

MALHEUR COUNTY COMMUNITY HEALTH ASSESSMENT

The Malheur County Health Department completed a Community Health Assessment in conjunction with our Local Community Advisory Council (CAC). The CAC consistently received participation from the following organizations, agencies and community members since the inception of our local CAC in February, 2013. Following is a summary of the Community Health Assessments conducted along with the triangulation report.

Community Advisory Council Partners

- Malheur County Commissioners, Public Health, Juvenile Department and Sheriff's Office;
- Department of Human Services Adults & Persons with Disabilities, Child Welfare, Self-Sufficiency, & Community Development;
- Office of Representative Cliff Bentz
- Southeast Oregon Food Bank
- Malheur Council on Aging
- XL Hospice
- Malheur Education Service District
- Treasure Valley Relief Nursery
- Oregon Child Development Center
- Treasure Valley Pediatrics
- Valley Family Health Care
- St. Alphonsus Medical Center
- St. Luke's Family/Internal Medicine
- Debra Alexander, FNP
- Independent Chiropractic & Dental Providers
- Treasure Valley Physical Therapy
- Lifeways Mental Health, Developmental Disabilities & Addictions
- The Family Place Therapeutic Services
- Veteran's Advocates of Ore-Ida

Data Sources

Primary Data Sources:

- "Community Health Needs Survey, Malheur County" 2013. Conducted by the Eastern Oregon Coordinated Care Organization under the direction of the Malheur County CAC.
- Key Informant Interviews conducted by Malheur County CAC members in August and September, 2013.
- Malheur County Latino Focus Groups conducted by Armenia Sarabia of Greater Oregon Behavioral Health, Inc. (GOBHI), in September and October, 2013.

Secondary Data Sources:

- “Community Health Needs Survey, - Malheur County” 2013. Eastern Oregon Coordinated Care Organization: Community Advisory Council. Oregon.
- “County Health Calculator,” 2013. Robert Wood Johnson Foundation and the Virginia Commonwealth University Center on Human Needs.
- “County Health Rankings and Roadmaps – a Healthier Nation County by County,” 2013. Robert Wood Johnson Foundation and University of Wisconsin – Population Health Institute.
- “Data Elements for CCOs Reports,” 2013. Oregon Health and Science University. Office of Rural Health.
- “Malheur County’s Epidemiological Data on Alcohol, Drugs and Mental Health. 2000 to 2012. Oregon Health Authority. Office of Health Analytics and Addictions and Mental health Division.
- “Oregon Smile Survey,” Oregon Health Authority, 2012.
- “Prevention Chronic Diseases and Reducing Health Risk Factors,” 2013. Centers for Disease Control and Prevention. CDC 24/7: Saving Lives. Protecting People.
- “Quick Facts,” January 2013. Oregon Department of Human Services; Children, Adults and Families Division. Office of Business Intelligence and the Office of Forecasting, Research and Analysis.

Priority Needs

EOCCO staff supported the Malheur County LCAC in developing a draft needs assessment survey. This was mailed as a household survey to approximately 900 random households, from which there were 366 responses for a 35% response rate.

The Malheur County CAC group reviewed, suggested modifications and approved a Key Informant Interview guide with assistance from EOCCO staff. After reporting demographic information about prospective respondents, CAC members utilized this questionnaire in surveying a diverse group (age, income and community of residence) of 27 Malheur County residents. One-on-one interviews were then recorded and analyzed for major themes, which were shared with the CAC as a group.

Eliciting responses from our Hispanic community was a critical concern for our CAC. To this end, three separate focus groups were conducted by bilingual staff provided by EOCCO that included approximately 45 persons from local child care centers and faith based organizations. Major themes that emerged were coded and communicated in the form of reports to the CAC by GOBHI staff that facilitated the discussion of local health care resources, health concerns, and challenges unique to this community.

Primary information gathered was combined with secondary data, and prepared in a Triangulation report by EOCCO staff. The Triangulation identified topic areas where there were multiple data sources. At the November 25, 2013 CAC meeting, the group reviewed the triangulation and used a forced choice matrix to vote individually and privately on priorities based on the Triangulation report. CAC members who did not attend the meeting were included in the matrix vote by submitting emailed responses. EOCCO staff provided the group with rankings that identified the following priority areas:

1. Mental Health
2. Social Determinants of Health
3. Alcohol and Drugs
4. Children and Families

In addition to the Primary and Secondary Needs Assessment data described above, the Malheur Community Advisory Council has engaged community members and representatives from a diverse group of community, social, and health service agencies that invested over 250 hours in planning, education, and discussion around health priorities which would warrant action in Malheur County. As we move into the process of implementing a Community Health Improvement Plan, we are hopeful for the continued support of Greater Oregon Behavioral Health (GOBHI) and Eastern Oregon Coordinated Care Organization (EOCCO) to make an impact on health outcomes for our diverse rural frontier community.

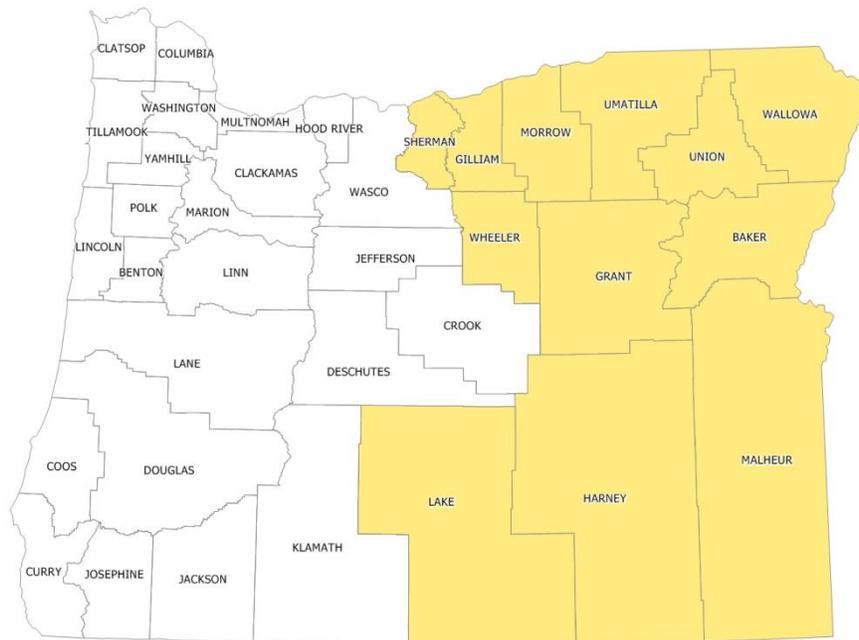
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Background, Community Engagement, and Areas of Focus

Background

In 2010, the Affordable Care Act was signed into law with the goal of making health care more effective and efficient. The law strives to achieve the “Triple Aim” of better health, better quality and lower costs. The State of Oregon applied for a Medicaid Waiver to implement its own plan to achieve the Triple Aim. This plan includes using Coordinated Care Organizations (CCOs) as the vehicle to deliver better care and lower cost. In addition, Health Exchanges will facilitate the goal of offering more health care coverage to people who currently do not have any.

The Eastern Oregon Coordinated Care Organization (EOCCO) includes the following counties; Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler.



Map provided by Oregon Office of Rural Health

Community Advisory Council’s (CACs) were formed in each county to accomplish transformation goals; they organized themselves in a way that allows them to work effectively and strategically. CACs identified the resources and activities communities need to achieve intended results.

Every community is different, but there are similarities in the process by which communities mobilize to affect change. Leadership, Assessment, Planning, Implementation, and Evaluation are critical phases of change.

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Local Community Advisory Council Membership

The primary charge of each LCAC is to advocate for preventive care practices, to oversee and collaborate with community partners on a Community Needs Assessment, and to develop, implement and report on a Community Health Improvement Plan.

CAC Members currently serving Malheur County:

| | | |
|--|-------------------------------------|-----------------------------|
| Stephanie Dockweiler – Chair Person | Patricia Sullivan Dr Travis Page | Joe Recla Steve Phillips |
| Judy Cordeniz – Vice Chair | Nikki Gallegos | Daniel Chudleigh |
| Shelly Gilman - Secretary | Brian Wolfe | Don Hodge |
| Dan Joyce – County Judge | Debra Alexander | Debra Thompson |
| Megan Gomeza – CAC Coordinator | Dr Dunbrasky | Douglas E. Williams |
| Nicole Albisu | Ken Rush | Dr Morris Smith |
| Sloma Hersley | Wendy Hill | Sean Hackette |
| Todd A. Dinsmore | Chris Phillips | Kathie Collins |
| Lung Hung | Andrea Dominguez | Kelly Poe |
| Jay Wettstein | Cliff Bentz | Linda Cummings |
| Eric Dahle | Alberta Savala | Linda Simmons |
| Lindsay Grosvenor | Benjamin Peterson | Raymond Millar |
| Sandy Hata | Bill Moore | Rick Palagi |
| Peter Lawson | Charlene Pelland | Leanna Benz |
| Ed Pierson | Charles “Kevin” Kolbaba | Sandra Raven |
| Angela Flying Eagle | Chris Cooley | Sherry Lane |
| | Louis Wettstein | Theresa Bingham-Abbott |

Quantitative Data Collection

EOCCO Community Advisory Councils conducted a Community Health Assessment by collaborating with the Oregon Health Authority Office of Equity and Inclusion to develop meaningful baseline data on health disparities.

Each CAC partnered with local public health authority, local mental health authority and hospital systems to develop a shared Community Health Assessment process. Existing county resources were used from community partners when available.

