



Adventist Health Portland



2020-2022

Community Health Needs Assessment

Portland Adventist Medical Center

Adventist Health - Portland is a not-for-profit, faith-based organization which includes Adventist Medical Center, (AMC) a 302-bed community hospital. The hospital provides a full range of inpatient, outpatient, emergency and diagnostic services to communities in and near East Portland. AMC serves more than 900,000 residents. Our hospital is located at 10123 SE Market Street, Portland, Oregon 97216. For a listing of our medical clinics please visit their [web site](#).

Our mission, vision and values are core to the daily operations of this organization. As a healthcare delivery system, our technology, quality and cost structures are in line with our values. The difference you will notice at Adventist Health is the culture of delivering care. Providing exceptional patient centered care through staff who are passionate about the mission of whole person care is what sets us apart from other providers. We believe that our ability to decrease anxiety and increase compliance, results in improved clinical outcomes and increased patient satisfaction. Please visit our web site for more information. [Please use this link](#) for our web site or visit us on [Facebook](#).

Service is the network that links us with our customers. We are the connection between our mission and the people we serve. Only through our behaviors will people experience the mission of this organization.

Affiliation With OHSU

In 2018, Adventist Health Portland announced an agreement to affiliate with OHSU. This means the organizations will integrate their clinical activities and services as part of the same health system but remain independently owned organizations.

This affiliation brings together the strength of our well-respected community hospital with the only academic health center in Oregon and provides increased access to patients throughout Portland.

Services & Programs

Our network of services is here to serve all our communities' health needs. Our emphasis on wellness and whole-person care means that we don't just treat our patients after they get sick, we want to keep them healthy.

- Adventist Health Medical Group
- Arthritis and Bone Care
- Cancer Care
- Cardiac Care
- Diabetes and Endocrine Care
- Diagnostic and Imaging Services
- Family Birth Place
- Home Care
- Hospitalist Service
- Internal Medicine
- Laboratory
- Emotional Wellness
- Nutrition
- Orthopedics
- Palliative Care
- Pastoral Care
- Primary Care/ Family Medicine
- Pulmonary Medicine
- Rehabilitation
- Robotic-Assisted Surgery
- Sleep Disorders Center
- Stroke Care
- Surgery
- Urgent Care
- Wellness Services
- Women's Services
- Wound Healing and Hyperbaric Medicine

Collaborating to achieve whole-person health in our communities

Adventist Health Portland invites you to partner with us to help improve the health and wellbeing of our community. Whole-person health—optimal wellbeing in mind, body and spirit—reflects our heritage and guides our future. Adventist Health Portland is part of Adventist Health, a faith-based, nonprofit health system serving more than 80 communities in California, Hawaii, Oregon and Washington. Community has always been at the center of Adventist Health’s mission—Living God’s love by inspiring health, wholeness and hope.

The Community Health Needs Assessment is one way we put our faith-based mission into action. Every three years, we conduct this assessment with our community. The process involves input and representation from all: community organizations, providers, educators, businesses, parents, and the often marginalized—low-income, minority, elderly and other underserved populations.

We use the Community Health Needs Assessment to achieve the following goals:

- Learn about the community’s most pressing health needs
- Understand the health behaviors, risk factors and social determinants that impact our community’s health
- Identify community resources and prioritize needs
- Collaborate with community partners to develop collective strategies
- Partnering with our communities for better health

While conducting the Community Health Needs Assessment we solicited feedback and input from a broad range of stakeholders. Contributors to the process included these partners:

- Healthy Columbia Willamette Collaborative
- Project Access Now
- Central City Concern

Data Sources

The assessment drew from publicly available secondary data sources, as well as from nationally recognized data sources. We collected data on key health indicators, morbidity, mortality, and various social determinants of health from the Census, Centers for Disease Control and Prevention, Community Commons, and various other state and federal databases. In addition, to validate data and ensure a broad representation of the community, Adventist Health Portland partnered with the Healthy Columbia Willamette Collaborative to conduct a community health survey, key interviews and focus groups. Questions focused on access to, and use of, health care services; vision of a healthy community; and top community health needs and barriers to accessing resources.

Ranking of Community Health Needs and Concerns

Methodology:

Using the four sources of information listed below, thirty-one areas of health were ranked based on the information collected from those sources.

- Healthy Columbia Willamette Collaborative (Appendix A)
- AH Hospital Data
- AH CHNA identified Trends
- East Multnomah County Service Provider Survey

The following Adventist Health Portland Committees reviewed the findings from the Primary data (Page 29) and Secondary data (Page 33) sources listed above and approved the final ranking.

- AH Community Benefits Outreach Committee
- AH Community Mission Integration Committee (Board Sub-committee). This committee includes members of the community.

The thirty-one categories were determined based on specific health outcomes data such as diabetes or cancer as well as poor quality of life indicators such as homelessness and poverty as identified in this and previous reports. Based on input from community on the severity, magnitude, opportunity for partnership, existing resources, mission alignment, resources of hospital, importance to community along with the various at-risk groups that were engaged through the HCWC process (see Appendix A), Adventist Health Portland has identified the following prioritized significant community health needs. See Appendix E for additional ranking information. Only the final ranking and listening session data was used for ranking purposes from the HCWC report.

Portland Adventist Medical Center’s Top Priority Health Needs for 2020-2022

Prioritized Need	Health Indicator
Chronic Disease	Racial disparities, Heart Disease and Stroke, Cancer, Diabetes, Obesity
Access to Care	Access to care and resources, Cultural and Language Barriers, Racism and Prejudice
Behavioral Health	Suicide, Anxiety/Stress, Depression, Alcohol & Drug Misuse, Alzheimer’s
Social Determinates	Housing/Homelessness, Hunger/Food Access, Transportation, Safety

Making a difference: Results from our 2017-2019 CHNA/CHP

Adventist Health wants to ensure that our efforts are making the necessary changes in the communities we serve. In 2017 we conducted a CHNA and the identified needs were:

Priority Need - Chronic Disease

Objective 1: Reduce local cancer deaths through prevention, early detection and patient support efforts for the following cancer types: Breast, Colorectal, Lung and Skin.

Intervention: Continue to develop funding and outreach partnerships to improve **mammography screening** for those not covered by insurance. Number of Community Members Served with special grant: 47 Mammography screens in 2018 (an increase over 2016 and 2017).

Intervention: Continue provider education and outreach to qualifying Smokers for **Low-dose Lung CT Scan Program**. Number of Community Members Served in 2018: 537 Smoker CT Scans (a significant increase over 2017.)

Intervention: Provide free **skin cancer screening** and interactive educational activity at two-day Impact Your Health Portland Clinic at Portland Adventist Academy. Number of guests served: 160 quizzes returned and 72 skin cancer screens.

Intervention: Continue community **Radon Awareness Campaign** and **Free Home Radon screening** kit distribution in 2018. Number of Community Households Served: 19 Home Radon Kits, and educational outreach to around 300 individuals.

Intervention: Support the community education and mammography screening work of **Komen Foundation** at the Race for the Cure. Also provide practical nutrition support (bananas) to 2,000 Race for the Cure participants in 2018.

Intervention: Provide **Cancer Navigator** support services to help patients better navigate treatment and the stress often connected with cancer care. 189 persons/families served in 2018. Also provided **medical transport** to treatment services for 200 cancer patients.

Intervention: Community **Colorectal/Digestive Health Outreach** Activities in March 2018. (Included in Objective 6)

Objective 4: Reduce deaths from Heart Disease

Intervention: Provide training and/or information on AHA “Hands-only” CPR at 2018 Montavilla Street Fair. Number of Community Members Served: Approx. 45 HOCPR interactions (English/Spanish)

Priority Need - Access to Care

Objective 1: Strengthen the continuum of health care and create additional healthcare access points with a focus on low-income adults, ages 19– 64, and those living below 200% of the FPL.

Intervention: Continue work with **Compassion Connect** holding free community medical/dental clinics to address the need for access to health care in our greater service area.

- Number of Community Members Served in 2018: 3,373
- Volunteers Serving: 3,144
- Churches uniting: 126

Intervention: Impact Your Health Portland free clinic offering free dental care, vision, general medical care, and health education services to uninsured and under-insured people in the Portland metro area. Number of Community Members Served: 674 guests served by 650 volunteers in 2018

Intervention: CCC Housing Is Health Clinic. Number of Community Members Served: N/A under construction in 2018. To open in 2019.

Objective 2: Continue to assist the uninsured/underinsured by removing undesirable barriers to receiving appropriate health care or being crushed by unmanageable health care bills.

Intervention: Adventist Health Financial Assistance Policy updated regularly.

Intervention: Patient Enrollment Assistance into means tested programs. Number of Community Members Served: **Approximately 1,100**

Intervention: Help fund **Project Access NOW** which connects low-income, uninsured people to donated care across the Portland metropolitan area. **The mission of Project Access NOW is “...to improve the health of our community by creating access to care and services for those most in need.”** Number of Community Members Served: **Estimated 1,146**

Intervention: Provide medical transport services for Cancer and Behavioral health. Persons served in 2018: 200+

Objective 3: To establish practices and processes, as well as develop capacity to help provide **more culturally responsive whole-person healthcare services** to selected communities within our service area.

Intervention: Meet with area Russian Community Pastors and other groups to better understand their needs and barriers to care. Pastors session held on May 11, 2018 Attendees: 22

Intervention: Hire more Russian-speaking Associates in Emergency Department, AHMG clinics, etc. to facilitate the patient experience and improve quality of care. 7 new Russian-speaking staff hired and now serving in this project.

Intervention: Had AHP healthcare providers address various health topics on Russian radio and local Russian print media. # Sessions/articles Participated in **Portland Slavic Festival**.

Objective 4: Train/mentor multiethnic young people, and more seasoned adults to be whole-person health care workers serving our community.

Intervention: Training of Clinical and Community Chaplains of diverse cultural backgrounds

- Clinical Pastoral Education Students (13 CPE students trained in 2018)
- Spiritual Care Volunteers (8 volunteers regularly engaged in 2018)
- Area Pastors (12 on-call chaplain/pastors engaged)

Intervention: Student Healthcare Leaders Program for High School age students in partnership with local schools. Our first two groups completed the program in 2018. Total: 28 students from seven High Schools, plus Home School students.

Priority Need – Behavioral Health/Addictions

Objective 1: Continue funding & leadership support for the **UNITY Center for Behavioral Health** (a partnership) which opened in 2017. The acute and emergency mental health services provided fill a huge community need.

Objective 2: Expand access to outpatient, intermediate mental health care on AH Campus.

Intervention: Continue to develop the **Outpatient Emotional Wellness Clinic**. Add new, cutting edge treatment for depression. Number of Community Members Served in 2018: 402 patients

Objective 3: Provide additional Behavioral Health and related services on Eastside in partnership with other groups like Central City Concern.

Intervention: Help fund and build **CCC Eastside Health Center** and housing facility. Number of Community Members Served: Facility under construction. To open in 2019.

Objective 4: Serve 2,000 residents via First Friday, Soup & Salad, Grief Support, Bible Study group and PrayerWorks/AMEN Programs to address emotional and spiritual needs.

Intervention: Further develop/promote First Friday Program, etc. Number of Community Members Served in 2018: 767 served, 2,058 attended meetings

Intervention: Weekly Grief recovery and Bible study groups, Grieving through the Holiday, and Resilience in Grief Program: Community encounters in 2018: Approx. 814

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Mission, Vision and Values

Adventist Health Portland shares the mission, vision, values and culture of our parent company, Adventist Health, a faith-based, non-profit integrated health system serving more than 75 communities on the West Coast and Hawaii.

Adventist Health Portland is part of the OHSU health system but remains an independent organization with a faith-based mission.

Our Mission

Living God's love by inspiring health, wholeness and hope.

Our Vision

We will transform the health experience of our communities by improving health, enhancing interactions and making care more accessible.

Our Values

- Integrity
- Compassion
- Respect
- Excellence

Our mission and values are core to our daily operations. We are committed to providing exceptional patient-centered care through team members who are passionate about the mission of whole-person care. We also respond to community needs by being a leader in quality healthcare, health awareness and wellness education.

For more than 100 years, Adventist Health has served the communities around us with excellent quality and service. We continuously strive to be the best place for patients to receive care, for physicians to practice, for team members to work and for volunteers to serve. Our dedication puts us at the forefront of our industry.

Portland Adventist Medical Center

Portland, Oregon

Executive Summary

One of the goals of any CHNA is improving the preparation process, data gathering and addressing gaps in our previous CHNA. We believe we have addressed the short falls with this document.

We have also continued our membership with the Healthy Columbia Willamette Collaborate and we continue to use the CHNA generated by that organization as a major supplement to our own CHNA.

The following bullet points are the major findings of this report.

Demographics:

- Since our 2011-2013 and 2014-2016 CHNAs it has been observed that the concentration of our patients, either receiving charity care and Medicaid, has increase by a substantial amount in a number the zip codes in our service area.
- Since our 2011-2013 and 2017-2019 CHNA it has been observed that the concentration of our patients, either receiving charity care and Medicaid, has increase by a substantial amount in a number the zip codes out of our service area.

Racial and Ethnic Health Disparities

- Black/African Americans experienced the greatest number of disparities with the highest level of concern relative to other communities of color.
- In Multnomah County, all racial and ethnic groups experienced some disparities relative to their non- Latino White counterparts. A striking number of disparities exist for Black/African Americans and American Indian/Alaska Natives. Numerous disparities also exist for Latinos and Asian/Pacific Islanders, but those communities also fared better than non-Latino Whites for some indicators
- While two out of three uninsured Oregonians in 2012 were White, Oregonians of color were significantly over-represented among the uninsured

Aging

- Over the past 10 years, the population age 65 and over increased from 37.8 million in 2007 to 50.9 million in 2017 (a 34% increase) and is projected to reach 94.7 million in 2060.
- About 28% (14.3 million) of older persons lived alone (9.5 million women, 4.8 million men).
- Among women age 75 and over, 44% lived alone.
- In 2017, 4,681,000 older adults (9.2%) were below the poverty level.

Primary Data: Summary of what we heard from our community

- Behavior/Mental Health
 - Community support, both as crucial to maintaining cultural values and establishing a sense of belonging, and to help ease depression and other mental health concerns.
 - Significant stress, often because of racism, discrimination, and feelings of exclusion from the community due to their race/ethnicity, socio-economic status, LGBTQ+ identities, disability status, and citizenship status.
 - Cultural/social isolation, and geographic isolation.
- Access to Affordable Health Care
 - Lack of access to the health care system, citing financial and cultural barriers
 - Difficulty affording medical costs and medications.
 - Language barriers, and a lack of translators, were cited as significant barriers to health among participants.
- Life Style Concerns surrounding:
 - Drug and Alcohol Abuse
 - Safety concerns impacting the health of their community
 - Obesity
 - Lack of Exercise
- Social Determinates of Health
 - Housing
 - Unaffordable housing costs and rent hikes greatly contribute to the stress community members face on a regular basis
 - Homelessness
 - Need for infrastructure changes to the transportation system

Secondary Data:

- Chronic diseases and conditions—such as heart disease, stroke, cancer, type 2 diabetes, obesity, and arthritis—are among the most common, costly, and preventable of all health problems.

Diabetes:

- Diabetes was the seventh leading cause of death in the United States and in Oregon.
- The increase in diabetes deaths has almost exactly paralleled the rise in obesity.
- The prevalence of diabetes among adults in Oregon has more than doubled over the past 20 years.
- African Americans are three times as likely and American Indian and Alaska Natives are twice as likely to have diabetes compared to non-Latino whites.

Obesity:

- Obesity is the number two cause of preventable death in Oregon and nationally, second only to tobacco use.

- Preventing obesity among Oregonians lowers the risk of diabetes, heart disease, stroke, cancer, high blood pressure, high cholesterol, arthritis, stress and depression.
- In Multnomah County approximately 26% of adults in the county are obese and 30.2% are overweight

Heart Disease:

- Heart Disease is the second leading cause of death in Oregon.
- Cardiovascular disease rates are highest among blacks in Multnomah County.
- Stroke is the fifth leading cause of death in Oregon.
- Stroke death rates among blacks in Multnomah County is higher than the national rate.
- Hypertension rates is highest among blacks in Multnomah County

COPD/Asthma/Allergies:

- The death rate for COPD is declining except for black women.
- From 2001–2002 to 2013–2014, current asthma prevalence significantly increased among adults; by weight status, asthma prevalence increased among adults in the overweight category but not among adults in normal weight or obese categories.
- Allergies are the 6th leading cause of chronic illness in the U.S.

Cancer:

- The death rate from all cancers combined continues to decline.
- Cancer remains the second most common cause of death in the United States, exceeded only by heart disease, accounting for nearly one in every four deaths. The number one cause of death on Oregon.
- The top 5 most common cancer sites in the US are female breast, lung and bronchus, prostate, colorectal, and melanoma of the skin.
- In Oregon in 2015, there were 19,883 new cases of cancer. For every 100,000 people, 400 cancer cases were reported.
- In Oregon, approximately 276 radon-related lung cancer deaths happen each year. Radon is the second leading cause of lung cancer.
- More than one in three Oregonians with a household income of less than \$15,000 a year smoke. In comparison, one in 10 Oregonians with a household income of more than \$50,000 a year smoke.
- Race and ethnicity are also important factors. Thirty-five percent of American Indians in Oregon smoke compared to 21 percent of non-Hispanic Whites
- Cigarette smoking has decreased from 1996 to 2016. However, use of non-cigarette products is on the rise.

Behavioral Health:

- Anxiety disorders are the most common mental illness in the U.S., affecting 40 million adults in the United States age 18 and older, or 18.1% of the population every year.

- Anxiety has become the number one mental health issue in North America. It's estimated that one third of the North American adult population experiences anxiety unwellness issues.
- Major depression is one of the most common mental disorders in the United States.
- An estimated 70 percent of adults in the United States have experienced a traumatic event at least once in their lives and up to 20 percent of these people go on to develop posttraumatic stress disorder, or PTSD.
- People who have been traumatized need support and understanding from those around them
- Race is also a strong indicator of whether a child is likely to experience ACEs.
- Alzheimer's disease is the most common cause of dementia among older adults
- More women than men have Alzheimer's or other dementias. Almost two-thirds of Americans with Alzheimer's are women.
- One of the top 10 leading causes of death in the United States.
- The 6th leading cause of death among US adults.
- The 5th leading cause of death among adults aged 65 years or older
- The rate of suicides in Oregon rose 28.2% form 1999-2016
- In 2016, suicide became the second leading cause of death among those aged 10–34 and the fourth leading cause among those aged 35–54.

Illicit Drug Use:

- The opioid overdose epidemic continues to worsen in the United States.
- Fentanyl is the most prevalent and the most significant synthetic opioid threat to the United States.
- According to the National Survey on Drug Use and Health (NSDUH), cocaine use has remained relatively stable since 2009.
- Across the Tri-County region in 2015 there were:
 - 159 fatal opioid overdoses; two
 - Deaths occur at younger ages among males than females in all three counties.
 - Deaths from heroin occur at younger ages than from prescription opioids in all three counties.
 - Over 90% of opioid deaths occurred among those of white race.
- From 2007 to 2017, the number of deaths attributable to alcohol increased 35 percent.
- 22% of Multnomah County reports to drink excessively.

Hepatitis C:

- 81% of U.S. residents infected with HCV were born between 1945 and 1965.
- At least 50% of persons infected with HCV are unaware of their infection.
- HCV testing, followed by appropriate care and treatment, can reduce risk for liver cancer by 70% and mortality by 50%.
- Injection drug use accounted for most new HCV infections in Oregon.

Sexually Transmitted Diseases:

- Chlamydia, gonorrhea and syphilis are the most common bacterial STIs in Oregon. During 2017, these three infections continued to increase alarmingly, representing indisputable statewide epidemics with little evidence of abating.
- Forty-eight percent of cases diagnosed with HIV in Oregon during 2006–2015 were Multnomah County residents.
- New diagnosis rates were nearly five times higher among Blacks and African Americans than Whites.
- The rate of new diagnoses for Hispanics was 1.8 times higher than for White non-Hispanics.

Social Determinates of Health:

- Social determinants of health are conditions in the environments in which 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.
- That high-income American households are getting wealthier faster than those at the bottom has been widely noted.
- The number of people in poverty fell by 2.5 million between 2015 and 2016.
- Poverty is a strong predictor of poor health. People with lower socioeconomic status experience higher rates of early death. They also have higher rates of factors that contribute to chronic disease, such as smoking and obesity.
- Adult Oregonians living at or below the federal poverty limit and/or have not completed high school tend to have higher levels of disability status and higher levels of food insecurity than those of more economic means.
- Adults living below the federal poverty limit and/or who have not completed high school were less likely to report good to excellent general health and more likely to report fair to poor general health than those with higher income and education. In addition, they were more than twice as likely to report frequent mental distress and that poor physical or mental health limited their daily activities.
- Multnomah County child poverty prevalence is 19%, 50% of black children live in Poverty, 41% for Hispanic Children, 13% for White children.
- African American households face hunger at a rate more than twice that of white, non-Hispanic households. And getting enough to eat is a consistent struggle for 1 in 4 African American children
- 40.0 million people lived in food-insecure households (US)
- Overall, households with children had a substantially higher rate of food insecurity than those without children
- The rate of food insecurity (being without access to a sufficient quantity of affordable, nutritious food) in Oregon is 14.6%.
- Between 2007 and 2018, the number of individuals experiencing homelessness increased in 22 states and the District of Columbia. The largest increase was in New York

(11,771 more people), a 42 percent rise. Washington and Oregon also had large increases (3,135 and 1,268 more people).

- Oregon has the highest rate of unsheltered people in families in the US (54.3%)
- Oregon has the third highest rate of unsheltered veterans in the US (56.0%)
- Oregon has the fourth highest rate of unsheltered chronically homeless individuals in the US (78.5%)

Introduction

On behalf of the Adventist Health-Portland (AHP), the Community Benefit Committee conducted a Community Health Needs Assessment (CHNA) to distinguish the unmet medical and public health needs within the greater East Multnomah County area. The study has two objectives. One objective was to meet state and federal requirement that the hospital conduct a comprehensive community health needs assessment every three years. The second, ultimately more important objective was to conduct a study that would provide a guide for AMC to build a consensus on the area's health care needs and provide a basis for the implementation plan to best direct our resources to improve the health of the area's residents.

The information for this report was collected from multiple sources. First, a web base information survey which was available to the public. Secondly, a Community Health Expert survey was sent to public health experts within the hospital and through the community. Thirdly, our membership with the Healthy Columbia Willamette Collaborate gave us access to the group's in-debt analysis of the community health needs of Multnomah County. The data also includes a review of publicly collected health and demographic statistics.

Adventist Medical Center, like other non-profit hospitals, is a tax-exempt institution and has a statutory obligation to provide community services. The State of Oregon and the Federal government require non-profit hospitals to report the value of the community services provided during the year. The government identities that collect this data have the responsibility to assure the public that all healthcare organizations claiming non-profit, tax-exempt status fulfill their fiduciary obligation by providing community benefit commensurate in value to the organization's tax savings.

The guidelines used to determine what activities qualify as measurable community benefit, for both the state of Oregon and the Internal Revenue Department, are based on the guidelines created by the Catholic Hospital Association. With the passage of the Accountable Care Act, non-profit hospitals will be receiving additional scrutiny. For the first time, we will have to meet federal standards for our community benefit programs.

Under the direction and guidance of AMC administration, there has been a renewed emphasis in focus on the hospital's mission. This community health needs assessment will provide guidance in "...**focusing outreach and planning on improving the health of our local communities...**"

Whom We Serve

In conducting a community health needs assessment, a hospital has many decisions to make. One of the decisions a hospital needs to make is to determine what is the community that they serve as it applies to their needs assessment?

The Treasury Department and the IRS allow a hospital facility to consider all the relevant facts and circumstances in defining the community it serves. A hospital needs to make sure that it does nothing to exclude any at risk populations.

Adventist Medical Center (AMC) is a member of the Healthy Columbia Willamette Collaborate (HCWC) (see appendix C). The Needs Assessment that was developed by the HCWC is substantial and meets the Federal requirements required. The decision was made by the AMC Community Benefit Committee to supplement the work completed with the Collaborate with a Community Health Needs Assessment of a more narrowly defined area. Using our hospital's patients to determine a community area that would direct hospital resources to be used to address the community needs identified by this needs assessment.

In keeping with the spirit of recent IRS proposed regulations, AMC has determined from its hospital patient base, the zip codes where our patients live.

“Finally, if a hospital facility uses a method of defining its community that takes into account patient populations, these proposed regulations require the hospital facility to treat as patients all individuals who receive care from the hospital facility, without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for financial assistance.” 78 FR 20523 April 2, 2013

This data set was drawn from 108,864 unduplicated patients from January 2017 to December 2018. In the following table, the top 33 zip codes are listed. The first column lists the zip codes in order of total amount of patients from most to least. For each zip code, the number of Charity Care and Medicaid patients for that zip code is listed along with the total of both. For each category, a percent of the zip codes total patient counted is listed. For example, for zip code 97236, 5.3% of the 29,940 patients from that zip code had Charity Care and 33.79% had Medicaid. Please note that the patients are patients that were either inpatients or outpatients that use AMC hospital facilities for health care services.

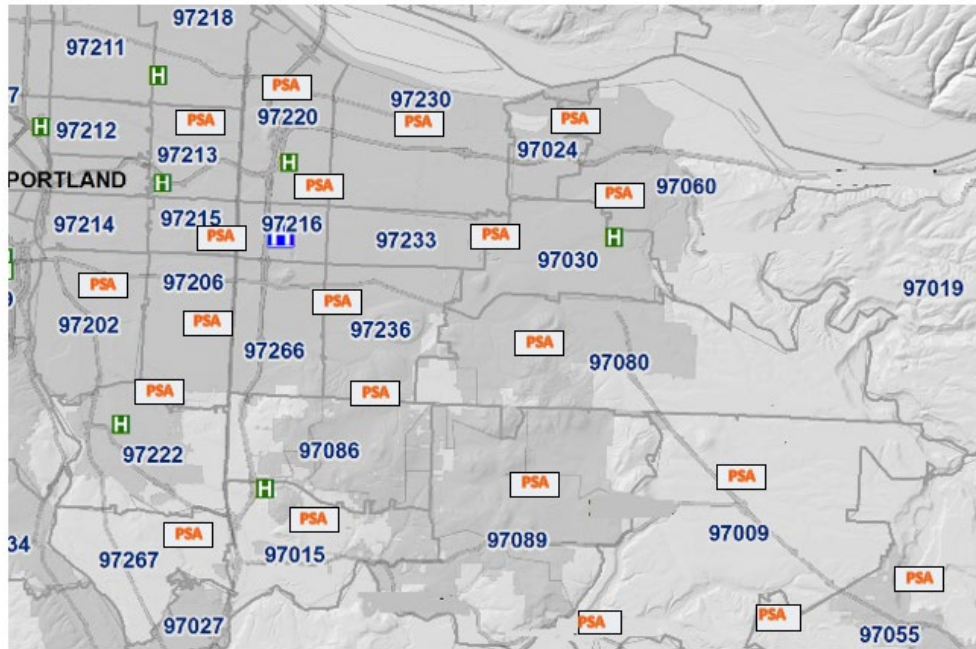
The second table represents the top ten zip codes for AMC patients using either Charity Care or Medicaid and a column for combined total of Charity Care and Medicaid patients. For zip code 97233, 42.8% of the AMC patient count for 97233 were either Charity Care or Medicaid patients. This was a small increase from our last assessment. It also had the lowest median income for those ten zip codes. 97209 had a small sample size and is out of our service area.

**Adventist Medical Center 2017-2018 Through September
Unique Patient Count By Zip Code**

Zip Code	Patient Count	Percent of Total Patient Count	Patients with Charity	Percent of Patent Total per Zip Code	Patients with Medicaid	Percent of Patent Total per Zip Code	Total Percent Charity and Medicaid	Poverty*	Median Household Income*	Population Estimate per Zip Code*
97236	29940	18.36%	1574	5.30%	10116	33.79%	39.00%	28	42109	40274
97233	27301	16.73%	1725	6.30%	9963	36.49%	42.80%	28.5	39240	42001
97230	25603	15.69%	1063	4.20%	5369	20.97%	25.10%	17.4	49423	39884
97030	24006	14.75%	506	2.10%	3182	13.26%	15.40%	21.1	47374	37604
97266	22717	13.89%	1281	5.60%	7774	34.22%	39.90%	22.4	43815	34757
97080	21701	13.34%	411	1.90%	2209	10.18%	12.10%	10.1	69847	43247
97216	16712	10.22%	1382	8.30%	4765	28.51%	36.80%	22.4	41809	17112
97220	15181	9.32%	707	4.70%	3917	25.80%	30.50%	17.6	47284	30374
97206	14850	9.10%	583	3.90%	3701	24.92%	28.80%	13.5	59622	50655
97055	13673	8.40%	268	2.00%	1671	12.22%	14.20%	9.9	67601	18317
97086	11758	7.21%	197	1.70%	1302	11.07%	12.70%	7.2	84531	29969
97060	10442	6.43%	220	2.10%	1142	10.94%	13.00%	15.1	62740	22442
97222	8590	5.28%	173	2.00%	1072	12.48%	14.50%	14.1	55031	35965
97045	8451	5.18%	124	1.50%	877	10.38%	11.80%	8.3	73618	54861
97089	8351	5.14%	116	1.40%	541	6.48%	7.90%	8.2	90784	12931
97015	7799	4.79%	125	1.60%	906	11.62%	13.20%	8.9	67873	21844
97267	6780	4.17%	90	1.30%	780	11.50%	12.80%	9.5	67272	32201
97009	6662	4.09%	123	1.80%	670	10.06%	11.90%	11.8	68580	8522
97024	6229	3.83%	155	2.50%	903	14.50%	17.00%	13	56781	10456
97023	5443	3.31%	139	2.60%	664	12.20%	14.80%	11.2	68750	10344
97213	4407	2.70%	174	3.90%	1015	23.03%	27.00%	10	67882	32284
97202	3791	2.34%	95	2.50%	706	18.62%	21.10%	13.8	66017	42189
97027	3737	2.29%	58	1.60%	360	9.63%	11.20%	11.6	57400	12484
97215	3038	1.85%	78	2.60%	465	15.31%	17.90%	7.9	76178	17939
98682	2979	1.82%	73	2.50%	78	2.62%	5.10%	11.2	67569	56411
97022	2475	1.51%	68	2.70%	250	10.10%	12.80%	6	57052	3698
97067	2459	1.50%	47	1.90%	321	13.05%	15.00%	8.4	55918	2355
97218	2223	1.36%	129	5.80%	676	30.41%	36.20%	27.4	58853	15556
97211	2010	1.23%	121	6.00%	533	26.52%	32.50%	13	73312	34856
97209	1879	1.15%	145	7.70%	1163	61.89%	69.60%	18.6	54747	16507
97214	1766	1.08%	63	3.60%	402	22.76%	26.30%	14.1	60754	25398
97217	1658	1.02%	100	6.00%	477	28.77%	34.80%	14	70027	34327
97203	1468	0.90%	71	4.80%	481	32.77%	37.60%	24.5	55174	34089
Average								14.5	61,363	938,348

* American Finder 2013-2017 5 Year Estimates Above chart includes hospital patients only. It does not include Home Health, Hospice or Clinic patients.

Primary Service Area Patient Mapping by Zip Code



Adventist Medical Center 2017-2018 Zip Code Summary							
Charity Care		Medicaid		Charity Care/Medicaid Combined			
Top Ten Zip Codes for Charity Patients	Percent of Patent Total per Zip Code	Top Ten Zip Codes for Medicaid Patients	Percent of Patent Total per Zip Code	Top Ten Zip Codes for Combined Charity and Medicaid Patients	Percent of Patent Total per Zip Code	Population*	Median Household Income*
97216	8.3%	97209	61.89%	97209	69.6%	54,747	16,507
97209	7.7%	97233	36.49%	97233	42.8%	39,240	42,001
97233	6.3%	97266	34.22%	97266	39.9%	43,815	34,757
97217	6.0%	97236	33.79%	97236	39.0%	42,109	40,274
97211	6.0%	97203	32.77%	97203	37.6%	55,174	34,089
97218	5.8%	97218	30.41%	97216	36.8%	41,809	17,112
97266	5.6%	97217	28.77%	97218	36.2%	58,853	15,556
97236	5.3%	97216	28.51%	97217	34.8%	70,027	34,327
97203	4.8%	97211	26.52%	97211	32.5%	73,312	34,856
97220	4.7%	97220	25.80%	97220	30.5%	47,284	30,374

*Population and Income Levels from <http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml>

**Growth of Charity Care and Medicaid Patients Seeking Care at AHP Per
Zip Code 2011-2013 to 2017-2018**

Zip Code	2017-2018 Total Percent Charity and Medicaid	2012-2013	Change
97236	49.49%	39.73%	9.76%
97233	50.39%	41.01%	9.38%
97266	51.39%	39.55%	11.84%
97230	32.92%	27.82%	5.10%
97030	21.85%	19.40%	2.45%
97080	15.30%	12.89%	2.41%
97206	37.47%	28.49%	8.98%
97220	43.86%	31.63%	12.23%
97216	34.24%	28.48%	5.76%
97055	15.62%	12.34%	3.28%
97086	15.82%	12.48%	3.34%
97060	15.79%	13.13%	2.66%
97222	22.61%	17.88%	4.73%
97045	17.17%	11.40%	5.77%
97015	17.71%	14.08%	3.63%
97089	9.68%	5.66%	4.02%
97023	16.25%	14.27%	1.98%
97267	16.52%	11.76%	4.76%
97009	10.77%	9.86%	0.91%
97024	20.47%	17.48%	2.99%
97202	26.19%	16.35%	9.84%
97213	30.13%	19.14%	10.99%



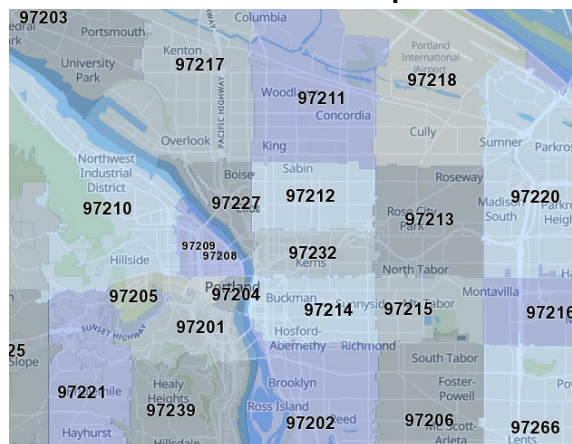
Zip Code Seeing increases in Total Percent Charity and Medicaid Over Time	Overall Increase Across all Three Periods	AHP Patients per Zip Code	AHP Charity and Medicaid Patients	% AHP Charity and Medicaid Patients of Total Patients	Poverty*	Median Household Income*	Population Estimate per Zip Code*
97233	1.79%	27,301	11,688	43%	28.5%	39,240	42,001
97216	8.32%	16,712	5,147	31%	22.4%	41,809	17,112
97089	2.24%	8,351	657	8%	8.2%	90,784	12,931
97023	0.53%	5,443	803	15%	11.2%	68,750	10,344
97267	1.04%	6,780	870	13%	9.5%	67,272	32,201
97009	2.04%	6,662	793	12%	11.8%	68,580	8,522
97202	4.75%	3,791	801	21%	13.8%	66,017	42,189
97213	7.86%	4,407	1,189	27%	10.0%	67,882	32,284
97203	N/A	1,649	1,189	72%	24.5%	55,174	34,089
97209	N/A	1,879	1,308	70%	18.6%	54,747	16,507
97218	N/A	2,223	805	36%	27.4%	58,853	15,556
97217	N/A	1,658	577	35%	14.0%	70,027	34,327
97211	N/A	2,010	654	33%	13.0%	73,312	34,856
97214	N/A	1,766	465	26%	14.1%	60,754	25,398

* American Finder 2013-2017 5 Year Estimates Above chart includes hospital patients only. It does not include Home Health, Hospice or Clinic patients.

