homes (Horizons, Pendleton Cottages) and for kids the school system and Intermountain ESD. – Physician

Affordable Care/Services

> Cost of health care for those who have private insurance. Provider turnover seems to be high in these counties. – Social Services Provider

Awareness/Education

> Limited knowledge for people with disabilities, such as intellectual and developmental and how to support them. – Social Services Provider

Comorbidities

> Mental health, physical wellbeing and substance misuse. – Community Leader

Access to Home Health Services

> We have no home health or durable medical equipment available in Pendleton. All of those services have to come from Hermiston area. – Social Services Provider

Primary Care Services

ABOUT PREVENTIVE CARE

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

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

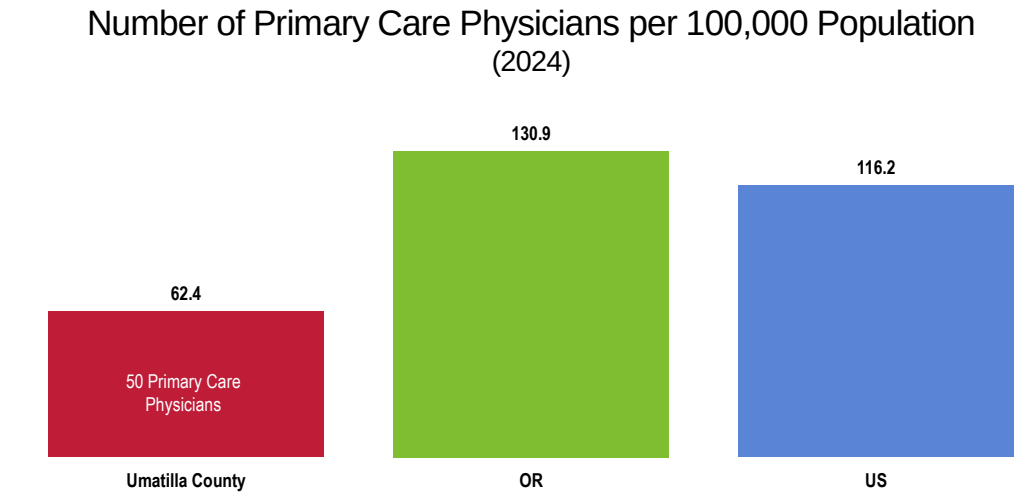
Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

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

Access to Primary Care

Note that this indicator takes into account *only* primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.

The following chart shows the number of active primary care physicians per 100,000 population. This indicator is relevant because a shortage of health professionals contributes to access and health status issues. [COUNTY-LEVEL DATA]

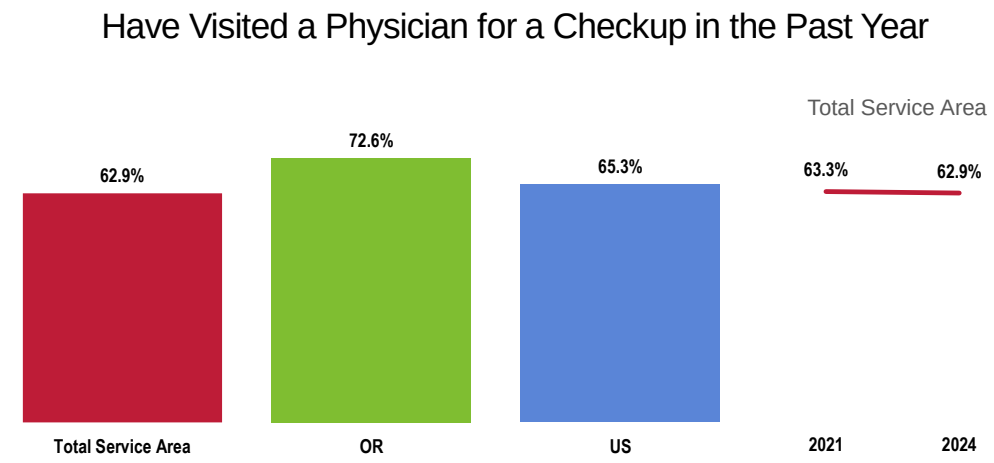


Sources:
- Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved December 2024 via SparkMap (sparkmap.org).