Reflected in the table(s) below is county specific quantitative data collected through this process:

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| OHA Required Data Elements for CCOs | Statewide | Baker | Gilliam | Grant | Harney | Lake | Malheur | Morrow | Sherman | Umatilla | Union | Wallowa | Wheeler |
|--|-----------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Age PSU 2012 | | | | | | | | | | | | | |
| Total | 3,899,801 | 16,210 | 1,900 | 7,450 | 7,315 | 7,920 | 31,395 | 11,300 | 1,765 | 77,120 | 26,175 | 7,015 | 1,425 |
| Ages 0 - 17 | 861,856 | 3,252 | 351 | 1,362 | 1,601 | 1,473 | 7,927 | 3,125 | 348 | 20,397 | 5,956 | 1,356 | 260 |
| Ages 18 - 64 | 2,456,875 | 9,183 | 1,095 | 4,147 | 4,224 | 4,727 | 18,533 | 6,630 | 1,012 | 46,434 | 15,548 | 3,904 | 736 |
| Ages 65+ | 581,070 | 3,775 | 454 | 1,941 | 1,490 | 1,720 | 4,934 | 1,545 | 405 | 10,289 | 4,671 | 1,756 | 429 |
| Race 2007-2011 ACS | | | | | | | | | | | | | |
| White | 87.6% | 96% | 92.8% | 95.2% | 92.9% | 92.1% | 81.1% | 88.0% | 95.9% | 87.4% | 94.0% | 96.3% | 96.7% |
| African American / Black | 1.7% | 0.4% | 0.3% | 0.4% | 0.4% | 0.6% | 1.4% | 0.2% | 0.2% | 0.6% | 0.4% | 0.2% | 0.0% |
| American Indian | 1% | 1.1% | 0.2% | 1.0% | 2.9% | 2.0% | 0.8% | 0.7% | 0.4% | 2.2% | 0.4% | 0.4% | 0.4% |
| Asian * | 3.9% | 0.4% | 0.3% | 0.2% | 1.0% | 0.5% | 1.1% | 0.9% | 0.2% | 0.9% | 0.8% | 0.2% | 0.0% |
| Pacific Islander | | 0.0% | 0.2% | 0.0% | 0.1% | 0.2% | 0.2% | 0.1% | 0.0% | 0.1% | 0.1% | 0.6% | 0.0% |
| Other | 1% | 0.3% | 4.5% | 0.3% | 0.3% | 1.4% | 10.0% | 6.1% | 1.2% | 4.2% | 0.8% | 0.5% | 0.9% |
| 2 or More | 2.8% | 1.9% | 1.7% | 2.9% | 2.3% | 3.3% | 5.4% | 4.0% | 2.3% | 4.6% | 2.8% | 1.9% | 2.0% |
| Ethnicity Hispanic 2007-2011 ACS | 11.5% | 3.3% | 8.3% | 2.6% | 3.8% | 6.4% | 30.9% | 30.6% | 5.8% | 23.0% | 3.5% | 2.2% | 1.2% |
| Language 2007-2011 ACS speak English less than "very well" | 6.4% | 1.4% | 2.3% | 0.7% | 0.7% | 2.0% | 10.1% | 13.9% | 3.1% | 8.1% | 2.5% | 0.7% | 0.9% |
| Gender 2007-2011 ACS (F / Female; M/Male) | 49.3% F | 50.7% M | 54.3% M | 49.3% M | 51.6% M | 52.5% M | 54.6% M | 50.9% M | 50.5% M | 52% M | 49.1% M | 50% M | 47.4% M |
| LGBT identification (Lesbian, Gay, Bi-sexual, Transgender) | | | | | 1.6% | | | | | | | | |
| Family size 2007-2011 ACS | 3.02 | 2.66 | 2.6 | 2.63 | 2.6 | 2.6 | 3.25 | 3.35 | 2.78 | 3.2 | 2.85 | 2.86 | 2.55 |
| Disability status (N/A more recent than 2000 Census) | | | | | | | | | | | | | |
| Employment 2012 OR Employment Dept unemployed | 8.7% | 10% | 7.4% | 13.4% | 12.6% | 12.8% | 9.8% | 8.2% | 8.4% | 8.4% | 9.2% | 10.2% | 7.6% |
| Households Homeless | N/A | 4 | 8 | N/A | 3 | 31 | 31 | 5 | N/A | 107 | 20 | 0 | 1 |
| Renters | 36.9% | 30.80% | 37.0% | 29.2% | 34.8% | 33.9% | 34.3% | 28.2% | 33.5% | 35.6% | 34.8% | 25.1% | 26.1% |
| Overall health Good, Very Good, or Excellent BRFSS 2006-2009 | 86.9% | 85.5% | 77.7% | 87.0% | 83.6% | 91.4% | 83.8% | 85.7% | 77.7% | 82.7% | 87.0% | 88.8% | 79.2% |
| Tobacco use Smoking BRFSS 2006-2009 | 17.1% | 20.0% | 22.8% | 24.4% | 14.3% | 19.9% | 22.0% | 23.0% | 22.8% | 24.2% | 14.0% | 13.0% | S |
| Tobacco use Smokeless BRFSS 2006-2009 by males | 6.3% | 18.3% | 8.4% | 30.3% | 28.7% | S | 23.5% | 19.6% | 8.4% | 13.3% | 20.9% | 19.0% | S |
| Obesity BRFSS 2006-2009 | 24.5% | 22.3% | 31% | 27.9% | 22.8% | 19% | 33% | 36.0% | 31% | 36.0% | 23% | 19.5% | S |
| Heart disease 2007-2011 Death Rate per 100,000 | 163.1 | 272.8 | 237.8 | 231.8 | 230.9 | 176.8 | 237.3 | 118.0 | 251.7 | 161.3 | 177.2 | 235.6 | 345.8 |
| Stroke 2007-2011 Death Rate per 100,000 | 47.9 | 63.5 | 54.1 | 62 | 62.5 | 80.8 | 62 | 39.3 | 22.9 | 50.4 | 62.6 | 62.5 | 55.3 |
| Intentional injuries | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Unintentional injuries 2007-2011 Death Rate per 100,000 | 41.9 | 78.5 | 21.6 | 56.6 | 84.2 | 68.2 | 44.8 | 42.9 | 68.6 | 44.7 | 45.8 | 59.6 | 69.2 |
| Suicide 2007-2011 Death Rate per 100,000 | 16.2 | 31.1 | 43.2 | 24.3 | 21.7 | 30.3 | 14.1 | 10.7 | 11.4 | 17.7 | 19.1 | 17 | 41.5 |
| Prescription drug abuse (no county specific data) | | | | | | | | | | | | | |
| Mental health conditions Good BRFSS 2006-2009 | 66.4% | 72.1% | 66.8% | 66.9% | 75.9% | 79.0% | 81.3% | 74.8% | 66.8% | 71.6% | 63.9% | 77.9% | 95.7% |

* Statewide lists as "Asian / Pacific Islander" and county specific data lists two group = "Asian" and "Pacific Islander."

** S - Suppressed Data

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| | Statewide | Baker | Gilliam | Grant | Harney | Lake | Malheur | Morrow | Sherman | Umatilla | Union | Wallowa | Wheeler |
|---|-----------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| <u>EOCCO Specific Data:</u> | | | | | | | | | | | | | |
| % of population without high school diploma 2007-2011 ACS | 11.1% | 11.6% | 13.2% | 11.0% | 11.2% | 12.8% | 20.4% | 22.9% | 9.6% | 18.2% | 11.0% | 7.3% | 12.6% |
| % single parents 2007-2011 ACS | 30.4% | 31.5% | 34.5% | 33.3% | 30.9% | 29.8% | 31.6% | 33.2% | 26.0% | 32.4% | 31.2% | 35.1% | 48.9% |
| % elderly poverty (Age data only 18 or less) | | | | | | | | | | | | | |
| % of population in poverty 2011 Small Area Income and Poverty | 17.3% | 20% | 11.8% | 17.2% | 18.6% | 20.6% | 24.5% | 16.1% | 15.0% | 17.7% | 15.8% | 16% | 20.1% |
| Binge Drinking (BRFSS data) | | | | | | | | | | | | | |
| Male | 18.7% | 11.1% | 17.0% | S | S | 13.6% | S | S | 17.0% | 17.5% | S | 28.5% | S |
| Female | 10.8% | 9.6% | 4.3% | 26.6% | S | S | 10.2% | 18.6% | 4.3% | 6.6% | 5.6% | 43.1% | S |
| Heavy Drinking (BRFSS data) | | | | | | | | | | | | | |
| Male | 5.4% | S | S | S | S | S | S | S | S | S | S | S | S |
| Female | 6.1% | 5.9% | S | 10.5% | S | S | S | S | S | 2.6% | 4.8% | 17.8% | S |
| Physical activity levels (BRFSS data) Met CDC recommendations | 55.8% | 42.3% | 57% | 57% | 54% | 60% | 57% | 52% | 57% | 60% | 50% | 44% | S |
| DUI Rates Arrests 2009 Criminal Justice Commission per 100,000 | 506 | 389 ** | 1,014 | 896.8 | 1007 | 750.6 | 474 | 488.2 | 669.6 | 578.6 | 473 | 212.9 | 345.5 |
| % of population without personal transportation 2007-2011 ACS | 7.7% | 5.8% | 5.3% | 6.4% | 6.6% | 4% | 6.4% | 6.1% | 2.2% | 6.1% | 7.4% | 5.1% | 1.5% |
| % of population without access to phone 2007-2010 ACS | 2.9% | 4.2% | 1.9% | 2.3% | 3.8% | 4.4% | 2.7% | 3.0% | 1.3% | 3.0% | 3.1% | 2.1% | 1.0% |
| <u>EOCCO Specific Data which relates to youth and potentially the Early Learning Councils</u> | | | | | | | | | | | | | |
| % of population under age 18 PSU 2012 | 22.3% | 20.1% | 18.5% | 18.3% | 21.9% | 18.6% | 25.2% | 27.7% | 19.7% | 26.4% | 22.8% | 19.3% | 18.3% |
| % of births to mothers younger than 18 2010 OHA | 2.2% | 1.8% | 4.8% | n/a | 3.4% | 1.4% | 4.4% | 1.8% | n/a | 3.6% | 2.5% | 1.6% | n/a |
| low birth weight infants 2010 OHA per 1000 births | 63 | 67.1 | n/a | 50.8 | 90.9 | 114.3 | 56.6 | 49.1 | n/a | 63.2 | 85.4 | 16.4 | 133.3 |
| % of mothers receiving inadequate prenatal care 2010 OHA | 5.5% | 5.5% | 4.8% | 8.5% | 6.0% | 7.2% | 12.8% | 13.5% | 6.2% | 9.7% | 9.6% | 3.4% | n/a |
| % premature births (Not recorded by OHA) | | | | | | | | | | | | | |
| % of women experiencing abuse before or during pregnancy | | | | | | | | | | | | | |
| Infant mortality rate (HIPPA issue?) 2009 OHA per 1000 births | 4.8 | 32.7 | n/a | 4.0 | 12.7 | n/a | n/a |
| Maternal Depression/Prenatal Depression Rates | | | | | | | | | | | | | |
| Child Maltreatment Rates Abuse DHS 2011 per 1000 under 18 | 13.4 | 24.1 | 60 | 11.4 | 12.3 | 25.4 | 19.4 | 16.5 | n/a | 9.3 | 22.5 | 14.9 | 53.1 |
| % of schools meeting physical education standards (as measure of child access to physical activity) | | | | | | | | | | | | | |
| # or % of children on school lunch program (potential measure of food insecurity) 2011-2012 School Year | 51.7% | 42.8% | 32.6% | 58.4% | 59.7% | 50.4% | 69.8% | 71.4% | 52.4% | 62.9% | 53.3% | 37.5% | 48.5% |
| % of children attending preschool prior to entering kindergarten | | | | | | | | | | | | | |
| % of children screened with a developmental tool (by 36 months of age) | | | | | | | | | | | | | |
| % of children current with immunizations by age 3 | 66.6% | 72.3% | 68.7% | 62.3% | 53.4% | 53.8% | 61.8% | 68.1% | 68.7% | 58.0% | 63.7% | 57.9% | S |

* 2008 rate

** S = Suppressed Data

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Community Engagement Process

Community Advisory Councils used qualitative assessments to explore values, perceptions, and the “why” behind the “what” of community members. These assessments do not strive for a statistical sampling. Rather they reach for the reason behind the numbers generated from the quantitative assessments such as surveys, vital statistics and behavioral risk factor studies.