N/A insignificant data from previous periods

Zip Code	2017-2018 Total Percent Charity and Medicaid	2016 Total Percent Charity and Medicaid	2012-2013 Total Percent Charity and Medicaid	Change 2017-2018,2016	Change 2016-2012,2013	Overall Across all Three Periods
97236	39.00%	49.49%	39.73%	-10.49%	9.76%	-0.73%
97233	42.80%	50.39%	41.01%	-7.59%	9.38%	1.79%
97266	39.90%	51.39%	39.55%	-11.49%	11.84%	0.35%
97230	25.10%	32.92%	27.82%	-7.82%	5.10%	-2.72%
97030	13.26%	21.85%	19.40%	-8.59%	2.45%	-6.14%
97080	12.10%	15.30%	12.89%	-3.20%	2.41%	-0.79%
97206	28.80%	37.47%	28.49%	-8.67%	8.98%	0.31%
97220	30.50%	43.86%	31.63%	-13.36%	12.23%	-1.13%
97216	36.80%	34.24%	28.48%	2.56%	5.76%	8.32%
97055	13.20%	15.62%	12.34%	-2.42%	3.28%	0.86%
97086	12.70%	15.82%	12.48%	-3.12%	3.34%	0.22%
97060	13.00%	15.79%	13.13%	-2.79%	2.66%	-0.13%
97222	14.40%	22.61%	17.88%	-8.21%	4.73%	-3.48%
97045	11.80%	17.17%	11.40%	-5.37%	5.77%	0.40%
97015	13.20%	17.71%	14.08%	-4.51%	3.63%	-0.88%
97089	7.90%	9.68%	5.66%	-1.78%	4.02%	2.24%
97023	14.80%	16.25%	14.27%	-1.45%	1.98%	0.53%
97267	12.80%	16.52%	11.76%	-3.72%	4.76%	1.04%
97009	11.90%	10.77%	9.86%	1.13%	0.91%	2.04%
97024	17.00%	20.47%	17.48%	-3.47%	2.99%	-0.48%
97202	21.10%	26.19%	16.35%	-5.09%	9.84%	4.75%
97213	27.00%	30.13%	19.14%	-3.13%	10.99%	7.86%
97203	37.60%					
97209	69.60%					
97218	36.20%					
97217	34.80%					
97211	32.50%					
97214	26.30%					

Area Codes 97209, 97218, 97217, 97211, 97214 and 97203 would not be considered part of our Service area due to low number of total patients from those Zip Codes



Race and Ethnicity Information

Race as a % of Population per Zip Code 2013-2017 American Community Survey 5-Year Estimates and Percentage Change from 2010-2014												
Zip Code	White		Black / African		American Indian/ Alaska Native Alone		Asian Alone		Native Hawaiian or other Pacific Islander		Hispanic/ Latino	
	%	% Change	%	% Change	%	% Change	%	% Change	%	% Change	%	% Change
97009	83.5%	-4.8%	0.0%	-0.1%	0.7%	0.6%	1.4%	0.9%	0.0%	0.0%	12.1%	3.0%
97015	72.6%	0.6%	1.5%	0.0%	0.9%	-0.5%	6.4%	-2.6%	0.7%	-0.8%	12.3%	2.3%
97022	91.7%	2.1%	0.5%	-0.1%	1.1%	-0.3%	0.0%	-1.7%	0.0%	0.0%	4.4%	-1.8%
97023	89.4%	0.8%	0.0%	-0.4%	0.7%	-0.2%	2.1%	1.4%	0.0%	0.0%	5.6%	-2.2%
97024	70.7%	-2.4%	3.9%	-0.4%	2.3%	0.8%	3.7%	0.3%	0.0%	0.0%	16.6%	0.1%
97027	79.8%	-3.9%	1.0%	-0.4%	0.5%	0.3%	2.3%	-0.6%	0.1%	0.1%	13.9%	4.5%
97030	70.5%	0.7%	3.1%	1.1%	0.4%	-0.2%	2.9%	-0.5%	0.1%	-1.1%	18.4%	0.0%
97045	88.1%	0.8%	0.8%	0.2%	0.8%	0.2%	0.9%	-0.5%	0.1%	0.1%	5.7%	-1.9%
97055	89.1%	-1.3%	0.4%	0.1%	0.2%	-0.1%	0.5%	-0.1%	0.0%	-0.1%	6.9%	1.0%
97060	69.5%	-2.7%	2.5%	0.2%	0.6%	-0.1%	4.4%	-2.4%	0.0%	-0.5%	19.5%	5.0%
97067	87.4%	-3.8%	0.0%	0.0%	0.0%	0.0%	1.4%	1.4%	0.0%	-0.1%	10.7%	2.1%
97080	77.2%	-2.9%	1.9%	0.9%	0.6%	-0.5%	2.5%	-0.1%	0.2%	-0.6%	13.4%	1.9%
97086	67.6%	-0.9%	1.5%	-0.1%	0.4%	0.2%	15.5%	0.8%	0.3%	0.0%	9.8%	-0.4%
97089	86.2%	-2.8%	0.5%	0.2%	1.5%	0.7%	3.3%	-0.3%	0.2%	0.2%	6.2%	1.8%
97202	80.2%	-2.1%	1.5%	-0.5%	0.3%	0.1%	5.3%	-0.2%	0.4%	0.3%	7.5%	0.7%
97203	62.5%	1.6%	8.7%	-0.6%	1.1%	0.2%	3.9%	-0.1%	1.2%	-1.3%	17.0%	0.3%
97206	74.0%	-0.4%	2.3%	-0.2%	0.5%	-0.3%	8.9%	-0.7%	0.3%	-0.1%	9.6%	1.2%
97209	80.1%	-2.5%	3.9%	0.3%	0.3%	-0.2%	4.8%	0.0%	0.0%	-0.1%	6.3%	0.9%
97211	69.2%	5.4%	14.4%	-4.2%	0.3%	-0.5%	3.2%	0.1%	0.1%	0.0%	7.1%	-0.4%
97213	80.6%	1.4%	3.4%	-1.2%	1.0%	0.3%	6.7%	0.2%	0.0%	-1.0%	5.3%	1.3%
97214	84.4%	-0.3%	1.7%	0.3%	0.4%	-0.3%	4.4%	0.8%	0.0%	-0.1%	4.6%	-0.8%
97215	84.2%	-1.6%	0.6%	-0.4%	0.7%	0.0%	5.4%	0.8%	0.0%	0.0%	6.3%	1.6%
97216	60.8%	0.2%	4.2%	-1.3%	1.4%	0.5%	11.9%	-4.3%	3.7%	3.1%	14.0%	2.1%
97217	71.4%	0.9%	10.4%	-0.1%	0.2%	0.1%	4.1%	-1.2%	0.6%	0.0%	8.6%	-0.3%
97218	54.5%	2.5%	8.8%	-5.5%	0.9%	0.3%	6.2%	0.4%	0.5%	0.0%	24.2%	0.9%
97220	57.2%	-3.0%	8.0%	0.6%	1.1%	0.2%	14.3%	2.9%	1.2%	0.7%	12.6%	-1.9%
97222	80.4%	-2.7%	1.2%	-0.5%	0.5%	0.0%	3.8%	0.8%	0.1%	-0.2%	11.4%	3.2%
97230	57.8%	-2.6%	9.1%	-0.5%	0.7%	0.2%	10.2%	1.2%	2.0%	0.1%	15.1%	1.0%
97233	50.7%	-6.6%	11.2%	4.7%	0.8%	0.0%	9.4%	0.9%	1.5%	-0.1%	21.2%	-0.6%
97236	55.7%	-6.1%	8.0%	1.5%	0.6%	0.0%	14.8%	3.6%	1.4%	0.8%	14.9%	-1.8%
97266	55.2%	-0.8%	4.2%	-1.1%	1.1%	0.5%	17.3%	1.1%	0.7%	0.7%	17.2%	-1.4%
97267	84.6%	0.4%	1.9%	0.2%	0.7%	0.1%	2.0%	0.3%	0.3%	0.0%	8.0%	0.2%
98682	75.0%	-0.9%	1.9%	-0.2%	0.6%	-0.1%	5.1%	-0.4%	0.9%	0.1%	11.1%	0.3%

Multnomah County

Multnomah County, OR is home to a population of 799,766 people, from which 92.7% are citizens. The ethnic composition of the population of Multnomah County, OR is composed of 563,483 White residents (70.5%), 90,821 Hispanic residents (11.4%), 55,428 Asian residents (6.93%), 43,968 Black residents (5.5%), and 36,216 Two+ residents (4.53%). The most common foreign languages in Multnomah County, OR are Spanish (59,719 speakers), Vietnamese (13,701 speakers), and Chinese (10,787 speakers), but compared to other places, Multnomah County, OR has a relative high number of Other Slavic (4,284 speakers), Russian (9,279 speakers), and Vietnamese (13,701 speakers).

As of 2016, 92.7% of Multnomah County, OR residents were US citizens, which is lower than the national average of 93%. In 2015, the percentage of US citizens in Multnomah County, OR was 92.6%, meaning that the rate of citizenship has been growing in that location.

The median property value in Multnomah County, OR is \$367,700, which is 1.79 times larger than the national average of \$205,000. Between 2015 and 2016 the median property value increased from \$321,700 to \$367,700, a 14.3% increase. The homeownership rate of Multnomah County, OR is 53%, which is lower than the national average of 63.1%. People in Multnomah County, OR have an average commute time of 25.6 minutes, and they commute by Drove Alone. Car ownership in Multnomah County, OR is approximately the same as the national average, with an average of 2 cars per household. https://datausa.io/profile/geo/multnomah-county-or/#category_health_risks

Clackamas County

Clackamas County, OR is home to a population of 408,062 people, from which 97% are citizens. The ethnic composition of the population of Clackamas County, OR is composed of 336,551 White residents (82.5%), 34,415 Hispanic residents (8.43%), 15,775 Asian residents (3.87%), 14,407 Two+ residents (3.53%), and 3,656 Black residents (0.9%). The most common foreign languages in Clackamas County, OR are Spanish (21,311 speakers), Chinese (3,661 speakers), and Russian (3,341 speakers), but compared to other places, Clackamas County, OR has a relative high number of Russian (3,341 speakers), Other Slavic (932 speakers), and Laotian (379 speakers).

Clackamas County, OR is home to a population of 408,062 people, from which 97% are citizens. The ethnic composition of the population of Clackamas County, OR is composed of 336,551 White residents (82.5%), 34,415 Hispanic residents (8.43%), 15,775 Asian residents (3.87%), 14,407 Two+ residents (3.53%), and 3,656 Black residents (0.9%). The most common foreign languages in Clackamas County, OR are Spanish (21,311 speakers), Chinese (3,661 speakers), and Russian (3,341 speakers), but compared to other places, Clackamas County, OR has a relative high number of Russian (3,341 speakers), Other Slavic (932 speakers), and Laotian (379 speakers).

The median property value in Clackamas County, OR is \$374,900, which is 1.83 times larger than the national average of \$205,000. Between 2015 and 2016 the median property value increased from \$336,200 to \$374,900, a 11.5% increase. The homeownership rate of Clackamas County, OR is 70.5%, which is higher than the national average of 63.1%. People in Clackamas County, OR have an average commute time of 26.8 minutes, and they commute by Drove Alone. Car ownership in Clackamas County, OR is approximately the same as the national average, with an average of 2 cars per household. <https://datausa.io/profile/geo/clackamas-county-or/>

Racial and Ethnic Health Disparities

According to the Multnomah County Health Department Report “2014 Report Card on Racial and Ethnic Health Disparities” December 2014. (The full report can be found at <http://web.multco.us/health/reports>.)

“In Multnomah County, all racial and ethnic groups examined in this report experienced some disparities relative to their non- Latino White counterparts. A striking number of disparities exist for Black/African Americans and American Indian/Alaska Natives. Numerous disparities also exist for Latinos and Asian/Pacific Islanders, but those communities also fared better than non-Latino Whites for some indicators.

Non-Latino Black/African American

Black/African Americans experienced the greatest number of disparities with the highest level of concern relative to other communities of color. As shown in Figure 1, of the 33 indicators examined in this report, Black/African Americans experienced disparities for nine indicators that *require intervention* and 18 indicators that *need improvement*. There were only four indicators where a disparity was not detected. There were no indicators where the group fared significantly better than the non-Latino White comparison group. Black/African Americans experienced a geographic disparity for each of the physical environment indicators.”

Black/African Americans experienced the largest number of health disparities among racial/ethnic groups in Multnomah County. The report shows statistically significant disparities for 9 of the 18 health indicators for African Americans.

Health indicators requiring improvement/intervention include:

- Cigarette use
- Obesity
- Teen birth rates
- Health Insurance
- Children with untreated tooth decay
- First trimester prenatal care
- Low birth weight babies
- Infant mortality
- Stroke mortality
- Prostate cancer mortality
- Gonorrhea
- HIV incidence
- Diabetes mortality
- Coronary Heart Disease
- All cancer

Relative to their White non-Hispanic counterparts African Americans:

- continued to have significantly higher proportions of mothers who did not receive prenatal care
- in their first trimester experienced an infant mortality rate that was almost twice as high.
- had a higher stroke mortality rate.
- had a diabetes mortality rate more than two and a half as high.
- were almost two times as likely to die of prostate cancer though there was no disparity in other forms of cancer.
- Homicide rates about six times higher.

Social and Economic indicators with improvement needed include:

- Children living in poverty
- Children living in single-parent households
- Children not meeting third-grade reading standards
- Unemployment

Asian/Pacific Islanders

Asian/Pacific Islanders experienced fewer health disparities than other racial/ethnic groups in Multnomah County. For 11 indicators, Asian/Pacific Islanders, did significantly better than non-Latino Whites.

Though this group fared well for many indicators, it is likely that aggregation of data into this large group is masking some disparities being experienced by sub-groups of Asian/Pacific Islanders. More attention should be given to disaggregated data for this population. A supplemental report focusing on Pacific Islander health disparities is forthcoming.

Health indicators with improvement needed include:

- First trimester prenatal care
- Low birth weight babies
- Homicide rates

Adults without health insurance was the one indicator that *requires intervention* level for Asian/Pacific Islanders. The percentage without health insurance is more than two times higher among non-Latino Asian/Pacific Islanders in Multnomah County than among non-Latino Whites.

Relative to their White non-Hispanic counterparts Asian/Pacific Islanders:

- continued to have significantly higher proportions of mothers who did not receive prenatal care in their first trimester.
- continued to have higher proportions of low birth weight births.
- experienced a higher homicide rate.

Social and Economic indicators with improvement needed include:

- Third-grade reading level
- Post-high school education

Native Americans

There are statistically significant disparities in 5 of the 18 health indicators for Native Americans and 12 at the *needs improvement level*. However, for seven of the other health indicators, Native Americans did not have a sufficient number of events to calculate a rate.

Health indicators requiring intervention:

- Teen births
- Current cigarette smoking
- Adults with no physical activity outside of work

Health indicators needing improvement include:

- No first trimester prenatal care
- Stroke mortality

- Infant mortality
- Low birthweight
- Self-reported mental health

Relative to their White non-Hispanic counterparts:

- Native American had higher rates of teen births.
- Native Americans continued to have significantly higher proportions of mothers who did not receive prenatal care in their first trimester.

Social and Economic indicators with improvement needed include:

- Are more than twice as likely to have children living in poverty
- Twice as likely to have children not meeting third-grade reading standards
- Lack of post-high school education

Hispanics

There are statistically significant disparities in 6 of the 18 health indicators for Hispanics. There were also eight indicators where Latinos fared significantly better than non-Latino Whites.

Health indicators requiring intervention include:

- Obesity
- First trimester prenatal care
- Untreated tooth decay
- Teen birth rate
- Lack of health insurance

Health indicators needing improvement include:

- HIV incidence
- Diabetes mortality rates
- Overall Health status

Relative to their White non-Hispanic counterparts Hispanics:

- continued to have significantly higher proportions of mothers who did not receive prenatal care in their first trimester
- Experienced a teen birth rate that was 3.5 times higher
- Latino adults were two times more likely to lack health insurance

Social and Economic indicators with improvement needed include:

- Are more than twice as likely to have children living in poverty
- Twice as likely to have children not meeting third-grade reading standards
- Lack of post-high school education
- Homicide rate

From the “Facing Race- 2013 Legislative Report Card on Racial Equity.

Whites are far less likely to face poverty than communities of color in Oregon. In 2012, the poverty rate for Whites was only 15 percent, but 30 percent for Latinos, 34 percent for Native Americans and Alaska Natives, 36 percent for Native Hawaiians and Pacific Islanders and 41 percent for African Americans.

- As for public education, in Multnomah County, just 7 percent of White students do not graduate from high school compared to 30 percent of students of color.
- In Oregon’s placement of children in foster care, Native American youth are more than five times as likely to be placed into foster care; African American youth are four times as likely, and Pacific Islanders are twice as likely to white youth.
- Oregon’s population is increasingly diverse—more multiracial, multicultural and multilingual. From 1990 to 2012, Oregonians of color have increased from just 9.2 percent of the state’s population to 22.4 percent.
- Communities of color face greater obstacles to health insurance than White Oregonians generally do. The primary source of health coverage in Oregon— job-based insurance—is not accessed by people of color to the same degree given the higher unemployment and underemployment rates.
- While two out of three uninsured Oregonians in 2012 were White, Oregonians of color were significantly over-represented among the uninsured

As We Age

From the 2018 Profile of Older Americans:

- Over the past 10 years, the population age 65 and over increased from 37.8 million in 2007 to 50.9 million in 2017 (a 34% increase) and is projected to reach 94.7 million in 2060.
- Between 2007 and 2017 the population age 60 and over increased 35% from 52.5 million to 70.8 million.
- The 85 and over population is projected to more than double from 6.5 million in 2017 to 14.4 million in 2040 (a 123% increase).
- Racial and ethnic minority populations have increased from 7.2 million in 2007 (19% of the older adult population) to 11.8 million in 2017 (23% of older adults) and are projected to increase to 27.7 million in 2040 (34% of older adults).
- The number of Americans age 45-64 – who will reach age 65 over the next two decades – increased by 9% between 2007 and 2017.
- More than one in every seven, or 15.6%, of the population is an older American.
- Persons reaching age 65 have an average life expectancy of an additional 19.5 years (20.6 years for females and 18.1 years for males).

- There were 86,248 persons age 100 and over in 2017 (0.2% of the total age 65 and over population).
- Older women outnumber older men at 28.3 million older women to 22.6 million older men.
- In 2017, 23% of persons age 65 and over were members of racial or ethnic minority populations--9% were African-Americans (not Hispanic), 4% were Asian (not Hispanic), 0.5% were American Indian and Alaska Native (not Hispanic), 0.1% were Native Hawaiian/Pacific Islander (not Hispanic), and 0.8% of persons 65 and older identified themselves as being of two or more races. Persons of Hispanic origin (who may be of any race) represented 8% of the older population.
- A larger percentage of older men are married as compared with older women---70% of men, 46% of women. In 2018, 32% older women were widows.
- About 28% (14.3 million) of older persons lived alone (9.5 million women, 4.8 million men).
- Among women age 75 and over, 44% lived alone.
- The median income of older persons in 2017 was \$32,654 for males and \$19,180 for females. The real median income (after adjusting for inflation) of all households headed by older people increased by 1.1% (which was not statistically significant) between 2016 and 2017. Households containing families headed by persons age 65 and over reported a median income in 2017 of \$61,946.
- In 2017, 4,681,000 older adults (9.2%) were below the poverty level. This poverty rate is not statistically different from the poverty rate in 2016 (9.3%). In 2011, the U.S. Census Bureau released a new Supplemental Poverty Measure (SPM) which considers regional variations in living costs, non-cash benefits received, and non-discretionary expenditures but does not replace the official poverty measure. In 2017, the SPM showed a poverty level for persons age 65 and over of 14.1% (almost 5 percentage points higher than the official rate of 9.2%). This increase is mainly due to including medical out-of-pocket expenses in the poverty calculations.
- The need for caregiving increases with age. In January-June 2018, the percentage of older adults age 85 and over needing help with personal care (20%) was more than twice the percentage for adults ages 75–84 (9%) and five times the percentage for adults ages 65–74 (4%).
- Among adults age 75 and over, 42% report the television is their first source of emergency information as compared with 31% for the total population. The percentage of older adults receiving information from the internet (9%) is much lower than for the total population (31%).

1 Principal sources of data for the Profile are the U.S. Census Bureau, the National Center for Health Statistics, and the Bureau of Labor Statistics. The Profile incorporates the latest data available but not all items are updated on an annual basis.

2 This report includes data on the 65 and over population unless otherwise noted. The phrase “older adults or older persons” refers to the population age 65 and over.

3 Numbers in this report may not add up due to rounding.

Primary Data

Primary Sources

A primary source provides direct or firsthand evidence about an event, object, person, or work of art. Primary sources provide the original materials on which other research is based and enable students and other researchers to get as close as possible to what happened during an event or time period. Published materials can be viewed as primary resources if they come from the time period that is being discussed and were written or produced by someone with firsthand experience of the event. Often primary sources reflect the individual viewpoint of a participant or observer. Primary sources can be written or non-written (sound, pictures, artifacts, etc.). In scientific research, primary sources present original thinking, report on discoveries, or share new information.

Primary Data from Surveys and Listening Sessions Community Needs Surveys

2019 East and Mid-County Service Provider Survey

Q1 Please tell us how much you agree with the following statements about our community.

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	TOTAL	WEIGHTED AVERAGE
There is a high quality healthcare system in our community.	23.08% 3	61.54% 8	15.38% 2	0.00% 0	13	1.92
Our community is a good place to raise children.	15.38% 2	46.15% 6	38.46% 5	0.00% 0	13	2.23
Our community is a good place to grow old.	15.38% 2	53.85% 7	30.77% 4	0.00% 0	13	2.15
There is plenty of economic opportunity in our community.	0.00% 0	61.54% 8	38.46% 5	0.00% 0	13	2.38
Our community is a safe place to live.	0.00% 0	46.15% 6	53.85% 7	0.00% 0	13	2.54
There is plenty of help for individuals and families in need in our community.	0.00% 0	53.85% 7	46.15% 6	0.00% 0	13	2.46

Q2 When you imagine a strong, vibrant and healthy community what are the most important features you think of? (Please choose five.)

- 79.92% Safe environment
- 69.23% Good Schools
- 69.23% Health Services
- 61.54% Affordable Housing
- 46.15% Livable Wages
- 46.15% Mental Health Services

Q3 The next two questions are about health problems that have the largest impact on the community. We would like for you to pick five of the most important health problems in East Multnomah County.

- 92.31% Mental Health

69.23% Drugs and Alcohol Abuse

38.46% Diabetes

38.46% Cancer Screening

38.46% Overweight/Obesity

Q4 Please pick the top five unhealthy behaviors that you believe are a problem in East Multnomah County.

84.62% Poor Eating Habits

84.62% Drug/Substance Abuse

53.85% Smoking/Tobacco Use

53.85% Not Going to Doctor on Regular Basis

53.85% Alcohol Abuse

46.15% Lack of Exercise

Q5 This question is about community-wide issues that have the largest impact on the overall quality of life in East Multnomah County. Please pick five from this list of community issues.

63.23% Drug and Alcohol Abuse

61.54% Low Income/Poverty

61.54% Affordability of Health Services

53.85% Homelessness

53.85% Inadequate/Unaffordable Housing

Q6 In your opinion, what would improve the quality of life for residents of East Multnomah County? (Please choose up to five.)

76.92% Safe Neighborhoods (less Crime)

69.23% More Mental Health Services

69.23% More Affordable Housing

46.15% Substance Abuse Treatment

38.46% More Incentives for Healthy Behaviors

Healthy Columbia Willamette Collaborate

Collaborative Origin

In 2010, local health care and public health leaders in Clackamas, Multnomah, and Washington counties in Oregon and Clark County in Washington began to discuss the upcoming need for several community health assessments and health improvement plans within the region in response to the Affordable Care Act and Public Health Accreditation¹. They recognized these requirements as an opportunity to align the efforts of hospitals, public health and the residents of the communities they serve to develop an accessible, real-time assessment of community health across the four-county region. By working together, they would eliminate duplicative efforts, facilitate the prioritization of community health needs, enable joint efforts for implementing and tracking improvement activities, and improve the health of the community.

Members

With start-up assistance from the Oregon Association of Hospitals and Health Systems, the Healthy Columbia Willamette Collaborative (Collaborative) was developed. It is a large public-private collaborative comprised of 14 hospitals and four local public health departments in the four-county region. Members include: Adventist Medical Center, Clackamas County Health Department, Clark County Public Health Department, Kaiser Permanente, Legacy Emanuel Medical Center, Legacy Good Samaritan Medical Center, Legacy Meridian Park Medical Center, Legacy Mount Hood Medical Center, Legacy Salmon Creek, Multnomah County Health Department, Oregon Health & Science University, PeaceHealth Southwest Medical Center, Providence Milwaukie, Providence Portland, Providence St. Vincent, Providence Willamette Falls, Tuality Healthcare and Washington County Health Department.

HCWC Prioritized Core Issues

Overview:

The Conveners collected feedback from HCWC Data Workgroup members and their external partners through a survey about the 10 Core Issues which were identified for the CHNA. After review of the feedback received and assessment of the underlying data supporting each Core Issue, five Core Issues were prioritized.

Top 10 Core Issues:

The identified Core Issues are listed in alphabetical order:

1. Access to: Health Care, Transportation, and Resources
2. Behavioral Health (Depression and Intentional Self-harm)
3. Chronic Conditions (Heart Disease, Diabetes, Hypertension)
4. Community Representation
5. Culturally Responsive Care
6. Discrimination/Racism

7. Isolation
8. Liver Disease
9. Sexually Transmitted Infections (Chlamydia and Gonorrhea)
10. Trauma

Prioritized Core Issues:

- Behavioral Health
- Community Representation
- Culturally Responsive Care
- Isolation
- Sexually Transmitted Infections

The prioritized Core Issues were chosen because they were identified as key gaps in the region by both HCWC Data Workgroup members and external partners. The underlying data also suggests these Core Issues are not being adequately addressed and there is significant room for improvement across the region.

The Core Issues of Discrimination & Racism and Trauma also rose to the top through the prioritization process but are more accurately reflected in the CHNA as drivers/influencers for each of the prioritized issue above.

The Core Issues of Access to: Health Care, Transportation and Resources, Chronic Conditions, and Liver Disease, were not prioritized as they were not

Survey Conclusions

A review of the results of the two surveys shows similar concerns among the both. Those concerns are as follows:

- Behavior/Mental Health
 - Community support, both as crucial to maintaining cultural values and establishing a sense of belonging, and to help ease depression and other mental health concerns.
 - Significant stress, often because of racism, discrimination, and feelings of exclusion from the community due to their race/ethnicity, socio-economic status, LGBTQ+ identities, disability status, and citizenship status.
 - Cultural/social isolation, and geographic isolation.
- Access to Affordable Health Care
 - Lack of access to the health care system, citing financial and cultural barriers
 - Difficulty affording medical costs and medications.
 - Language barriers, and a lack of translators, were cited as significant barriers to health among participants.
- Life Style Concerns surrounding:
 - Drug and Alcohol Abuse
 - Safety concerns impacting the health of their community

- Obesity
- Lack of Exercise
- Social Determinates of Health
 - Housing
 - Unaffordable housing costs and rent hikes greatly contribute to the stress community members face on a regular basis
 - Homelessness
 - Need for infrastructure changes to the transportation system

These results will be added to concerns raised by the following sections of secondary data research. The data is drawn from publicly available data. Analysis will be made based on trends in occurrences of the major areas of illness, leading causes of death and cost of medical care.

Secondary Data

Secondary sources describe, discuss, interpret, comment upon, analyze, evaluate, summarize, and process primary sources. A secondary source is generally one or more steps removed from the event or time period and are written or produced after the fact with the benefit of hindsight. Secondary sources often lack the freshness and immediacy of the original material. On occasion, secondary sources will collect, organize, and repackage primary source information to increase usability and speed of delivery, such as an online encyclopedia. Like primary sources, secondary materials can be written or non-written (sound, pictures, movies, etc.).

Oregon Leading Causes of Death 2017, 2016 and 2014

OR Leading Causes of Death, 2017	Deaths	Rate***	State Rank*	U.S. Rate**
1. Cancer	8,083	154.2	25th (tie0)	152.5
2. Heart Disease	6,942	134.0	47th	165.0
3. Chronic Lower Respiratory Diseases	2,088	39.7	32nd	40.9
4. Accidents	2,076	44.7	37th	49.4
5. Stroke	2,066	39.9	17th	37.6
6. Alzheimer's disease	1,850	36.0	18th	31.0
7. Diabetes	1,243	23.9	14th (tie)	21.5
8. Suicide	825	19.0	15th	14.0
9. Chronic Liver Disease/Cirrhosis	642	12.6	16th (tie)	10.9
10. Flu/Pneumonia	573	11.1	45th	14.3

OR Leading Causes of Death, 2016	Deaths	Rate***	State Rank*	U.S. Rate**
1. Cancer	8,078	155.9	31st	155.8
2. Heart Disease	6,968	135.0	46th	165.5
3. Accidents	2,105	46.0	34th (tie)	47.4
4. Chronic Lower Respiratory Diseases	2,080	40.4	30th	40.6
5. Stroke	1,943	37.8	23rd (tie)	37.3
6. Alzheimer's disease	1,786	34.8	20th	30.3
7. Diabetes	1,240	24.0	11th (tie)	21.0
8. Suicide	772	17.8	16th	13.5
9. Chronic Liver Disease/Cirrhosis	606	12.2	15th (tie)	10.7
10. Hypertension	557	10.6	7th	8.6

OR Leading Causes of Death, 2014	Deaths	Rate***	State Rank*	U.S. Rate**
1. Heart Disease	7,863	160.2	48th	167.0
2. Cancer	6,524	132.1	31st	161.2
3. Chronic Lower Respiratory Disease	1,955	40.1	32nd	40.5
4. Accidents	1,821	41.0	35th (tie)	40.5
5. Stroke	1,803	37.4	22nd (tie)	36.5
6. Alzheimer's disease	1,411	28.5	20th	25.4
7. Diabetes	1,083	22.4	19th	20.9
8. Suicide	782	18.6	11th	13.0
9. Chronic Liver Disease/Cirrhosis	599	12.8	8th	10.4
10. Hypertension	497	9.8	8th (tie)	8.2

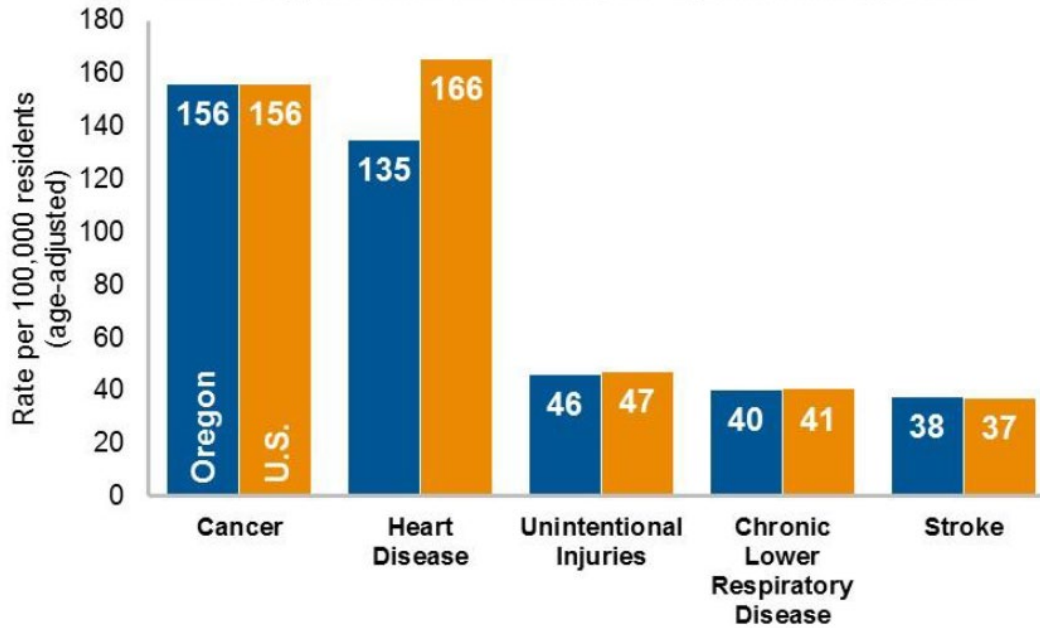
* Rankings are from highest to lowest.

** Rates for the U.S. include the District of Columbia and (for births) U.S. territories. Refer to notes in publication tables for more detail.