Notes:
- Doctors classified as "primary care physicians" by the AMA include general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs, and general pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

Utilization of Primary Care Services

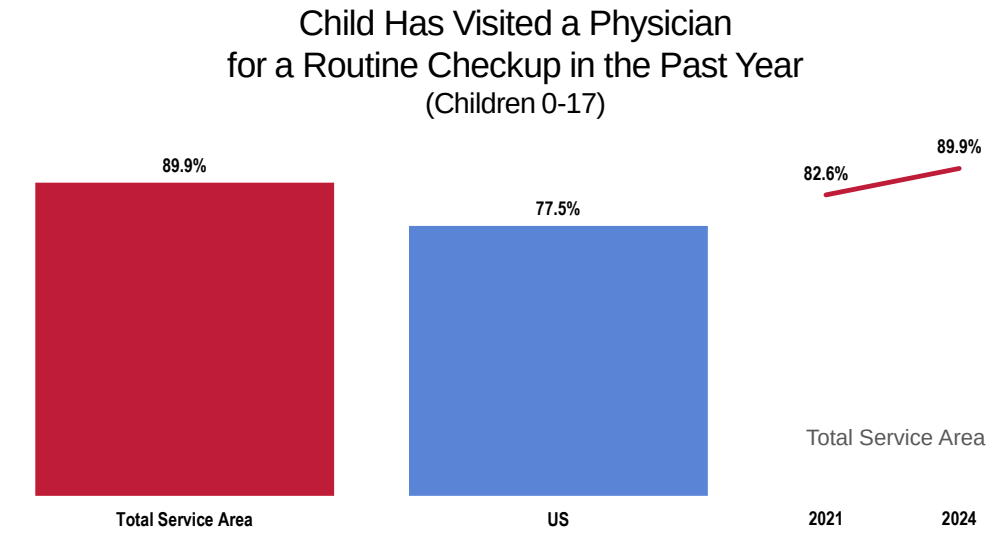
PRC SURVEY ► "A routine checkup is a general physical exam, not an exam for a specific injury, illness, or condition. About how long has it been since you last visited a doctor for a routine checkup?"



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 16]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.

Notes:
- Asked of all respondents.

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



Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 91]
- 2023 PRC National Health Survey, PRC, Inc.

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

Oral Health

ABOUT ORAL HEALTH

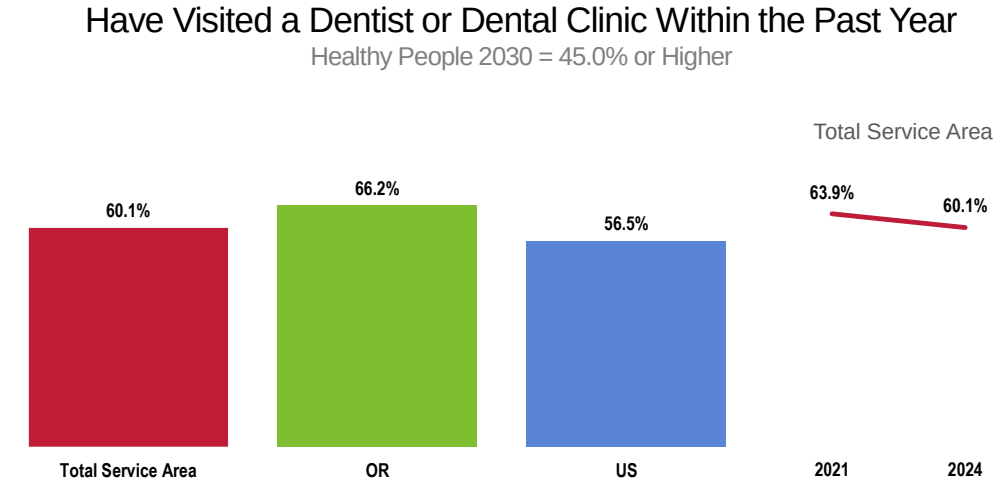
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems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