Qualitative assessments help the assessment process to determine the distance between what the statistics show as a community need and what the community perceives as a need. The Grant County CAC utilized available qualitative assessment data from a 2012-2013 Community Health Improvement Partnership (CHIP) Community Health Needs Assessment which included community engagement techniques in the form of a Household Mail-out Survey, Community-Wide Participation Meeting, and Key Informant Interviews. Summarized results from these assessments are included in this report.

Health Assessment Mail-Out Survey

The household mail-out survey is an assessment tool with the greatest potential for accurately determining and measuring “what” or “how” a population is thinking, feeling, behaving, regarding a specific issue or set of issues. . Each local Community Advisory Council wanted to ensure a diverse representation of community members in their qualitative data collection. In total, 3,098 community members in nine rural counties participated in the survey and are representative of each respective county in terms of geography, age, and race / ethnicity. Typically more females than males responded to the survey.

The table at the end of this report provides an overview of survey findings. The goal was to identify community members’ perceptions of the most pressing community health issues. In summary, the primary concerns in *each* of the respective counties are obesity and alcohol and other substance use / abuse. Domestic violence and child abuse were also noted among half of the counties as either primary or secondary community health concerns. Respondents also reported problems related to access to health care in rural Oregon.

There is a particular nuance within the behavioral health data that warrants further investigation. While 20 percent to 40 percent of respondents reported being bothered by little interest in doing things and by feeling down or depressed, less than 12 percent reported needing treatment for mental health issues (or substance use). This difference indicates that respondents were more likely to experience feeling emotionally “down” or depressed but less likely to seek help for these feelings; or to believe their distress needed attention. These data seem even more significant when compared to other health needs. For example, over 80 percent of all respondents received needed medical care and between 43 percent and 94 percent received the dental care they needed.

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Key Informant Interviews

Key Informant interviews are not meant to be a statistical sampling of communities. This process gathers qualitative information – opinions, attitudes and beliefs. The concern is not with specific numbers. Hence, instead of stating “Seven key informants of the 65 interviewed perceived...” We use terms like “*many*,” “*some*,” “*majority*,” “*most*,” etc. The key is being consistent in their use.

Twenty-seven (27) key informant interviews were completed. Respondent ages were fairly evenly distributed across the ages of 30-39; 40-65 and older than 65. The majority were women. There was a largely even distribution across medium and low income levels. Approximately half were white and half Hispanic. There were *many* from Ontario and a *few* from Nyssa plus a *few* from Vale. There appeared to be none from Jordan Valley or Juntura areas.

The following is a summary of *key findings* reflecting attitudes, opinions and beliefs of participants. The findings ARE NOT intended as a statement of fact and to consider them as such would be erroneous.

Key questions and responses taken from the Key Informant Report:

What do you perceive as the most important health system (resource) problem facing your community?

- Interest in tiered payment system
- Health care coverage for those with pre-existing conditions
- Help for people who are employed but uninsured

What do you see as the most important health problems facing your community?

- Obesity
- Diabetes
- Drugs and Alcohol abuse
- Mental health

What is your perception of other community functions?

- *Many* people said there was poor quality of care in ER
- *Some* people are confused about Foot Care services in the county
- *Many* people said that Hospice care is good quality
- *Many* people said there is no preventive services available in the county
- A *Few* people said that Mental Health services are inadequate

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Focus Groups

A focus group is a data collection procedure in the form of a carefully planned group discussion among about ten people plus a moderator and observer, in order to obtain diverse ideas and perceptions on topic of interest in a relaxed, permissive environment that fosters the expression of different points of view, with no pressure for consensus.

CAC members in some counties conducted Focus Groups to gain residential perceptions of local healthcare issues. CAC's developed methods for selecting and identifying their interviewers, which included Hispanic populations. Modified questionnaires were designed to fit characteristics that are unique to their local healthcare systems and used in the group interviews.

Malheur County held three separate Latino Focus Groups between September 19th and October 14th of 2013. The focus group moderator and topic discussions were the same with each group. Following is a combined summary of Participant *Key Responses* from all three groups.

What do you feel are the most pressing health system problems facing Malheur County?

- The need for language assistance during provider visits, lack of medical interpreters available in clinics and hospitals make it difficult for monolingual Spanish speakers; better understanding/treatment by receptionist in provider offices regarding language barriers.
- Prenatal care is of high concern for the region; especially for the uninsured; new program called CAWEM is helping.
- Issue related to Latino and Caucasian population; nutrition, alcohol & drug use, and a high teen pregnancy rate.
- Difficulty in recruiting and retaining bilingual clinicians/providers.
- The need for health promoters to better serve the Latino population by providing educational material

What do you perceive are the biggest health status issues in Malheur County?

- Drug & Alcohol use, especially in the youth; wide-spread in Latino and Caucasian communities; more education/awareness needs to be done in the schools; need for better services in the community toward alcohol and drug prevention geared toward youth; parents need to be taught early signs of depression in teenagers to help prevent youth from drug and alcohol use (self-medicating); need to start Spanish speaking Al-ANON group(s) for family support.
- Teen pregnancies, young (14 yr. old) Latino girls are getting pregnant at a higher rate than Caucasian girls; young girls are becoming single parents; increased teen high school

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dropout rates; parents need to learn how to communicate with their children about sex education and teen pregnancy repercussions.

- Need for Spanish speaking Health Fair(s) which would allow Spanish speakers to learn about nutrition and other health related problems facing their communities.

Do you have a local healthcare provider, if not, where do you go for services?

- Valley Family Health Care was used by participants from all three focus groups, but scheduled appointments often take up to three weeks to be seen.
- People often go to the ER for Urgent Care needs.

Are there special beliefs or specific needs that the health system does not address or recognize?

- Participants expressed the need for clinics and hospitals to provide medical interpreters.

Are healthcare providers sensitive to the needs of the Latino community? Are you treated with respect?

Yes, providers treat them with respect. The need to provide qualified/certified medical interpreters is needed to help people feel comfortable knowing that what they are saying is being conveyed in a professional manner.

What are difficulties experienced in getting to health care services?

Transportation

- Transportation is not a huge issue with the Latino population locally, but it could be a barrier when getting to healthcare services for people who travel out of town.

Access (including payment/insurance), time when services are offered

- Participants expressed concern regarding payment and insurance coverage at time of services.

Language

- Bilingual speaking individuals do not have difficulties with services, but monolingual Spanish speakers seeking healthcare services have difficulties; written brochures and other patient materials would be helpful for monolingual speaking people.

How do you learn about healthcare services? (word of mouth, posters, etc.) What do you think is a good way to reach your community about healthcare services?

- By attending community events, radio advertisement, their local churches and schools; by mail, flyers and word of mouth

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MALHEUR COUNTY

Partners

The Malheur County Community Advisory Council (CAC) consistently received participation from the following organizations, agencies and community members since its inception in February, 2013. Following is a summary of the Community Health Assessments conducted by the local CAC.

- Malheur County Commissioners, Public Health, Juvenile Department and Sheriff's Office;
- Department of Human Services Adults & Persons with Disabilities, Child Welfare, Self-Sufficiency, & Community Development;
- Office of Representative Cliff Bentz
- Southeast Oregon Food Bank
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Data Sources

Primary Data Sources

- "Community Health Needs Survey, Malheur County" 2013. Conducted by the Eastern Oregon Coordinated Care Organization under the direction of the Malheur County CAC.
- Key Informant Interviews conducted by Malheur County CAC members in August and September, 2013.
- Malheur County Latino Focus Groups conducted by Armenia Sarabia of Greater Oregon Behavioral Health, Inc. (GOBHI), in September and October, 2013.

Secondary Data Sources

- "Community Health Needs Survey, - Malheur County" 2013. Eastern Oregon Coordinated Care Organization : Community Advisory Council. Oregon.
- "County Health Calculator," 2013. Robert Wood Johnson Foundation and the Virginia Commonwealth University Center on Human Needs.
- "County Health Rankings and Roadmaps – a Healthier Nation County by County," 2013. Robert Wood Johnson Foundation and University of Wisconsin – Population Health Institute.
- "Data Elements for CCOs Reports," 2013. Oregon Health and Science University. Office of Rural Health.

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- “Malheur County’s Epidemiological Data on Alcohol, Drugs and Mental Health. 2000 to 2012. Oregon Health Authority. Office of Health Analytics and Addictions and Mental health Division.
- “Oregon Smile Survey,” Oregon Health Authority, 2012.
- “Prevention Chronic Diseases and Reducing Health Risk Factors,” 2013. Centers for Disease Control and Prevention. CDC 24/7 : Saving Lives. Protecting People.
- “Quick Facts,” January 2013. Oregon Department of Human Services; Children, Adults and Families Division. Office of Business Intelligence and the Office of Forecasting, Research and Analysis.

Priority Needs

EOCCO staff supported the Malheur County LCAC in developing a draft needs assessment survey. This was mailed as a household survey to approximately 900 random households, from which there were 366 responses for a 35% response rate.

The Malheur County CAC group reviewed, suggested modifications and approved a Key Informant Interview guide with assistance from EOCCO staff. After reporting demographic information about prospective respondents, CAC members utilized this questionnaire in surveying a diverse group (age, income and community of residence) of 27 Malheur County residents. One-on-one interviews were then recorded and analyzed for major themes, which were shared with the CAC as a group.

Eliciting responses from our Hispanic community was a critical concern for our CAC. To this end, three separate focus groups were conducted by bilingual staff provided by EOCCO that included approximately 45 persons from local child care centers and faith based organizations. Major themes that emerged were coded and communicated in the form of reports to the CAC by GOBHI staff that facilitated the discussion of local health care resources, health concerns, and challenges unique to this community.