*** Death rates are age-adjusted. Refer to source notes below for more detail.

FIGURE 1

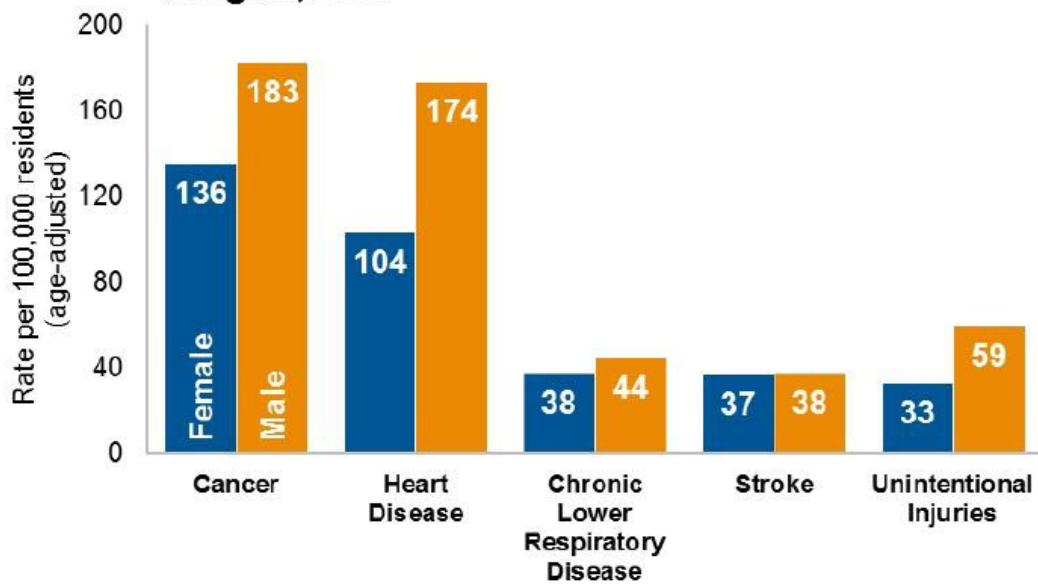
Leading causes of death, Oregon & U.S., 2016



Source: Oregon Death Certificate Data & CDC WONDER (U.S.)

FIGURE 2

Leading causes of death by sex, Oregon, 2016



Source: Oregon Death Certificate Data

The State of Oregon/Multnomah County Health Factors

In the University of Wisconsin Population Health Institute's report, County Health Rankings 2010, 2013 and County Health rankings 2019, a snapshot of the overall health of Oregon by county has shown the following. The summary health factors represent a weighted summary that are what influences the health of the county and the summary health outcomes represent how healthy a county is.

2010 Oregon Health Factors & Outcomes Ranking by County								
Health Factors Ranking						Health Outcomes Ranking		
County	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment	Sum	Mortality	Morbidity	Summary
Multnomah	11	2	16	14	9	17	22	21
Clackamas	6	4	3	23	5	4	4	3

2013 Oregon Health Factors & Outcomes Ranking by County								
Health Factors Ranking						Health Outcomes Ranking		
County	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment	Sum	Mortality	Morbidity	Summary
Multnomah	9	6	17	17	9	14	19	15
Clackamas	6	3	3	15	4	4	5	5

2019 Oregon Health Factors & Outcomes Ranking by County								
Health Factors Ranking						Health Outcomes Ranking		
County	Health Behaviors	Clinical Care	Social & Economic Factors	Physical Environment	Sum	Mortality	Morbidity	Summary
Multnomah	7	5	9	11	8	6	5	6
Clackamas	3	3	3	34	3	4	1	4

http://www.countyhealthrankings.org/app/oregon/2019/compare/snapshot?counties=41_005%2B41_051

The health factors ranking is based on four factors: health behaviors, clinical care, social and economic, and physical factors.

Health Behaviors include measures of smoking, diet and exercise, alcohol use and risky sex behavior.

Clinical care includes measures of access to care and quality of care.

Social and economic factors include measures of education, employment, income, family and social support, and community safety.

The physical environment includes measures of environmental quality and the built environment. Factors within this category have changed in the 2018 ranking.

The health outcomes ranking is based on measures of mortality and morbidity.

The mortality rank represents length of life and is based on a measure of premature death; the years of potential life lost prior to age 75.

The morbidity rank is based on measures that represent health-related quality of life and birth outcomes. Four morbidity measures were combined: self-reported fair or poor health, poor physical health days, poor mental health days, and the percent of births with low birth weight.

Prevalence of Selected Chronic Conditions among Adults by County						
County	Arthritis	Asthma	Heart Attack	Coronary Heart Disease	Stroke	Diabetes
Multnomah	21.70%	10.10%	3.70%	4.20%	2.50%	9.00%
Clackamas	26.40%	9.40%	3.70%	3.80%	2.80%	8.00%
Oregon in Total	27.20%	10.70%	4.20%	4.20%	3.10%	9.00%

Data from BRFSS, by County, Oregon, Chronic Diseases among Oregon Adults

Rates are age-adjusted.

Age-adjusting a rate is a way to make fairer comparisons between groups with different age distributions. For example, a county having a higher percentage of elderly people may have a higher rate of death or hospitalization than a county with a younger population, merely because the elderly is more likely to die or be hospitalized. The same distortion can happen when we compare races, genders, or time periods. Age adjustment can make the different groups more comparable.

Preventive Clinical Services Performed

Age-adjusted Prevalence of Preventive Health Screening among Adults by County				
County	Current1 on colorectal cancer screening (50-75 years old; %)	Pap test within past three years (women 21-65 years old with a cervix; %)	Mammogram within past two years (women 50-74 years old; %)	Cholesterol checked within past five years (%)
Multnomah:2012-2015	67.00%	81.90%	78.70%	73.00%
Multnomah:2010-2013	63.70%	81.40%	81.20%	70.10%
Multnomah:2008-2011	62.30%	86.20%	84.60%	76.00%
Clackamas:2012-2015	72.80%	87.70%	83.60%	74.20%
Clackamas:2010-2013	66.60%	86.10%	78.90%	74.20%
Clackamas:2008-2011	64.40%	87.20%	82.50%	74.50%
Oregon in Total: 2012-2015	64.80%	81.50%	75.50%	72.80%
Oregon in Total: 2010-2013	61.10%	81.70%	75.30%	70.80%
Oregon in Total:2008-2011	61.20%	84.40%	79.70%	73.10%

Current1 on colorectal cancer screening includes: having a fecal occult blood test (FOBT) in the past year; a colonoscopy within the past 10 years; or, a sigmoidoscopy within the past five years as well as an FOBT within the past three years.

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Health screenings among adults, Oregon 2017

	Unadjusted (%)	Age-adjusted (%)	Number of adults
Cholesterol checked within past five years	84.6	82.3	2,765,700
Current ¹ on colorectal cancer screening (50-75 years old)	72.6	NA	914,400
FOBT within past year (50-75 years old)	14.6	NA	183,900
Mammogram within past two years (women 50-74 years old)	76.9	NA	489,800

FOBT = Fecal occult blood test
 NA = not applicable or available

¹Current on colorectal cancer screening includes: having a fecal occult blood test (FOBT) in the past year; a colonoscopy within the past 10 years; or, a sigmoidoscopy within the past five years as well as an FOBT within the past three years.

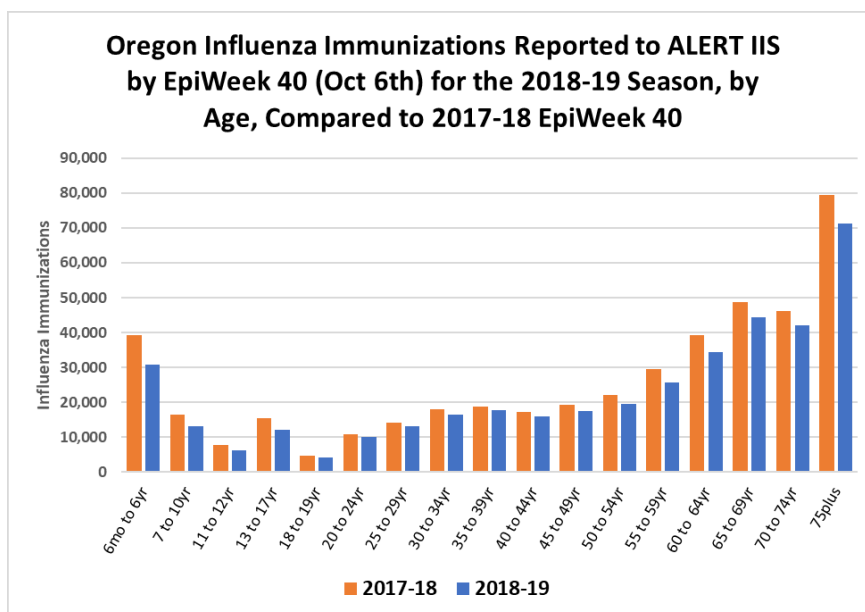
Source: Oregon Behavioral Risk Factors Surveillance System 2017; age-adjusted to the 2000 standard population.

Note: For an explanation of using unadjusted versus age-adjusted estimates, please see <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/DataReports/Pages/TechnicalNotes.aspx>.

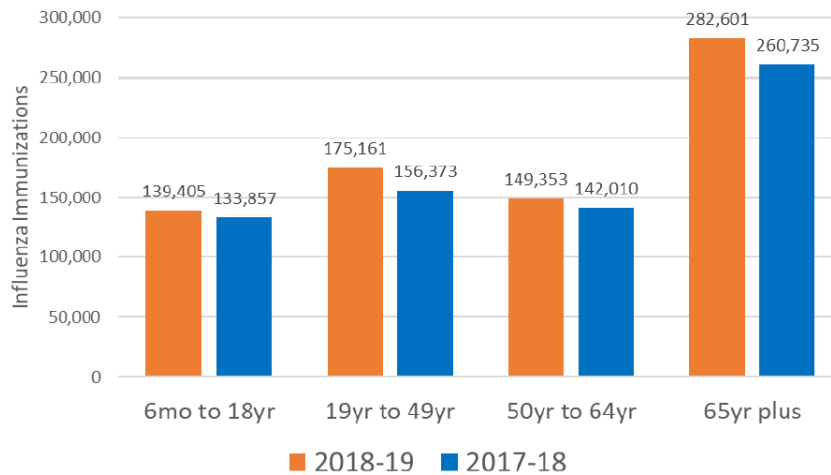
Suggested citation: Oregon Health Authority, Public Health Division, Health Promotion and Chronic Disease Prevention section. Health screenings among adults, Oregon 2017. <http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/DataReports/Pages/AdultData.aspx>.

Created November 2018. Accessed 1-10-2019

Influenza vaccination



Oregon Influenza Immunization Totals by Age Groups, EpiWeek 42



<https://www.oregon.gov/OHA/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/Pages/research.aspx>

Oregon Birth Data 2017	State	Rank*	U.S.**
Percent of Births to Unmarried Mothers	36.2	34th	39.8
Cesarean Delivery Rate	28.1	37th	32.0
Preterm Birth Rate	8.4	47th (tie)	9.9
Teen Birth Rate †	15.0	36th (tie)	18.8
Low Birthweight Rate	6.8	44th	8.3

¹ Excludes data from U.S. territories
[†]Number of live births per 1,000 females aged 15-19

The above data has been consistent since 2014 except for Teen Birth rate which has dropped both in Oregon and nationally.

<https://www.cdc.gov/nchs/pressroom/states/oregon/oregon.htm>

Diabetes

In 2013–2016, the prevalence of total diabetes was 14.0% among U.S. adults. The prevalence of diagnosed diabetes was 9.7%, and the prevalence of undiagnosed diabetes was 4.3%. These results show that among all adults with diabetes, 30.7% had undiagnosed diabetes.

Men had a higher prevalence of total diabetes than women. The prevalence of total, diagnosed, and undiagnosed diabetes increased with age and weight status. Differences were seen in the prevalence of diagnosed, undiagnosed, and total diabetes among the race and Hispanic-origin groups. The prevalence of total, diagnosed, and undiagnosed diabetes was higher among Hispanic adults than among non-Hispanic

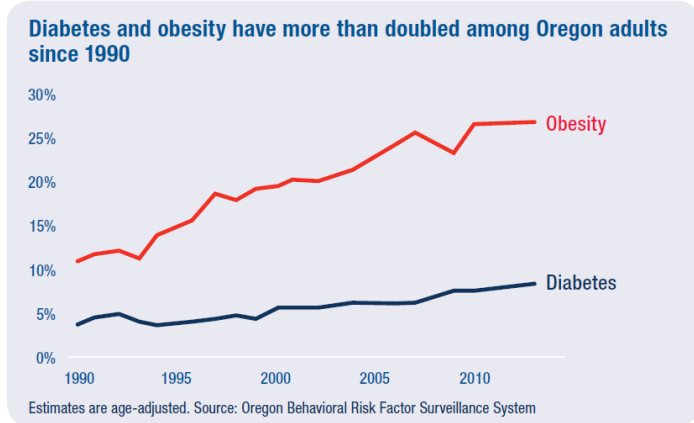
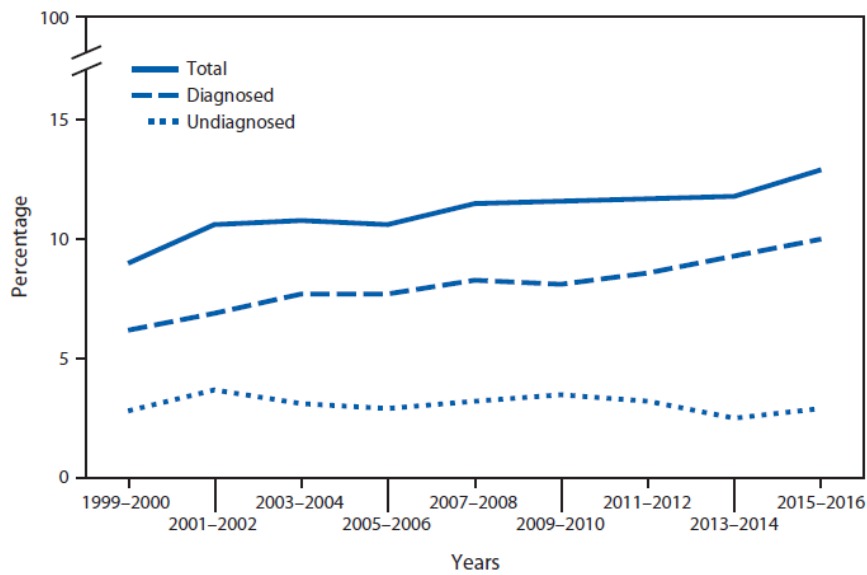
white adults, and the prevalence of total and diagnosed diabetes was higher among non-Hispanic black adults than among non-Hispanic white adults. No significant differences were seen in the prevalence of total, diagnosed, or undiagnosed diabetes between non-Hispanic Asian and non-Hispanic white adults.

Continued monitoring of total, diagnosed, and undiagnosed diabetes will provide information about the burden of diabetes among adults in the United States

The rates of diagnosed diabetes in adults by race/ethnic background are:

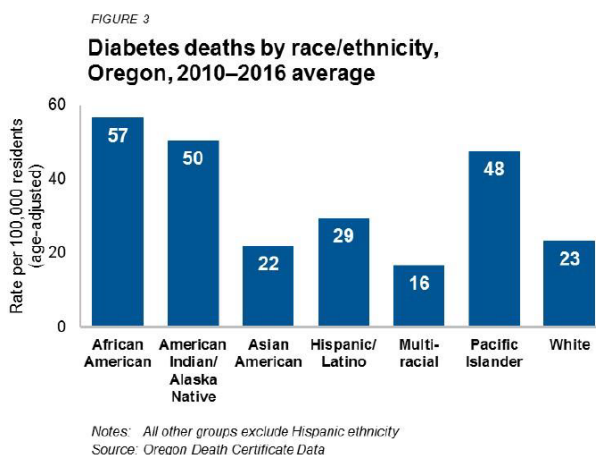
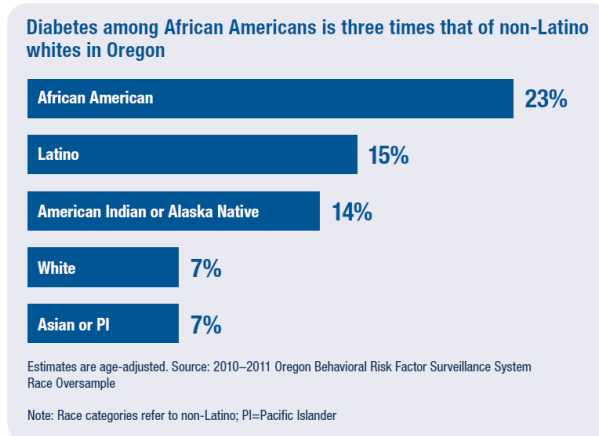
- 7.4% of non-Hispanic whites
- 8.0% of [Asian Americans](#)
- 12.1% of [Hispanics](#)
- 12.7% of [non-Hispanic blacks](#)

Age-Adjusted Prevalence of Total, Diagnosed, and Undiagnosed Diabetes* Among Adults Aged ≥20 Years
 — National Health and Nutrition Examination Survey, 1999–2000 to 2015–2016[†]



Diabetes was the seventh leading cause of death in the United States in 2015 based on the 79,535 death certificates in which diabetes was listed as the underlying cause of death. In 2015, diabetes was mentioned as a cause of death in a total of 252,806 certificates.

Diabetes may be underreported as a cause of death. Studies have found that only about 35% to 40% of people with diabetes who died had diabetes listed anywhere on the death certificate and about 10% to 15% had it listed as the underlying cause of death.



In 2016, Diabetes was the 7th leading cause of death.

- Total deaths in Oregon in 2016: 1,240
- Deaths per 100,000 people in Oregon in 2016: 30.4
- Deaths per 100,000 people in Oregon in 1997: 25.9
- The increase in diabetes deaths has almost exactly paralleled the rise in obesity, Hedberg said. Many of the same factors associated with hypertension, specifically diet, are at the root of the increase.
- The prevalence of diabetes among adults in Oregon has more than doubled — an increase of 124% — over the past 20 years. There are approximately 287,000 adults with diagnosed diabetes in Oregon and an estimated 110,000 adults with diabetes who do not know it.
- Diabetes is slightly more common among men compared to women (9.2% vs. 7.8%).
- More than 18% of adults aged 65 years and over have been diagnosed with diabetes compared to 2% of adults aged 18 to 34 years.

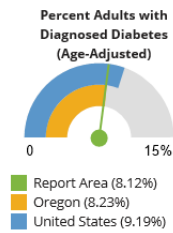
- African Americans are three times as likely and American Indian and Alaska Natives are twice as likely to have diabetes compared to non-Latino whites.
- An estimated 1.1 million (37%) adults have prediabetes, which puts them at high risk for developing type 2 diabetes.
- In 2013, about 821,000 (27%) adults were considered obese and 1,014,000 (33%) were overweight.

Diabetes (Adult)

This indicator reports the percentage of adults aged 20 and older who have ever been told by a doctor that they have diabetes. This indicator is relevant because diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues.

Report Area	Total Population Age 20+	Population with Diagnosed Diabetes	Population with Diagnosed Diabetes, Crude Rate	Population with Diagnosed Diabetes, Age-Adjusted Rate
Report Area	891,993	74,844	8.39	8.12%
Clackamas County, OR	293,357	28,749	9.8	8.5%
Multnomah County, OR	598,636	46,095	7.7	7.9%
Oregon	2,980,097	271,886	9.12	8.23%
United States	236,919,508	23,685,417	10	9.19%

[Download Data](#)



Note: This indicator is compared with the state average.
 Data Source: Centers for Disease Control and Prevention, [National Center for Chronic Disease Prevention and Health Promotion](#), 2013. Source geography: County

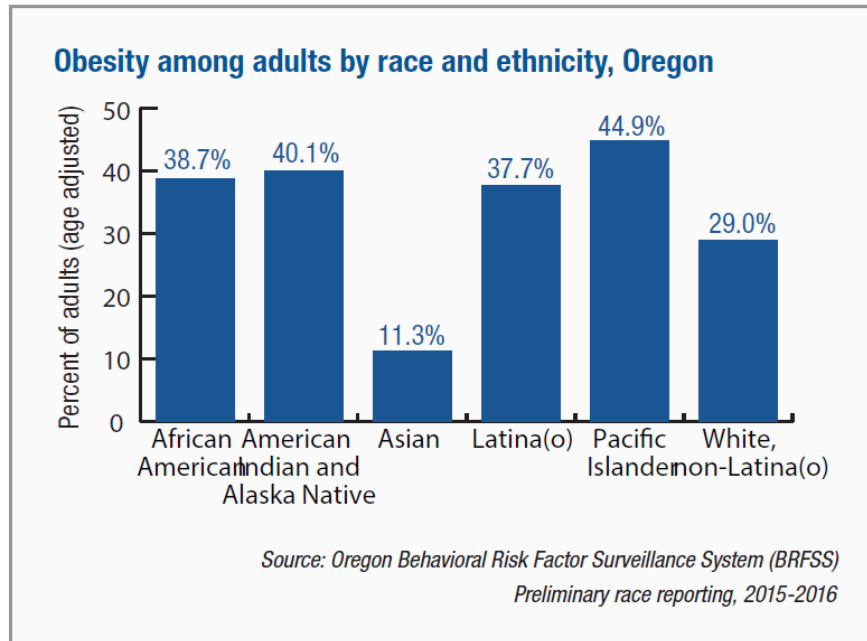


[View larger map](#)

Obesity

Obesity is the number two cause of preventable death in Oregon and nationally, second only to tobacco use.

- Obesity related conditions account for 1,400 deaths in Oregon each year. Preventing obesity among Oregonians lowers the risk of diabetes, heart disease, stroke, cancer, high blood pressure, high cholesterol, arthritis, stress and depression.
- Children and adolescents who are obese are at increased risk for becoming obese as adults.
- Starting in 2018, coordinated care organizations (CCOs) will be held accountable to a metric for weight assessment, nutrition and physical activity counseling for children and adolescents. This preliminary measure begins conversations between local and state public health authorities and CCOs about strategies to address obesity.



Multnomah County, Oregon, is tackling obesity throughout the community. Approximately 26% of adults in the county are obese and 30.2% are overweight. Among children, 26% of eighth grade students and 23.4% of 11th grade students are overweight or at risk of becoming overweight. Approximately 70% of adults in Multnomah County do not eat the recommended daily intake of fruits and vegetables, and 14% of adults reported no physical activity in the last 30 days.

Although some communities in Multnomah County have made great strides in the areas of access to healthy food and support of local farmers, disadvantaged populations are still struggling. Oregon is consistently ranked as one of the nation’s most food-insecure states. Further, approximately 15% of the 735,334 residents in Multnomah County live under the Federal poverty level. In addition to obesity-prevention efforts aimed at Multnomah County’s entire population, certain initiatives target high-risk populations, such as low-income groups and black residents.

Heart Disease and Stroke

What is heart disease?

Heart disease is the leading cause of death in the United States. More than 600,000 Americans die of heart disease each year. That’s one in every four deaths in this country.

The term “heart disease” refers to several types of heart conditions. The most common type is coronary artery disease, which can cause heart attack.

Heart Disease, Stroke and other Cardiovascular Diseases

- Cardiovascular disease, listed as the underlying cause of death, accounts for nearly 836,546 deaths in the US. That’s about 1 of every 3 deaths in the US.
- About 2,300 Americans die of cardiovascular disease each day, an average of 1 death every 38 seconds.

- Cardiovascular diseases claim more lives each year than all forms of cancer and Chronic Lower Respiratory Disease combined.
- About 92.1 million American adults are living with some form of cardiovascular disease or the after-effects of stroke. Direct and indirect costs of total cardiovascular diseases and stroke are estimated to total more than \$329.7 billion; that includes both health expenditures and lost productivity.
- Nearly half of all NH black adults have some form of cardiovascular disease, 47.7 percent of females and 46.0 percent of males.
- Coronary Heart Disease is the leading cause (43.8 percent) of deaths attributable to cardiovascular disease in the US, followed by Stroke (16.8 percent), Heart Failure (9.0 percent), High Blood Pressure (9.4 percent), diseases of the arteries (3.1 percent), and other cardiovascular diseases (17.9 percent).
- Heart disease accounts for 1 in 7 deaths in the US.
- Heart Disease (including Coronary Heart Disease, Hypertension, and Stroke) remains the No. 1 cause of death in the US.
- Coronary heart disease accounts for 1 in 7 deaths in the US, killing over 366,800 people a year.

Stroke

- Someone in the US has a stroke about once every 40 seconds.
- Stroke accounts for 1 of every 19 deaths in the US.
- Stroke kills someone in the US about every 3 minutes 45 seconds.
- When considered separately from other cardiovascular diseases, stroke ranks No. 5 among all cause of death in the US, killing nearly 133,000 people a year.
- From 2005 to 2015, the age-adjusted stroke death rate decreased 21.7 percent, and the actual number of stroke deaths declined 2.3 percent.
- Each year, about 795,000 people experience a new or recurrent stroke. Approximately 610,000 of these are first attacks, and 185,000 are recurrent attacks.
- Stroke is a leading cause of serious long-term disability in the US.

Sudden Cardiac Arrest

- In 2015, any-mention sudden cardiac arrest mortality in the US was 366,807.
- Most of the Out of Hospital Cardiac Arrests (OHCA) occurs at public settings (39.5 percent). In 2015, home or residence (27.5 percent) and nursing homes (18.2 percent) were the second and third most common locations of OHCA.

Oregon Summary Statistics

Total CVD Hospitalization, Medicare Beneficiaries, Percentage Discharged Home, All Races/Ethnicities, Both Genders, 2013-2015

Race or Ethnicity	Total Cardiovascular Disease Hospitalization, Medicare Beneficiaries, Percentage Discharged Home	
	State	National
All Races/Ethnicities	66.8	61.5
Black	65.5	60
White	66.8	61.6
Hispanic	68.3	65

Oregon Summary Statistics

Heart Failure Death Rate per 100,000 (any mention), 35+, All Races/Ethnicities, Both Genders, 2014-2016

Race or Ethnicity	Heart Failure Death Rate per 100,000	
	State	National
All Races/Ethnicities	218.3	168.6
Black (Non-Hispanic)	231.8	184.2
White (Non-Hispanic)	223.9	176
Hispanic	120.2	108.9
American Indian and Alaskan Native	227.1	165.2
Asian and Pacific Islander	107.4	74.9

Oregon Summary Statistics

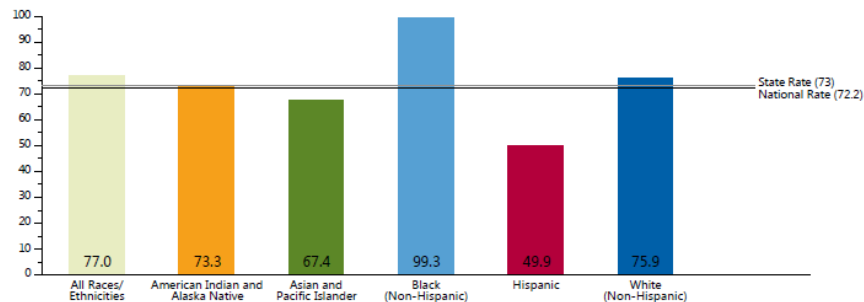
Hypertension Death Rate per 100,000 (any mention), 35+, All Races/Ethnicities, Both Genders, 2014-2016

Race or Ethnicity	Hypertension Death Rate per 100,000	
	State	National
All Races/Ethnicities	218.6	221.7
Black (Non-Hispanic)	288.7	353.3
White (Non-Hispanic)	223	211.7
Hispanic	140.1	194.2
American Indian and Alaskan Native	230.3	252.5
Asian and Pacific Islander	135.3	149.7

County Profile for Multnomah, OR

CDC Interactive Atlas of Heart Disease and Stroke

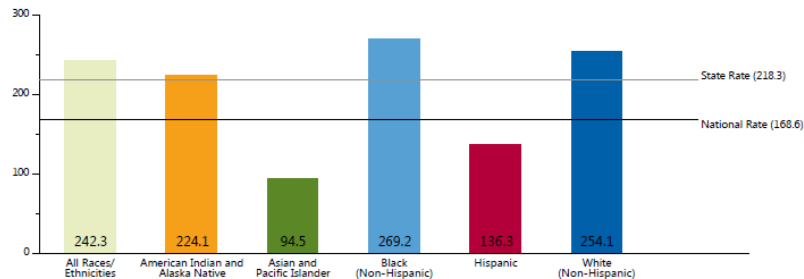
Stroke Death Rate per 100,000, 35+, All Races/Ethnicities, Both Genders, 2014-2016



County Profile for Multnomah, OR

CDC Interactive Atlas of Heart Disease and Stroke

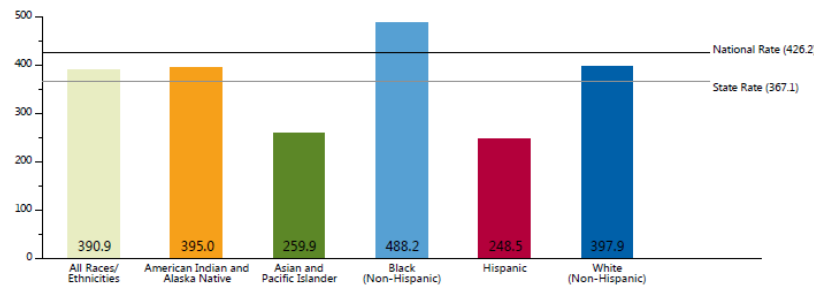
Heart Failure Death Rate per 100,000 (any mention), 35+, All Races/Ethnicities, Both Genders, 2014-2016



County Profile for Multnomah, OR

CDC Interactive Atlas of Heart Disease and Stroke

Total Cardiovascular Disease Death Rate per 100,000, 35+, All Races/Ethnicities, Both Genders, 2014-2016



Chronic Obstructive Pulmonary Disease

In the United States, an estimated [16 million adults](#) have COPD. However, that may be an underestimate. The [American Lung Association \(ALA\)](#) thinks there may be as many as 24 million American adults living with COPD.

- Overall, the crude rate for COPD-related deaths among adults aged 25 and over remained flat with 132.1 deaths per 100,000 population occurring in 2000 compared with 130.4 in 2014. The age-adjusted rate declined 12.3%, from 134.6 deaths per 100,000 standard population in 2000 to 118.0 in 2014.
- For men aged 25 and over, the crude death rate declined from 146.4 in 2000 to 134.5 in 2009 but remained stable afterward. The age-adjusted rate declined 22.5%, from 183.0 in 2000 to 141.9 in 2014.

- Among women in the same age group, the crude death rate increased from 119.0 in 2000 to 123.7 in 2014. The age-adjusted rate declined 3.8%, from 104.9 in 2000 to 100.9 in 2014.
- The age-adjusted death rate remained higher for men than for women, although the gender gap narrowed over time
- Overall, the age-adjusted death rate for black adults aged 25 and over declined 11.5%, from 98.8 deaths per 100,000 standard population in 2000 to 87.4 in 2014 ([Figure 4](#)).
- For black men, the age-adjusted death rate declined 24.3%, from 159.8 in 2000 to 121.0 in 2014.
- For black women, the death rate increased 4.2%, from 64.1 in 2000 to 66.8 in 2014.
- The death rate was higher for black men than for black women throughout the period, although the gender gap decreased over time.

Asthma

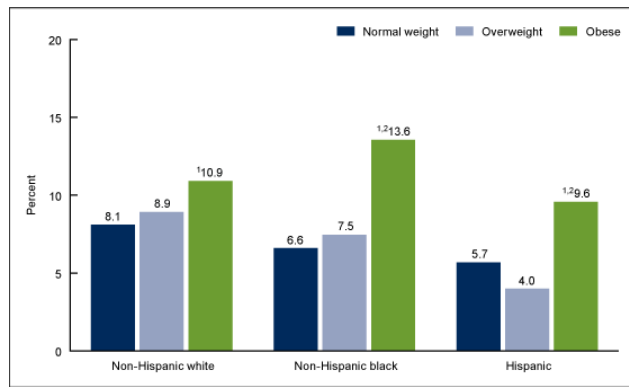
Data from the National Health and Nutrition Examination Survey, 2001-2014

- In 2011–2014, current asthma prevalence was 8.8% among adults. It was higher among adults with obesity (11.1%) compared with adults in normal weight (7.1%) and overweight (7.8%) categories.
- Women with obesity had higher current asthma prevalence (14.6%) than those in normal weight (7.9%) and overweight (9.1%) categories. Current asthma prevalence did not differ significantly by weight status for men.
- Current asthma prevalence was highest among adults with obesity for all race and Hispanic origin groups and age groups.
- Overall current asthma prevalence among adults increased from 2001–2002 (7.1%) to 2013–2014 (9.2%). By weight status, prevalence increased among overweight adults but not among adults in the obese or normal weight categories

From 2001–2002 to 2013–2014, current asthma prevalence significantly increased among adults; by weight status, asthma prevalence increased among adults in the overweight category but not among adults in normal weight or obese categories.

- Among adults, overall current asthma prevalence increased significantly from 2001–2002 (7.1%) to 2013–2014 (9.2%).
- Among weight status subgroups, current asthma prevalence increased among adults in the overweight category, from 5.6% in 2001–2012 to 8.4% in 2013–2014.
- There was no significant trend in current asthma prevalence among adults in the normal weight or obese categories.

Status and race and Hispanic origin: United States, 2011–2014 current asthma prevalence



Oregon 2016 BRFSS
Asthma

Current asthma prevalence.

(Weighted Column Percents)

	Age Groups						
	Total	18-24	25-34	35-44	45-54	55-64	65+
Doesn't currently have asthma	89.7	89.0	90.4	89.2	88.3	89.3	91.3
Currently has asthma	10.3	11.0	9.6	10.8	11.7	10.7	8.7
Male							
Doesn't currently have asthma	92.6	90.8	91.9	93.1	92.4	92.3	94.2
Currently has asthma	7.4	9.2	8.1	6.9	7.6	7.7	5.8
Female							
Doesn't currently have asthma	87.0	87.2	88.8	85.3	84.3	86.5	88.8
Currently has asthma	13.0	12.8	11.2	14.7	15.7	13.5	11.2

Denominator is: All survey respondents.

Have you ever been told by a doctor, nurse, or other health professional that you had asthma?