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

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

Dental Care

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

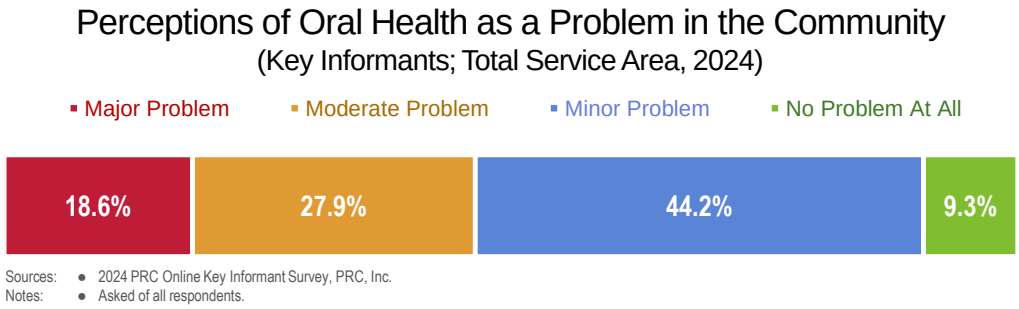


Sources:
- 2024 PRC Community Health Survey, PRC, Inc. [Item 17]
- Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia. United States Department of Health and Human Services, Centers for Disease Control and Prevention (CDC): 2022 OR data.
- 2023 PRC National Health Survey, PRC, Inc.
- US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes:
- Asked of all respondents.

Key Informant Input: Oral Health

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



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

Lack of Providers

> No pediatric dentist. EOCCO coverage for Advantage dental only. Advantage dental is not reliable, they cancel a lot, they are very far booked out. Patients find it difficult to get an appointment, to get people on the phone. Lack of coverage for some Medicare patients. – Physician
>
> Some limited dentists are available to see new patients. Existing patients are scheduled out too far. – Social Services Provider
>
> Our community only has access to one provider, Advantage Dental, which has a waitlist of six to eight months. – Other Health Provider
>
> There are only about two dental providers and many procedures under OHP are still not covered such as root canals and crowns, that can be thousands of dollars. – Social Services Provider
>
> Access to available appointments, additional providers. – Social Services Provider
>
> We have very limited access to dentists in our area. The number of providers seems to go down every year. The biggest problem is with regard to patients on EOCCO. These patients are required to see an advantage dental dentist. The dental offices cannot keep providers and the wait time for treatment is at minimum 9 months for some 18 months! This is making it impossible for the most vulnerable patients to get the care that they need and their teeth are getting worse and worse. On top of that we are seeing that there are no pediatric dentists in the area unless you have specific advanced problems with a referral. This is very problematic as it is difficult for children to get adequate care in an office that doesn't specialize or have appropriate tools for them. These problems are of particular concern as we know that oral health leads to physical health and is connected to things like heart disease, stroke, and potential connections with dementia. – Social Services Provider

Vulnerable Populations

> Oral health has been a major problem among Latino-Hispanic and Indigenous communities for long time already. Too many children do not have access or means that their parents could take them to regular visits with a provider. This issue is also long due for solution among older people in their families, who already might have been there for too many years working in the fields, without access to oral health. Our concern is also how these oral health issues could have been affecting their health in many other diseases. – Other Health Provider

Co-Occurrences

> There is a higher incidence of periodontal disease than ever before. There is a direct correlation between diabetes, heart disease, stroke, and periodontal disease. – Other Health Provider

Access to Care for Medicaid Patients

> Lack of dental providers specifically for those on Oregon Health Plan, OHP. – Other Health Provider
>
> Again, lack of low income or fixed income providers. – Other Health Provider