Primary information gathered was combined with secondary data, and prepared in a Triangulation report by EOCCO staff. The Triangulation identified topic areas where there were multiple data sources. At the November 25, 2013 CAC meeting, the group reviewed the triangulation and used a forced choice matrix to vote individually and privately on priorities based on the Triangulation report. CAC members who did not attend the meeting were included in the matrix vote by submitting emailed responses. EOCCO staff provided the group with rankings that identified the following priority areas:

- 1. Mental Health**
- 2. Social Determinants of Health**
- 3. Alcohol and Drugs**
- 4. Children and Families**

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In addition to the Primary and Secondary Needs Assessment data described above, the Malheur Community Advisory Council has engaged community members and representatives from a diverse group of community, social, and health service agencies that invested over 250 hours in planning, education, and discussion around health priorities which would warrant action in Malheur County. As we move into the process of implementing a Community Health Improvement Plan, we are hopeful for the continued support of Greater Oregon Behavioral Health (GOBHI) and Eastern Oregon Coordinated Care Organization (EOCCO) to make an impact on health outcomes for our diverse rural frontier community.

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Survey Summary:

| | Totals N=3,098 | Baker N=242 | Gilliam N=209 | Grant N=1,041 | Lake (South) N=421 | Lake (North) N= 143 | Malheur N=298 | Sherman N=195 | Union N=259 | Wallowa N=140 | Wheeler N=150 |
|--|-------------------|----------------|--|------------------|--------------------------|---------------------------|------------------|--|--|------------------|------------------|
| 1. What is your health insurance status? (Top cited) | Medicare – 36% | Medicare – 45% | Employer or family member’s employer – 42.6% | Medicare – 36% | Medicare – 34.6% | Medicare – 45% | Medicare – 39.9% | Employer or family member’s employer – 37.4% | Employer or family member’s employer – 42.9% | Medicare – 42.9% | Medicare – 48.7% |
| 2. Do you have one person you think of as your personal doctor or health care provider? (percent Yes) | 80% | 85% | 83% | 70.9% | 88.7% | 82.7% | 83% | 82% | 83% | 92% | 82% |
| 3. Thinking about the last six months, was there a time when you or someone in your household needed medical care? (Yes) | 80% | 79% | 81% | 78% | 76% | 76.8% | 83% | 81% | 84% | 81% | 82% |
| 4. If you or someone in your household needed care in the last six months, did they get all the care they needed? (Yes) | 84% | 85% | 92% | 79.3% | 85% | 80% | 86% | 91% | 85% | 80% | 89% |

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|--|-------------------------|-------------------------|---------------------------|---------------------------|----------------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|---------------------------|
| 5. Thinking of the most recent time within the last 6 months you or someone in your household went without needed care, what were the main reasons? Mark all that apply? (Top Reason) | It costs too much – 36% | It costs too much – 34% | It costs too much – 32.7% | It costs too much – 27.3% | Couldn't get appointment – 31.5% | It costs too much – 35.8% | It costs too much – 16.4% | It costs too much – 40.9% | It costs too much – 15.1% | It costs too much – 39.6% | It costs too much – 33.3% |
| 6. Thinking about the last six month, was there a time when you or someone in your household needed dental care? (Yes) | 74% | 67% | 75% | 74% | 71.2% | 69% | 65% | 76% | 80% | 77% | 69% |
| 7. If you or someone in your household needed dental care in the last six months, did they get all the care they needed? (Yes) | 70% | 68% | 81% | 69% | 80% | 43.6% | 94% | 73% | 73% | 68% | 73% |

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|--|-------------------|----------------|------------------|------------------|--------------------------|---------------------------|------------------|------------------|----------------|------------------|------------------|
| 8. Thinking about the last six months, was there a time when you or someone in your household needed prescription medications? (Yes) | 88% | 87% | 89% | 87% | 86% | 79% | 94% | 88% | 91% | 89% | 86% |
| 9. If you or someone in your household needed prescription medications in the last six months, did they get all the medications they needed? (Yes) | 92% | 93% | 95% | 92% | 93% | 88% | 88% | 94% | 88% | 82% | 92% |

**Community Advisory Council Health Assessment
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|---|-------------------|----------------|------------------|------------------|--------------------------|---------------------------|------------------|------------------|----------------|------------------|------------------|
| 10. Thinking about the last six months, was there a time when you or someone in your household needed treatment for mental health or substance use? (Yes) | 7% | 9% | 7% | 7% | 5.1% | 11% | 11% | 6% | 8% | 7% | 4% |
| 11. If you or someone in your household needed mental health or substance use treatment in the last six months, did they get all the help they needed? (Yes) | 55% | 48% | 27% | 51.5% | 70% | 63.2% | 44% | 44% | 81% | 50% | 27% |

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|--|---|--|--|---|--|--|---|--|--|--|--|
| 12. If you regularly seek care outside of your county, what are the main reasons why? (Top cited) | Needed care that I can't get locally – 45.5% | Needed care that I can't get locally – 36.5% | Needed care that I can't get locally – 49.6% | Needed care that I can't get locally – 43% | Needed care that I can't get locally – 39.8% | Needed care that I can't get locally – 35.3% | Needed care that I can't get locally – 31.4% | Needed care that I can't get locally – 53.8% | Needed care that I can't get locally – 32.8% | Needed care that I can't get locally – 41.8% | Needed care that I can't get locally – 44.6% |
| 13. Have you ever been told by a doctor or other health professional that you have any of the following? (Top Three Answers) | High blood pressure – 25.2% High cholesterol- 21.5% Arthritis – 14.2% | Arthritis -44% High Blood pressure - 43.5% High choleste rol - 36.5% | High cholesterol – 41.6% High blood pressure – 38.3% Arthritis – 24.4% | High blood pressure – 35.5% High cholesterol – 29.8% Diabetes – 11% | High blood pressure – 16.9% Arthritis – 15.8% Vision – 14% | High blood pressure – 17.3% High cholesterol – 14.9% Arthritis – 13.3% | Arthritis – 33.4% High cholesterol – 29.7% Depressed or anxiety – 20.5% | High cholesterol – 39% Arthritis – 37.9% High blood pressure – 32.3% | High blood pressure – 34% Arthritis – 30.1% High cholesterol – 27.4% | High blood pressure – 45.5% Arthritis – 41.1% High cholesterol – 29.3% | High blood pressure – 58.3% Arthritis – 44.7% High cholesterol – 44.7% |

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|---|-------------------|----------------|------------------|------------------|-----------------------|---------------------------|------------------|------------------|----------------|------------------|------------------|
| 14. Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things? (Yes – several days, more than half or every day total) | 28% | 29% | 25% | 25% | 30% | 40.1% | 33% | 27% | 29% | 32% | 31% |
| 15. Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless? (Yes – several days, more than half or every day total) | 26% | 27% | 23% | 24% | 25% | 32% | 30% | 20% | 28% | 31% | 30% |

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|---|-------------------|----------------|------------------|------------------|--------------------------|---------------------------|------------------|------------------|----------------|------------------|------------------|
| 16. Does a physical, mental, or emotional problem now limit your ability to work or perform routine tasks? (Yes) | 22% | 25% | 14% | 18% | 25% | 37% | 28% | 18% | 19% | 22% | 24% |
| 17. In the last 12 months, how often have you or members of your household ever cut the size of meals or skipped meals because there wasn't enough money for food? (Yes – Sometimes or Often) | 14.5% | 18% | 8% | 12% | 16.3% | 18.6% | 21% | 9% | 15% | 20% | 12% |

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|---|-------------------|----------------|------------------|------------------|-----------------------|------------------------|------------------|------------------|----------------|------------------|------------------|
| 18. In the last 12 months how often have you been worried that your food would run out before you got money to buy more? (Yes – Sometimes or Often) | 18.2% | 21% | 10% | 16% | 19% | 23% | 26% | 14% | 26% | 24% | 16% |
| 19. In the last 12 months, were you or other members of your household unable to pay your rent, mortgage, or utility bills? (Yes) | 9% | 11% | 5% | 3.2% | 12% | 18% | 18% | 8% | 13% | 11% | 5% |

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|--|---|---|---|--|--|--|---|---|---|---|---|
| 20. In the last 12 months, how often did you have a difficult time accessing transportation when you needed it? (Yes – Sometimes or Often) | 10% | 11% | 11% | 9.3% | 11.3% | 16% | 13% | 8% | 9% | 8% | 11% |
| 21. Which of the following would you say is the most important health concern our community is facing today? (Top Three) | Alcohol – 23% Obesity – 20% Substance or drug use – 10.3% | Obesity - 29.3% Substance or drug use / abuse - 24% Domestic violence – child abuse / neglect - 21.1% | Obesity – 24.4% Lack of recreational facilities – 20.1% Substance or drug use / abuse – 19.1% | Alcohol or drug use – 45.2% Obesity – 16.9% Lack of access to good health care – 13.3% | Alcohol or drug use – 48.1% Obesity – 20.5% Lack of recreational facilities – 7.1% | Alcohol or drug use – 31.3% Obesity – 14.9% Lack of access to good health care – 13.4% | Obesity – 31.1% Substance or drug use / abuse – 28% Domestic violence – child abuse / neglect – 24.9% | Substance or drug use / abuse – 22.1% Obesity – 21.5% Alcohol use – 15.9% | Obesity – 33.6% Substance or drug use / abuse – 26.6% Domestic violence – child abuse / neglect – 17.4% | Obesity – 25% Substance or drug use / abuse – 17.1% Lack of recreational facilities – 15.7% | Obesity – 29.3% Substance or drug use / abuse – 17.3% Tobacco use – 10.7% |

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|---|---|--|---|---|--|--|--|---|---|---|---|
| 22. Which of the following would you say is the second most important health concern our community is facing today? (Top Three) | Obesity – 13% Lack of recreational facility – 12% Alcohol or drug use – 10% | Substance or drug use / abuse - 19% Obesity - 11.2% Alcohol use - 9.5% | Substance or drug use / abuse – 14.4% Alcohol use – 10.5% Lack of recreational facilities – 10% | Alcohol or drug use – 25% Domestic violence – 15.9% Obesity – 13.7% | Alcohol or drug use – 22% Obesity – 18.9% Domestic violence or child abuse/neglect – 14.1% | Alcohol or drug use – 23.4% Domestic violence or child abuse/neglect – 12.5% Lack of access to good health care – 11.7 | Substance or drug use / abuse – 23.5% Child abuse / neglect – 9.6% Lack of access to good health care – 8.2% | Substance abuse or drug use / abuse – 18.5% Alcohol use – 16.9% Obesity – 12.3% | Substance or drug use / abuse – 22% Child abuse / neglect – 12.4% Obesity – 10.8% | Alcohol use – 14.3% Obesity – 13.6% Substance or drug use / abuse – 13.6% | Alcohol use – 21.3% Substance or drug use / abuse – 14% Obesity – 12% |
| 23. If you could do one thing to improve our community's access to health care, what would it be? (Top cited) | More primary care providers – 35.8% | More specialists - 14.9% | Expanded hours for outpatient services – 24.9% | More primary care providers – 37.7% | More primary care providers – 38.5% | More primary care providers – 38.8% | More primary care providers – 21.8% | More primary care providers – 28.2% | More primary care providers – 18.9% | More specialists – 18.6% | More primary care providers – 23.3% |

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|--|-------------------|----------------|------------------|------------------|-----------------------|------------------------|------------------|------------------|----------------|------------------|------------------|
| 24. What would be the best way for you to receive health education information about resources and programs that are available in our community? (Top cited) | Mail – 51.4% | Mail - 49.6% | Mail – 48.3% | Mail – 47.5% | Mail – 46% | Mail – 66% | Mail – 53.6% | Mail – 61.5% | Mail – 48.6% | Mail – 47.9% | Mail – 58% |

Local Public Health Authority:

Date:

Minimum Standards

To the best of your knowledge, are you in compliance with these program indicators from the Minimum Standards for Local Health Departments?