(Weighted Column Percents)

		Age Groups						
		Total	18-24	25-34	35-44	45-54	55-64	65+
Yes		16.7	22.7	19.1	16.4	16.9	14.9	12.9
No		83.3	77.3	80.9	83.6	83.1	85.1	87.1
Male								
Yes		14.2	25.4	17.3	12.5	13.3	10.7	10.0
No		85.8	74.6	82.7	87.5	86.7	89.3	90.0
Female								
Yes		19.0	20.0	21.0	20.3	20.6	18.8	15.5
No		81.0	80.0	79.0	79.7	79.4	81.2	84.5

Denominator is: All survey respondents.

Allergy

- Asthma and allergic diseases, such as allergic rhinitis (hay fever), food allergy, and eczema, are common for all age groups in the United States. Asthma affects more than 24 million people in the U.S., including more than 6 million children.¹
- Allergies are the 6th leading cause of chronic illness in the U.S. with an annual cost in excess of \$18 billion. More than 50 million Americans suffer from allergies each year.²
- Allergic rhinitis, often called hay fever, is a common condition that causes symptoms such as sneezing, stuffy nose, runny nose, watery eyes and itching of the nose, eyes or the roof of the mouth.
- Allergic rhinitis can be seasonal or perennial.
- Symptoms of seasonal allergic rhinitis occur in spring, summer and/or early fall. They are usually caused by allergic sensitivity to pollens from trees, grasses or weeds, or to airborne mold spores.

- People with perennial allergic rhinitis experience symptoms year-round. Perennial allergic rhinitis is generally caused by sensitivity to house dust mites, animal dander, cockroaches and/or mold spores. Underlying or hidden food allergies rarely cause perennial nasal symptoms.
- Once diagnosed, allergic rhinitis treatment options are: avoidance, eliminating or decreasing your exposure to the irritants or allergens that trigger your symptoms, medication and immunotherapy (allergy shots).
- Immunotherapy (allergy shots) helps reduce hay fever symptoms in about 85% of people with allergic rhinitis.
- The prevalence of food and skin allergies increased in children under 18 years from 1997-2011.

Cancer

- Cancer remains the second most common cause of death in the United States, exceeded only by heart disease, accounting for nearly one in every four deaths.
- The incidence of some cancers, including kidney, thyroid, pancreas, liver, uterus, melanoma of the skin, myeloma (cancer of plasma cells), leukemia, testis and oral cavity and pharynx, is rising.
- The burden of some types of cancer weighs more heavily on some groups than on others. The rates of both new cases and deaths from cancer vary by socioeconomic status, sex, and racial and ethnic group.
- The economic burden of cancer also is taking its toll. As the U.S. population ages and newer technologies and treatments become available, national expenditures for cancer continue to rise and could potentially exceed overall medical care expenditures combined.
- Researchers believe that rising obesity in the U.S. has contributed to the increasing death rates for endometrial, pancreatic, and liver cancers. Researchers also believe that hepatitis C infection among Baby Boomers has contributed to increasing rates for liver cancer, and that human papillomavirus (HPV) infection has contributed to the increasing rates for oral cavity and pharynx cancers.
- Researchers say the decreases in mortality for lung cancer and several other cancer sites are largely due to reduced tobacco use. However, cigarette smoking still accounts for more than 25% of cancer deaths in the US. Improved treatments have also helped lower the death rate for several cancers, especially breast, prostate, colorectal, leukemia, and Non-Hodgkin lymphoma.

The top 5 most common cancer sites in the US are female breast, lung and bronchus, prostate, colorectal, and melanoma of the skin.

Female breast

Estimated New Cases 2018: 268,670

Estimated Deaths 2018: 41,400

5-year survival varied by stage at diagnosis from 26.5% (stage IV) to 100% (stage I) for cases diagnosed between 2007 and 2013.

Overall incidence rate increased from 2010-2014:

- rising for all races
- highest in whites
- lowest among Asian or Pacific Islanders

Overall mortality rate decreased from 2011-2015:

- decreasing for all races except American Indian/Alaskan Natives and API
- highest in blacks
- lowest among API

Lung and bronchus

Estimated New Cases 2018: 234,030

Estimated Deaths 2018: 154,050

Prostate

Prostate Cancer Deaths

After years of significant decline, the death rate trend for prostate cancer stabilized from 2013 to 2015.

Estimated number of prostate cancer deaths in 2018: 29,430*

Prostate cancer is the 6th leading cause of cancer death in the US.

Estimated number of new prostate cancer cases in 2018: 164,690*

Prostate cancer is the 3rd most common cancer in the US, after breast and lung/bronchus cancers.

Colorectal

Estimated New Cases 2018: 140,250

Estimated Deaths 2018: 50,630

Melanoma of the skin

Estimated New Cases 2018: 91,270 *

Estimated Deaths 2018: 9,320 *

HPV and Cancer

What are human papillomaviruses?

[Human papillomaviruses](#) (HPVs) are a group of more than 200 related viruses. More than 40 HPV types can be easily spread through direct sexual contact, from the skin and mucous membranes of infected people to the skin and mucous membranes of their partners. They can be spread by vaginal, anal, and oral sex ([1](#)). Other HPV types are responsible for non-genital [warts](#), which are not sexually transmitted.

Each year, about 42,700 new cases of cancer are found in parts of the body where human papillomavirus (HPV) is often found. HPV causes about 33,700 of these cancers.

An HPV-associated cancer is a specific cellular type of cancer that is diagnosed in a part of the body where HPV is often found.

Cancer burden: Oregon-All Types of Cancer, 2015

In Oregon in 2015, there were 19,883 new cases of cancer. For every 100,000 people, 400 cancer cases were reported.

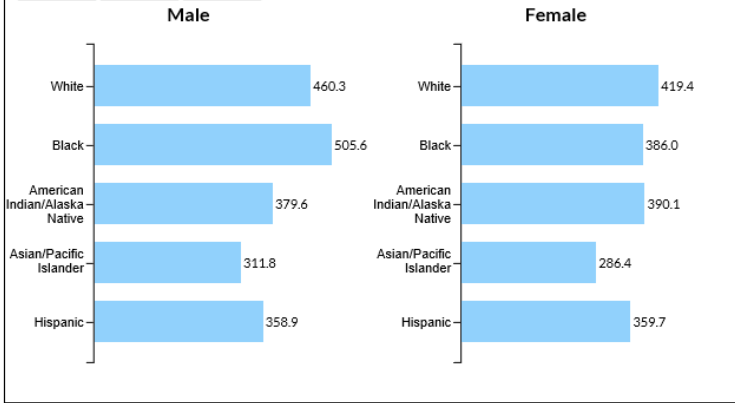
The same year, there were 8,093 people who died of cancer. For every 100,000 people in Oregon, 160 died of cancer

Rate of cancer deaths are down yet the number is up.

Rate of New Cancers by Sex and Race/Ethnicity

All Types of Cancer
Rate per 100,000 people

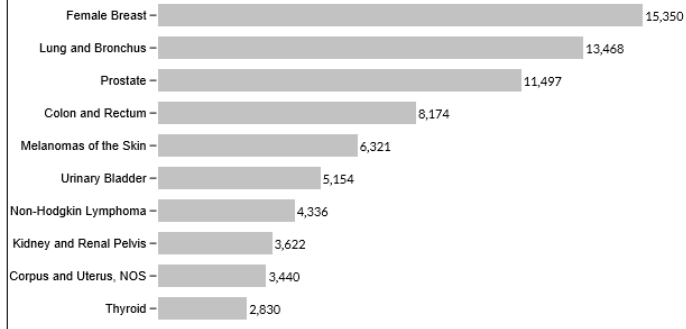
Chart Table Export



Top 10 Cancers by Number of New Cancer Cases

Oregon, 2011-2015, Male and Female

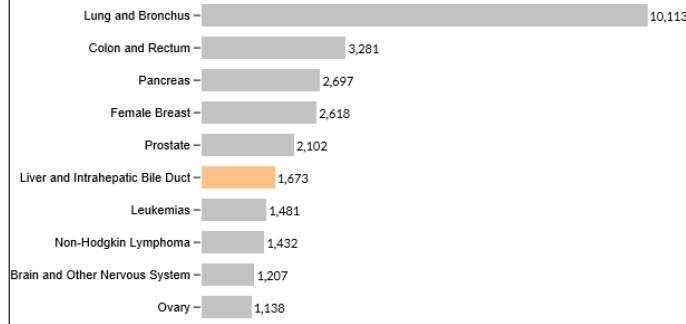
Chart Table Export



Top 10 Cancers by Number of Cancer Deaths

Oregon, 2011-2015, Male and Female

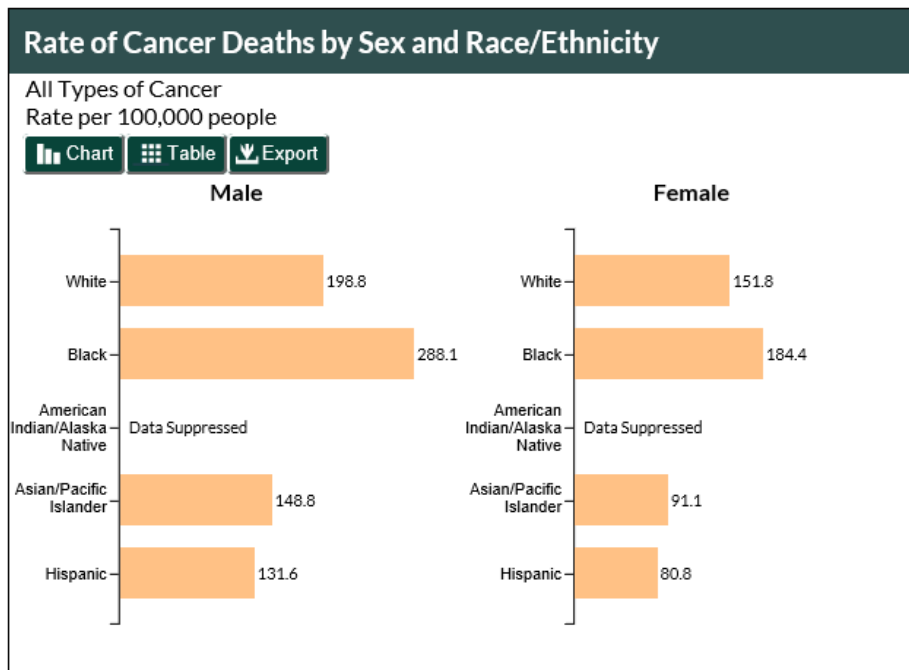
Chart Table Export



Multnomah County

In Multnomah County, Oregon from 2011-2015, there were 17,683 new cases of cancer. For every 100,000 people, 456 cancer cases were reported.

Over those years, there were 6,307 people who died of cancer. For every 100,000 people in Multnomah County, Oregon, 169 died of cancer.



In **Multnomah County, Oregon** from **2011-2015**, there were **2,839 new cases of Female Breast Cancer**. For every 100,000 women, **136 Female Breast Cancer cases** were reported.

Over those years, there were **420 women who died of Female Breast Cancer**. For every 100,000 women in **Multnomah County, Oregon**, **20 died of Female Breast Cancer**.

In **Multnomah County, Oregon** from **2011-2015**, there were **2,153 new cases of Lung and Bronchus cancer**. For every 100,000 people, **59 Lung and Bronchus cancer cases** were reported.

Over those years, there were **1,513 people who died of Lung and Bronchus cancer**. For every 100,000 people in **Multnomah County, Oregon**, **42 died of Lung and Bronchus cancer**.

In **Multnomah County, Oregon** from **2011-2015**, there were **1,772 new cases of Prostate Cancer**. For every 100,000 men, **97 Prostate Cancer cases** were reported.

Over those years, there were **290 men who died of Prostate Cancer**. For every 100,000 men in **Multnomah County, Oregon**, **21 died of Prostate Cancer**.

In **Multnomah County, Oregon** from **2011-2015**, there were **1,406 new cases of Colon and Rectum cancer**. For every 100,000 people, **37 Colon and Rectum cancer cases** were reported.

Over those years, there were **528 people who died of Colon and Rectum cancer**. For every 100,000 people in **Multnomah County, Oregon**, **14 died of Colon and Rectum cancer**.

In **Multnomah County, Oregon** from **2011-2015**, there were **1,163 new cases of Melanomas of the skin**. For every 100,000 people, **29 Melanomas of the skin cases were reported**.

Over those years, there were **123 people who died of Melanomas of the skin**. For every 100,000 people in **Multnomah County, Oregon**, **3 died of Melanomas of the skin**.

In **Multnomah County, Oregon** from **2011-2015**, there were **501 new cases of Liver Cancer**. For every 100,000 people, **12 Liver Cancer cases were reported**.

Over those years, there were **336 people who died of Liver Cancer**. For every 100,000 people in **Multnomah County, Oregon**, **8 died of Liver Cancer**.

AH 2017 Top Sites- (includes class case 00)

Rank	Diagnostic Site	Gender		Stage						Total	% of Total
		Male	Female	0	I	II	III	IV	Unk		
1	Breast Female	0	104	14	38	39	9	2	2	104	29.3%
2	Lung	33	45	1	26	10	13	26	2	78	22.0%
3	Colon	21	17	0	6	10	9	10	3	38	10.7%
4	Prostate	38	0	0	5	18	12	3	0	38	10.7%
5	Urinary Bladder	17	9	11	5	4	3	0	3	26	7.3%
6	Rectum	10	7	0	0	2	4	4	7	17	4.8%
7	Non-Hodgkins Lympho	6	9	0	6	5	0	4	0	15	4.2%
8	Pancreas	10	4	0	1	5	1	7	0	14	3.9%
9	Stomach	7	6	0	1	2	2	7	1	13	3.7%
10	Kidney	7	5	0	8	1	1	1	1	12	3.4%
TOTALS		149	206	26	96	96	54	64	19	355	100%

Radon

Radon is odorless, tasteless and invisible. It is a naturally occurring radioactive gas that comes up from the ground and is drawn into buildings, where it can build up to dangerous levels. The EPA estimates that radon is responsible for more than 20,000 lung cancer deaths per year in the United States. Radon is the second leading cause of lung cancer in the U.S. after cigarette smoking, and the leading cause of lung cancer among non-smokers.

In Oregon, approximately 276 radon-related lung cancer deaths happen each year. Radon is the second leading cause of lung cancer.

Behavioral Health

As reported by the NIH- National Institute of Mental Health:

Mental Illness

Mental illnesses are common in the United States. Nearly one in five U.S. adults' lives with a mental illness (44.7 million in 2016). Mental illnesses include many different conditions that vary in degree of severity, ranging from mild to moderate to severe. Two broad categories can be used to describe these conditions: Any Mental Illness (AMI) and Serious Mental Illness (SMI). AMI encompasses all recognized mental illnesses. SMI is a smaller and more severe subset of AMI. Additional information on mental illnesses can be found on the NIMH Health Topics Pages.

Prevalence of Any Mental Illness (AMI)

In 2016, there were an estimated 44.7 million adults aged 18 or older in the United States with AMI. This number represented 18.3% of all U.S. adults.

The prevalence of AMI was higher among women (21.7%) than men (14.5%).

Young adults aged 18-25 years had the highest prevalence of AMI (22.1%) compared to adults aged 26-49 years (21.1%) and aged 50 and older (14.5%).

The prevalence of AMI was highest among the adults reporting two or more races (26.5%), followed by the American Indian/Alaska Native group (22.8%). The prevalence of AMI was lowest among the Asian group (12.1%).

Mental Health Treatment — AMI

NSDUH defines mental health treatment as having received inpatient treatment/counseling or outpatient treatment/counseling, or having used prescription medication for problems with emotions, nerves, or mental health. In 2016, among the 44.7 million adults (over 18) with AMI, 19.2 million (43.1%) received mental health treatment in the past year.

More women with AMI (48.8%) received mental health treatment than men with AMI (33.9%).

The percentage of young adults aged 18-25 years with AMI who received mental health treatment (35.1%) was lower than adults with AMI aged 26-49 years (43.1%) and aged 50 and older (46.8%).

Mental Health Treatment — AMI

NSDUH defines mental health treatment as having received inpatient treatment/counseling or outpatient treatment/counseling, or having used prescription medication for problems with emotions, nerves, or mental health. In 2016, among the 44.7 million adults with AMI, 19.2 million (43.1%) received mental health treatment in the past year.

More women with AMI (48.8%) received mental health treatment than men with AMI (33.9%).

The percentage of young adults aged 18-25 years with AMI who received mental health treatment (35.1%) was lower than adults with AMI aged 26-49 years (43.1%) and aged 50 and older (46.8%).

Adult Ranking

States with high rankings have lower prevalence of mental illness and higher rates of access to care for adults. Lower rankings indicate that adults have higher prevalence of mental illness and lower rates of access to care. Oregon ranked 48th. 44th overall, 41st for youth.

Prevalence of Mental Illness

A high ranking on the Prevalence Ranking indicates a lower prevalence of mental health and substance use issues. States that rank 1-10 have lower rates of mental health and substance use problems compared to states that ranked 42-51. Oregon 51st.

Access to Care Ranking

The Access Ranking indicates how much access to mental health care exists within a state. The access measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. A high Access Ranking indicates that a state provides relatively more access to insurance and mental health treatment. Oregon 12th.

Ranking the States: Mental Health America Report: Overall Ranking

A high overall ranking indicates lower prevalence of mental illness and higher rates of access to care. A low overall ranking indicates higher prevalence of mental illness and lower rates of access to care. The combined scores of all 15 measures make up the overall ranking. The overall ranking includes both adult and youth measures as well as prevalence and access to care measures.

The 15 measures that make up the overall ranking include:

- | | |
|---|--|
| 1. Adults with Any Mental Illness (AMI) | 9. Adults with AMI who are Uninsured |
| 2. Adults with Dependence or Abuse of Illicit Drugs or Alcohol (Marijuana, Heroin, Cocaine) | 10. Adults with Disability who Could Not See a Doctor Due to Costs |
| 3. Adults with Serious Thoughts of Suicide | 11. Youth with MDE who Did Not Receive Mental Health Services |
| 4. Youth with At Least one Past Year Major Depressive Episode (MDE) | 12. Youth with Severe MDE who Received Some Consistent Treatment |
| 5. Youth with Alcohol Dependence and Illicit Drugs Use (Marijuana, Heroin, Cocaine) | 13. Children with Private Insurance that Did Not Cover Mental or Emotional Problems |
| 6. Youth with Severe MDE | 14. Students Identified with Emotional Disturbance for an Individualized Education Program |
| 7. Adults with AMI who Did Not Receive Treatment | 15. Mental Health Workforce Availability |
| 8. Adults with AMI Reporting Unmet Need | |

Rank	State	Rank	State
1	Massachusetts	26	Georgia
2	South Dakota	27	Montana
3	Minnesota	28	Alaska
4	Vermont	29	New Hampshire
5	Connecticut	30	Missouri
6	Iowa	31	Wyoming
7	North Dakota	32	North Carolina
8	Maine	33	Florida
9	Hawaii	34	Washington
10	New Jersey	35	Arkansas
11	Illinois	36	Oklahoma
12	Maryland	37	Utah
13	New York	38	Louisiana
14	Delaware	39	Texas
15	District of Columbia	40	Virginia
16	Pennsylvania	41	Alabama
17	Michigan	42	West Virginia
18	Nebraska	43	Colorado
19	Kansas	44	Oregon
20	Ohio	45	South Carolina
21	New Mexico	46	Tennessee
22	Kentucky	47	Idaho
23	Rhode Island	48	Indiana
24	California	49	Arizona
25	Wisconsin	50	Mississippi
		51	Nevada

Data Sources: <http://www.mentalhealthamerica.net/issues/mental-health-america-glossary-and-citations>

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Adult Ranking

States with high rankings have lower prevalence of mental illness and higher rates of access to care for adults. Lower rankings indicate that adults have higher prevalence of mental illness and lower rates of access to care.

The 7 measures that make up the Adult Ranking include:

1. Adults with Any Mental Illness (AMI)
2. Adults with Alcohol Dependence and Illicit Drugs Use (Marijuana, Heroin, and Cocaine)
3. Adults with Serious Thoughts of Suicide
4. Adults with AMI who Did Not Receive Treatment
5. Adults with AMI Reporting Unmet Need

6. Adults with AMI who are Uninsured
7. Adults with Disability Who Could Not See a Doctor Due to Costs

Rank	State	Rank	State	Rank	State
1	Massachusetts	18	Texas	35	Oklahoma
2	Iowa	19	Michigan	36	Missouri
3	Hawaii	20	Rhode Island	37	North Carolina
4	North Dakota	21	Nebraska	38	Washington
5	South Dakota	22	Kansas	39	South Carolina
6	Maine	23	Virginia	40	Colorado
7	Minnesota	24	Florida	41	Louisiana
8	Illinois	25	New Mexico	42	Arizona
9	New Jersey	26	Arkansas	43	Mississippi
10	Connecticut	27	Alabama	44	Tennessee
11	Wisconsin	28	Ohio	45	Idaho
12	Delaware	29	Georgia	46	New Hampshire
13	New York	30	Wyoming	47	Indiana
14	Maryland	31	West Virginia	48	Oregon
15	California	32	Kentucky	49	Alaska
16	Pennsylvania	33	District of Columbia	50	Nevada
17	Vermont	34	Montana	51	Utah

Data Sources: <http://www.mentalhealthamerica.net/issues/mental-health-america-glossary-and-citations>

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Youth Ranking

States with high rankings have lower prevalence of mental illness and higher rates of access to care for youth. Lower rankings indicate that youth have higher prevalence of mental illness and lower rates of access to care.

The 7 measures that make up the Youth Ranking include:

1. Youth with At Least One Past Year Major Depressive Episode (MDE)
2. Youth with Alcohol Dependence and Illicit Drugs Use (Marijuana, Heroin, Cocaine)
3. Youth with Severe MDE
4. Youth with MDE who Did Not Receive Mental Health Services
5. Youth with Severe MDE who Received Some Consistent Treatment
6. Children with Private Insurance that Did Not Cover Mental or Emotional Problems

7. Students Identified with Emotional Disturbance for an Individualized Education Program

Rank	State	Rank	State	Rank	State
1	South Dakota	18	New York	35	Washington
2	Vermont	19	Kansas	36	Wyoming
3	Minnesota	20	Georgia	37	Florida
4	Massachusetts	21	Nebraska	38	Indiana
5	Connecticut	22	New Hampshire	39	California
6	North Dakota	23	Delaware	40	Idaho
7	District of Columbia	24	Utah	41	Oregon
8	Iowa	25	New Mexico	42	South Carolina
9	New Jersey	26	Montana	43	Wisconsin
10	Pennsylvania	27	Hawaii	44	Texas
11	Ohio	28	Alabama	45	Oklahoma
12	Maine	29	North Carolina	46	Arkansas
13	Illinois	30	Missouri	47	Virginia
14	Maryland	31	Louisiana	48	Colorado
15	Kentucky	32	Tennessee	49	Mississippi
16	Alaska	33	Rhode Island	50	Arizona
17	Michigan	34	West Virginia	51	Nevada

Data Sources: <http://www.mentalhealthamerica.net/issues/mental-health-america-glossary-and-citations>

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Prevalence of Mental Illness

The scores for the six prevalence and nine access to treatment measures make up the Prevalence and Access to Care Ranking.

The 6 measures that make up the Prevalence Ranking include:

1. Adults with Any Mental Illness (AMI)
2. Adults with Alcohol Dependence and Illicit Drugs Use (Marijuana, Heroin, Cocaine)
3. Adults with Serious Thoughts of Suicide
4. Youth with At Least One Past Year Major Depressive Episode (MDE)
5. Youth with Alcohol Dependence and Illicit Drugs Use (Marijuana, Heroin, Cocaine)
6. Youth with Severe MDE.

A high ranking on the Prevalence Ranking indicates a lower prevalence of mental health and substance use issues. States that rank 1-10 have lower rates of mental health and substance use problems compared to states that ranked 42-51.

Rank	State	Rank	State	Rank	State
1	South Dakota	18	Connecticut	35	Wyoming
2	Hawaii	19	District of Columbia	36	Ohio
3	Georgia	20	Nebraska	37	Utah
4	North Dakota	21	Pennsylvania	38	West Virginia
5	Texas	22	New York	39	Idaho
6	New Jersey	23	Michigan	40	Maine
7	South Carolina	24	California	41	Washington
8	Alabama	25	Oklahoma	42	Wisconsin
9	Illinois	26	Minnesota	43	Nevada
10	Florida	27	Arkansas	44	Alaska
11	Mississippi	28	Virginia	45	Arizona
12	Iowa	29	Delaware	46	Vermont
13	Kansas	30	North Carolina	47	Indiana
14	Louisiana	31	New Mexico	48	Rhode Island
15	Maryland	32	Kentucky	49	Colorado
16	Tennessee	33	Massachusetts	50	New Hampshire
17	Missouri	34	Montana	51	Oregon

Data Sources: <http://www.mentalhealthamerica.net/issues/mental-health-america-glossary-and-citations>

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Access to Care Ranking

The Access Ranking indicates how much access to mental health care exists within a state. The access measures include access to insurance, access to treatment, quality and cost of insurance, access to special education, and workforce availability. A high Access Ranking indicates that a state provides relatively more access to insurance and mental health treatment.

The 9 measures that make up the Access Ranking include:

1. Adults with AMI who Did Not Receive Treatment
2. Adults with AMI Reporting Unmet Need
3. Adults with AMI who are Uninsured
4. Adults with Disability who Could Not See a Doctor Due to Costs
5. Youth with MDE who Did Not Receive Mental Health Services
6. Youth with Severe MDE who Received Some Consistent Treatment
7. Children with Private Insurance that Did Not Cover Mental or Emotional Problems
8. Students Identified with Emotional Disturbance for an Individualized Education Program
9. Mental Health Workforce Availability

Rank	State
1	Vermont
2	Massachusetts
3	Minnesota
4	Maine
5	Connecticut
6	Rhode Island
7	New Hampshire
8	South Dakota
9	Iowa
10	Delaware
11	New York
12	Oregon
13	Wisconsin
14	Ohio
15	North Dakota
16	Michigan
17	Colorado

Rank	State
18	Pennsylvania
19	Maryland
20	Alaska
21	District of Columbia
22	Illinois
23	New Mexico
24	Hawaii
25	Kentucky
26	New Jersey
27	Nebraska
28	Washington
29	Montana
30	California
31	Wyoming
32	Kansas
33	Indiana
34	Utah

Rank	State
35	West Virginia
36	North Carolina
37	Idaho
38	Arkansas
39	Arizona
40	Missouri
41	Oklahoma
42	Virginia
43	Georgia
44	Florida
45	Louisiana
46	Tennessee
47	Nevada
48	Alabama
49	Texas
50	South Carolina
51	Mississippi

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AH Top Emergency and Outpatient Mental Health Diagnosis

August 2017-July 2018

Diagnosis Code	Diagnosis Name	Major Type Desc	Encounters
F41.9	Anxiety disorder, unspecified	Emergency	460
F32.9	Major depressive disorder, single episode, unspecified	Emergency	333
R45.851	Suicidal ideations	Emergency	82
F03.90	Unspecified dementia without behavioral disturbance	Emergency	40
F20.0	Paranoid schizophrenia	Emergency	17
F41.8	Other specified anxiety disorders	Emergency	5

*Source: Internal RCI-Encounter Table

Diagnosis Code	Diagnosis Name	Major Type Desc	Encounters
F41.9	Anxiety disorder, unspecified	Outpatient	149
F32.9	Major depressive disorder, single episode, unspecified	Outpatient	133
F33.1	Major depressive disorder, recurrent, moderate	Outpatient	65
F33.2	Major depressive disorder, recurrent severe without psychotic features	Outpatient	53
F03.90	Unspecified dementia without behavioral disturbance	Outpatient	52
F41.8	Other specified anxiety disorders	Outpatient	50
F32.1	Major depressive disorder, single episode, moderate	Outpatient	27
F33.9	Major depressive disorder, recurrent, unspecified	Outpatient	22
F20.0	Paranoid schizophrenia	Outpatient	11

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Anxiety

From the Anxiety and Depression Association of America:

- Anxiety disorders are the most common mental illness in the U.S., affecting 40 million adults in the United States age 18 and older, or 18.1% of the population every year.
- Anxiety disorders are highly treatable, yet only 36.9% of those suffering receive treatment.

Prevalence of Any Anxiety Disorder Among Adolescents

- Based on diagnostic interview data from National Comorbidity Survey Adolescent Supplement (NCS-A), Figure 3 shows lifetime prevalence of any anxiety disorder among U.S. adolescents aged 13-18.³
 - An estimated 31.9% of adolescents had any anxiety disorder.
 - Of adolescents with any anxiety disorder, an estimated 8.3% had severe impairment. DSM-IV criteria were used to determine impairment.
 - The prevalence of any anxiety disorder among adolescents was higher for females (38.0%) than for males (26.1%).
 - The prevalence of any anxiety disorder was similar across age groups.

Anxiety has become the number one mental health issue in North America. It's estimated that one third of the North American adult population experiences anxiety unwellness issues.

Anxiety Disorders affect 18.1 percent of adults in the United States (approximately 40 million adults between the ages of 18 to 54). - National Institute of Mental Health (NIMH).

Current estimates put this number much higher - **approximately 30 percent** - as many people don't seek help, are misdiagnosed, or don't know they have issues with anxiety.

NUMBERS AND PERCENTAGES REFER TO ADULT U.S. POPULATION AFFECTED.

Generalized Anxiety Disorder: 6.8 million, 3.1%.

- Women are twice as likely to be afflicted than men. We believe the number of men who struggle with generalized anxiety is much higher because many don't report it to their doctors.
- Very likely to be co-exist with other disorders.

Obsessive Compulsive Disorder: 2.2 million, 1.0%.

- It is equally common among men and women.
- One third of afflicted adults had their first symptoms in childhood.
- In 1990 OCD cost the U.S. 6% of the total \$148 billion mental health bill.

Panic Disorder: 6 million, 2.7%.

- Women are twice as likely to be afflicted than men (we believe the number of men who struggle with panic disorder is much higher because many don't report it to their doctors).
- Often co-exists with depression.

Posttraumatic Stress Disorder: 7.7 million, 3.5%.

- Women are more likely to be afflicted than men.
- Rape is the most likely trigger of PTSD, 65% of men and 45.9% of women who are raped will develop the disorder.
- Childhood sexual abuse is a strong predictor of lifetime likelihood for developing PTSD.

Social Anxiety Disorder: 15 million, 6.8%.

- It is equally common among men and women.

Specific Phobia affects: 19 million, 8.7%.

- Women are twice as likely to be afflicted as men.

SOURCE: Anxiety Disorders Association of America (ADAA) <https://www.anxietycentre.com/anxiety-statistics-information.shtml>

Anxiety and Depression

It's not uncommon for someone with an anxiety disorder to also suffer from depression or vice versa. Nearly one-half of those diagnosed with depression are also diagnosed with an anxiety disorder.

Facts

Generalized Anxiety Disorder (GAD)

GAD affects 6.8 million adults, or 3.1% of the U.S. population, yet only 43.2% are receiving treatment. Women are twice as likely to be affected as men. GAD often co-occurs with major depression.

Panic Disorder (PD)

PD affects 6 million adults, or 2.7% of the U.S. population. Women are twice as likely to be affected as men.

Social Anxiety Disorder

SAD affects 15 million adults, or 6.8% of the U.S. population. SAD is equally common among men and women and typically begins around age 13. According to a 2007 ADAA survey, 36% of people with social anxiety disorder report experiencing symptoms for 10 or more years before seeking help.

Specific Phobias

Specific phobias affect 19 million adults, or 8.7% of the U.S. population. Women are twice as likely to be affected as men. Symptoms typically begin in childhood; the average age-of-onset is 7 years old. Obsessive-compulsive disorder (OCD) and posttraumatic stress disorder (PTSD) are closely related to anxiety disorders, which some may experience at the same time, along with depression.

Obsessive-Compulsive Disorder (OCD)

OCD affects 2.2 million adults, or 1.0% of the U.S. population. OCD is equally common among men and women. The average age of onset is 19, with 25 percent of cases occurring by age 14. One-third of affected adults first experienced symptoms in childhood.

Posttraumatic Stress Disorder (PTSD)

PTSD affects 7.7 million adults, or 3.5% of the U.S. population.

Women are more likely to be affected than men.

Rape is the most likely trigger of PTSD: 65% of men and 45.9% of women who are raped will develop the disorder.

Childhood sexual abuse is a strong predictor of lifetime likelihood for developing PTSD.

Major Depressive Disorder

The leading cause of disability in the U.S. for ages 15 to 44.3.

MDD affects more than 16.1 million American adults, or about 6.7% of the U.S. population age 18 and older in a given year.

While major depressive disorder can develop at any age, the median age at onset is 32.5 years old.

More prevalent in women than in men.

Persistent depressive disorder, or PDD, (formerly called dysthymia) is a form of depression that usually continues for at least two years.

Affects approximately 1.5 percent of the U.S. population age 18 and older in a given year. (about 3.3 million American adults). Only 61.7% of adults with MDD are receiving treatment. The average age of onset is 31 years old.

Children

Anxiety disorders affect 25.1% of children between 13 and 18 years old. Research shows that untreated children with anxiety disorders are at higher risk to perform poorly in school, miss out on important social experiences, and engage in substance abuse.

Anxiety disorders also often co-occur with other disorders such as depression, eating disorders, and attention-deficit/hyperactivity disorder (ADHD).

Older Adults

Anxiety is as common among older adults as among the young. **Generalized anxiety disorder (GAD)** is the most common anxiety disorder among older adults, though anxiety disorders in this population are frequently associated with traumatic events such as a fall or acute illness. Read the best way to **treat anxiety disorders** in older adults.

Source: <https://adaa.org/about-adaa/press-room/facts-statistics>

Depression

Major depression is one of the most common mental disorders in the United States. For some individuals, major depression can result in severe impairments that interfere with or limit one's ability to carry out major life activities.

Depression (major depressive disorder or clinical depression) is a common but serious mood disorder. It causes severe symptoms that affect how you feel, think, and handle daily activities, such as sleeping, eating, or working. To be diagnosed with depression, the symptoms must be present for at least two weeks.