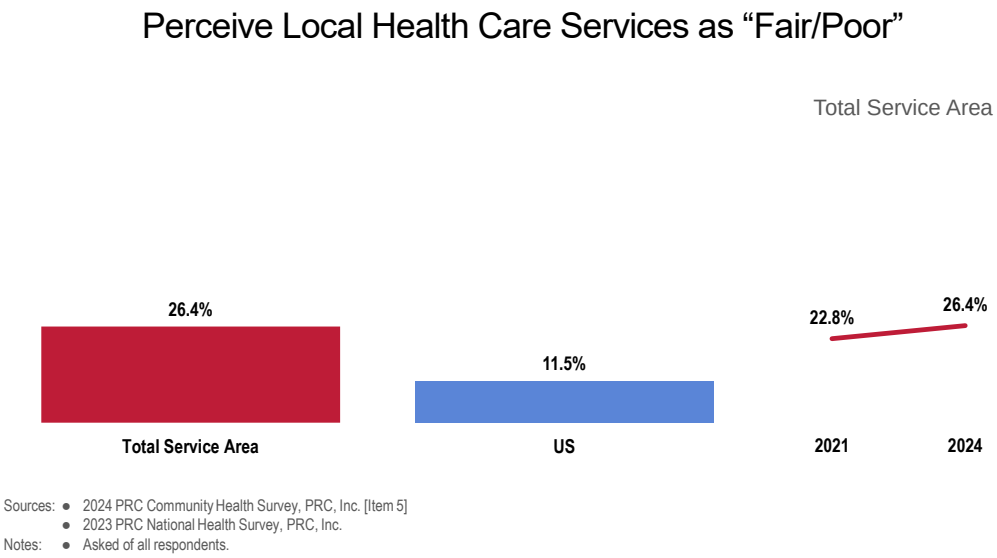
Prevention/Screenings

> A lot of children do not go to the dentist early enough, use of tobacco products, dental insurance/out-of-pocket cost. – Community Leader

LOCAL RESOURCES

Perceptions of Local Health Care Services

PRC SURVEY ► "How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?"



Sources: ● 2024 PRC Community Health Survey, PRC, Inc. [Item 5]
● 2023 PRC National Health Survey, PRC, Inc.
Notes: ● Asked of all respondents.

Resources Available to Address Significant Health Needs

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

Access to Health Care Services

- CAPECO
- Columbia River Clinic – Morrow
- Community Counseling Services
- Community Counseling Solutions
- Community Developmental Disabilities Program
- Community Health Advocates
- Doctors' Offices
- Doulas Latinas International
- Eastern Oregon Center for Independent Living
- Eastern Oregon Coordinated Care Organization
- Eastern Oregon Physical Therapy
- Good Shepherd
- Health Department
- Horizon Project Inc
- Hospitals
- Kayak Transportation
- Medicaid
- Mirasol Clinic
- Morrow County Health District
- Oregon Health Plan
- Pendleton Urgent Care
- Public Health
- St. Anthony's Hospital and Clinic
- Telehealth
- Transportation
- Transportation Solutions
- UCo Health
- Umatilla County Drug and Alcohol
- Urgent Care
- Yellowhawk Tribal Health Center

Cancer

- American Cancer Society
- Doulas Latinas International
- Eastern Oregon Cancer Center
- Good Shepherd
- Hospitals
- Kadlec
- Knight Cancer Research
- ScreenWise
- Tri-Cities Hospital
- Umatilla County Public Health Services
- Walla Walla St. Mary Hospital

Diabetes

- 24 Hour Fitness
- CAPECO
- Case Managers
- City of Pendleton
- Community Health Advocates
- Community Health Worker
- Department of Human Services
- Doctors' Offices
- Doulas Latinas International
- Eastern Oregon Center for Independent Living
- Eastern Oregon Coordinated Care Organization
- Good Shepherd
- Health Department
- Heppner Senior Center
- Hospitals
- Interpreter Services
- Livongo
- Mailed Prescription Programs
- Milton-Freewater Senior Center
- Mirasol Clinic
- Oregon Health Plan
- Oregon State University/Supplemental Nutrition Assistance Program
- Parks and Recreation
- Roundup Athletic Club
- St. Anthony's Hospital and Clinic
- Stanfield Senior Center
- Yellowhawk Tribal Health Center

Disabling Conditions

- Aging and Disability Resource Connection of Oregon
- Aging and People with Disabilities

- CAPECO
- City of Pendleton
- Clearview Disability Resources
- Dental Access
- Doctors' Offices
- Eastern Oregon Coordinated Care Organization
- Eastern Oregon Center for Independent Living
- Eastern Oregon Physical Therapy
- Food Resources
- Intellectual and Developmental Disabilities
- Medical Interpreters
- Mental Health Services
- Oregon Home Care Commission
- Oregon Older Adult Behavioral Health Initiative
- Rent/Mortgage Assistance
- Rise
- St. Anthony's Hospital and Clinic
- SUD Services
- Umatilla County Developmental Disabilities
- Veterans' Services
- Yellowhawk Tribal Health Center