I. Organization

1. Yes No A Local Health Authority exists which has accepted the legal responsibilities for public health as defined by Oregon Law.
2. Yes No The Local Health Authority meets at least annually to address public health concerns.
3. Yes No A current organizational chart exists that defines the authority, structure and function of the local health department; and is reviewed at least annually.
4. Yes No Current local health department policies and procedures exist which are reviewed at least annually.
5. Yes No Ongoing community assessment is performed to analyze and evaluate community data.
6. Yes No Written plans are developed with problem statements, objectives, activities, projected services, and evaluation criteria.
7. Yes No Local health officials develop and manage an annual operating budget.
8. Yes No Generally accepted public accounting practices are used for managing funds.
9. Yes No All revenues generated from public health services are allocated to public health programs.
10. Yes No Written personnel policies and procedures are in compliance with federal and state laws and regulations.
11. Yes No Personnel policies and procedures are available for all employees.
12. Yes No All positions have written job descriptions, including minimum qualifications.

Local Public Health Authority:

Date:

13. Yes No Written performance evaluations are done annually.
14. Yes No Evidence of staff development activities exists.
15. Yes No Personnel records for all terminated employees are retained consistently with State Archives rules.
16. Yes No Records include minimum information required by each program.
17. Yes No A records manual of all forms used is reviewed annually.
18. Yes No There is a written policy for maintaining confidentiality of all client records which includes guidelines for release of client information.
19. Yes No Filing and retrieval of health records follow written procedures.
20. Yes No Retention and destruction of records follow written procedures and are consistent with State Archives rules.
21. Yes No Local health department telephone numbers and facilities' addresses are publicized.
22. Yes No Health information and referral services are available during regular business hours.
23. Yes No Written resource information about local health and human services is available, which includes eligibility, enrollment procedures, scope and hours of service. Information is updated as needed.
24. Yes No 100% of birth and death certificates submitted by local health departments are reviewed by the local Registrar for accuracy and completeness per Vital Records office procedures.
25. Yes No To preserve the confidentiality and security of non-public abstracts, all vital records and all accompanying documents are maintained.
26. Yes No Certified copies of registered birth and death certificates are issued within one working day of request.
27. Yes No Vital statistics data, as reported by the Center for Health Statistics, are reviewed annually by local health departments to review accuracy and support ongoing community assessment activities.

Local Public Health Authority:

Date:

28. Yes No A system to obtain reports of deaths of public health significance is in place.
29. Yes No Deaths of public health significance are reported to the local health department by the medical examiner and are investigated by the health department.
30. Yes No Health department administration and county medical examiner review collaborative efforts at least annually.
31. Yes No Staff is knowledgeable of and has participated in the development of the county's emergency plan.
32. Yes No Written policies and procedures exist to guide staff in responding to an emergency.
33. Yes No Staff participate periodically in emergency preparedness exercises and upgrade response plans accordingly.
34. Yes No Written policies and procedures exist to guide staff and volunteers in maintaining appropriate confidentiality standards.
35. Yes No Confidentiality training is included in new employee orientation. Staff includes: employees, both permanent and temporary, volunteers, translators, and any other party in contact with clients, services or information. Staff sign confidentiality statements when hired and at least annually thereafter.
36. Yes No A Client Grievance Procedure is in place with resultant staff training and input to assure that there is a mechanism to address client and staff concerns.

Control of Communicable Diseases

37. Yes No There is a mechanism for reporting communicable disease cases to the health department.
38. Yes No Investigations of reportable conditions and communicable disease cases are conducted, control measures are carried out, investigation report forms are completed and submitted in the manner and time frame specified for the particular disease in the Oregon Communicable Disease Guidelines.
39. Yes No Feedback regarding the outcome of the investigation is provided to the reporting health care provider for each reportable condition or communicable disease case received.

Local Public Health Authority:

Date:

40. Yes No Access to prevention, diagnosis, and treatment services for reportable communicable diseases is assured when relevant to protecting the health of the public.
41. Yes No There is an ongoing/demonstrated effort by the local health department to maintain and/or increase timely reporting of reportable communicable diseases and conditions.
42. Yes No There is a mechanism for reporting and following up on zoonotic diseases to the local health department.
43. Yes No A system exists for the surveillance and analysis of the incidence and prevalence of communicable diseases.
44. Yes No Annual reviews and analysis are conducted of five year averages of incidence rates reported in the Communicable Disease Statistical Summary, and evaluation of data are used for future program planning.
45. Yes No Immunizations for human target populations are available within the local health department jurisdiction.
46. Yes No Rabies immunizations for animal target populations are available within the local health department jurisdiction.

Environmental Health

47. Yes No Food service facilities are licensed and inspected as required by Chapter 333 Division 12.
48. Yes No Training is available for food service managers and personnel in the proper methods of storing, preparing, and serving food.
49. Yes No Training in first aid for choking is available for food service workers.
50. Yes No Public education regarding food borne illness and the importance of reporting suspected food borne illness is provided.
51. Yes No Each drinking water system conducts water quality monitoring and maintains testing frequencies based on the size and classification of system.
52. Yes No Each drinking water system is monitored for compliance with applicable standards based on system size, type, and epidemiological risk.

Local Public Health Authority:

Date:

53. Yes No Compliance assistance is provided to public water systems that violate requirements.
54. Yes No All drinking water systems that violate maximum contaminant levels are investigated and appropriate actions taken.
55. Yes No A written plan exists for responding to emergencies involving public water systems.
56. Yes No Information for developing a safe water supply is available to people using on-site individual wells and springs.
57. Yes No A program exists to monitor, issue permits, and inspect on-site sewage disposal systems.
58. Yes No Tourist facilities are licensed and inspected for health and safety risks as required by Chapter 333 Division 12.
59. Yes No School and public facilities food service operations are inspected for health and safety risks.
60. Yes No Public spas and swimming pools are constructed, licensed, and inspected for health and safety risks as required by Chapter 333 Division 12.
61. Yes No A program exists to assure protection of health and the environment for storing, collecting, transporting, and disposing solid waste.
62. Yes No Indoor clean air complaints in licensed facilities are investigated. **These are referred to DEQ.**
63. Yes No Environmental contamination potentially impacting public health or the environment is investigated.
64. Yes No The health and safety of the public is being protected through hazardous incidence investigation and response.
65. Yes No Emergency environmental health and sanitation are provided to include safe drinking water, sewage disposal, food preparation, solid waste disposal, sanitation at shelters, and vector control.
66. Yes No All license fees collected by the Local Public Health Authority under ORS 624, 446, and 448 are set and used by the LPHA as required by ORS 624, 446, and 448.

Local Public Health Authority:

Date:

Health Education and Health Promotion

67. Yes No Culturally and linguistically appropriate health education components with appropriate materials and methods will be integrated within programs.

68. Yes No The health department provides and/or refers to community resources for health education/health promotion.

69. Yes No The health department provides leadership in developing community partnerships to provide health education and health promotion resources for the community.

70. Yes No Local health department supports healthy behaviors among employees.

71. Yes No Local health department supports continued education and training of staff to provide effective health education.

72. Yes No All health department facilities are smoke free.

Nutrition

73. Yes No Local health department reviews population data to promote appropriate nutritional services.

74. The following health department programs include an assessment of nutritional status:

a. Yes No WIC

b. Yes No Family Planning

c. Yes No Parent and Child Health

d. Yes No Older Adult Health

e. Yes No Corrections Health

75. Yes No Clients identified at nutritional risk are provided with or referred for appropriate interventions.

76. Yes No Culturally and linguistically appropriate nutritional education and promotion materials and methods are integrated within programs.

77. Yes No Local health department supports continuing education and training of staff to provide effective nutritional education.

Local Public Health Authority:**Date:****Older Adult Health**

78. Yes No Health department provides or refers to services that promote detecting chronic diseases and preventing their complications.

79. Yes No A mechanism exists for intervening where there is reported elder abuse or neglect.

80. Yes No Health department maintains a current list of resources and refers for medical care, mental health, transportation, nutritional services, financial services, rehabilitation services, social services, and substance abuse services.

81. Yes No Prevention-oriented services exist for self health care, stress management, nutrition, exercise, medication use, maintaining activities of daily living, injury prevention and safety education.

Parent and Child Health

82. Yes No Perinatal care is provided directly or by referral.

83. Yes No Immunizations are provided for infants, children, adolescents and adults either directly or by referral.

84. Yes No Comprehensive family planning services are provided directly or by referral.

85. Yes No Services for the early detection and follow up of abnormal growth, development and other health problems of infants and children are provided directly or by referral.

86. Yes No Child abuse prevention and treatment services are provided directly or by referral.

87. Yes No There is a system or mechanism in place to assure participation in multi-disciplinary teams addressing abuse and domestic violence.

88. Yes No There is a system in place for identifying and following up on high risk infants.

89. Yes No There is a system in place to follow up on all reported SIDS deaths.

Local Public Health Authority:

Date:

90. Yes No Preventive oral health services are provided directly or by referral.

91. Yes No Use of fluoride is promoted, either through water fluoridation or use of fluoride mouth rinse or tablets.

92. Yes No Injury prevention services are provided within the community.

Primary Health Care

93. Yes No The local health department identifies barriers to primary health care services.

94. Yes No The local health department participates and provides leadership in community efforts to secure or establish and maintain adequate primary health care.

95. Yes No The local health department advocates for individuals who are prevented from receiving timely and adequate primary health care.

96. Yes No Primary health care services are provided directly or by referral.

97. Yes No The local health department promotes primary health care that is culturally and linguistically appropriate for community members.

98. Yes No The local health department advocates for data collection and analysis for development of population based prevention strategies.

Cultural Competency

99. Yes No The local health department develops and maintains a current demographic and cultural profile of the community to identify needs and interventions.

100. Yes No The local health department develops, implements and promotes a written plan that outlines clear goals, policies and operational plans for provision of culturally and linguistically appropriate services.