Some forms of depression are slightly different, or they may develop under unique circumstances, such as:

- **Persistent depressive disorder** (also called dysthymia) is a depressed mood that lasts for at least two years. A person diagnosed with persistent depressive disorder may have episodes of major depression along with periods of less severe symptoms, but symptoms must last for two years to be considered persistent depressive disorder.
- **Postpartum depression** is much more serious than the “baby blues” (relatively mild depressive and anxiety symptoms that typically clear within two weeks after delivery) that many women experience after giving birth. Women with postpartum depression experience full-blown major depression during pregnancy or after delivery (postpartum depression). The feelings of extreme sadness, anxiety, and exhaustion that accompany postpartum depression may make it difficult for these new mothers to complete daily care activities for themselves and/or for their babies.
- **Psychotic depression** occurs when a person has severe depression plus some form of psychosis, such as having disturbing false fixed beliefs (delusions) or hearing or seeing upsetting things that others cannot hear or see (hallucinations). The psychotic symptoms typically have a depressive “theme,” such as delusions of guilt, poverty, or illness.
- **Seasonal affective disorder** is characterized by the onset of depression during the winter months, when there is less natural sunlight. This depression generally lifts during spring and summer. Winter depression, typically accompanied by social withdrawal, increased sleep, and weight gain, predictably returns every year in seasonal affective disorder.
- **Bipolar disorder** is different from depression, but it is included in this list is because someone with bipolar disorder experiences episodes of extremely low moods that meet the criteria for major depression (called “bipolar depression”). But a person with bipolar disorder also experiences extreme high – euphoric or irritable – moods called “mania” or a less severe form called “hypomania.” Above from: <https://www.nimh.nih.gov/health/topics/depression/index.shtml>

Trauma

Complex Trauma

Many of the children and young people found in child welfare, mental health, special education, and justice settings have been exposed to trauma in their early years. The literature differentiates between type 1, or acute trauma, which results from exposure to a single overwhelming event, and type 2, or complex trauma (a.k.a. developmental or relationship trauma), which results from extended exposure to traumatizing situations. Bessel van der Kolk (2005) describes complex trauma as “the experience of multiple, chronic and prolonged, developmentally adverse traumatic events, most often of an interpersonal nature...and early life onset”. Kinniburgh and her colleagues (2005) note that in terms of both experience and effect, “exposure to complex interpersonal trauma is qualitatively distinct from acute trauma”

Outcomes of complex trauma

Following exposure to acutely traumatizing events, some people develop the symptoms of post-traumatic stress disorder. These involve the repeated, cue-triggered, involuntary re-experiencing of the terror and helplessness (often through nightmares or flashbacks); a focus on avoiding cues that might be reminders of the trauma; hyperarousal and hypervigilance; problems with concentration and focus; and an exaggerated startle response (the formal criteria can be found in American Psychiatric Association, 1994).

Children affected by developmental trauma need adults in their lives who can understand the pervasive impact of their experiences and who recognize that the pain from ruptured connections can lead to a range of challenging behaviors. They need adults who can develop trauma-informed approaches that promote healing and connection. The three treatment elements outlined here can be applied by anyone who has a role in caring for, teaching, or otherwise mentoring these children and constitute the essential features of healing environments.

<https://s3-us-west-2.amazonaws.com/cxl/backup/prod/cxl/gklugiewicz/media/507188fa-30b7-8fd4-aa5f-ca6bb629a442.pdf>

- An estimated 70 percent of adults in the United States have experienced a traumatic event at least once in their lives and up to 20 percent of these people go on to develop posttraumatic stress disorder, or PTSD.
- An estimated 5 percent of Americans—more than 13 million people—have PTSD at any given time.
- Approximately 8 percent of all adults—1 of 13 people in this country—will develop PTSD during their lifetime.
- An estimated 1 out of 10 women will get PTSD at some time in their lives. Women are about twice as likely as men to develop PTSD.

Extreme Trauma and PTSD

- PTSD may develop following exposure to extreme trauma.
 - Extreme trauma is a terrifying event or ordeal that a person has experienced, witnessed, or learned about, especially one that is life-threatening or causes physical harm.
 - The experience causes that person to feel intense fear, horror, or a sense of helplessness.
- The stress caused by trauma can affect all aspects of a person’s life including mental, emotional, and physical well-being.
- Research suggests that prolonged trauma may disrupt and alter brain chemistry. For some people, this may lead to the development of PTSD.

Risk Factors

Those at risk for developing PTSD include:

- Anyone who has been victimized or has witnessed a violent act, or who has been repeatedly exposed to life-threatening situations. This includes survivors of:
 - Domestic or intimate partner violence
 - Rape or sexual assault or abuse
 - Physical assault such as mugging or carjacking
 - Other random acts of violence such as those that take place in public, in schools, or in the workplace
 - Children who are neglected or sexually, physically, or verbally abused, or adults who were abused as children
 - Survivors of unexpected events in everyday life such as:
 - Car accidents or fires

- Natural disasters, such as tornadoes or earthquakes
- Major catastrophic events such as a plane crash or terrorist act
- Disasters caused by human error, such as industrial accidents
- Combat veterans or civilian victims of war
- Those diagnosed with a life-threatening illness or who have undergone invasive medical procedures
- Professionals who respond to victims in trauma situations, such as, emergency medical service workers, police, firefighters, military, and search and rescue workers
- People who learn of the sudden unexpected death of a close friend or relative
- Estimated risk for developing PTSD for those who have experienced the following traumatic events:
 - Rape (49 percent)
 - Severe beating or physical assault (31.9 percent)
 - Other sexual assault (23.7 percent)
 - Serious accident or injury, for example, car or train accident (16.8 percent)
 - Shooting or stabbing (15.4 percent)
 - Sudden, unexpected death of family member or friend (14.3 percent)
 - Child's life-threatening illness (10.4 percent)
 - Witness to killing or serious injury (7.3 percent)
 - Natural disaster (3.8 percent)

<http://www.ptsdalliance.org/alliance-formed-to-raise-awareness-about-ptsd/>

Adverse Childhood Experiences

In "The Prevalence of Adverse Childhood Experiences, Nationally, by State, and by Race or Ethnicity," authors Vanessa Sacks and David Murphey used data from the 2016 National Survey of Children's Health to determine which children 17 and under are more likely to experience trauma, and where these children live.

They looked at the data regarding eight ACEs:

- Parental divorce or separation
- Parental death
- Parental incarceration
- Violence among adults in the home
- Victim or witness to neighborhood violence
- Living with a mentally ill adult
- Living with someone who has a substance abuse problem

- Experiencing economic hardship often, such as the family finding it difficult to afford food and housing

ACEs aren't limited to this set, Sacks noted, and they also change over time as scholars better understand trauma. For instance, experiencing violence in one's neighborhood and homelessness didn't used to be considered ACEs; they are now. Some researchers are calling for racism to be designated one as well. But one thing is clear: The more ACEs a child experiences, rather than any particular one, the more likely they are to struggle later.

The most prevalent ACEs that American children experience are economic hardship and divorce or separation of a parent or guardian. Nationally, one in every ten kids has experienced three or more of them. Maryland, Massachusetts, and Minnesota had the most children with no ACEs, while in Arizona, Arkansas, Montana, New Mexico, and Ohio as many as one in seven children had experienced three or more. Arkansas had the most ACEs, with 56 percent of all children experiencing at least one, and Minnesota had the least at 37 percent—which is still more than a third of the state's children.

While Sacks said it's difficult to ascertain what causes such stark differences among states, one factor stands out: Some of the states with the most ACEs are also those with a high rate of child poverty. And though Sacks and Murphy didn't look at differences between urban and rural children, the 2011-2012 National Survey of Children's Health [found that rural children](#) were more likely to experience ACEs than urban children—due in part to the fact that rural children are more likely to live in poverty than their urban counterparts.

Race is also a strong indicator of whether a child is likely to experience ACEs. "In almost every group of states we looked at, as well as nationally, white and Asian children have the lowest rates of ACEs, while black and Hispanic children tend to have the highest," said Sacks. In numbers, this translates to 61 percent of black children, 51 percent of Latino children, 40 percent of white children, and 23 percent of Asian children having at least one adverse experience.

After economic hardship and divorce or separation, white children are most likely to experience an adult living with mental illness or dealing with substance abuse, while for black children parental incarceration is the next most-common ACE. African-American kids are also the most likely to have experienced the death of a parent or guardian. For Hispanic children, the next most-common ACEs are living with an adult with a substance abuse issue and parental incarceration.

<https://www.citylab.com/equity/2018/02/where-american-kids-are-in-crisis/553682/>

Become Trauma Informed

Becoming "trauma-informed" means recognizing that people often have many different types of trauma in their lives. People who have been traumatized need support and understanding from those around them. Often, trauma survivors can be re-traumatized by well-meaning caregivers and community service providers. The Iowa TIC project seeks to educate our communities about the impact of trauma on clients, co-workers, friends, family, and even ourselves. Understanding the impact of trauma is an important first step in becoming a compassionate and supportive community.

<http://www.traumainformedcareproject.org/>

Alzheimer's Disease

Alzheimer's disease is the most common cause of dementia among older adults. 5.7 million Americans are estimated to be living with Alzheimer's disease in 2018. It is the fifth leading cause of death for adults aged 65 years and older, and the sixth leading cause of death for all adults.

- Alzheimer's disease is not a normal part of aging.
- 5.7 million Americans are estimated to be living with Alzheimer's disease in 2018.
- Symptoms usually begin after age 60, but Alzheimer's disease likely starts a decade or more before problems first appear.
 - One of the top 10 leading causes of death in the United States.
 - The 6th leading cause of death among US adults.
 - The 5th leading cause of death among adults aged 65 years or older

More women than men have Alzheimer's or other dementias. Almost two-thirds of Americans with Alzheimer's are women.

Projections of Total Numbers of Americans Age 65 and Older with Alzheimer's Dementia by State-

Oregon- 2018 65,000 2025 84,000 Percent increase 29.2

Most studies indicate that older African- Americans are about twice as likely to have Alzheimer's or other dementias as older whites. Some studies indicate Hispanics are about one and one-half times as likely to have Alzheimer's or other dementias as older whites. Recent studies suggest the increased likelihood for Hispanics may be slightly lower than this, depending upon the specific Hispanic ethnic group observed (for example, Mexican-Americans compared with Caribbean-Americans).

Key Facts

- Alzheimer's disease is not a normal part of aging.
- 5.7 million Americans are estimated to be living with Alzheimer's disease in 2018.
- Symptoms usually begin after age 60, but Alzheimer's disease likely starts a decade or more before problems first appear.
- Risk factors include aging, diabetes, high blood pressure (hypertension), smoking cigarettes, and a family history of dementia.
- Alzheimer's death rates increased 55% and the number of Alzheimer's deaths at home increased from 14% to 25% while deaths in institutional settings decreased, from 1999 to 2014.
- More than 16 million Americans provide unpaid care for people with Alzheimer's or other dementias.
- Currently, there is no cure. There are pharmaceutical options for managing symptoms and care planning.

Alzheimer's disease is:

- One of the top 10 leading causes of death in the United States.

- The 6th leading cause of death among US adults.
- The 5th leading cause of death among adults aged 65 years or older
<https://www.cdc.gov/aging/aginginfo/alzheimers.htm>

Differences Between Women and Men in the Prevalence of Alzheimer’s and Other Dementias

More women than men have Alzheimer’s or other dementias. Almost two-thirds of Americans with Alzheimer’s are women. Of the 5.5 million people age 65 and older with Alzheimer’s in the United States, 3.4 million are women and 2.0 million are men. Based on estimates from ADAMS, among people age 71 and older, 16 percent of women have Alzheimer’s or other dementias compared with 11 percent of men.

Racial and Ethnic Differences in the Prevalence of Alzheimer’s and Other Dementias

Although there are more non-Hispanic whites living with Alzheimer’s and other dementias than any other racial or ethnic group in the United States, older African Americans and Hispanics are more likely, on a per-capita basis, than older whites to have Alzheimer’s or other dementias. Most studies indicate that older African-Americans are about twice as likely to have Alzheimer’s or other dementias as older whites. Some studies indicate Hispanics are about one and one-half times as likely to have Alzheimer’s or other dementias as older whites. Recent studies suggest the increased likelihood for Hispanics may be slightly lower than this, depending upon the specific Hispanic ethnic group observed (for example, Mexican-Americans compared with Caribbean-Americans).

There is evidence that missed diagnoses of Alzheimer’s and other dementias are more common among older African-Americans and Hispanics than among older whites. Based on data for Medicare beneficiaries age 65 and older, Alzheimer’s or another dementia had been diagnosed in 6.9 percent of whites, 9.4 percent of African-Americans and 11.5 percent of Hispanics. Although rates of diagnosis were higher among African-Americans than among whites, according to prevalence studies that detect all people who have dementia irrespective of their use of the health care system, the rates should be even higher for African-Americans.

Suicide

Suicide is a major public health concern. Suicide is among the leading causes of death in the United States. Based on recent nationwide surveys, suicide in some populations is on the rise.

- **Suicide** is defined as death caused by self-directed injurious behavior with intent to die as a result of the behavior.
- A **suicide attempt** is a non-fatal, self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in injury.
- **Suicidal ideation** refers to thinking about, considering, or planning suicide.

According to the [Centers for Disease Control and Prevention \(CDC\) WISQARS Leading Causes of Death Reports](#), in 2016:

- Suicide was the tenth leading cause of death overall in the United States, claiming the lives of nearly 45,000 people.

- Suicide was the second leading cause of death among individuals between the ages of 10 and 34, and the fourth leading cause of death among individuals between the ages of 35 and 54.
- There were more than twice as many suicides (44,965) in the United States as there were homicides (19,362).
- Suicide rate is based on the number of people who have died by suicide per 100,000 population. Because changes in population size are considered, rates allow for comparisons from one year to the next.
- Figure 1 shows the age-adjusted suicide rates in the United States for each year from 1999 through 2016 for the total population, and for males and females presented separately.
 - During that 17-year period, the total suicide rate increased 28% from 10.5 to 13.4 per 100,000.
 - The suicide rate among males remained nearly four times higher (21.3 per 100,000 in 2016) than among females (6.0 per 100,000 in 2016).

Data from the National Vital Statistics System, Mortality

- For 2000–2016, the age-adjusted suicide rate increased 30%, from 10.4 to 13.5 per 100,000 population, increasing on average by about 1% per year from 2000 through 2006 and by 2% per year from 2006 through 2016.
- For females aged 10–74, suicide rates in 2016 were higher than in 2000.
- For males aged 15–74, suicide rates in 2016 were higher than in 2000.
- In 2016, for females, suffocation accounted for a higher percentage of suicides among those under age 25, while poisoning accounted for a higher percentage among those aged 45 and over.
- In 2016, firearms were the most common means of suicide among males aged 15 and over.

Oregon

- **Why is suicide a problem in Oregon?**
- In 2015, 762 Oregon residents died by suicide. Suicide is the second leading cause of death among Oregonians aged 15 to 34 years of age, and the 8th leading cause of death among all ages in Oregon. In addition, more than 2,000 hospitalizations are due to self-harm or suicide attempts in Oregon each year.
- Approximately 16% of eighth graders and 11th graders reported seriously considering suicide in the past 12 months in 2015. Nearly eight percent of eighth graders and six percent of 11th graders self-reported having attempted suicide one or more times in the previous 12 months in 2015.
- Cost estimates, including average medical-related costs and average work loss cost are nearly 800 million dollars each year.
[Source: CDC WISQARS, Oregon healthy Teen Survey, and Injury and Violence Prevention Program, OHA](#)
- Suicide is a serious public health problem that affects individuals, families, and communities. In 2015 alone, more than 44,000 Americans died by suicide and almost half a million Americans received medical care for self-inflicted injuries.
- Oregon’s suicide rate has been higher than the national average for the past three decades. Oregon’s age-adjusted suicide rate of 17.7 per 100,000 residents in 2015 was 33 percent higher

than the national average and Oregon ranked 13th place among all US states in suicide incidence. Suicide rates for Oregon and U.S. states have increased since 2000.

Racial and Ethnic Disparities

- Suicide is the eighth leading cause of death among American Indians/Alaska Natives across all ages.
- Among American Indians/Alaska Natives aged 10 to 34 years, suicide is the second leading cause of death.
- The suicide rate among American Indian/Alaska Native adolescents and young adults ages 15 to 34 (19.5 per 100,000) is 1.5 times higher than the national average for that age group (12.9 per 100,000).
- The percentages of adults aged 18 or older having suicidal thoughts in the previous 12 months were 2.9% among blacks, 3.3% among Asians, 3.6% among Hispanics, 4.1% among whites, 4.6% among Native Hawaiians /Other Pacific Islanders, 4.8% among American Indians/Alaska Natives, and 7.9% among adults reporting two or more races.
- Among Hispanic students in grades 9-12, the prevalence of having seriously considered attempting suicide (18.9%), having made a plan about how they would attempt suicide (15.7%), having attempted suicide (11.3%), and having made a suicide attempt that resulted in an injury, poisoning, or overdose that required medical attention (4.1%) was consistently higher than white and black students.

Gender Disparities

- Males take their own lives at nearly four times the rate of females and represent 77.9% of all suicides.
- Females are more likely than males to have suicidal thoughts.
- Suicide is the seventh leading cause of death for males and the fourteenth leading cause for females.
- Firearms are the most commonly used method of suicide among males (56.9%).
- Poisoning is the most common method of suicide for females (34.8%).

<https://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf>

Tobacco

More than one in three Oregonians with a household income of less than \$15,000 a year smoke. In comparison, one in 10 Oregonians with a household income of more than \$50,000 a year smoke.

Race and ethnicity are also important factors. Thirty-five percent of American Indians in Oregon smoke compared to 21 percent of non-Hispanic Whites.

These disparities must be addressed in order to reduce tobacco use and tobacco-related diseases.

Table 4.7 Adult tobacco use among Oregon Health Plan members, by race and ethnicity, Oregon, 2016

Race/ethnicity	Percent of OHP members (%)
American Indian/Alaska Native	41.4
African American/Black	32.6
White	30.6
Hispanic/Latino	13.3
Asian American	4.8
Hawaiian/Pacific Islander	35.7
Total	29.1

Cigarette sales in Oregon have declined by more than 50 percent since TPEP began in 1997. However, tobacco use remains the number-one cause of preventable death and disease in Oregon. It kills nearly 8,000 people each year. Tobacco use costs Oregonians \$2.5 billion a year in medical expenses, lost productivity and early death.

- Cigarette smoking has decreased from 1996 to 2016. However, use of non-cigarette products is on the rise.
- Data show that more than half of youth and young adults who use tobacco are using flavored tobacco or vaping products.
- Tobacco companies spend billions of dollars on tobacco marketing in the United States every year. In 2015, the Federal Trade Commission reported that the tobacco industry spent nearly \$8.9 billion marketing cigarettes and smokeless tobacco. This is almost \$25 million per day or approximately \$1 million an hour.
- The tobacco industry has shifted its marketing from billboards and TV commercials to convenience stores, pharmacies and grocery stores. Almost 75 percent of the tobacco industry's total marketing expenditures for cigarettes and smokeless tobacco products are in the retail environment. (6) In fact, the tobacco industry spends more than \$100 million every year to advertise and promote its products in Oregon's stores.

On August 9, 2017, Governor Kate Brown signed Senate Bill 754 into law. This law raised the required minimum age for a person to legally buy or obtain tobacco products, inhalant delivery systems, and tobacco product devices, from 18 to 21.

Figure 5.2 Youth use of cigarettes, non-cigarette tobacco products, and all tobacco products, Oregon, 2015 and 2017

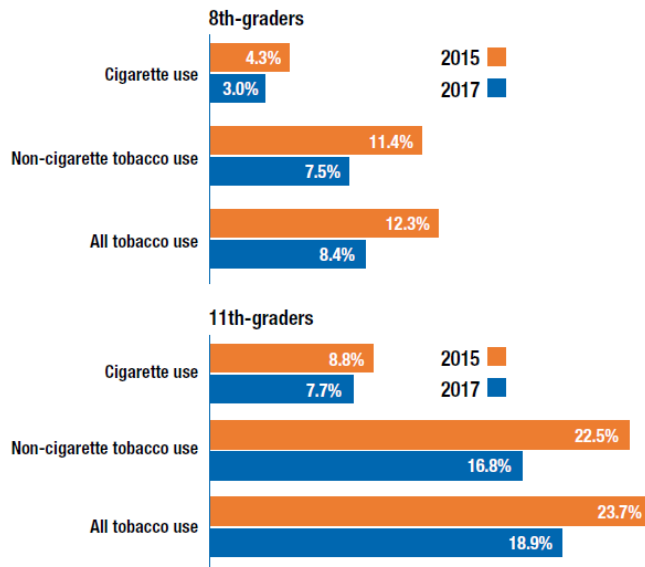
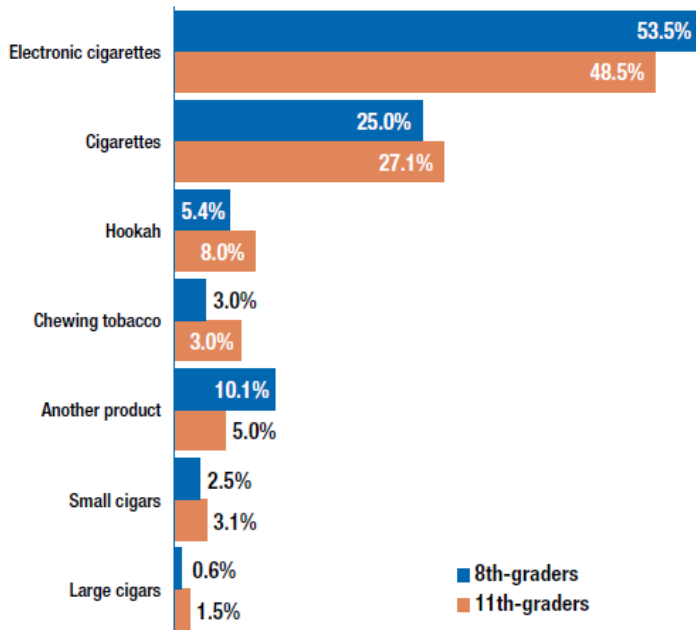


Figure 5.5 First product used among youth who have ever used tobacco, Oregon, 2017



Illicit Drug Use

Figure 68. Past Year Substance Use Disorder (SUD) and Mental Illness among Adults Aged 18 or Older: Numbers in Millions, 2016

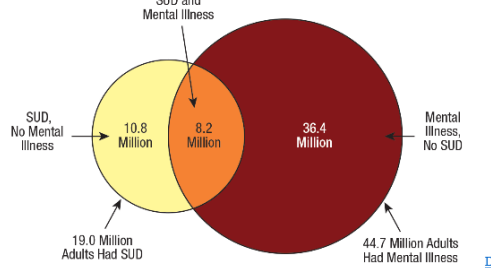
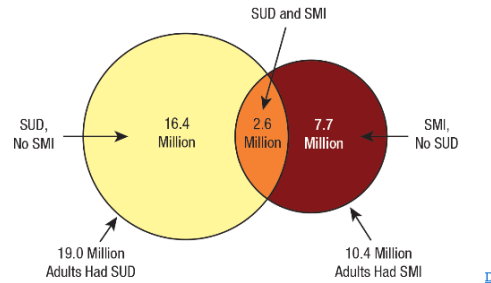


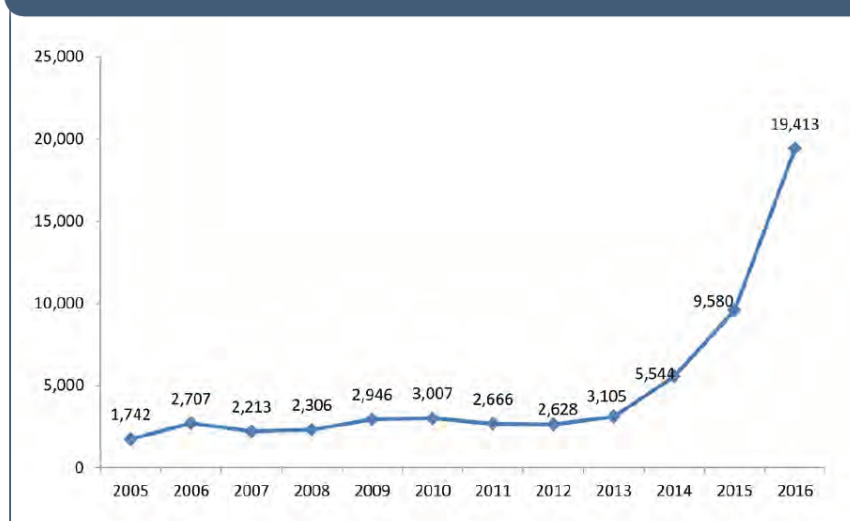
Figure 69. Past Year Substance Use Disorder (SUD) and Serious Mental Illness (SMI) among Adults Aged 18 or Older: Numbers in Millions, 2016



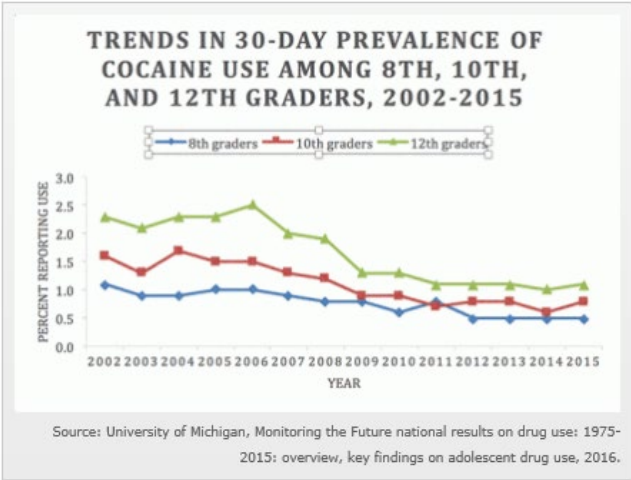
In 2016, synthetic opioids (primarily illegal fentanyl) passed prescription opioids as the most common drugs involved in overdose deaths in the United States.

In 2016, synthetic opioids were involved in nearly 50% (19,413) of opioid-related deaths, up from 14% (3,007) in 2010.

(U) Figure 1. Synthetic Opioid Drug Poisoning Deaths, 2005-2016.



Source: Centers for Disease Control and Prevention



Monitoring the Future Study: Trends in Prevalence of Methamphetamine for 8th Graders, 10th Graders, and 12th Graders; 2017 (in percent)*

Drug	Time Period	8th Graders	10th Graders	12th Graders
Methamphetamine	Lifetime	0.70	0.90	1.10
	Past Year	0.50	0.40	0.60
	Past Month	0.20	0.20	0.30

* Data in brackets indicate statistically significant change from the previous year. [Previous MTF Data](#) ►

National Survey on Drug Use and Health: Trends in Prevalence of Methamphetamine for Ages 12 or Older, Ages 12 to 17, Ages 18 to 25, and Ages 26 or Older; 2017 (in percent)*

Drug	Time Period	Ages 12 or Older	Ages 12 to 17	Ages 18 to 25	Ages 26 or Older
Methamphetamine	Lifetime	5.40	0.30	3.00	6.40
	Past Year	0.60	0.20	1.10	0.60
	Past Month	0.30	0.10	0.40	0.30

^ indicate low precision; no estimate reported.
Data in brackets indicate statistically significant change from the previous year.

Total opioid-related deaths

Between 2009 and 2015, there were a total of 1,298 deaths related to opioids in Clackamas, Multnomah, and Washington counties. Overall, around two thirds of deaths occurred in Multnomah County (Table 1). The number of opioid-related deaths in 2015 was not significantly different from the 2009-2014 median value in Clackamas (26 deaths, median 27) and Washington (30 deaths, median 35) counties, but was significantly lower than the median value in Multnomah County (103 deaths, median 121).

Table 1: Number and percentage of opioid-related deaths, Clackamas, Multnomah, and Washington counties, State Medical Examiner's Office Database, 2009-2015

	Clackamas		Multnomah		Washington		Total	
	Number	%*	Number	%*	Number	%*	Number	%*
2009	38	19	124	14	34	15	196	15
2010	23	11	117	14	33	14	173	13
2011	40	20	156	18	36	15	232	18
2012	27	13	131	15	39	17	197	15
2013	26	13	118	14	23	10	167	13
2014	24	12	112	13	38	16	174	13
2015	26	13	103	12	30	13	159	12
Total**	204	16**	861	66**	233	18**	1,298	100**

* Percent of county six-year total opioid-related deaths

**Percent of Tri-County total, six-year total opioid-related deaths

Sex and total opioid-related deaths

Men accounted for a larger proportion of total opioid-related deaths between 2009 and 2015 in each of the three counties, ranging from 56% in Washington County to 67% in Multnomah County (Figure 2).

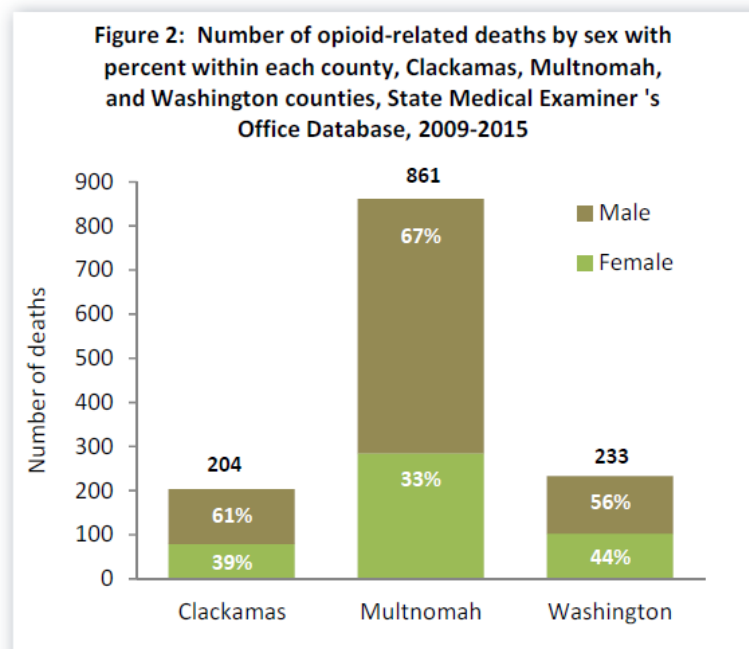
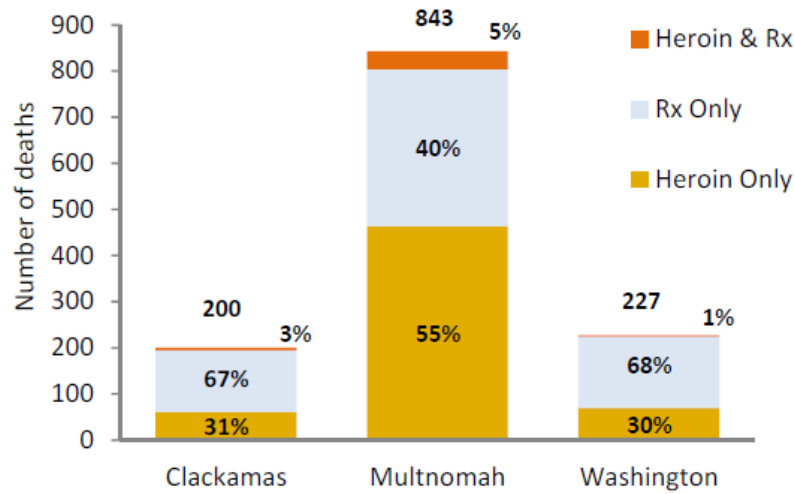


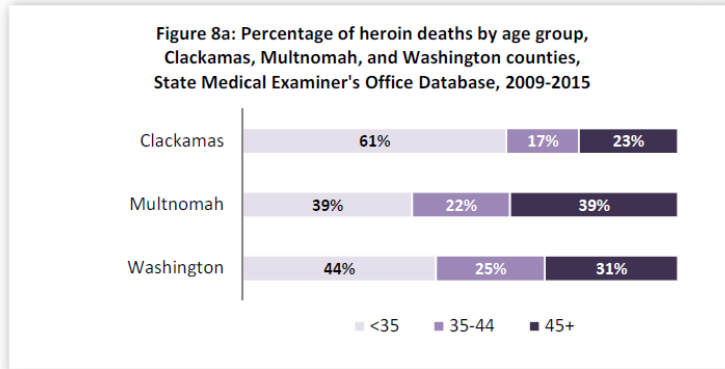
Figure 3: Number of opioid-related deaths with percentage within county by drug type, Clackamas, Multnomah, and Washington counties, State Medical Examiner's Office, 2009-2015



Key Findings

- Two thirds of opioid-related deaths occurred in Multnomah County.
- More opioid-related deaths in Multnomah County were caused by heroin (55%) compared to Washington County (30%) and Clackamas County (31%).
- Males died younger than females in all three counties.
- Heroin users died at a younger age in all three counties.
- Prescription opioid deaths have declined in Clackamas County over the time period, but not significantly.
- Prescription opioid deaths have declined significantly in Washington County.
- Prescription opioid deaths in Multnomah County have stayed steady.
- Heroin deaths in Multnomah County have declined significantly over the time period.
- Heroin deaths in Clackamas and Washington counties have not changed significantly over the time period.

Persons younger than 35 years old accounted for nearly two thirds of the heroin deaths in Clackamas County (61%), but less than half in Multnomah and Washington counties (39% and 44%, respectively) (Figure 8a). The distribution of deaths due to prescription opioids was similar in the three counties, with persons 45 years and older accounting for 52% of the total in Clackamas County and 56% of the total in Washington County (Figure 8b).



Alcohol

Hospitalization rates per 100,000 population, by Oregon county, 2016

Use unadjusted rates to estimate hospitalizations for individual counties;

use age-adjusted to compare among counties.

County	Alcoholic Liver disease*	
	Unadjusted	Age-adjusted
Clackamas	24.4	22.1
Multnomah	25.3	25.5

Includes only adults ages 18 and over.

* Alcoholic liver disease is damage to the liver and its function due to [alcohol abuse](#).

Hospitalizations include only those where the indicated condition was the primary diagnosis.

Rates are based on the number of hospitalized persons per 100,000 population.

Source: Oregon hospital discharges dataset, 2016; age-adjustment is to the 2000 standard population.