Heart Disease & Stroke

- Doctors' Offices
- Doulas Latinas International
- Good Shepherd
- Hospitals
- Kadlec
- Kadlec Cardiology
- Milton-Freewater Senior Center
- Mirasol Clinic
- St. Anthony's Hospital and Clinic
- Stanfield Senior Center
- Walla Walla St. Mary Hospital
- Yellowhawk Tribal Health Center

Infant Health & Family Planning

- CAPECO
- CHI Women's Clinic
- Doctors' Offices
- Head Start
- Health Department
- Hope With Options
- Hospitals
- Migrant Head Start
- Nurse Family Partnership
- Pendleton Pediatric Clinic
- Pregnancy Resource
- St. Anthony's Hospital and Clinic
- St. Anthony's Women's Clinic
- UCo Health
- Umatilla County Public Health Services
- WIC

Injury & Violence

- CAPECO
- Community Counseling Solutions
- EMS/Fire Department
- Hospitals
- Martha House
- Police Department
- School System

Mental Health

- Aging and Disability Resource Connection of Oregon
- Aspen Springs
- CAPECO
- Case Managers
- Cell Phone Apps
- Community Counseling
- Community Counseling Services
- Community Counseling Solutions
- Community Outreach Prevention and Engagement Services
- Counseling Support Center
- Detox
- Doctors' Offices
- Doulas Latinas International
- Eastern Oregon Center for Independent Living
- Eastern Oregon Trauma Center
- Greater Oregon Behavioral Health
- Health Department
- Hospitals
- Mirasol Clinic
- Morrow County Health District
- MOUD Treatment in Jails
- New Horizons
- Oregon Older Adult Behavioral Health Initiative
- Oregon Washington Health Network
- Parks and Recreation
- Peer Support Specialists
- Pendleton Psychological Services
- Private Pay
- Psychological Services
- Reaching Every Adult and Child through Hope
- Rivercrest Behavioral Health
- School System
- Social Services
- St. Anthony's Hospital and Clinic

- SUD Services
- Support Groups
- Telehealth
- The Veterans Crisis Line
- TM Counseling
- True North Health Solutions
- Umatilla County CARE
- Yellowhawk Tribal Health Center

Nutrition, Physical Activity & Weight

- 24 Hour Fitness
- Agape House
- Aging and Disability Resource Connection of Oregon
- Club 24
- Community Action Program of East Central Oregon
- Crossfit
- Department of Human Services
- Doctors' Offices
- Doulas Latinas International
- Farmers' Markets
- Fitness Centers/Gyms
- Food Banks
- Good Shepherd
- Grocery Stores
- Head Start
- Jenny Craig
- Meals on Wheels
- Nutritionist
- Oregon State University/Supplemental Nutrition Assistance Program
- Parks and Recreation
- Roundup Athletic Club
- Senior Centers
- St. Anthony's Hospital and Clinic
- Take Off Pounds Sensibly (TOPS)
- The Rac
- Walking Groups
- Weight Watchers
- WIC

Oral Health

- Advantage Dental
- Arrow Dental
- Caseworkers
- Dentists' Offices
- Good Shepherd
- McEntire Dental
- Morrow County Health District
- Oral Health Clinics
- Pendleton Dental

Respiratory Diseases

- Doctors' Offices
- Doulas Latinas International
- Good Shepherd
- Health Department
- Hospitals
- Kadlec
- Morrow County Health District
- St. Anthony's Hospital and Clinic
- UCo Health

Sexual Health

- Columbia Health Clinic
- Community Outreach Prevention and Engagement Services
- Doulas Latinas International
- Eastern Oregon Center for Independent Living
- Good Shepherd
- Health Department
- Mailed Prescription Programs
- Mirasol Clinic
- Morrow County Health District
- Public Health
- Reproductive Health Resource
- St. Anthony's Women's Clinic
- UCo Health
- Yakima Farm Workers' Clinic