101. Yes No The local health department assures that advisory groups reflect the population to be served.

102. Yes No The local health department assures that program activities reflect operation plans for provision of culturally and linguistically appropriate services.

Local Public Health Authority:

Date:

Health Department Personnel Qualifications

Local health department Health Administrator minimum qualifications:

The Administrator must have a Bachelor degree plus graduate courses (or equivalents) that align with those recommended by the Council on Education for Public Health. These are: Biostatistics, Epidemiology, Environmental health sciences, Health services administration, and Social and behavioral sciences relevant to public health problems. The Administrator must demonstrate at least 3 years of increasing responsibility and experience in public health or a related field.

Answer the following questions:

Administrator name: Rebecca Stricker, RN

Does the Administrator have a Bachelor degree? Yes ___ No x

Does the Administrator have at least 3 years experience in Yes x No ___
public health or a related field?

Has the Administrator taken a graduate level course in Yes ___ No x
biostatistics?

Has the Administrator taken a graduate level course in Yes ___ No x
epidemiology?

Has the Administrator taken a graduate level course Yes ___ No x
in environmental health?

Has the Administrator taken a graduate level course Yes ___ No x
in health services administration?

Has the Administrator taken a graduate level course in Yes ___ No x
social and behavioral sciences relevant to public health problems?

**a. Yes ___ No x The local health department Health Administrator meets minimum qualifications:
If the answer is “No”, submit an attachment that describes your plan to meet the minimum
qualifications.**

The Local Health Department has recently lost their Administrator. The interim administrator is a Registered Nurse and is filling this position temporarily; however she will be enrolled in required Bachelor’s degree classes by fall of this year.

Local Public Health Authority:

Date:

b. Yes No The local health department Supervising Public Health Nurse meets minimum qualifications:

Licensure as a registered nurse in the State of Oregon, progressively responsible experience in a public health agency;

AND

Baccalaureate degree in nursing, with preference for a Master's degree in nursing, public health or public administration or related field, with progressively responsible experience in a public health agency.

If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.

The Local Health Department Administrator supervises the nurses; however they have recently lost their Administrator. The interim administrator is a Registered Nurse and is filling this position temporarily; she will be enrolled in required Bachelor’s degree classes by fall of this year.

c. Yes No The local health department Environmental Health Supervisor meets minimum qualifications:

Registration as an environmental health specialist in the State of Oregon, pursuant to ORS 700.030, with progressively responsible experience in a public health agency

OR

a Master's degree in an environmental science, public health, public administration or related field with two years progressively responsible experience in a public health agency.

If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.

d. Yes No The local health department Health Officer meets minimum qualifications:

Licensed in the State of Oregon as M.D. or D.O. Two years of practice as licensed physician (two years after internship and/or residency). Training and/or experience in epidemiology and public health.

If the answer is “No”, submit an attachment that describes your plan to meet the minimum qualifications.

Local Public Health Authority:

Date:

Agencies are **required** to include with the submitted Annual Plan:

The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375–431.385 and ORS 431.416, are performed.

Local Public Health Authority

County

Date

Local Public Health Authority:

Date:

Agencies are **required** to include with the submitted Annual Plan:

The local public health authority is submitting the Annual Plan pursuant to ORS 431.385, and assures that the activities defined in ORS 431.375–431.385 and ORS 431.416, are performed.

Dan P. Joyce
Local Public Health Authority

Malheur
County

2/24/2014
Date

2010-2011 HISTORICAL DATA 2011-2012

ADOPTED 2012-2013

ACCT

DESCRIPTION

PROPOSED

APPROVED

ADOPTED

REVENUES

| 2010-2011 | 2011-2012 | 2012-2013 | ACCT | DESCRIPTION | PROPOSED | APPROVED | ADOPTED |
|-----------|-----------|-----------|-----------|--------------------------|-----------|-----------|-----------|
| 19,116 | 15,709 | 15,841 | 3-30-3401 | SCHOOL BASED CLINICS | 14,000 | 14,000 | 14,000 |
| 14,266 | 40,000 | 40,000 | 3-30-3402 | HEALTH IMMUNIZ.GRANTS | 39,000 | 39,000 | 39,000 |
| 49,093 | 35,522 | 35,155 | 3-30-3403 | HEALTH DEPT/CACCON | 35,000 | 35,000 | 35,000 |
| 39,083 | 52,002 | 46,656 | 3-30-3404 | STATE SUPPORT PUB HEALTH | 52,000 | 52,000 | 52,000 |
| 40,489 | 36,663 | 20,000 | 3-30-3405 | FAMILY PLANNING/STATE | 30,000 | 30,000 | 30,000 |
| 54,994 | 278,096 | 260,337 | 3-30-3406 | MEDICAID/BABIES FIRST | 260,000 | 260,000 | 260,000 |
| 275,254 | | | 3-30-3407 | ST HEALTH/WIC GRANT | | | |
| 784 | | | 3-30-3408 | AIDS PROGRAMS- STATE | | | |
| 37,998 | 38,451 | 39,651 | 3-30-3409 | ST HEALTH/MCH GRANT | 29,000 | 29,000 | 29,000 |
| 56,907 | 61,347 | 58,365 | 3-30-3411 | TOBACCO PREVENTION & ED | 55,000 | 55,000 | 55,000 |
| 2,307 | 2,872 | 2,872 | 3-30-3413 | TB CASE MANAGEMENT | 1,000 | 1,000 | 1,000 |
| 2,995 | 5,526 | 15,000 | 3-30-3430 | MEDICAID/HEALTHY START | 5,500 | 5,500 | 5,500 |
| 63,015 | 73,403 | 71,152 | 3-30-3433 | HEALTHY START FUNDS | 65,000 | 65,000 | 65,000 |
| 32,500 | 27,821 | 50,000 | 3-30-3434 | MEDICAID ADMIN MATCH | 55,000 | 55,000 | 55,000 |
| 1,672 | 80 | 2,000 | 3-30-3454 | HEALTHY COMMUNITIES | | | |
| 1,632 | 1,260 | 1,663 | 3-30-3470 | MEDICAID/PERINATAL | 2,000 | 2,000 | 2,000 |
| 101,513 | 79,858 | 83,093 | 3-30-3704 | OREGON MOTHERS CARE | 1,300 | 1,300 | 1,300 |
| 164,654 | 176,269 | 175,000 | 3-30-3780 | EMERGENCY PREPAREDNESS | 80,000 | 80,000 | 80,000 |
| 131,962 | 122,047 | 8,625 | 3-30-4512 | O.H.D./FPEP FEES | 175,000 | 175,000 | 175,000 |
| 42,333 | 39,679 | 100,000 | 3-40-4114 | GRANT REVENUE | 1,000 | 1,000 | 1,000 |
| 5,211 | 500 | 39,600 | 3-40-4511 | SCHOOL FEES | 100,000 | 100,000 | 100,000 |
| 3,822 | 270 | 2,500 | 3-40-4514 | SCHOOL NURSE CONTRACT | 39,600 | 39,600 | 39,600 |
| | | | 3-40-6500 | DONATIONS | | | |
| | | | 3-40-6602 | REIMBURSED TRAVEL | 2,500 | 2,500 | 2,500 |
| 1,142,000 | 1,086,610 | 1,067,510 | TOTAL | DEPT 412 REVENUES | 1,041,900 | 1,041,900 | 1,041,900 |

EXPENSES

| 2010-2011 | 2011-2012 | 2012-2013 | ACCT | DESCRIPTION | PROPOSED | APPROVED | ADOPTED |
|-----------|-----------|-----------|-----------|------------------------|-----------|-----------|-----------|
| 58,442 | 37,456 | 55,620 | 5-10-1101 | ADMIN NURSE | 55,460 | 55,460 | 55,460 |
| 15,056 | 15,360 | 15,816 | 5-10-1102 | HEALTH OFFICER | 15,672 | 15,672 | 15,672 |
| 55,673 | 56,765 | 58,464 | 5-10-1103 | R.N.COORDINATOR 1FTE | 59,640 | 59,640 | 59,640 |
| 52,743 | 54,263 | 56,376 | 5-10-1104 | ACCTG SPEC 1.6FTE | 57,504 | 57,504 | 57,504 |
| 50,137 | 49,847 | 52,872 | 5-10-1201 | NURSE PRACTITIONER | | | |
| 326,600 | 282,174 | 399,398 | 5-10-1203 | R.N. 7.2FTE | 420,883 | 420,883 | 420,883 |
| | 71,346 | | 5-10-1205 | R.N.HEALTHY START | | | |
| 76,899 | 58,452 | 58,464 | 5-10-1207 | R.N.JAIL 1FTE | 59,640 | 59,640 | 59,640 |
| 122,254 | 105,661 | 111,621 | 5-10-1220 | HEALTH SPEC 3-5FTE @.5 | 118,074 | 118,074 | 118,074 |
| 143,982 | 123,867 | 124,995 | 5-10-1222 | O.A.11 4FTE | 127,977 | 127,977 | 127,977 |
| 30,839 | 31,170 | 25,900 | 5-10-1231 | RN/SCHOOL NURSE | 25,900 | 25,900 | 25,900 |
| 27,451 | 27,980 | 29,205 | 5-10-1601 | NUTRITIONIST/CONTRACT | 29,205 | 29,205 | 29,205 |
| 386,844 | 393,985 | 493,249 | 5-10-2910 | PAYROLL COSTS | 501,139 | 501,139 | 501,139 |
| 1,346,920 | 1,308,326 | 1,481,980 | TOTAL | PERSONAL SERVICES | 1,471,094 | 1,471,094 | 1,471,094 |
| 10,130 | 10,278 | 12,000 | | UTILITIES | 12,000 | 12,000 | 12,000 |