2018 County Health Rankings

County	Excessive Drinking	Alcohol-impaired Driving Deaths*
Clackamas	21%	36%
Multnomah	22%	36%
Oregon	19%	32%

* Percent of total driving deaths

<http://www.countyhealthrankings.org/app/oregon/2018/measure/factors/134/data?sort=sc-4>

Primary Diagnosis Name	ICD Code	Emergency	Inpatient	Outpatient	Other	Grand Total
Alcohol abuse with intoxication, unspecified	F10.129	315	3	1		319
Other stimulant abuse, uncomplicated	F15.10	293	1	1	2	297
Alcohol dependence with intoxication, unspecified	F10.229	114	3			117
Other psychoactive substance abuse, uncomplicated	F19.10	77		6		83
Alcohol dependence, uncomplicated	F10.20	50	1	23		74
Alcohol abuse, uncomplicated	F10.10	49		12		61
Opioid abuse, uncomplicated	F11.10	49				49
Opioid dependence, uncomplicated	F11.20	8		22		30
Nicotine dependence, cigarettes, uncomplicated	F17.210	5		21		26
Nicotine dependence, unspecified, uncomplicated	F17.200			24		24
Cocaine abuse, uncomplicated	F14.10	22				22
Other stimulant abuse with intoxication, unspecified	F15.129	18	1			19
Cannabis abuse, uncomplicated	F12.10	15				15
Other stimulant abuse with stimulant-induced psychotic disorder, unspecified	F15.159	12				12
Tobacco use	Z72.0			10		10
Other stimulant use, unspecified, uncomplicated	F15.90	8				8
Cannabis abuse with other cannabis-induced disorder	F12.188	5	1			6
Cannabis use, unspecified, uncomplicated	F12.90	5		1		6
Cannabis use, unspecified with intoxication, unspecified	F12.929	4				4
Cannabis use, unspecified with other cannabis-induced disorder	F12.988	3	1			4
Opioid use, unspecified, uncomplicated	F11.90	3	1			4
Other psychoactive substance dependence, uncomplicated	F19.20	1		2		3
Other psychoactive substance use, unspecified, uncomplicated	F19.90	1		2		3
Other stimulant use, unspecified with stimulant-induced psychotic disorder, unspecified	F15.959	3				3
Alcohol dependence with intoxication, uncomplicated	F10.220		1	1		2
Cannabis dependence, uncomplicated	F12.20			2		2
Hallucinogen abuse, uncomplicated	F16.10	2				2
Other psychoactive substance abuse with intoxication, unspecified	F19.129	2				2
Other stimulant dependence, uncomplicated	F15.20	2				2
Other stimulant use, unspecified with intoxication, unspecified	F15.929	2				2
Alcohol abuse with intoxication, uncomplicated	F10.120	1				1
Alcohol dependence, in remission	F10.21			1		1
Cannabis abuse with intoxication, unspecified	F12.129	1				1
Cocaine abuse with intoxication, unspecified	F14.129	1				1
Nicotine dependence, cigarettes, in remission	F17.211			1		1
Nicotine dependence, other tobacco product, uncomplicated	F17.290			1		1
Opioid use, unspecified with intoxication, unspecified	F11.929		1			1
Other psychoactive substance dependence, in remission	F19.21			1		1
Other psychoactive substance use, unspecified with intoxication, unspecified	F19.929	1				1
Other stimulant dependence, in remission	F15.21			1		1
Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified	F13.129		1			1
Sedative, hypnotic or anxiolytic abuse, uncomplicated	F13.10	1				1
Grand Total	Total	1,073	15	133	2	1,223

From 2007 to 2017, the number of deaths attributable to alcohol increased 35 percent, according to a new analysis by the Institute for Health Metrics and Evaluation at the University of Washington. The death rate rose 24 percent.

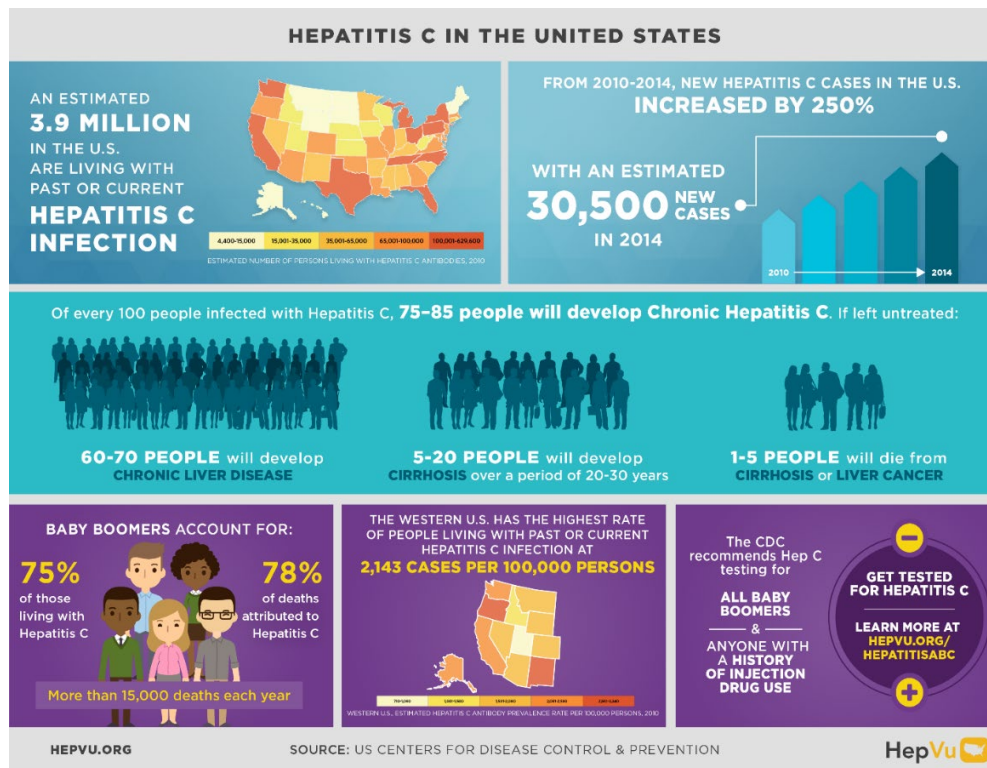
Alcohol/Drug Abuse

Primary Diagnosis Name	ICD Code	Emergency	Inpatient	Outpatient	Grand Total
Alcohol abuse with intoxication, unspecified	F10.129	315	3	1	319
Alcohol dependence with intoxication, unspecified	F10.229	114	3		117
Alcohol dependence, uncomplicated	F10.20	50	1	23	74
Alcohol abuse, uncomplicated	F10.10	49		12	61
Alcohol dependence with intoxication, uncomplicated	F10.220		1	1	2
Alcohol abuse with intoxication, uncomplicated	F10.120	1			1
Alcohol dependence, in remission	F10.21			1	1
Grand Total		529	8	38	575

Hepatitis C

81% of U.S. residents infected with HCV were born between 1945 and 1965.

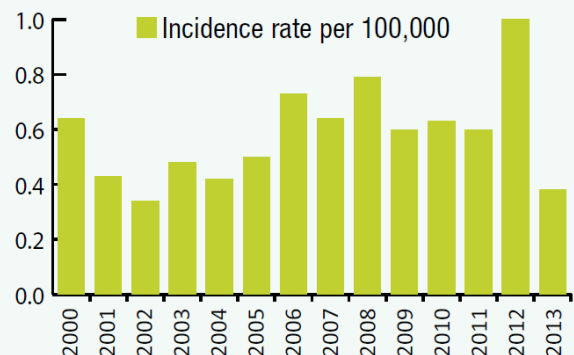
- At least 50% of persons infected with HCV are unaware of their infection.
- HCV testing, followed by appropriate care and treatment, can reduce risk for liver cancer by 70% and mortality by 50%.

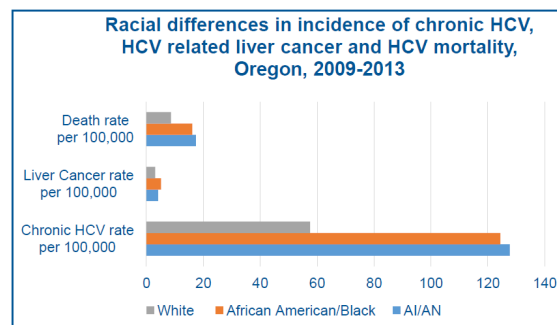
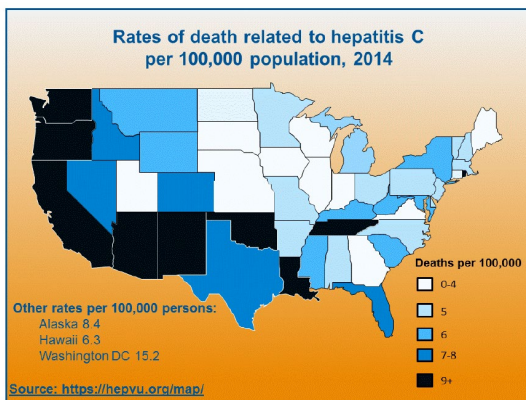
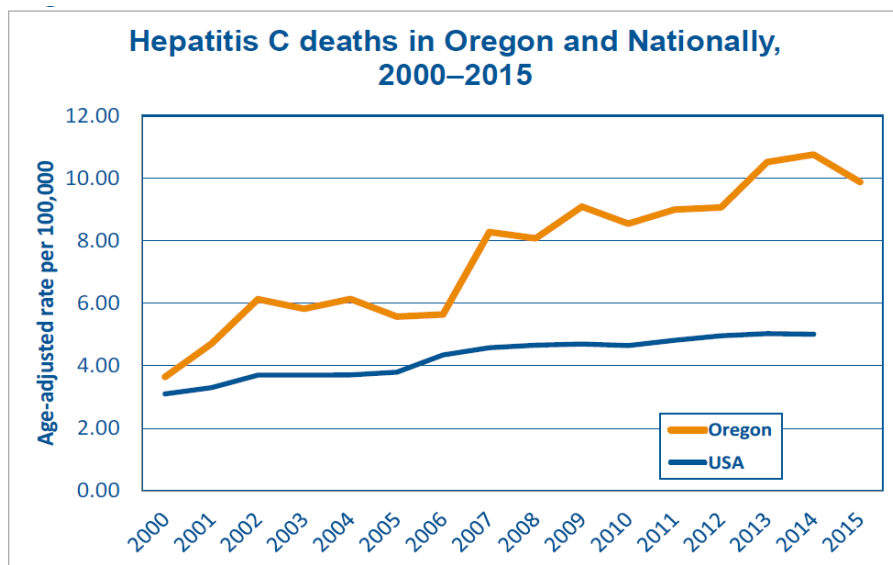
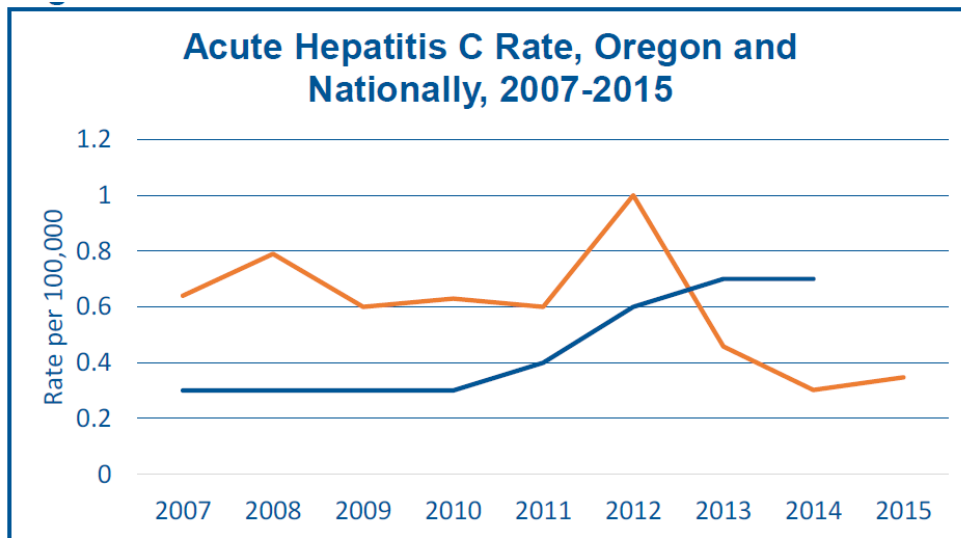


Facts at a glance

- Rates of acute HCV cases in Oregon were 50% higher than the national rate during 2007–2011.
- Injection drug use accounted for the majority of new HCV infections in Oregon.
- Rates of acute HCV in Oregon were four times higher in AI/ANs than in any other racial group.

Incidence of acute hepatitis C, Oregon, 2000–2013





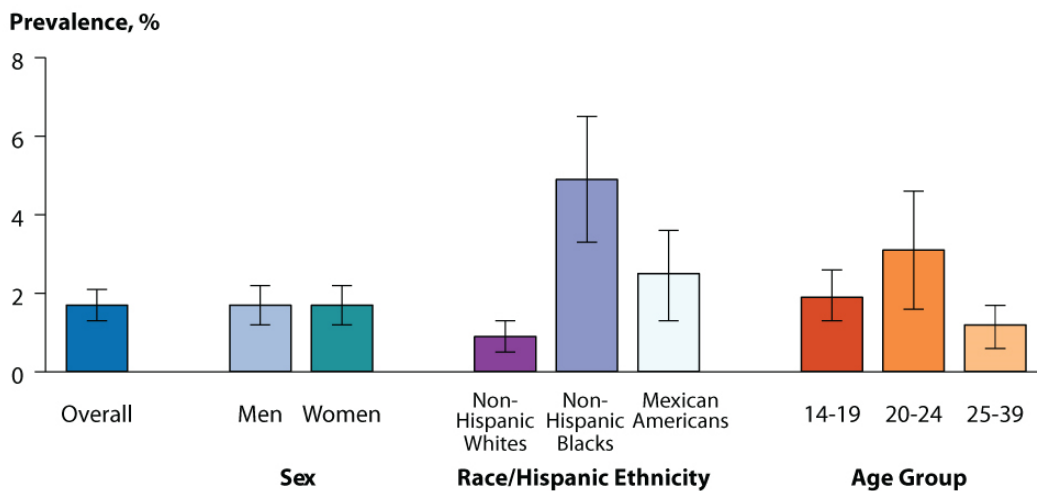
Sexually Transmitted Disease

Nearly 2.3 million cases of chlamydia, gonorrhea, and syphilis were diagnosed in the United States in 2017, according to preliminary data released today by the Centers for Disease Control and Prevention (CDC) at the National STD Prevention Conference in Washington, D.C. This surpassed the previous record set in 2016 by more than 200,000 cases and marked the fourth consecutive year of sharp increases in these sexually transmitted diseases (STDs).

The CDC analysis of STD cases reported for 2013 and preliminary data for 2017 shows steep, sustained increases:

- **Gonorrhea** diagnoses increased 67 percent overall (from 333,004 to 555,608 cases according to preliminary 2017 data) and nearly doubled among men (from 169,130 to 322,169). Increases in diagnoses among women — and the speed with which they are increasing — are also concerning, with cases going up for the third year in a row (from 197,499 to 232,587).
- **Primary and secondary syphilis** diagnoses increased 76 percent (from 17,375 to 30,644 cases). Gay, bisexual and other men who have sex with men (MSM) made up almost 70 percent of primary and secondary syphilis cases where the gender of the sex partner is known in 2017. Primary and secondary syphilis are the most infectious stages of the disease.
- **Chlamydia** remained the most common condition reported to CDC. More than 1.7 million cases were diagnosed in 2017, with 45 percent among 15- to 24-year-old females.

Figure 11. Chlamydia — National Estimates of Prevalence Among Persons Aged 14–39 Years by Sex, Race, Hispanic Ethnicity, or Age Group, National Health and Nutrition Examination Survey (NHANES), 2013–2016



Diagnoses of HIV infection

From 2012 through 2016, the rate of diagnoses of HIV infection in the United States decreased; the annual number of diagnoses remained stable (Table 1a). In 2017, the rate was 11.8.

Diagnoses of HIV Infection and Population in Children Aged <13 Years by Race/Ethnicity, 2017—United States

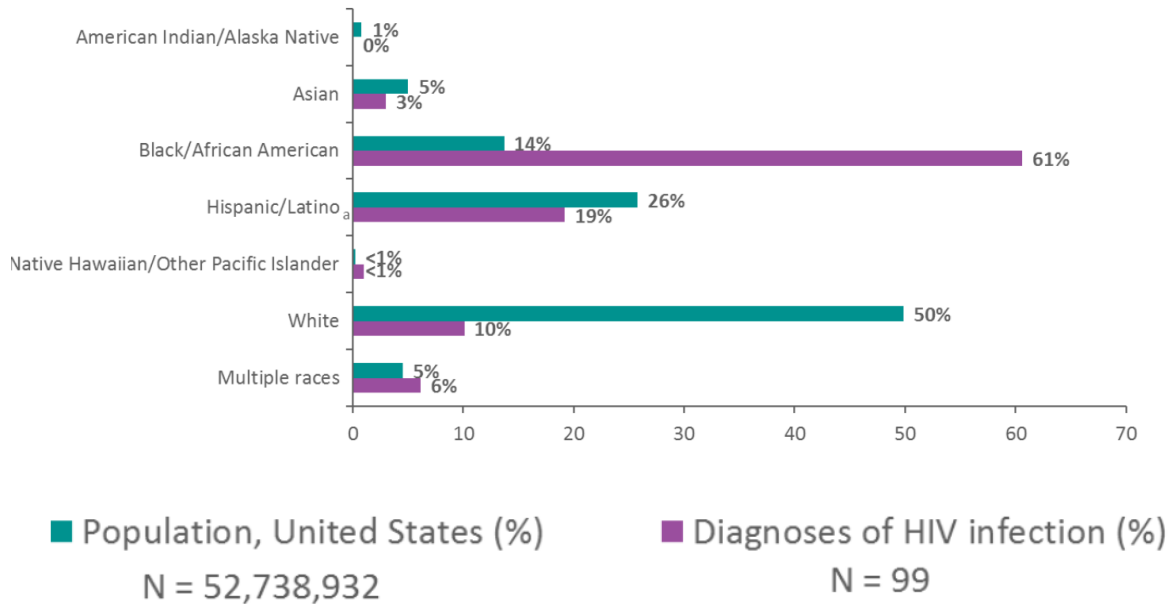
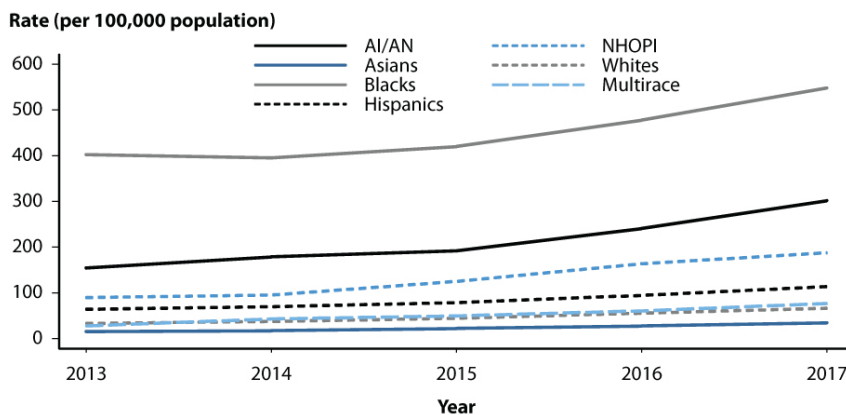


Figure 22. Gonorrhea – Rates of Reported Cases by Race and Hispanic Ethnicity, United States, 2013–2017



NOTE: Not all US jurisdictions reported cases in OMB-compliant Race categories in 2017. This may minimally under- or overestimate rates for Asians, NHOPI, or Multirace individuals. For completeness, data in this figure include cases reported from all jurisdictions. See [Section A1.5](#) in the Appendix for information on reporting STD case data for race and Hispanic ethnicity.

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders; OMB = Office of Management and Budget.

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Figure 36. Primary and Secondary Syphilis — Rates of Reported Cases by Region, United States, 2008–2017

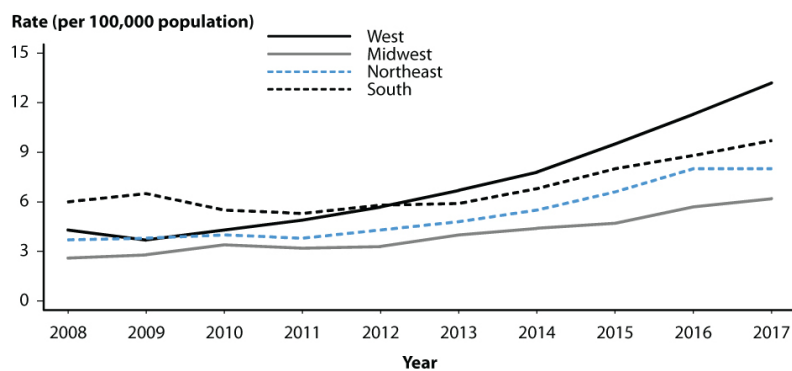
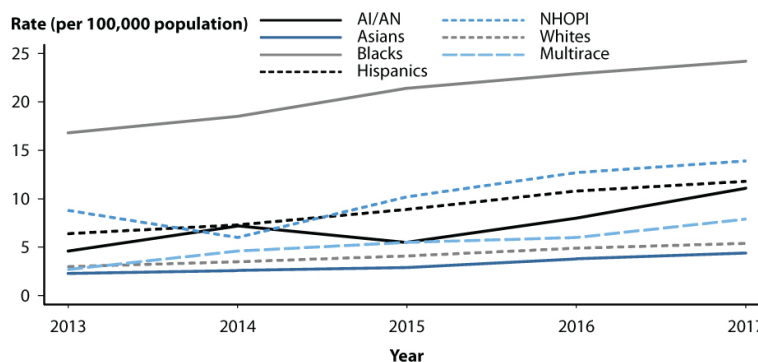


Figure 45. Primary and Secondary Syphilis — Rates of Reported Cases by Race and Hispanic Ethnicity, United States, 2013–2017



NOTE: Not all US jurisdictions reported cases in OMB-compliant Race categories in 2017. This may minimally under- or overestimate rates for Asians, NHOPI, or Multirace individuals. For completeness, data in this figure include cases reported from all jurisdictions. See [Section A1.5 in the Appendix](#) for information on reporting STD case data for race and Hispanic ethnicity.

ACRONYMS: AI/AN = American Indians/Alaska Natives; NHOPI = Native Hawaiians/Other Pacific Islanders; OMB = Office of Management and Budget.

Figure 2. Gonorrhea reported cases: Oregon, 1967–2017

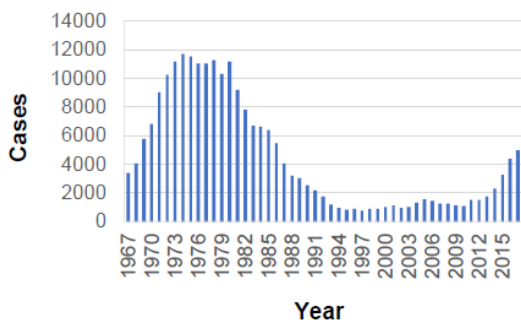


Figure 3. Syphilis: primary, secondary, early latent reported cases: Oregon 1967–2017

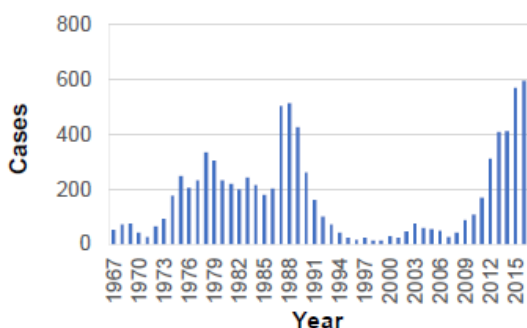


Figure 1. Chlamydia reported cases: Oregon, 1988–2017

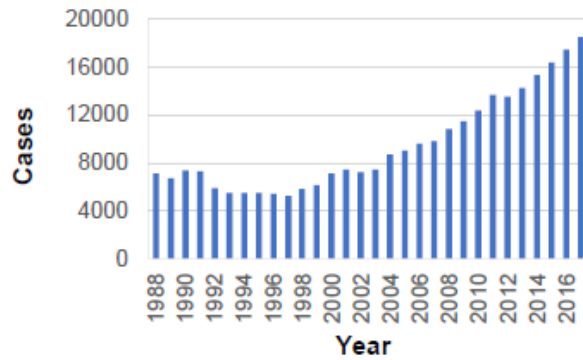


Figure 7. Incidence rate of gonorrhea and chlamydia by race and ethnicity, Oregon, 2017

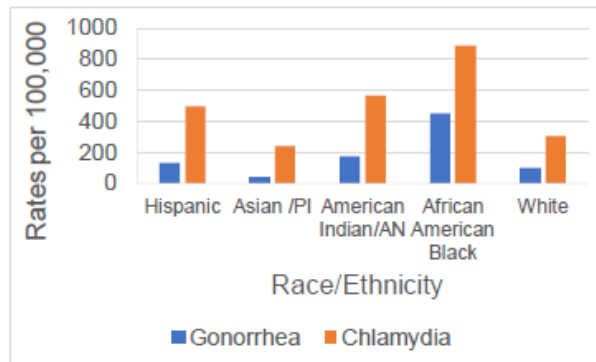
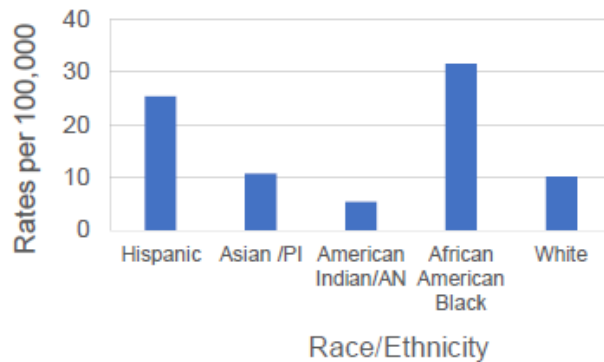


Figure 8. Incidence rate of syphilis by race and ethnicity, Oregon, 2017



Social Determinants of Health

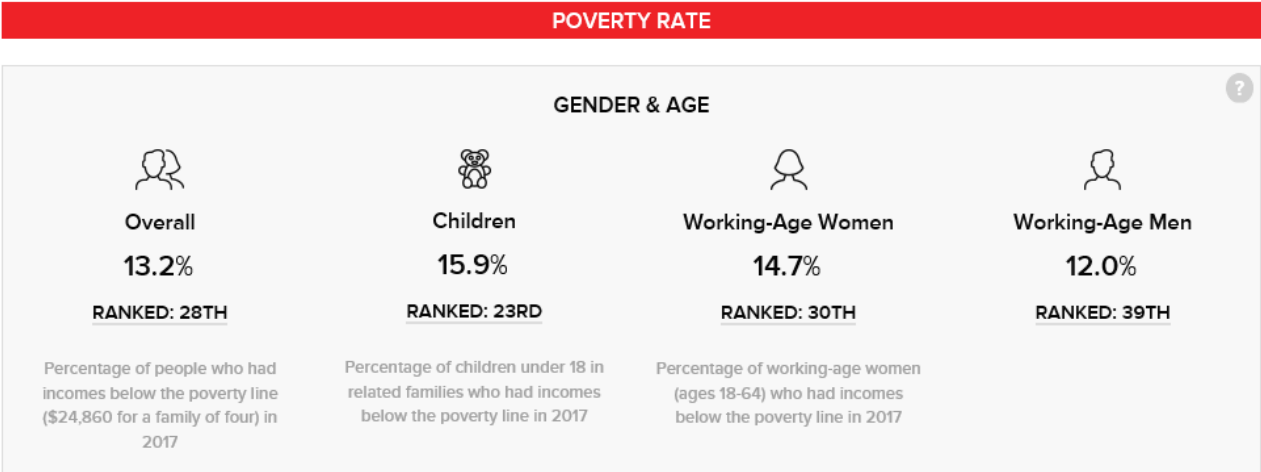
Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as “place.” In addition to the more material attributes of “place,” the patterns of social engagement and sense of security and well-being are also affected by where people live. Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

Understanding the relationship between how population groups experience “place” and the impact of “place” on health is fundamental to the social determinants of health—including both social and physical determinants.

Poverty

Oregon 2018

Population: 4,064,467 Number in Poverty: 537,974



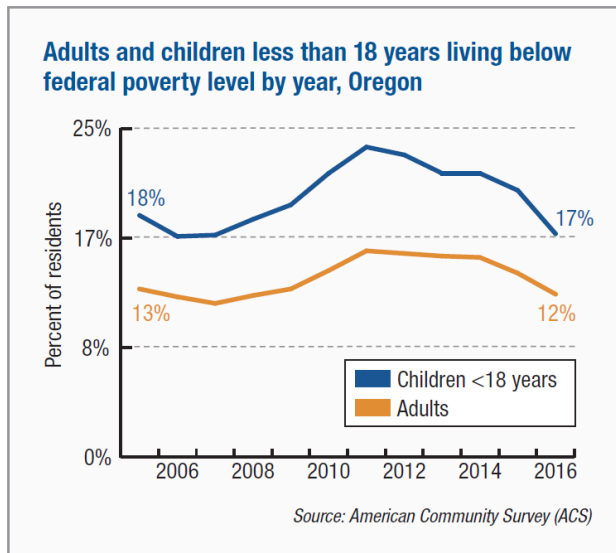
Oregon's 3rd District

Population: 827,041 Number in Poverty: 118,655

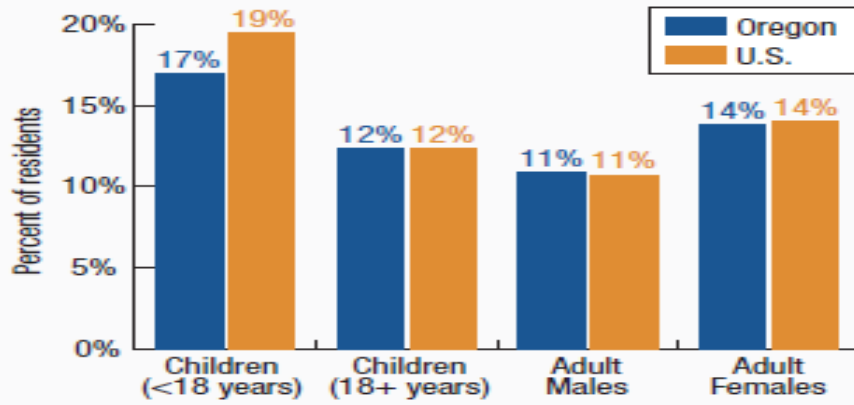
POVERTY RATE

GENDER & AGE

Overall	Children	Working-Age Women	Working-Age Men
14.3%	17.2%	15.3%	12.3%
RANKED: 279TH	RANKED: 225TH	RANKED: 264TH	RANKED: 297TH
Percentage of people who had incomes below the poverty line (\$24,860 for a family of four) in 2017	Percentage of children under 18 in related families who had incomes below the poverty line in 2017	Percentage of working-age women (ages 18-64) who had incomes below the poverty line in 2017	

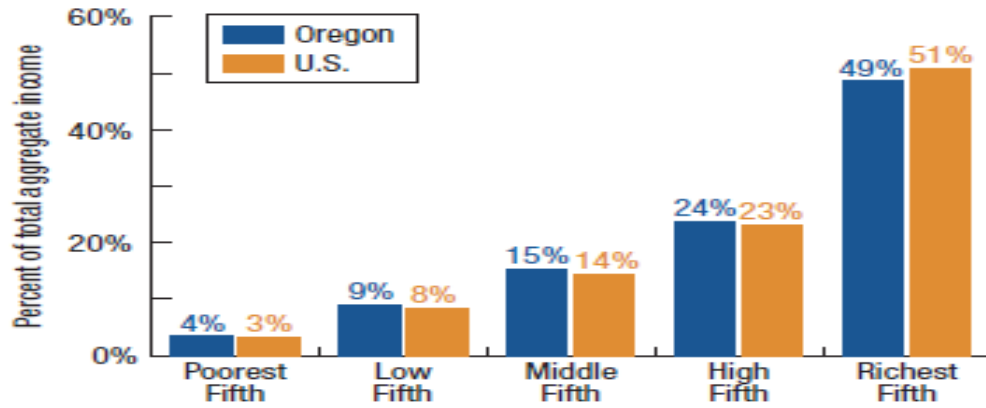


Population living below federal poverty level by age and sex, Oregon and U.S.

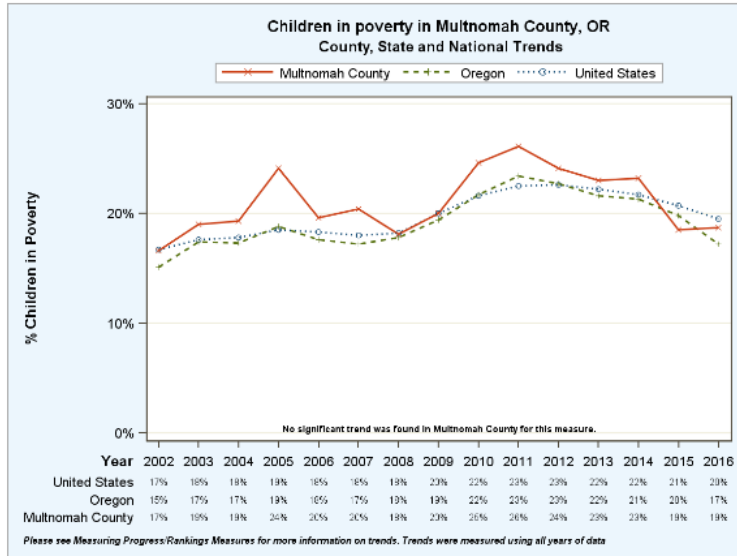


Source: American Community Survey (ACS), 2016

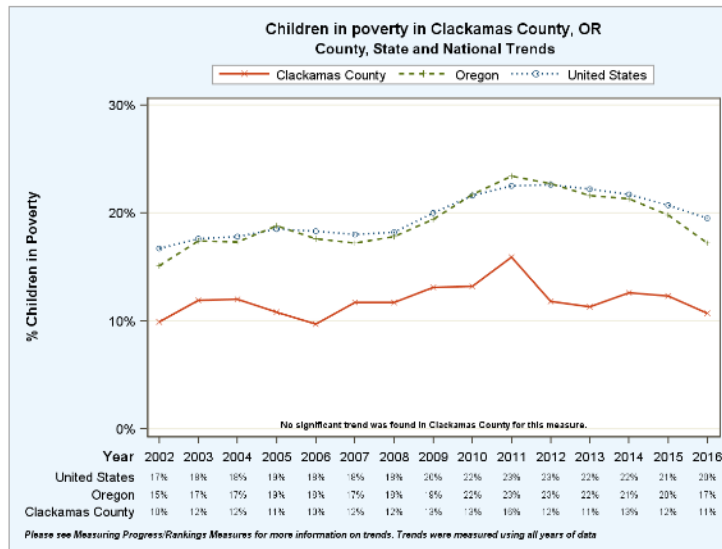
Aggregate income by household quintile, Oregon and U.S.