Social Determinants of Health

- Agape House
- Blue Mountain Community College
- CAPECO
- City Council
- City Planning
- Community Counseling Solutions
- Community Health Advocates
- Community Mental Health Programs
- Community Outreach Prevention and Engagement Services
- Department of Human Services
- Doctors' Offices
- Doulas Latinas International
- Eastern Oregon Center for Independent Living
- Eastern Oregon Coordinated Care Organization
- Euvalcree
- Food Banks

- Head Start
- Health Department
- Housing Authority
- Housing Complexes
- HUD Office
- Jobs Programs
- Kayak Transportation
- Low Income Apartments
- Martha House
- Mayor
- Medical Interpreters
- Oregon Human Development Corporation
- Parks and Recreation
- Pendleton Early Learning Center
- Pioneer Relief Nursery
- Religious Organizations
- Salvation Army
- Section 8 Housing
- St. Anthony's Hospital and Clinic
- Stepping Stones Alliance
- Triple P
- Umatilla County CARE
- WIC
- Yellowhawk Tribal Health Center

Substance Use

- AA/NA
- Blue Mountain Resource Network
- CAPECO
- Churches
- City Council
- Community Counseling Solutions
- Community Outreach Prevention and Engagement Services
- Detox
- Doctors' Offices
- Domestic Violence Services
- Eastern Oregon Alcoholism Foundation
- Eastern Oregon Center for Independent Living
- Eastern Oregon Detox Center
- Eastern Oregon Recovery Center
- Eastern Oregon Treatment Center
- Good Shepherd
- Inpatient Rehab
- Mayor
- Medication Assisted Treatment Center
- Methadone Clinic
- Mirasol Clinic
- New Horizons
- Oregon Health Authority
- Pendleton Detox
- Pendleton Treatment Center
- Powerhouse Residential Treatment Center
- Private Pay
- St. Anthony's Hospital and Clinic
- State
- Support Groups
- TM Counseling
- UCo Health
- Yellowhawk Tribal Health Center

Tobacco Use

- CAPECO
- Community Counseling Solutions
- Community Outreach Prevention and Engagement Services
- Drug Abuse Resistance Education
- Eastern Oregon Center for Independent Living
- Eastern Oregon Detox Center
- Good Shepherd
- Health Coaching
- Health Department
- Healthcare Educators
- Interpreter Services
- Pendleton School District
- Powerhouse Residential Treatment Center
- School System
- St. Anthony's Hospital and Clinic
- Tobacco Cessation Phone Line
- UCo Health
- Yellowhawk Tribal Health Center

APPENDIX

EVALUATION OF PAST ACTIVITIES

Community Benefit

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

- Over $8.9 million in community benefit, excluding uncompensated Medicare.
- More than $2.6 million in charity care and other financial assistance programs.

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

Addressing Significant Health Needs

St. Anthony Hospital conducted its last CHNA in 2021 and reviewed the health priorities identified through that assessment. Taking into account the top-identified needs — as well as hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined at that time that St. Anthony Hospital would focus on developing and/or supporting strategies and initiatives to improve:

- Access to Health Care Services
- Cancer
- Injury & Violence Prevention
- Heart Disease & Stroke
- Respiratory Disease
- Tobacco Use
- Infant Health

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

St. Anthony Hospital successfully completed a series of initiatives addressing key health needs in Umatilla County. These included expanding community healthcare access through increased provider recruitment, including partnering with an OB provider group to maintain adequate women's health coverage. The hospital also deployed its mobile health outreach van to provide services and education throughout the community. The clinic was able to provide expanded appointments in order to increase access to care. Cervical and reproductive cancer screenings were promoted through patient education and increased provider recruitment. The hospital strengthened its stroke program, earning recognition from the American Heart Association Stroke Program, and continued cardiac rehabilitation services. Safe sleep resources were integrated into community outreach efforts, and support for injury and violence prevention was maintained through continued partnerships with the Triple P parenting program, Pioneer Relief Nursery, and the car seat program. Pulmonary rehabilitation services improved respiratory disease management, and a smoking cessation program was continued with plans for expansion. These accomplishments leveraged collaborations with community organizations in order to carry out the goals outlined in the community health improvement plan.