| --- HISTORICAL DATA --- | | ADOPTED | | ACCT | DESCRIPTION | PROPOSED | APPROVED | ADOPTED |
|-------------------------|-----------|-----------|-----------|----------------------------|------------------------|-----------|-----------|---------|
| 2010-2011 | 2011-2012 | 2012-2013 | | | | | | |
| 19,443 | 29,779 | 20,000 | 5-20-4200 | JANITOR/BLDG MAINTENANCE | 14,000 | 14,000 | 14,000 | |
| 11,512 | 15,645 | 18,000 | 5-20-4300 | EQUIPMENT MAINTENANCE | 15,000 | 15,000 | 15,000 | |
| 10,531 | 7,384 | 8,000 | 5-20-5300 | TELEPHONE | 8,000 | 8,000 | 8,000 | |
| 5,476 | 6,228 | 7,500 | 5-20-5310 | POSTAGE, FRT | 7,500 | 7,500 | 7,500 | |
| 10,408 | 10,930 | 13,000 | 5-20-5400 | ADVERTISING | 10,000 | 10,000 | 10,000 | |
| 23,472 | 21,088 | 25,100 | 5-20-5800 | TRAVEL/TRAINING | 18,000 | 18,000 | 18,000 | |
| 4,192 | 390 | 2,500 | 5-20-5801 | REIMBURSED TRAVEL | 2,500 | 2,500 | 2,500 | |
| 17,387 | 16,962 | 18,200 | 5-20-6110 | OFFICE SUPPLIES | 15,000 | 15,000 | 15,000 | |
| 17,924 | 17,924 | | 5-20-6111 | D.P. SUPPORT | | | | |
| 4,180 | 3,848 | 3,500 | 5-20-6120 | LAB REG. & LICENSING FEE | 4,000 | 4,000 | 4,000 | |
| 1,029 | 1,772 | 3,325 | 5-20-6400 | EDUCATIONAL MATERIALS | 2,000 | 2,000 | 2,000 | |
| 37,713 | 55,784 | 50,000 | 5-20-6600 | CLINIC EXPENSE | 42,500 | 42,500 | 42,500 | |
| 128,131 | 127,714 | 139,000 | 5-20-6601 | VACCINE/IMMUNIZATIONS | 130,000 | 130,000 | 130,000 | |
| 32,287 | 169 | 500 | 5-20-6602 | TB CLINIC EXPENSE | 500 | 500 | 500 | |
| 15,000 | 28,279 | 20,000 | 5-20-6606 | MEDICAID ADMIN MATCH | 20,000 | 20,000 | 20,000 | |
| | | 5,900 | 5-20-7000 | SMALL EQUIPMENT | 9,000 | 9,000 | 9,000 | |
| | | 20,000 | 5-20-8020 | BABIES FIRST/MATCH FUNDS | 20,000 | 20,000 | 20,000 | |
| 348,820 | 374,374 | 368,525 | | TOTAL MATERIALS & SERVICES | 330,000 | 330,000 | 330,000 | |
| CAPITAL OUTLAY | | | | 5-40-7410 | CAP. OUTLAY/EQUIPMENT | | | |
| | 5,153 | | | TOTAL CAPITAL OUTLAY | | | | |
| TRANSFERS | | | | 5-50-8209 | SPECIAL FUNDS TRANSFER | | | |
| 21,500 | | | | TOTAL TRANSFERS | | | | |
| 1,717,240 | 1,687,853 | 1,850,505 | | TOTAL DEPT 412 EXPENSES | 1,801,094 | 1,801,094 | 1,801,094 | |

6/11/13
 9:54 AM
 LORINDA
 101-GENERAL FUND
 415-MEDICAL INVESTIGATION
 -- HISTORICAL DATA --
 2010-2011 2011-2012

BUDGET DOCUMENT
 YEAR 2013-2014
 ADOPTED 2012-2013
 ACCT DESCRIPTION

PAGE 32
 G11611
 G116-

PERSONAL SERVICES

| | | | | | | | | |
|--------|--------|--------|-----------|-------------------------|------|--------|--------|--------|
| 12,768 | 13,375 | 14,100 | 5-10-1201 | ACCTG SPEC | 4FTE | 14,376 | 14,376 | 14,376 |
| 8,062 | 9,532 | 10,100 | 5-10-2910 | PAYROLL COSTS | | 10,701 | 10,701 | 10,701 |
| 2,400 | 2,400 | 3,000 | 5-10-3210 | MED. INVESTIGATOR | | 3,000 | 3,000 | 3,000 |
| 1,295 | 1,960 | 2,000 | 5-10-3300 | DEPUTY INVESTIGATORS | | 2,000 | 2,000 | 2,000 |
| 24,525 | 27,267 | 29,200 | | TOTAL PERSONAL SERVICES | | 30,077 | 30,077 | 30,077 |

MATERIALS & SERVICES

| | | | | | | | | |
|-------|-------|--------|-----------|----------------------------|----------------|--------|--------|--------|
| 8,195 | 7,800 | 10,000 | 5-20-3211 | AUTOPSIES | 40% REIMBURSED | 10,000 | 10,000 | 10,000 |
| 8,195 | 7,800 | 10,000 | | TOTAL MATERIALS & SERVICES | | 10,000 | 10,000 | 10,000 |

| | | | | | | | | |
|--------|--------|--------|----------------|----------|--|--------|--------|--------|
| 32,720 | 35,067 | 39,200 | TOTAL DEPT 415 | EXPENSES | | 40,077 | 40,077 | 40,077 |
|--------|--------|--------|----------------|----------|--|--------|--------|--------|

EXPENSES

PROPOSED APPROVED ADOPTED

MALHEUR COUNTY HEALTH DEPARTMENT
ORGANIZATIONAL CHART 2013-2014

Malheur County Court
Judge – Dan Joyce
Commissioner – Don Hodge Commissioner – Lawrence P. Wilson

Health Officer
Morris Smith, MD

Health Department Interim Director
Rebecca Stricker, RN

County Jail Medical Staff
Denise Green, RN

(Other medical professionals in the County Jail are contracted through Malheur Medical Clinic in Nyssa, Oregon)

**Ontario School District,
School Nurse**
Chris Thomas, RN

WIC Coordinator
Sandy Ackley, RN, BS, IBCLC-LC

WIC Staff
Lindsay Grosvenor, RD
Jael Barron-Garcia – OAH
Dianne Alison – Health Specialist
Michelle Marines – OAH
Nydia Ketchu – Health Specialist

**Fiscal Services – Billing-
Vital Statistics**

Peggy Winslow

Health Department Staff
Connie Chaney – OAH
Imelda Madera - OAH
Jerrimi Helmick – FNP
Angie Gerrard– RN
Kathleen Quintero – RN
Mary Lue Galligar – RN
Hilary Heller- RN
Tracy Buster– RN
Lacy Beegle – RN
Rebecca Stricker – RN
Lori Dixon – RN
Susan Way – RN
Hilda Mejia – Health Specialist

Priority Areas -- Malheur County Data Triangulation Report

Triangulation: Items included in this report refers to information that is cross checked against at least three (3) data sources.

Date Ranges for Data: This report generally utilizes data and assessments that are only 3 years old, or less, except where there is state data which covers a date range due to the reconciliation of death data which occurs across counties and states on a scheduled cycle.

Mental Health (MH)—Score: 84

| Source | Findings |
|------------------|---|
| Household Survey | <p>Have you ever been told by a doctor or other health professionals that you have any of the following? 20.5% Depression or anxiety</p> <p>When asked about the <u>priority health problems</u> in the county, respondents stated: 3.8% Other mental illness 6.1% Depression</p> <p>When asked about the <u>second most significant health problems</u>, respondents stated: 3.8% Other mental illness 6.1% Depression (double checked the data and it is the same percentages as above)</p> <p>Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things? 67% not at all 20% several days 8% nearly every day 5% more than half the days</p> <p>Over the past 2 weeks, how often have you been bothered by feeling down, depressed or hopeless? 70% not at all 22% several days 4% more than half the days 4% nearly every day</p> <p>Does a physical, mental, or emotional problem now limit your ability to work or perform routine tasks? 28% yes 72% no</p> <p>Thinking about the last six months, was there a time when you or someone in your household needed treatment for mental health or substance use? 89% No 11% Yes</p> <p>If you or someone in your household needed mental health or substance use treatment in the last six months, did they get all the help they needed? 56% No</p> |

| | |
|---|---|
| | 44% Yes |
| EOCCO Data Packet | Suicide death rate (2007-2011), rate per 100,000, Malheur County 14.1, state 16.2 BRFSS 2006-2009 self reported good mental health Malheur 81.3%, state 66.4% |
| CAC Key Informant Interviews | A <i>few</i> stated mental health was the most important health problem facing the community. Another <i>few</i> also had statements about quality of services. |
| Latino Focus Groups | One group expressed concerns about depression in teenagers and the need for parent and teen awareness. Another group was also concerned about lack of access to mental health for families, in part due to the stigma about having mental health problems. The third focus group also viewed lack of access to mental health as one of the most pressing health system problems facing Malheur County. The biggest health status issue was also mental health. The group also expressed concern about the price of services and availability of bi-lingual staff. Sliding fee scales were explained but it was realized that few people know that is available at mental health or medical clinics. |
| Malheur County Epidemiological Data on Alcohol, Drugs and Mental Health | The Oregon Student Wellness Survey shows rate of suicide deaths in Malheur county at 15 per 100,000 as compared to 165 for the state. Domestic disturbances per 10,000 population was at 78 for Malheur County as compared to 47 for the state. Being the victim of violence is a risk factor for the onset of mental health problems among persons of all ages. Severe marital discord and substance abuse contribute to an increased likelihood of domestic disturbance. Major depressive episodes among adults in Malheur County were at 7%, the same as the state. Additionally, serious psychological distress among adults was at 12% -- the same as the state. The Oregon Healthy Teens survey reports % of youth who had a depressive episode in the past year, for 8 th graders, was 25% Malheur and 23% for the state. For 11 th graders it was 30% Malheur and 28% for the state. |
| Contributing Factors | International studies of Adverse Childhood Experiences (both environmental and psychological in nature) indicate they are contributing factors to depression as well as increase the risk of most other chronic diseases. Severe and persistent mental illness usually results in the use of medications which place the individual at risk for metabolic syndrome and diabetes. Due to the nature of mental illness, there may be potential noncompliance by the patient in supporting their own care. There appears to be a two-way risk between obesity and depression. Additionally, forty to 60 percent of heart disease patients suffer clinical depression and 30 to 50 percent of patients who suffer clinical depression are at risk of developing cardiovascular disease. |

Social Determinants of Health (SDH) includes the lifelong determinates in early childhood, poverty, drugs, employment, social support, food, physical environment and transportation. Drugs are covered in that section--**Score: 70**

| Source | Findings |
|------------------|--|
| Household Survey | <u>Transportation</u> When asked if “you could do one thing to improve our community’s access to health care, what would it be?” 9.9% transportation assistance (4 th out of a list of 6) |

When asked, “In the last 12 months, how often did you have a difficult time accessing transportation when you needed it?”

5% said often

8% said sometimes

Housing

When asked “what is the most important health concern in our community today,” 5.5% of the respondents stated housing insecurity. When asked the second most important health concern, 5.8% stated housing insecurity.

When asked, “In the last 12 months, were you or other members of your household unable to pay your rent, mortgage, or utility bills?”

18% said yes

Food

When asked “what is the most important health concern in our community today,” 5.8% of the respondents stated food insecurity. When asked the second most important health concern, 6.5% stated food insecurity.

When asked, “In the last 12 months, how often have you or members of your household ever cut the size of meals or skipped meals because there wasn’t enough money for food?”

4% replied often

17% replied sometimes

When asked, “In the last 12 months how often have you been worried that your food would run out before you got money to buy more?”