Source: American Community Survey (ACS), 2016



% Children in Poverty	19%
% Children in Poverty (Black)	50%
% Children in Poverty (Hispanic)	41%
% Children in Poverty (White)	13%

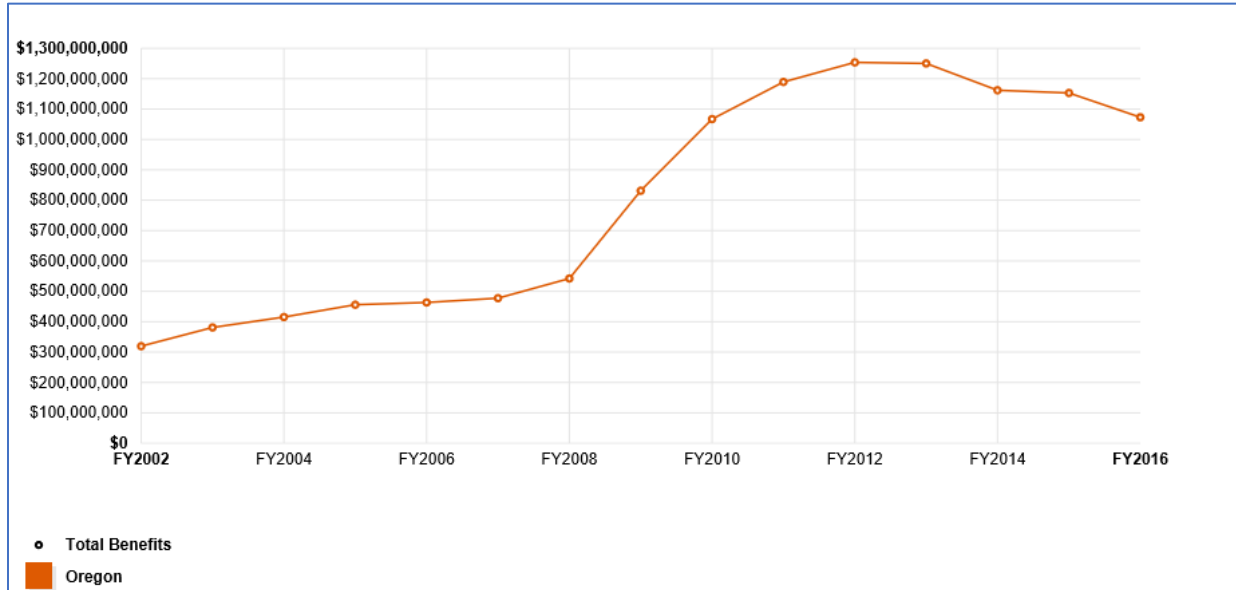


% Children in Poverty	11%
% Children in Poverty (Black)	15%
% Children in Poverty (Hispanic)	19%
% Children in Poverty (White)	9%

Hunger

Oregon

Supplemental Nutrition Assistance Program (SNAP) Total Benefits- Oregon FY2002-FY2016



In an average month, an estimated 260,000 people are receiving food from a food pantry in the Network.

- The rate of food insecurity (being without access to a sufficient quantity of affordable, nutritious food) in Oregon is 14.6%.
- About 552,900 Oregonians are food insecure, of those 194,070 are children.
- About 72% of the people who receive food have incomes below the federal poverty level.
- Of households utilizing food pantries, about 80% of them are able to meet their food needs for the month with the help of a pantry.
- 58% of households are getting benefit from SNAP
- 18% of client are 65 years or older
- 165 of households reported having someone who is unemployed.

<https://www.oregonfoodbank.org/our-work/hunger-in-oregon/>

DELIVERING SO MUCH MORE THAN JUST A MEAL IN OREGON

OREGON'S SENIOR POPULATION STRUGGLES WITH HUNGER AND ISOLATION			
Senior population	962,238 (23%)		
Seniors threatened by hunger	123,166 (13%)		
Seniors living alone	239,428 (25%)		
ADDITIONAL FACTORS CAN MAKE SENIORS EVEN MORE VULNERABLE			
Seniors living in poverty	81,450 (9%)		
Seniors that are non-white racial and/or an ethnic minority	10%		
Seniors experiencing falls with injury	10%		
Seniors with self-rated health as "fair to poor"	20%		
Seniors with a disability	32%		
INADEQUATE NUTRITION AND/OR LIMITED SOCIAL CONTACT HAS DIRECT HEALTH CONSEQUENCES THAT AFFECT THE HEALTHCARE SYSTEM AND ECONOMY			
Preventable hospitalizations	34%	Hospital readmissions	14%
Total Medicare spending (in billions)	\$6.51		
OLDER AMERICANS ACT (OAA) NUTRITION PROGRAMS IN OREGON ARE DELIVERING NUTRITIOUS MEALS, FRIENDLY VISITS AND SAFETY CHECKS TO THE MOST AT-RISK SENIORS			
	Congregate Meals	Home-Delivered Meals	Total
Seniors served each year	28,060	13,733	41,793
Meals served each year	836,335	1,750,765	2,587,100
OAA CLIENT PROFILE			
Live alone	38%	Live in poverty	13%
Live in a rural area	29%	Minority	8%
Women	49%		
FUNDING FOR THESE PROGRAMS VARY BASED ON THE NEEDS AND RESOURCES OF THE COMMUNITY, AND ARE MADE UP OF FEDERAL, STATE, LOCAL AND PRIVATE DOLLARS			
	Congregate Meals	Home-Delivered Meals	Total
OAA Expenditures	\$4,127,675	\$5,342,154	\$9,469,829 (81%)
Total Expenditures	\$5,101,753	\$6,552,791	\$11,654,544
TOGETHER, WE MUST INVEST MORE FULLY IN MEALS ON WHEELS TO ENSURE VULNERABLE SENIORS IN OREGON CAN REMAIN HEALTHIER AT HOME, AVOIDING MORE COSTLY HEALTHCARE FACILITIES			
Cost of serving a senior Meals on Wheels for an entire year	Cost of 1 day in a hospital	Cost of 10 days in a nursing home	
\$1,126	\$3,537	\$3,050	
MEALS ON WHEELS PROVIDES A SOLUTION THAT SERVES US ALL			



Information data sources available at www.mealsonwheelsamerica.org/facts. © November 2018 Meals on Wheels America

Homelessness

EXHIBIT 2.6: States with the Highest and Lowest Rates of Unsheltered Homeless Individuals, By State, 2018

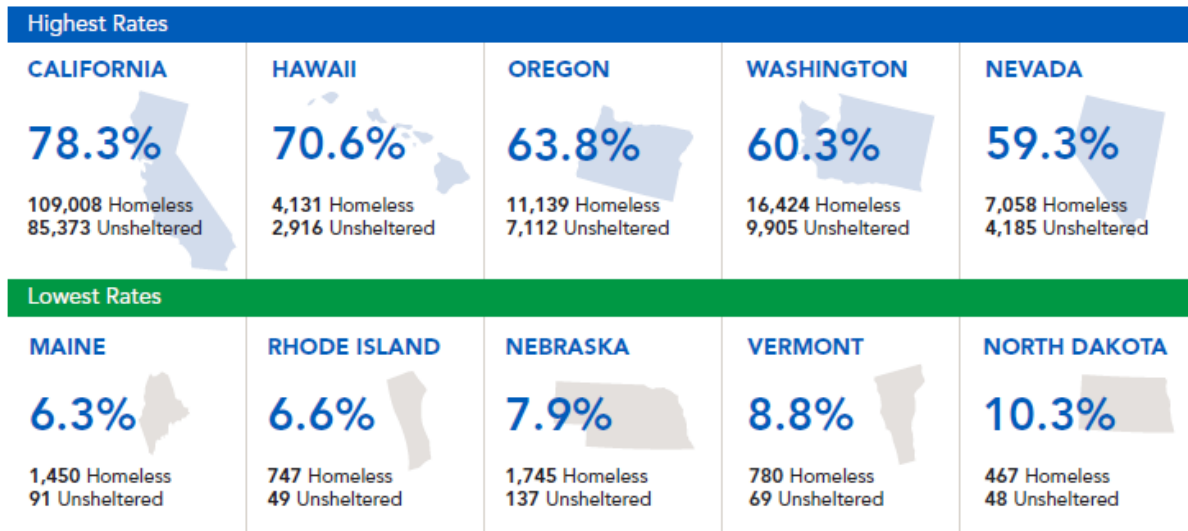
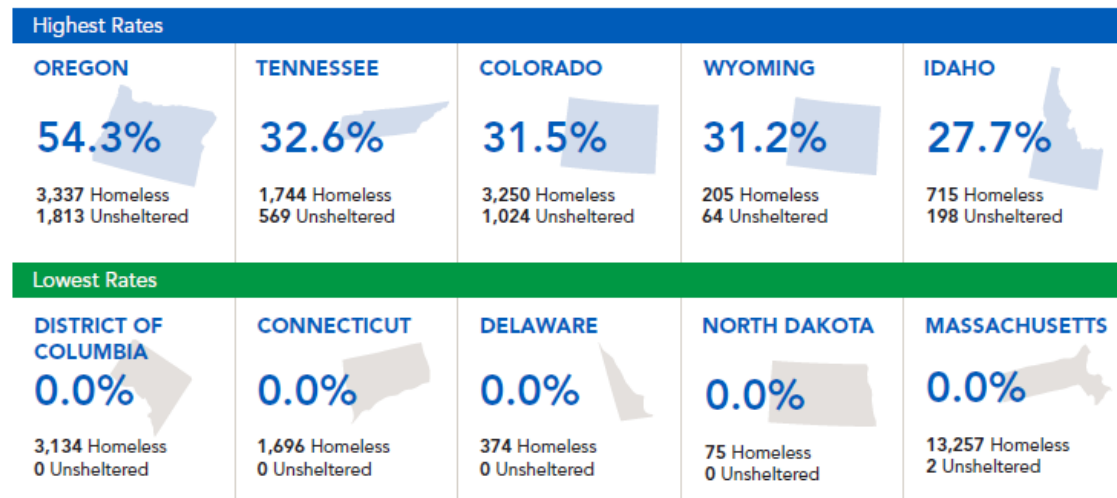


EXHIBIT 3.7: Highest and Lowest Rates of Unsheltered People in Families with Children By State, 2018



Note: Excludes Puerto Rico and U.S. territories.

EXHIBIT 5.6: States with the Highest and Lowest Rates of Unsheltered Veterans
2018

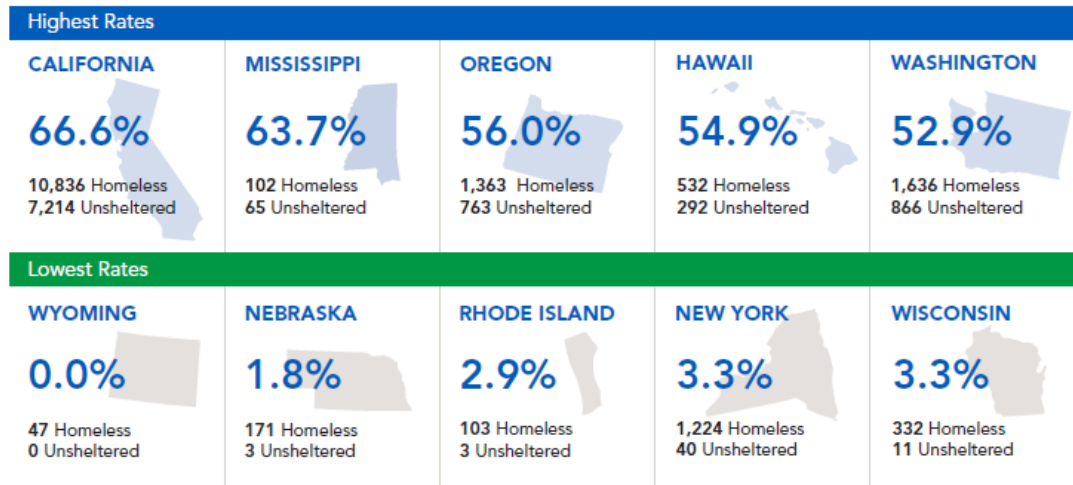


EXHIBIT 4.5: States with the Highest and Lowest Rates of Unsheltered Unaccompanied Homeless Youth
By State, 2018

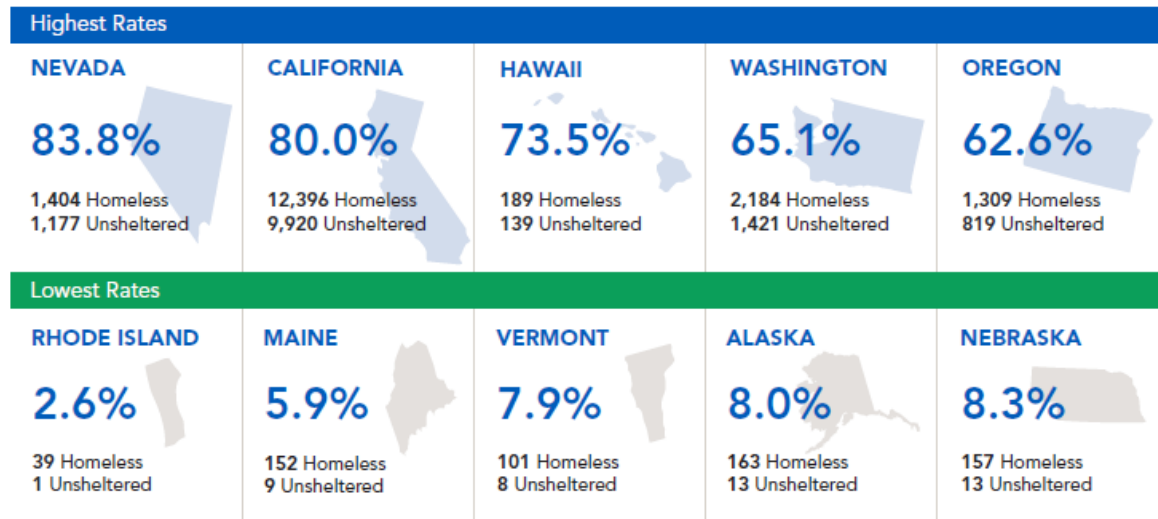
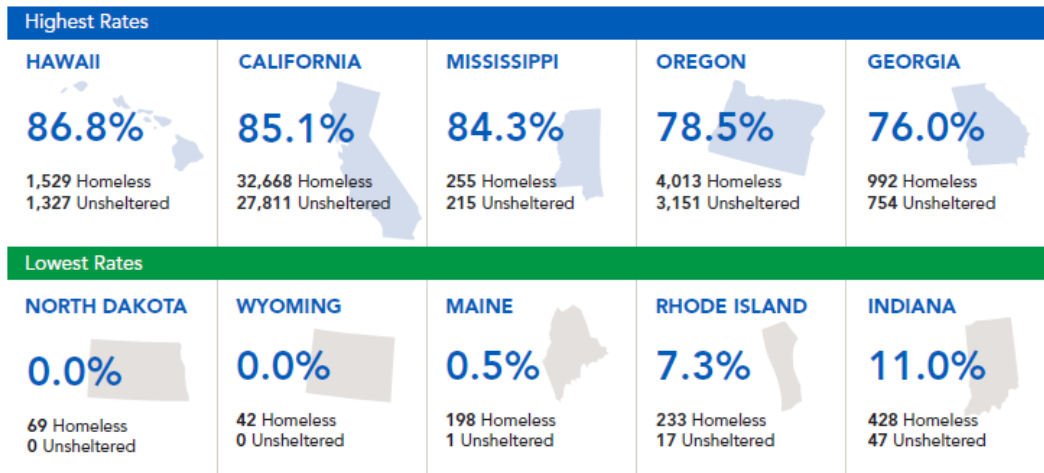


EXHIBIT 6.4: States with the Highest and Lowest Rates of Unsheltered Chronically Homeless Individuals
2018



Please contact us with your thoughts, possible program ideas, potential partnerships or connected individuals based on the information presented above.

Unemployment

Portland, Oregon Unemployment History

Date	National Unemployment Rate	Oregon Unemployment Rate	Portland Unemployment Rate	Portland Unemployed
December 2018	3.9%	—	—	—
November 2018	3.7%	3.9%	4.0%	53,177
October 2018	3.8%	3.8%	4.0%	53,293
September 2018	3.7%	3.8%	3.8%	49,836
August 2018	3.8%	3.8%	3.6%	47,837
July 2018	3.9%	3.9%	3.6%	48,189
June 2018	4.0%	4.0%	3.7%	48,613
May 2018	3.8%	4.1%	3.7%	48,567
April 2018	3.9%	4.1%	3.8%	49,631
March 2018	4.0%	4.1%	3.7%	49,059
February 2018	4.1%	4.1%	3.6%	47,979
January 2018	4.1%	4.1%	3.6%	48,160

Appendix A: Healthy Columbia Willamette Collaborate

HCWC Prioritized Core Issues

Overview:

The Conveners collected feedback from HCWC Data Workgroup members and their external partners through a survey about the 10 Core Issues which were identified for the CHNA. After review of the feedback received and assessment of the underlying data supporting each Core Issue, five Core Issues were prioritized.

Top 10 Core Issues:

The identified Core Issues are listed in alphabetical order:

11. Access to: Health Care, Transportation, and Resources
12. Behavioral Health (Depression and Intentional Self-harm)
13. Chronic Conditions (Heart Disease, Diabetes, Hypertension)
14. Community Representation
15. Culturally Responsive Care
16. Discrimination/Racism
17. Isolation
18. Liver Disease
19. Sexually Transmitted Infections (Chlamydia and Gonorrhea)
20. Trauma

Prioritized Core Issues:

- Behavioral Health
- Community Representation
- Culturally Responsive Care
- Isolation
- Sexually Transmitted Infections

The prioritized Core Issues were chosen because they were identified as key gaps in the region by both HCWC Data Workgroup members and external partners. The underlying data also suggests these Core Issues are not being adequately addressed and there is significant room for improvement across the region.

The Core Issues of Discrimination & Racism and Trauma also rose to the top through the prioritization process but are more accurately reflected in the CHNA as drivers/influencers for each of the prioritized issue above.

The Core Issues of Access to: Health Care, Transportation and Resources, Chronic Conditions, and Liver Disease, were not prioritized as they were not identified as a key gap in the community.

Listening Session Preliminary Report: African Americans in Multnomah County

When: November 17, 2018

Population: African Americans with Housing Concerns in Multnomah County

Location: Butte Hotel Rec Space

Total session participants: 19

Summary:

What makes their community healthy?

Participants described a healthy community as a diverse group of people living together, where everybody knows each other, and neighbors look out for each other. In a healthy community all resources are accessible even for residents without a car, and there are recreation centers and programs for kids to be involved in. A healthy community contains positive role models and events where neighbors can get to know each other. Participants also described the importance of a career, and the ability to save for retirement.

What is their community doing well?

Participants felt that the black community is incredibly resilient, and able to withstand the change that has happened in their community. Community members mentioned a park in North Portland that they use to gather and hold community events. They also saw improvement in the opportunities and resources available post-incarceration.

What could their community improve?

Participants felt that there needed to be a more level playing field with access to resources, as well as repairing what they perceive to be loops of frustration and lack of opportunity due to promises of help that do not come through. Overall, they wanted to see more black-owned businesses, more support and trust amongst their fellow community members, better access to health care and mental health resources, more programs for youth, and more diversity in their community.

Top emergent themes:

1. Community-led resources:

Participants expressed a desire for more community-led resources as well as more members of the black community in positions of leadership and education. Not only did participants desire more black community members to be role models for the younger generations, they also wanted more black-owned businesses to be formed and to invest in the black community. The resources and concerns that participants expressed a need for were food deserts and education about diet and lifestyle, more black-owned businesses such as grocery stores and clinics, more peer support specialists, more mental health services, continuing education, culturally-specific resources, and after school programs for inner city youth.

"I would like to see us as black people work together as a race that is proud and strong that wants to build."

2. Discrimination:

Participants described experiencing discrimination, racism, and prejudice in all facets of life, but especially emphasized its impact on employment opportunities and their experience in their neighborhoods. Participants described examples in their places of work where discrimination kept them from advancing or being promoted, and expressed that workplaces prioritized white employees and believed that organizational goals of diversity are just for show. Participants also described feeling discriminated and profiled by the police and feeling unwelcome in certain communities, especially in their own neighborhoods. Participants expressed that prejudice within the black community was a concern, and there was a perception of being viewed negatively and unfairly stereotyped by fellow black community members, and this was a reason why black people are not hired by or receiving help from black-owned-businesses in the area.

“I’m experiencing a lot of discrimination and bias. All the whites help their race move up and get bigger and better positions.”

“I thought that diversity was important, but now I see that’s a cover up – yeah, let’s hire a few blacks, let’s hire a few trans people – but they basically deny you from moving up.”

3. Lack of Community:

Participants expressed that their community felt closed off and that people lacked the trust and the willingness to help each other. There was a consensus that more individuals in their community needed to believe in the impact they could have and get more involved to strengthen their community. Participants felt that successful black community members left to live in other areas, such as Atlanta, rather than reinvesting in the Portland community. They also felt that black-owned businesses in the Portland area distance themselves from the black community. They felt that black youth were more likely to be involved in gangs than in school, and this could be partially attributed to a lack of programs, resources, and role-models to keep them engaged. Many participants referenced a shift in the black community that they had seen in their lifetime: their emphasis on community used to be strong and they felt they had a collective voice, and this has since faded.

“I’m 63. I’ve seen a lot of bullshit all my life. This is the second time I’ve been here. We are the hardest race in the world to work together with each other. We talk a good game, but we do nothing. All this will be forgotten in 2 hours. Black people working together is a healthy community. We haven’t come together since the day they took us off the avenue. We’ve been fighting each other since.”

4. Gentrification:

Participants explained how gentrification has wiped out black-owned-businesses, and the black-owned businesses that remain often do not acknowledge or give back to the black community. Participants expressed a loss of their neighborhoods, and expressed feeling pushed out of their community in N/NE Portland and pushed into the outskirts of Portland. They shared with the group that they used to have so many activities in their neighborhoods to keep them involved with their neighbors, as well as many black churches where they could come together. Now participants expressed being a part of neighborhoods, workplaces, schools, and communities where there are only a few black people and little diversity. They feel like they now have limited access to housing security, job security, and other opportunities.

“The community I was born and raised in is NE/N Portland, from Greely all the way to Broadway and to 82nd Ave. We were raised in this area, this was the area we lived in our whole lives – it’s now gone. It’s not healthy to have these communities gone ... Everything is gone. All the black people don’t live here anymore.”

Listening Session Preliminary Report: Pacific Islanders in Multnomah County

When: November 26, 2018

Population: Pacific Islanders in Multnomah County

Location: APANO/PI Coalition

Total session participants: 16

Summary:

What makes their community healthy?

Participants described a healthy community as one in which all people have access to affordable housing, healthy food, employment, and exercise. In a healthy community, people respect cultural traditions and work together to empower their community. A healthy community is supportive, family oriented, educated, and spiritual.

What is their community doing well?

Participants appreciate the Community Health Workers (CHWs) that work in their community and feel they serve as an excellent bridge between community members and the health care system; however, they wish there were more CHWs available. There are also certified interpreters and groups such as APANO that provide culturally competent services. Participants feel that the Pacific Islander community is slowly beginning to be recognized, which is a positive improvement. Another asset to the community is the existence of Utopia PDX, a space for queer and trans Pacific Islanders. Community members explained how identifying as a Pacific Islander and LGBTQ person can be isolating and lead to a disconnect from Pacific Islander culture, therefore having a space such as Utopia PDX has been a tremendous resource.

What could their community improve?

Participants felt that there needed to be more accountability for decisionmakers in the government, more transparency about where money goes, and more trust between decisionmakers and community members. They felt that more people and organizations outside of the Pacific Islander communities should get involved with the community; not only in terms of offering them more funding, but providing more services than just translation services that are at a reading level too high for the community. The group desired more community forums to create space for engagement and wanted the counties to provide them with the resources and funding to be able to help themselves.

Summary:

1. Cultural Competence:

Participants expressed a need for more Community Health Workers and interpreters to provide services for all the different Pacific Islander communities that reside in the area. They desired improved translations, with translation extending to prescription bottle labels and translations accessible at a 5th grade reading level. Participants expressed the importance of empowering community members by enabling them to communicate in their language and to express their culture. This empowerment is particularly important for the elderly and for people who have immigrated and may need a translator to communicate their needs. Participants also desired cultural investment beyond simply providing translation services, including outreach by the healthcare system to help shift the mindset of many Pacific Islanders who need help understanding the culture of medicine in the U.S. Participants discussed examples such as the common belief in their community that the hospital is where you go to die, as well as avoiding primary and preventive care for fear that going to the doctor may reveal unknown health concerns.

2. Representation:

A lack of representation was discussed among participants, who felt that current policies were often outdated or misinformed due to inaccurate data. Participants explained that the data could be improved with better representation, and that current policies serve as barriers. They discussed the need to establish institutional solutions, and desired shared power in decision making. Participants would also like to see greater youth representation, and to have more youth involvement in organizations.

3. Education

Participants desired increased education about healthy lifestyles, as well as support for maintaining a healthy lifestyle. Participants explained that parents want to be knowledgeable about prevention and insurance, but they often don't know what questions to ask. Additionally, there are language and immigration barriers, and many adults must rely on their children to translate for them. Participants feel that greater education is needed regarding immigration, because many community members are undocumented and do not seek

services when they need them for fear of deportation. Education is also needed regarding the purpose of hospitals and preventive care, as participants explained that currently their community views doctors and hospitals as a place to go when you are dying, not as a place to go for preventive care.

4. Accountability and Trust

Participants feel there is a lack of trust between community members and decision makers, and they believe increased accountability is needed to build trust. Participants would like to see changes and results within their community, rather than more reports. There is a perception that money is not being spent the way that it should be spent, and participants feel that there should be a mechanism to hold the government and hospitals accountable for how they spend money. Participants also noted a lack of follow-through at past listening sessions and expressed a desire to see that information shared back to their community.

“We need to build the capacity for us to advocate for ourselves”

5. Connection between health and culture

Participants want to see their traditional values more incorporated into the dominant healthcare culture. For example, two-way communication between doctors and patients to enact the belief that everybody brings their own wisdom; and more acknowledgement of traditional health practices and community members cultural wisdom surrounding wellness. Participants suggested utilizing the Pacific Islands’ cultural traditions of story-telling to encourage healthy behaviors and healthy eating habits within the community. It was emphasized that the many cultures of the Pacific Islands are more collectivist; for participants, the health of their community is directly tied to establishing harmony between their interpersonal connections, environment, food culture, and cultural traditions.

“We need to go back to warrior spirit and push past prejudice, racism, discrimination”

“To be strong is to feel the connections and support each other through things happening with children and with jobs. To have people stand by you and understand what you are going through is what is critical to health.”

Listening Session Preliminary Report: Latino Population in Multnomah County

When: November 27, 2018

Population: Latino population

Location: Shaver Elementary School

Total session participants: 14

Summary:

What makes their community healthy?

Participants feel that their community is healthy when kids are playing outdoors and have access to healthy activities, when the community is clean, when they feel safe to go to school and be out in their neighborhood, when the crime rates are low and apartment management is equitable, and when everyone has access to health insurance.

What is their community doing well?

Participants feel their community does well with encouraging kids to be involved with community activities, particularly when those activities were promoting healthy behaviors. Examples included gardening, picnics, and healthy eating education. Participants also appreciate how some schools, such as Shaver, are making an effort to be culturally specific and inclusive. Participants noted how their community has been supported by programs that offer assistance or classes, such as Medicaid, Programa Hispano, Latino Network, SnowCap, the library, churches, and assistance with food and rent offered by schools.

What could their community improve?

Participants felt that their community needed improved access to health care and resources that are integral to maintaining health, such as healthy food, activities, and opportunities to voice their concerns. Participants

also felt their community was facing increased stress from a perceived lack of safety and experiences of racism and discrimination. The community desired greater support for establishing and maintaining healthy behaviors within their families.

Top emergent themes:

1. Access to Resources:

Participants lacked access to basic resources necessary to maintain a healthy community and life, this included assistance in finding employment, legal support, accessing comprehensive women's health screenings, health fairs, culturally-specific resources, and more resources to help them cope with stress and depression. Participants desired classes that could teach healthy cooking and how to eat a balanced diet, particularly for children and families. One area of concern was the lack of healthy food options provided to children at school – they felt that the schools needed to provide food options that emphasized fruits, vegetables, and encourage better hydration. Participants noted the lack of exercise classes and family-centered activities that could include the whole family, such as Zumba classes held in a park.

2. Access to Care:

Participants felt they lacked access to information and services that are important for their health, such as mammograms, pap smears, colon cancer screenings, and diabetes. They desired opportunities to learn more about mental health and wellness, with an emphasis on stress, depression, and anxiety. Participants wished more health fairs, providing free screenings, were offered. They also explained that mental health counseling needs to be available for the whole family, including having mental health counselors at elementary schools for children whose parents do not have insurance. Counseling for other issues, such as drugs, alcohol, tobacco, or other addictions, was also cited as a need among community youth. Additionally, participants discussed the need for more appointment availability at doctors' offices to allow for back to back scheduling for families with multiple children.

3. Racism and safety:

Participants noted how racism and racial profiling are detrimental to the health of their community. They discussed the difficulty in finding housing as a Latino family, being denied housing due to their race/ethnicity or receiving unfair treatment from building management. As a result, participants often don't feel that it is safe for their kids to play outside and they expressed feeling wary about interacting with their neighbors. Participants also felt distrustful of law enforcement, citing racial profiling and negative interactions their community has had with the police. Participants described their fear of the police and racial profiling as a large contributing factor to their community's health and feelings of unsafety. Safety is a concern for participants, who discussed an inability to exercise outdoors or let their kids play in the park, not only because of fear of deportation and racial profiling, but due to other factors such as the large amounts of trash in their neighborhoods, vandalism, and drugs present in their community. Participants discussed how the issue of homelessness intertwines with these factors to create an atmosphere of neglect.

4. Support for Families:

Participants discussed a need for increased support of family needs, including the needs of both children and adults. Stress was identified as a major issue within families, and participants expressed that marriage counseling or classes for new parents could help to reduce that stress. Participants described the need to extend the classes and workshops that aid with interpersonal and psychosocial stress to their children, such as classes to teach kids how to handle bullying or learn about substance abuse prevention. Participants also identified the need for affordable childcare, which is not something that is currently available for many families. There was a consensus among participants of a need for more family-friendly activities, such as classes to help them grow their own food, community gatherings in public spaces, more opportunities for free physical activities, and activities that provide their kids with opportunities to immerse into the dominant U.S. culture.

Listening Session Preliminary Report: Veterans in Washington County

When: December 1, 2018

Population: Veterans & Spouses of Veterans

Location: VFW Hillsboro

Total session participants: 10

Summary:

What makes their community healthy?

Participants described a healthy community as one in which people worked together to solve issues, even if they shared different views on the problem. A healthy community has houses and streets that are well-maintained, and neighborhoods that are safe for walking around. The community members in a healthy community have healthy social lives as well as physical health, and they can afford groceries and housing.

What is their community doing well?

Participants appreciated many of the organizations that work on behalf of the community, and veterans, such as VFW. The Portland VA was highlighted as a helpful resource for mental health, however it lacked sustained support for older veterans. Participants also emphasized the positive impact of organizations that are not government affiliated, such as the Boys and Girls club, and voiced support for tax-funded community organizations. Participants also appreciated the way that transit officers deal with situations involving individuals with mental health issues or drugs in their system. Participants referenced how transit officers do a good job of interacting with these individuals without escalating the situation.

What could their community improve?

Participants want more support for veterans, more tax money for programs, and believed there needed to be a better enforcement of immigration and drug laws. They think that politicians should be held more accountable, specifically by holding town halls outside of election years. Participants wanted education reform with a stronger emphasis on English-language curriculum and Civics. They wanted their community to be able to more openly express their opinions, and that there needed to be a shift in policies so that community members who rely on benefits (OHP, SNAP) are held more accountable. Participants felt that a large stumbling block of community health was keeping Portland, and the state of Oregon as a sanctuary city/state.

Top emergent themes:

1. Addiction and Homelessness

Participants discussed the need to proper support to end the cycle of drug addiction and homelessness. Participants believe that most people who are homeless also suffer from addiction issues, and although there are programs that offer help, the services are often designed as a one-time intervention rather than on-going support. Participants feel that support systems need to be more holistic and comprehensive in order to help people overcome addiction and homelessness, emphasizing the addiction is a disease like any other. The participants felt that current drug laws were not being properly enforced, and not only does this exacerbate the housing crisis, but they felt that it was a conflict of interest for the U.S. to continue to support and provide aid to the countries whose cartels are providing and selling the drugs that are causing the issues. Additionally, participants believe that the government needs to think more strategically about how to pay for affordable housing, which they feel is sorely missing from their community.

2. Lack of education:

Participants feel that the education system is lacking and contributing to poor health conditions. A major concern that was discussed is the perceived neglect of teaching English in school in favor of teaching other languages, such as Spanish. Participants explained that English is a vital tool for a successful life in the United States and believe that schools should focus on English to bridge the gap between cultures. Another area of

education that participants felt was lacking was Civics, both local and national. Participants discussed how schools no longer teach about the Bill of Rights and the Constitution, and that schools no longer adopt a view of American pride. Participants also felt that education for children should have more of an emphasis on good manners, empathy, and religion.

3. Threats to community values:

Participants referenced a lack of manners and empathy that they believe is contributing to the poor health of their community. There was discussion about a lack of care and compassion, as well as feeling that some members of the community were not graciously accepting what was being offered to them. Discussing immigration, participants explained that all Americans are immigrants, but they believe that immigration law and sanctuary cities are too lenient, and that the current immigrants should work to assimilate to America rather than expect America adapt. They desired a return to religious values, of any religion, to inspire compassion and morality. Participants felt that all individuals should be held accountable if they are provided with government benefits, such as SNAP or OHP. They viewed this accountability as giving back to the community in some way, through volunteering or working.

"This country was created because the people who came here were suppressed in the countries they came from. The people that come here now want to change our country to their country.

Different traditions that families continue to have but they don't push them on anyone else. I want to give immigrants credit -- they take care of elders/family and we don't as Americans. If we were families and took care of families, our health care costs would go down."