8% replied often

18% replies sometimes

Medical Care Coverage

When asked about the most recent time, in the last six months, that the survey respondent or someone in their household went without care, the main reasons were:

| | |
|--------|---|
| 0% | I didn’t have childcare |
| 1.00% | I didn’t have transportation |
| 1.40% | The doctor wouldn’t take the insurance |
| 1.70% | No doctor locally for the care I needed |
| 2.00% | I don’t like doctors |
| 2.70% | Office Wasn’t open when I could go |
| 3.80% | Didn’t know where to go to get the care |
| 4.10% | Couldn’t get appointment quickly enough |
| 9.20% | Didn’t have insurance |
| 16.40% | It cost too much |

EOCCO
Data
Packet

Transportation

According to the American Community Survey (2007-2011) 6.4% of Malheur County residents have no vehicle as compared to 7.7% statewide. This is recognizably more of an issue in isolated rural communities.

Food

69.8% of Malheur children are on the school lunch program (2011-2012 school year) as compared

| | |
|---------------------------------------|---|
| | <p>to 51.7% statewide. This a potential measure of food insecurity.</p> <p><u>Poverty</u> 24.5% are in poverty as compared to 17.3% statewide</p> <p><u>Medical Care Coverage</u> 18.9% of the population is uninsured</p> |
| CAC Key Informant Interviews | <p><u>Medical Care Coverage</u> The <i>majority</i> of respondents noted the most important health system problems in the community are issues related to the lack of affordability of health care and health insurance.</p> |
| Latino Focus Groups | <p><u>Medical Care Coverage</u> All focus groups addressed issues around lack of health insurance and misunderstanding of the health insurance exchange and the Oregon Health Plan. Additionally, even with insurance, there are sometimes too many items which need to be paid out of pocket.</p> <p><u>Transportation</u> Transportation was not regarded as a huge issue except for the need for out of town travel. OHP participants sometimes need to travel to Portland for services and that travel is an additional burden on the family.</p> |
| Statewide Area Agency on Aging Report | <p><u>Poverty</u></p> <ul style="list-style-type: none"> Estimates that 475 Malheur County residents who are 65 and over live in poverty. |
| Contributing Factors | <p><u>Poverty</u> Poverty decreases access to appropriate health care. Poverty also cuts off vital resources to the poor and places them in an environment of ongoing stress. The stress can be passed on to the next generation and therefore has long-lasting effects on Americans' general wellness that can be difficult to reverse. (Also, see the references to Adverse Childhood Experiences below.)</p> |

Alcohol and Drugs (AD)—Score: 69

| Source | Findings |
|---------------------|---|
| Household Survey | <p>When asked about the <u>priority health problems</u> in the county, respondents stated: 28% Substance or drug use/abuse 9.6%% Alcohol use</p> <p>When asked about the <u>second most significant health problems</u>, respondents stated: 23.5% Substance or drug use/abuse 9.2 % Alcohol use</p> <p>If you or someone in your household needed mental health or substance use treatment in the last six months, did they get all the help they needed? 89% No 11% Yes</p> |
| Latino Focus Groups | <p>Two of the focus groups strongly emphasized their concern about drug and alcohol use. There were specific statements about the prevalence amongst youth and concern that because youth see parents who drink they may find it acceptable. Concern was also expressed about the link between use of alcohol, as self-medication, and depression in the teen population.</p> |
| CAC Key Informant | <p>A <i>few</i> respondents noted abuse of drugs and alcohol as the more important health problems facing the community.</p> |

| Interviews | | | | | | | | | | | | | | | | |
|--|---|-----------------|---------------|-----------------|-------------|---------------|----------------|------------|-------|--------|--------|----------------|------------|------------|-------|-------|
| Mental Health Assessment | <p>Areas of improvement and unmet needs included:</p> <ul style="list-style-type: none"> • Adolescent A&D residential treatment • Sobering room and detox facilities • Tweener’s dual diagnosis (MH * A/D) • Cultural norms that endorse family/rural alcohol & drug (tobacco) use. • Marijuana – border issue | | | | | | | | | | | | | | | |
| EOCCO Data Packet | <p>DUI rates from 2008 were 474 per 100,000 for Malheur County as compared to 506 statewide.</p> <p>BRFSS Data for 2008-2011 shows Malheur County respondents self-report as shown in table below.</p> <p>Binge drinking is defined as: consumption of 5 or more drinks by men or 4 or more drinks by women within a short time span.</p> <p>Heavy drinking in men is more than two drinks per day and in women is more than one.</p> <table border="1" data-bbox="358 747 1404 894"> <thead> <tr> <th></th> <th>Malheur Males</th> <th>Malheur Females</th> <th>State Males</th> <th>State Females</th> </tr> </thead> <tbody> <tr> <td>Binge Drinking</td> <td>Suppressed</td> <td>10.2%</td> <td>18.70%</td> <td>10.80%</td> </tr> <tr> <td>Heavy Drinking</td> <td>Suppressed</td> <td>Suppressed</td> <td>5.40%</td> <td>6.10%</td> </tr> </tbody> </table> | | Malheur Males | Malheur Females | State Males | State Females | Binge Drinking | Suppressed | 10.2% | 18.70% | 10.80% | Heavy Drinking | Suppressed | Suppressed | 5.40% | 6.10% |
| | Malheur Males | Malheur Females | State Males | State Females | | | | | | | | | | | | |
| Binge Drinking | Suppressed | 10.2% | 18.70% | 10.80% | | | | | | | | | | | | |
| Heavy Drinking | Suppressed | Suppressed | 5.40% | 6.10% | | | | | | | | | | | | |
| <p>Malheur County Epidemiological Data on Alcohol, Drugs and Mental Health</p> <p>(This was emailed to your CAC in September and, due to other supporting data, it is recommended you review the entire document.)</p> | <p>The current report is through 2011 but it does note the rate of death from motor vehicle crashes involving alcohol. The age adjusted rates, at per 100,000 population, are 14 for Malheur County as compared to 10 for the state. This number has held steady with only a slight decline in recent years (from 16 to 14).</p> <p>The percent of fatal motor vehicle accidents that involve alcohol is 40% in Malheur County as compared to 38% statewide.</p> <p>Rate of death per 100,000 population from alcohol-induced diseases, age adjusted is 8 in Malheur Co as compared to 14 for the state (2007-2011 time period).</p> <p>Utilizing a series of questions related to alcohol use, attempts to cut down, impact on work, home and school, the assessment estimated the number of persons with Alcohol Abuse or Dependence in the past year in Malheur County by age group, include 596 in the 18-25 year age range and 1306 who are 26 or older. There is no comparison data.</p> <p>Alcohol use by youth at the 11th grade level (youth who drank alcohol one or more days in the past 30 days) is at 37% as compared to the state at 36%.</p> <p>Percentage of 11th graders who binge drank was 27 as compared to 21 for the state.</p> <p>9% of Malheur County 11th graders reported drinking and driving as compared to 5% for the state.</p> <p>91% of Malheur County 8th graders report their parents think it is wrong or very wrong for youth to drink alcohol as compared to 90% statewide. For 11th graders, that figure is 85% in Malheur County as compared to 79% statewide.</p> | | | | | | | | | | | | | | | |

| | |
|----------------------|---|
| | <p>37% of all Malheur County 11th graders reported drinking alcohol one or more times in the past 30 days. State rate is 36%.</p> <p>Percent of Malheur 8th graders who say it would be sort of easy or very easy to get marijuana is 71% as compared to 33% for the state. The percent for 11th graders was 63% as compared to 69% for the state.</p> <p>Domestic disturbances per 10,000 population was at 78 for Malheur County as compared to 47 for the state. Being the victim of violence is a risk factor for the onset of mental health problems among persons of all ages. Severe marital discord and substance abuse contribute to an increased likelihood of domestic disturbance.</p> |
| Contributing Factors | Alcohol is a known carcinogen. A causal link has been established between drinking alcohol and cancers of the mouth, pharynx, esophagus, colon, rectum, liver, larynx and breast. Alcohol consumption is a leading cause of chronic liver disease. It is toxic to many organ systems including the heart, stomach, pancreas and nervous system. |

Children and Families (C)—Score: 68

| Source | Findings |
|---------------------|---|
| Household Survey | <p>When asked about the most important health concerns our community is facing today, responses included: 24.9% Domestic violence/child abuse/neglect</p> <p>When asked the second most important health concern our community is facing today, responses included: 5.5% Domestic violence 9.6% Child abuse/neglect</p> |
| EOCCO Data Packet | <p>27.1% of Malheur children live in poverty as compared to 17% statewide (this piece of data actually from the Oregon Community Foundation 2011 report on Eastern Oregon)</p> <p>20.4% of population is without a diploma as compared to 11.1% statewide</p> <p>31.6% are single parents compared to 30.4% statewide</p> <p>25.2% of the population is under the age of 18 as compared to 22.3% statewide</p> <p>4.4% of births were to mothers younger than 18 as compared to 2.2% statewide</p> <p>56.6 per 1000 low birth weight infants as compared to 61.4 for the state</p> <p>12.8% of mothers receiving inadequate prenatal care as compared to 5.5% for the state</p> <p>19.4 per 1000 Child Maltreatment Rates for Abuse as report by DHS in 2011</p> <p>69.8% of children on a school lunch program as compared to 51.7% statewide</p> <p>21.3% of 2011 assessed child abuse/neglect reports in the county were founded as compared to 23.2% for Oregon (Children’s First for Oregon Data Book)</p> <p>61.8% of children are current with their immunizations by age 3 as compared to 66.6% statewide</p> <p>2.7% of the population live without a phone as compared to 2.9% statewide – it is not known how this might impact families with children</p> |
| Latino Focus Groups | <p>Two of the three focus groups expressed concern about teen pregnancy and the need for additional prevention education. It was noted that Latino students drop out when pregnant.</p> <p>Additionally there is an issue with undocumented mothers who are not on OHP until they deliver. This is a new program called CAWEM which is available to undocumented mothers to cover their prenatal care needs but no one addressed how well this service is known or how much it is being utilized.</p> |
| Malheur County | Please see the mental health section for the details provided there. |

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| Epidemiological Data on Alcohol, Drugs and Mental Health | |
| OR Smile | 73% of all 1 st through 3 rd graders in Malheur County have dental caries as compared to 50% for Oregon as a whole. |
| Contributing Factors | International studies of Adverse Childhood Experiences (ACEs) (both environmental and psychological in nature) indicate they are significant contributing factors to depression as well as increase the risk of most other chronic diseases (diabetes, obesity and cardiovascular problems). There is very strong evidence of the link, and prevention of ACEs or remediation through building resiliency can help to reduce future life problems. More can be learned at the Centers for Diseases Control (CDC) website: http://www.cdc.gov/ace/findings.htm |