4. Representation

Participants feel that their views and concerns are not being taken into consideration, and that the government only cares about minority populations, to the detriment of the majority. Participants feel that they have worked hard and contributed to society, and yet their needs as members of the majority population are being ignored. During this discussion, participants referenced Town Halls that have been held with politicians. Participants explained that veterans are not chosen to ask a question during these Town Halls. Overall, participants believe that all Americans should have the right to express their opinions and to be listened to.

Quotes from the session:

"I don't believe the community is healthy at all right now."

"We can't solve national conflicts at the neighbor level, but we can start at that level."

"Envision a world where everyone can work with each other."

"It's not a privilege to be an American, it's an honor."

Listening Session Preliminary Report: Latino Population in Washington County

When: November 13, 2018

Population: Latino

Location: Virginia Garcia Memorial Health Center

Total session participants: 17

Summary:

What makes their community healthy?

Participants described a healthy community as one with a foundation of trust, where everyone is happy and making progress in their lives. A healthy community has low crime rates, no violence, and has many opportunities for families to be active and come together. To have a healthy community, people must feel free to express themselves and be polite and engaging with one another, and they must have resources available to them to help meet all their needs.

What is their community doing well?

Participants described their community as having very strong community leaders; they observe many people taking care of others who are not able to drive or need other assistance and highlighted the seniors in their community as good leaders. They appreciated the programs offered by Adelante Mujeres, classes at Virginia Garcia to help people stay active, and the food assistance provided by churches, cultural centers, and local food banks. Participants gave many examples of resources to help their community be food secure and healthy, such as nutrition centers, health vouchers, low-income assistance, immigrant programs, and assistance at schools.

What could their community improve?

Participants described feeling like their community is unhealthy: many are sick or suffering from chronic conditions. They do not feel a connection with their neighbors or community members, and they desire developing a greater trust in their community. They feel there is a lack of understanding on the resources available, as well as language barriers and other cultural barriers to accessing them. Participants noted the inequality in the services people are able to access, and felt that their community members – seniors, especially – needed better advocates in the health system. Participants are also concerned about children’s health and the technology available to them.

Top emergent themes:

1. Access to resources and food security:

Participants desired spaces where they could come together and learn about issues of concern in their community, as well as spaces where they can exercise or learn new skills. They felt positively about the resources available through the school systems to help connect their children to services and programs but desired more youth-focused workshops for them to participate in outside of school. Overall, there was a desire for free indoor recreational areas to exercise and be physically active in the winter time. Participants describe feeling food insecure despite the current resources available to them, such as churches, cultural centers, and food banks. They want to eat healthy and incorporate local produce when possible, but often must choose less nutritious foods because they are cheaper. Transportation was also cited as a large issue to accessing health care, especially due to concerns that the time spent getting to the appointments would mean a loss of a whole day’s pay. Most of the income gets spent on paying their rent and their utility bills, and they desired more financial assistance to help them with these costs.

2. Community support:

Participants emphasized the importance of community members supporting one another to make sure they get their needs met and believed that trust between community members is crucial to their health. They desired to become more involved in their schools, churches, workshops, and cultural centers because it would help them stay connected to others and share resources and information with one another. With community support, they can stay healthier by exercising together with their neighbors and children and can hold each other accountable. They wanted to see more of their community members volunteering, communicating better, asking for help, and sharing mental health struggles with one another.

3. Family concerns:

Participants described a multitude of concerns they are trying to navigate to keep their families happy, healthy, and safe: worries about insurance access, care for seniors, communication between parents and children, long work hours that keep families apart, bad influences on children, diabetes, depression, illness, and overuse of technology that harms their children’s development and performance at school. Participants were very concerned about the technology available to children in their community, and desired to better understand internet and social media so that they could better monitor what their children were exposed to. A large barrier to monitoring their children’s cell phone and internet use is not understanding how to operate parental controls and parents who are absent because of their work schedules. They desired ways to get their children involved in the community, such as more youth-focused groups and workshops for them to participate in. Overall, they wanted more resources to help them address bullying, sexual abuse, self-harm, substance abuse, and safety concerns with their children.

4. Cultural barriers and discrimination:

Participants described inequities due to language barriers, both in terms of navigating the healthcare system as well as seeking out services and assistance. They felt like there were not enough advocates and interpreters available who could help them access and apply for services. Participants described feeling uncertain about U.S. laws, and desired to have resources to help them learn English. A barrier to accessing services was not having a Social Security Number, which participants felt hindered their access to economic opportunity. Participants felt exploited by businesses who give them the worst jobs because they are “illegal,” and they described being denied the ability to leave work for appointments or care for their children when they are sick. Due to immigration status and lack of opportunities in the Latino community, they often must get by on only one income.

Listening Session Preliminary Report: Rural Youth in Clackamas County

When: December 5, 2018

Population: Rural Youth in Sandy, Clackamas County

Location: AntFarm Cafe

Total session participants: 10

Summary:

What makes their community healthy?

Participants described a healthy community as one where everyone cooperates with each other and is self-sustaining. A healthy community is one where the town takes responsibility for its community members, keeps towns clean, has schools with appropriate curriculum, plentiful resources, and people are well informed and do not treat others differently because of race, ethnicity, sexuality, gender identity, or lack of opportunity. Participants felt that the most important feature of a healthy community are different groups of people working together to achieve common goals.

What is their community doing well?

Participants felt that their community has many thriving local businesses, and that many community members are working together to improve the community. They described partnerships between Sandy AntFarm Youth and AmeriCorps as a community strength, and appreciated the free lunch and dinners hosted by local churches to engage diverse groups of community members in dialogue. Community center outreach programs, food provided by the Action Center, and native council meetings where people come together to solve issues were also highlighted.

What could their community improve?

Participants described racism and prejudice as hindrances to the health of their community; social media was a barrier to these concerns, with participants describing that the majority of people use it in a vacuum and don't engage with people who have different viewpoints and identities. Overall, participants felt that their community needed to increase their engagement and communication across subgroups to help bridge the assumptions that lead to racism and prejudice. Participants also expressed the need for more jobs to be available, an improved educational curriculum that is more comprehensive, as well as better understanding of how Sandy's government works.

Top emergent themes:

1. Community cooperation:

Participants emphasized community cohesiveness and cooperation as the key to improving their community and felt that Sandy could benefit from more communication on all fronts. Isolation between different groups of people with opposing viewpoints or different identities was a common source of tension, and community members believe that this exacerbates inequalities and mistreatment of community members and must be rectified by creating a culture of openness and willingness to learn about other sub-groups. Overall, participants felt that their tight-knit community should

encourage more activities, and that people should think more critically about the cons of closed-off groups and strive to be more open when interacting with people whose identities challenge viewpoints. Participants described different methods of communicating in sub-cultures that they belonged to, and desired for these practices to expand into the larger community.

[Social media] “expands on itself and gets out of control...no one challenges you because everyone agrees with you.”

2. Misinformation and poor education:

Participants are very concerned about the misinformation being disseminated in their community. They emphasized how important it is to have a well-rounded education, and that includes formal education curriculum as well as more access to reliable sources of news instead of propaganda that misleads people about sub-communities. Social media was a barrier to interacting with communities (both internet communities and their local community), because it removes the challenge of communicating with people who may disagree with their viewpoints. They believe that the educational system needs to be improved to meet the needs of youth who will soon need skills to help them as adults: financial knowledge, sex education, home economics. They addressed the misconception that schools expect that parents are supposed to teach these skills to their children, noting that this is often not the case, and students would be better served if they had more resources at school to help them navigate the real-world responsibilities of adulthood.

“We’ve been having an issue...kids are graduating high school with not much financial knowledge, no sex ed, and they don’t know what they want to do...but at least they know the quadratic formula!”

“Kids who don’t know how to grow up. They assume parents will teach that, but there’s a flaw: some people don’t have parents.”

3. Racism and prejudice:

Participants described racism and prejudice in their community as hinderances to the health of their community. Participants noted that not only do they struggle with discrimination based on skin color, but also because of ethnicity, age, gender, and sexuality. As mentioned above, community members envision more communication as a solution that could bridge the gap between different sub-groups of people. Participants described that white community members often cannot see the racism within their community, and that those who are racist are often speaking out online and not in person, as that platform amplifies their voice. Many participants experienced racism and discrimination in the work place and described feeling as if their identities negated their viewpoints in other community members’ eyes.

[On racism] “Just because you don’t see it, doesn’t meant it’s not happening.”

“Racism and prejudices from childhood are a hard boulder to move.”

4. Access to resources:

Participants desired more resources that would aid them in finding jobs, working and cooperating with their community members, and establishing better communication between sub-groups. Overall, they felt that the resources available to them were not always known by community members and did not feel they had sufficient resources to help them obtain their goals. They wanted more community center outreach programs to encourage healthy behaviors, which they acknowledge that programs are already aiming to improve upon. They appreciated services that allowed them to access food, such as Action Center as well as free food offered by the schools, but they expressed concerns that these programs are abused by people who are food secure, and that programs like these could lead to many people depending solely on the resource.

[On resources available] “It’s hard to answer this because we don’t know what we have to begin with.”

“I wouldn’t have had Thanksgiving if it wasn’t for the Action Center.”

“I personally go to the Action Center because I need food...it’s an annoyance to watch the food be carted away by people who have fridges full of food – they eat just a little bit and then toss it as if it’s nothing.”

Listening Session Preliminary Report: Elderly Rural Population in Clackamas County

When: December 5th, 2018

Population: Elderly (65+) Rural

Location: Estacada Community Center

Total session participants: 6

Summary:

What makes their community healthy?

Participants felt that a healthy community included family, good schools, and safety. They described a healthy community as one that supports individuality, as well as supports each other with homegrown food and a local workforce. Participants cited transportation and access to health care as critical components to a healthy community.

What is their community doing well?

Though isolated from many resources, the number of medical clinics and providers available in Estacada has increased in recent years. Participants expressed positivity towards the natural beauty of the environment as well as community features, such as the library and the skate park.

What could their community improve?

Participants expressed a desire for greater civic engagement among community members, a stronger focus on community development and infrastructure, and more opportunities for community involvement and support. Participants discussed how younger generations leave Estacada due to lack of opportunity, and people who are new to the area do not seem to share the same values. Participants would like to build a stronger sense of community among the people who live in, and support, Estacada.

Top emergent themes:

1. Decision Makers:

Participants discussed at length how the dominant population and politics of Portland shape laws, policies, and what the state focuses on. They felt that Estacada, as well as other rural communities, do not see their interests and needs reflected unless they align with Portland's. There was an emphasis on communities making their voices known, both through voting and social media, to influence decisionmakers on both the local level and the state level. Participants noted that, for example, money the community had tried to raise for a community swimming pool was funneled into other projects by decisionmakers without consulting community members.

2. Access to Care:

Access to health care was a large barrier to health for participants – while they noted that Estacada now offers better medical care than it had in the past, many services are not available in their remote area. The community lacks the resources to help people with medical assistance, such as getting to medical appointments, and they emphasized that if they required specialty care or critical care their options in Estacada are very limited. Even when services are available in Estacada, they require a vehicle to get to them, which further isolates community members who are not able to drive or do not have transportation. Overall, participants need transportation and clinics to better bridge the gaps.

One participant shared her experience of attempting to find in-home care for her husband at the end of his life. They could not find care givers who were willing to drive that far out to Estacada care for him, and the only aid they received was from an Adventist clinic that came out for one hour to show them how to change sheets while the patient was in the bed – tricks they later could not remember. Her and her daughter ended up being her husband's caregivers because they had no other option.

3. Community Support:

Participants discussed the need to build a stronger sense of community and emphasized the power of community centers and schools to create a supportive community. Participants spoke about the

importance of families being engaged in community activities. They believe it is not enough to offer sports at school, and that by emphasizing family-activities like the town used to have (dance halls, movie theater, bowling alley) more families will choose to stay in Estacada. Participants also expressed interest in hosting workshops to expand community members skills like computer classes and using cell phones.

4. Infrastructure:

Participants noted that the reason many people leave Estacada is to access resources, community services, social connections, job security, education, and healthcare. Participants expressed a need for more affordable grocery stores, more programs and extracurricular activities for children, community centers, and more business development to keep people in Estacada. Participants noted that outsiders emphasize the beauty and scenery that surrounds towns like theirs, but do not invest in the community's wellbeing or fund community development and infrastructure. Participants discussed the changes in the lumber industry that has historically supported their community, and how multiple businesses have closed due to unaffordable rent. Participants believe that investing in businesses, particularly family-oriented businesses such as a movie theater and bowling alley, would encourage economic growth in Estacada. Participants also discussed the need for infrastructure changes regarding the roads and transportation system. They referenced streets that are too narrow for cars, inadequate parking, and a lack of public transportation available for individuals without personal vehicles.

Listening Session Preliminary Report: People in Affordable Housing in Washington County

When: December 7, 2018

Population: People in Affordable Housing

Location: The Knoll

Total session participants: 10

Summary:

What makes their community healthy?

Participants described a healthy community as a community that is safe, has affordable housing, a sense of community and connection among residents, and affordable resources nearby.

What is their community doing well?

Participants appreciate the resources available within their community, such as the close proximity of the senior center, the friendliness of building management, the availability of public transportation, and the amenities offered through affordable housing programs.

What could their community improve?

Participants felt their community could be improved by having improved transportation and access to resources. They often feel priced-out of participating in community events and feel socially isolated due to a lack of safety in their community. Participants also emphasized the need to address housing issues for individuals experiencing homelessness.

Top emergent themes:

1. Transportation:

Participants described their issues and needs concerning transportation as two-fold: On one hand, they were concerned about the noise and safety issues caused by traffic, construction projects, and inaccessibility of sidewalks and safe walkways. On the other hand, they desired more communal transportation options as many of them did not drive on freeways or did not have access to cars. Participants wanted more places to be accessible by foot, particularly grocery stores, farmer's markets, and community events, and felt that people living in their community without a car were socially isolated and unable to access a lot of what their community has to offer.

"[I] have a car but don't get on the freeway, so can't go to things that you have to go on the

freeway to get to."

2. Access to affordable resources:

Participants felt that there needed to be more grocery stores within walking distance, more resources to help them exercise, and greater access to community events and communal transportation. While they acknowledged that there were a lot of resources in the area, such as yoga, Pilates, tai chi, and senior centers, these services were not affordable to community members. Participants emphasized that they do not expect every service to be free, but that there should be more opportunities for income-based sliding scale payment options so they are not so excluded from participating. Participants felt that, without a car, their access to healthy food was greatly reduced. They also expressed a great need for affordable dental care in the area as well as better access to affordable insurance.

"Even the senior center costs."

"Don't mind paying a bit, but I don't want to be priced out."

"You have to be missing so many teeth before they will provide dentures. Dental care is ridiculous."

3. Housing Concerns:

Housing and homelessness were discussed at length by the participants, who acknowledged how hard it was to maintain housing due to the high costs of rent and stagnant wages, as well as very high utility bills. Fear and safety concerns due to homeless individuals in the area was expressed, but participants also expressed understanding for how easy it is to become houseless. Crucial to community health is to prioritize affordable housing and assistance with utilities as well as reduce the wait time it takes to get access to the affordable housing. One participant told the group that they were waitlisted for affordable housing for over three years.

"If it's not affordable, what kind of good health or life are you going to have?"

4. Safety:

Participants described safety as one of the most important building blocks of having a healthy community. They described concerns about homeless individuals committing crimes in the area, concerns about sex-trafficking, feeling unsafe in their apartment complex, not having enough funding in their community to take the steps needed to make people feel safer from violence (more law enforcement, security cameras, safer housing options). Environmental safety was also an issue of concern, with many mentioning the poor air quality and diesel fumes as factors that impact health. Participants also discussed feeling unsafe on the roads or walking due to a lack of sidewalks, traffic, and icy conditions in the winter.

"People drive like they are on fire and it's scary."

Listening Session Preliminary Report: Latino Farmworkers in Clackamas County

When: November 16, 2018

Population: Latino Farmworkers in Molalla

Location: Plaza los Robles

Total session participants: 10

Summary:

What makes their community healthy?

Participants describe a healthy community as one that works together and is united, with family, neighbors, and coworkers that respect each other. For a community to be healthy, there need to be easily accessible clinics and resources for mental health, healthy eating, and preventive health. Providers should be available and local, and everyone should have access to insurance that makes appointments affordable.

What is their community doing well?

Participants felt the resources in the community, including parenting classes, busses to Woodburn, Latino-specific activities, afterschool homework help for kids, programs to help pay utility bills, access to food, purchase gifts and school supplies for children, and church community service programs are assets to the

community. Specific resources mentioned as assets were: OCDC, Todos Juntos, the Catholic church, food banks, Salud Clinic, and the migrant program at the local school.

What could their community improve?

Participants noted the cost of health care is too expensive, and the community needs more low-income clinics, Spanish-speaking providers and language services, and access to dental care, and better transportation. Overall, they felt their community could do a better job of exercising, eating well, providing youth resources, and utilizing preventive services. Language barriers, racism, youth marijuana use, and discrimination were all mentioned as barriers to the health of the community. Participants noted that a census to gauge community needs is useful in Mexico and could be implemented in their community, and that the community needs to be more involved and assist one another.

Top emergent themes:

1. Access to services:

Participants discussed lacking access to medical services due to transportation and financial barriers, noting the high costs of health services, few low-income clinics, confusion navigating and obtaining insurance, and lack of access to dental care. Overall, to improve access, participants said they needed more mental health clinics, providers, dentists, vision services, and better and affordable comprehensive insurance options to help them access resources already available. They explained that the limited number of medical clinics available in Molalla were further limited due to high costs and language barriers. Many participants expressed frustration that they earned too much money to qualify for the already-existing low-income clinics but were still unable to afford medical services without insurance. Participants desired more information on preventive health, and more medical clinics providing a full spectrum of services in one easily accessible hub: medical, mental, and dental health. Many participants do not have a Social Security Number or ID that is required to get assistance and referenced the lack of Spanish speaking services in Molalla to help them access what is available to them without this identification. Participants referenced feeling geographically isolated; Woodburn is the closest available resource hub to Molalla and they often must travel there to meet all of their needs.

2. Language barriers:

Language barriers, and a lack of translators, were cited as significant barriers to health among participants. Participants described getting turned away by providers because they require Spanish-speaking services; noting that language barriers make everything more difficult, from accessing dental care to going to the bank and managing finances. They discussed an inability to be treated at clinics due to providers in Molalla not speaking Spanish, expressing that it was extremely difficult to communicate their concerns. They described difficulties resolving issues with their children at school because they don't have access to interpreters for parent teacher conferences and other meetings and often must heavily rely on their children to be their interpreters.

3. Discrimination and stress:

Participants discussed experiencing significant stress, often because of racism, discrimination, and feelings of exclusion from the community due to language barriers. Participants feel unwelcome in establishments where they are unable to speak the language, and specifically felt that they were often turned away by healthcare providers because they were discriminating against the Hispanic/Latino community, as well as those without insurance. Members described feeling stressed that they didn't have close access to emergency services in Spanish and would need to travel very far if there was an emergency and they needed critical care. Overall, they felt their health and wellbeing was at risk due to their geographic isolation from resources and services available in Spanish. Participants also expressed concern about their children, and not feeling connected to their children's lives at school. They worried that their children could be dealing with mental health issues, bullying, or drugs, and that the parents would have no way of knowing.

4. Healthy lifestyle and education:

Participants desired more education about preventive health services, healthy eating,

and healthy exercise habits. Conversely, participants felt that Latino/Hispanic community members weren't utilizing the resources they already had available to them, perhaps due to not being aware of what was available. They also felt their community lacked access to healthy food options and grocery stores, which was a hindrance to the health of their community. They wanted better resources and healthy outlets for the young members of their community, who they felt needed interventions for marijuana use and drug addiction and more access to healthy activities. Participants discussed the need for more youth-oriented activities. They explained that many youths in their community are involved in drugs, and that there are no activities available to them other than hanging out in the park. Participants believe there should be resources like creative centers, soccer fields, and summer programs to engage the youth of their community in positive activities.

Listening Session Preliminary Report: Arabic Population in Washington County

When: November 30, 2018

Population: Arabic population

Location: Beaverton

Total session participants: 9

Summary:

What makes their community healthy?

Participants describe a healthy community as one where all community members have a healthy lifestyle, community support, access to preventive and mental health care, are housing secure, do not fear discrimination or bias, there is job security, and there are fewer language and education related barriers.

What is their community doing well?

Participants appreciate that their community aids low-income families for housing, transportation, and medical care through programs like Habitat for Humanity, OHP, Medicare, IRCO, and TriMet. Free meals are offered to low-income children in school, and language classes are offered for free to help with English and Arabic language skills.

What could their community improve?

Participants feel that their community could improve access to resources for mental health support, education and job transfer options, translation and interpreting services, more gender exclusive recreational spaces, affordable housing, and services to assist with financial security and integrating into the healthcare system.

Top emergent themes:

1. Community support:

Participants placed an emphasis on community support, both as crucial to maintaining cultural values and establishing a sense of belonging, as well as to help ease depression and other mental health concerns. Participants desire more community activities, especially ones that are tied to healthy lifestyle choices and rooted in community values. Participants also explained the strain immigration put on their community – many of their loved ones are still in their home countries, making them feel isolated from their support systems.

"We don't have that much social life here. I am always cooking or working or cleaning here, back home we get together with family and friends regularly."

2. Cultural competency and identity:

Participants expressed a desire to maintain their cultural values, with special emphasis on their religious values as well as their social values. They emphasized that their community needed more mental health support; however, cultural barriers and stigma within their community create a reluctance to discuss mental health with professionals. Additionally, participants worry about Arabic interpreters gossiping about them. Language barriers were cited as extremely detrimental to their community's health, making it difficult to

access healthcare, connect to other communities in the area, and connect to assistance. They want to see more schools teach Arabic and about Arabic cultures to create more understanding of their lifeways and culture in their larger community. Participants felt that greater cultural competency and understanding within the community would allow their community members, particularly women, to become more involved. For example, offering exercise and swimming hours that are women-only is a cultural consideration that participants desire.

3. Education and Employment:

Participants note that the transfer of their education and careers they had before moving to the U.S. wasn't equitable and didn't set them up for success. Most of their education from back home is not recognized, and they describe having to spend a lot of money and time to transfer their degrees and make up missing classes when trying to obtain similar jobs in the United States. For example, one participant at the session was a dentist back in her home country but works in the U.S. as a medical interpreter because her credentials are not transferrable. Participants felt they were unable to take the time to complete or transfer their educational credits while also working to earn enough to support themselves and their families. Additionally, participants felt that they did not have access to job security, and that there were not enough jobs that met their financial needs. They also desired more job training. [People who have degrees/advanced skills] *"are well experienced but are neglected and should be recognized"*

"Not many jobs fit us...most of our education from back home doesn't count, we have to get evaluated and re-get degrees"

"This is a big problem for all of us – have a degree back home that is not recognized here and so you have to choose: work or study."

4. Access to resources:

Participants felt they lacked access to necessary information and resources that are critical to maintaining health. They feel that, as immigrants, the healthcare system is new to them and they desired more support to help them integrate and utilize preventive care and insurance, as well as to navigate the available resources. They felt there needed to be more resources to help them understand law enforcement, as well as the cultural norms surrounding legal and safety procedures. Participants expressed a need for more Community Health Workers (CHWs) and community organizations to help them better utilize the health system. While they appreciate the interpretation services currently available, they pushed for more Arabic interpreters who were not part of the same cultural community, as well as stricter training concerning patient privacy among interpreters. Participants also struggled with a lack of resources for dealing with financial insecurity, they expressed a need for affordable housing and affordable healthcare.

"I don't have any idea how to deal with things here – like if we get pulled over by a police officer officer – I don't know what to do."

5. Discrimination and challenges of immigration:

Participants discussed experiencing discrimination stemming from cultural and religious differences. Female participants expressed fear about attention received for wearing a Hijab and feel that the negativity expressed towards them has increased lately. In addition to facing challenges of discrimination and cultural misunderstandings, participants discussed other challenges that accompany being an immigrant or refugee in their community, such as no credit history to assist in financial endeavors. Participants explained that renting or buying a house without a co-signer is not an option without established credit history. They also face high car insurance costs due to a lack of driving history. Participants desired programs to help them navigate these challenges so they could set down roots in their community.

"It wasn't like that in Oregon before...from time to time can tell someone is staring, giving the looks. Feeling sometimes uncomfortable."

"Because I came here as a single mom, I faced a lot of barriers."

Appendix B

Community Resources

Portland Adventist Community Services

11020 NE Halsey Street

Portland, Or 97220

503-252-8500

WWW.portlandacs.org

Volunteers needed.

PACS is a private, not-for-profit service organization that addresses the needs of low-income families and individuals. In 2009, PACS programs served 288,681 people.

PACS services include:

- Client Choice Grocery Warehouse
- Thrift Ministry
- Needs Assessment and Referral to other agencies if necessary

Multnomah County Health and Human Services

501 SE Hawthorne Blvd.

Portland, OR 97214

503-823-4000

Information center

1221 SW 4th Ave.

Portland, OR 97204

503+823-4000

<http://web.multco.us/health-human-services>

Clackamas County Social Services

2051 Kaen Road

Oregon City, OR 97045

503-655-8640

<http://www.co.clackamas.or.us/socialservices/>

Multnomah County Aging and Disability

421 SW Oak Street, Suite 510

Portland, OR 97204

503-988-3620

<http://web.multco.us/ads> 307

Washington County Department of Disability, Aging, and Veterans services

133 SE 2nd Avenue
Hillsboro, OR 97123
503-640-3489
<http://www.co.washington.or.us/HHS/DAVS/>

Compassion Connect

P.O. Box 808
Fairview, OR 97024
<http://www.compassionconnect.com/>
Volunteers needed.

Compassion Connect was formed with the belief that the Church is to be a transformational presence in the community, daily reflecting the Kingdom of God by addressing the needs of the whole person. We believe that there is more that unites us as Christians than divides us, and that by working together as church communities our witness and impact is magnified. Compassion Connect serves as an umbrella organization for these local church collaboratives by providing experience, inspiration, and guidance as churches work to build relationships of grace with their neighbors
Health, Housing, Helps

Catholic Charities

2740 SE Powell Boulevard, #5
Portland, Oregon 97202
503- 231-4866
<http://www.catholiccharitiesoregon.org/>

Volunteers needed.

Catholic Charities brings hope, resources and advocacy to the poor and most vulnerable among us regardless of faith, race, marital status or condition in life. Our activities are based upon the fundamental belief in the dignity and sanctity of human life and the principles of Catholic Social Teaching. We serve as the professional social service arm of the Archdiocese of Portland.

Snow Cap Community Charities

17805 SE Stark Street
Portland, OR 97024
503-674-8785
<http://www.snowcap.org/>

Volunteers needed.

SnowCap Community Charities is a philanthropic organization created to provide food, clothing, advocacy and other services to the poor.

The Oregon Food Bank

7900 NE 33rd Drive
Portland, OR 97211
503-282-0555

<http://www.oregonfoodbank.org/>

Volunteers needed.

We work with a cooperative network of regional food banks, partner agencies and programs to distribute emergency food to hungry families. In addition, we are working to fight hunger's root causes through public policy, outreach and education

Central City Concern

232 NW 6th Ave.

Portland, OR 97209

503-294-1681

<http://www.centralcityconcern.org>

Central City Concern (CCC) is a 501(c)(3) nonprofit agency serving single adults and families in the Portland metro area who are impacted by homelessness, poverty and addictions. Founded in 1979, the agency has developed a comprehensive continuum of affordable housing options integrated with direct social services including healthcare, recovery and employment. CCC currently has a staff of 500, an annual operating budget of \$38 million and serves more than 13,000 individuals annually.

American Lung Association in Oregon 7420 SW Bridgeport Rd., Suite 200 Tigard, OR 97224
(503) 924-4094 www.lungusa.org/oregon

Volunteers needed

Portland Rescue Mission

503-Mission (647-7466)

<http://www.portlandrescuemission.org/>

The Wallace Medical Concern

Rockwood Building

124 NE 181st Ave, Suite 103

Portland, OR 489-1760

<http://wallacemedical.org/>

Iron Tribe

“IRON TRIBE is a Community Organization of Ex-Cons in Recovery. We are men and women who have been incarcerated and are now engaged in a program of living that is based upon recovery, peer support and building community. Our mission is to provide peer support and guidance for the releasing ex-con and people in recovery, as they navigate successful integration into our community. IRON TRIBE encompasses all nations, tribes, ethnicities, lineages and religious preferences. We celebrate the diversity that is contained within each individual, moving beyond simple tolerance to understanding that each individual is unique, encouraging each member in a safe, positive, and nurturing environment. Together we are collectively known as: IRON TRIBE.” From Iron Tribe web site.

<http://www.irontribenetwork.org/> 310

Appendix C

Existing Health Care Facilities and Resources

Health-related Associations

Oregon Alliance for Senior Health Services
Oregon Ambulatory Surgical Center Association
Oregon Association for Home Care
Oregon Association of Hospitals and Health Systems
Oregon Health Care Association
Oregon Hospice Association
Oregon Medical Association
Oregon Nurses Association

Community Health Coalitions

- The Oregon Medical Association works closely with the following coalitions in its community health advocacy efforts.
- Alliance for Community Traffic Safety. The Mission of ACTS Oregon is to reduce fatalities, injuries and the severity of injuries resulting from vehicle crashes throughout Oregon. Its vision is to motivate individuals and communities throughout Oregon to solve their traffic safety problems by providing resources, technical training and education.
- Health Reform Collaborative. The Oregon Health Reform Collaborative is a group of over 25 organizations committed to creating solutions to Oregon's health care crisis. Representing providers, insurers, underserved populations, businesses, consumers, and faith-based communities, these groups together work on behalf of thousands of Oregonians.
- Healthy Kids Learn Better Healthy Kids Learn Better is a statewide effort to help local schools and communities form partnerships and reduce physical, social and emotional barriers to learning.
- Human Services Coalition of Oregon The Human Services Coalition of Oregon is comprised of organizations and individuals whose purpose is to educate and advocate in the Oregon Legislature for vulnerable Oregonians.
- Immunization Policy Advisory Team. The DHS Immunization Policy Advisory Team, as experts in immunization and/or policy fields, will advise the Immunization Program of the Oregon Department of Human Services on the development, prioritization and implementation of immunization policy issues.
- Oregon Adult Immunization Coalition. The Oregon Adult Immunization Coalition, a statewide network of health and community partners, will promote prevention and control of vaccine-preventable disease through immunization of adults in Oregon and Southwest Washington.
- Oregon Alliance for Drug Endangered Children A Drug Endangered Children program is a multi-agency approach to assist and protect children whose lives, health, and safety are jeopardized by drug manufacture, drug dealing, or drug abuse in the family home. DEC

is designed to provide a comprehensive response by coordinating the efforts of law enforcement, child protective services, prosecutors, and health professionals.

- Oregon Alliance Working for Antibiotic Resistance Education Oregon AWARE encourages the appropriate use of antibiotics and aims to reduce the problem of antibiotic-resistant bacteria in Oregon.
- Oregon Asthma Program. The OAP is working to make sure that all Oregonians with asthma get quality medical care and have the right information and skills to manage their disease.
- Oregon Environmental Council. The OEC's mission is to bring Oregonians together for a healthy environment. Oregon Health Care Volunteer Registry The intent of the OHCV is to create a pool of volunteers who are potentially available to respond to national, state, and local disasters.
- Oregon Nutrition Policy Alliance. The ONPA's mission is to increase awareness about the impact of nutrition on the health of Oregonians and to promote policy that creates a healthy, active Oregon.
- Oregon Partnership for Cancer Control. The Partnership is a group of individuals and organizations with a commitment to reducing the burden of cancer in our state by enhancing cancer prevention activities, increasing equity in access to care, promoting research and awareness of cancer issues, and maximizing the quality of life for those affected by cancer.
- Oregon Partnership to Immunize Children. OPIC facilitates the collaboration of public and private partners to protect Oregon's children against vaccine-preventable diseases.
- Physical Education for All Kids. PEAK's mission is to promote quality physical education for all Oregon children.
- <http://www.theoma.org/media/public-health-fact-sheets/community-health-coalitions>

Human Services Coalition of Oregon

<http://oregonhsco.com/> (unverified for 2016)

The Human Services Coalition of Oregon is comprised of organizations and individuals whose purpose is to educate and advocate in the Oregon Legislature for vulnerable Oregonians. Immunization Policy Advisory Team. The DHS Immunization Policy Advisory Team, as experts in immunization and/or policy fields, will advise the Immunization Program of the Oregon Department of Human Services on the development, prioritization and implementation of immunization policy issues. Oregon Adult Immunization Coalition. The Oregon Adult Immunization Coalition, a statewide network of health and community partners, will promote prevention and control of vaccine-preventable disease through immunization of adults in Oregon and Southwest Washington.

Oregon Alliance for Drug Endangered Children A Drug Endangered Children program is a multi-agency approach to assist and protect children whose lives, health, and safety are jeopardized by drug manufacture, drug dealing, or drug abuse in the family home. DEC is designed to provide a comprehensive response by coordinating the efforts of law enforcement, child protective services, prosecutors, and health professionals. Oregon Alliance Working for Antibiotic Resistance Education Oregon AWARE encourages the appropriate use of antibiotics

and aims to reduce the problem of antibiotic-resistant bacteria in Oregon. Oregon Asthma Program **Oregon Environmental Council**

Oregon Health Care Volunteer Registry

The intent of the OHCV is to create a pool of volunteers who are potentially available to respond to national, state, and local disasters.

Oregon Nutrition Policy Alliance

The ONPA's mission is to increase awareness about the impact of nutrition on the health of Oregonians and to promote policy that creates a healthy, active Oregon.

Oregon Partnership for Cancer Control

The Partnership is a group of individuals and organizations with a commitment to reducing the burden of cancer in our state by enhancing cancer prevention activities, increasing equity in access to care, promoting research and awareness of cancer issues, and maximizing the quality of life for those affected by cancer.

Oregon Partnership to Immunize Children

OPIC facilitates the collaboration of public and private partners to protect Oregon's children against vaccine-preventable diseases.

Physical Education for All Kids PEAK's mission is to promote quality physical education for all Oregon children. Oregon AWARE encourages the appropriate use of antibiotics and aims to reduce the problem of antibiotic-resistant bacteria in Oregon. Oregon Asthma Program **Oregon Environmental Council**

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NORTHWEST PORTLAND

- Cornell Urgent Care is a resource for uninsured or underinsured patients suffering from non-life-threatening injuries or illness.
- Legacy Clinic Good Samaritan: Please visit the Legacy Clinic page to get contact information for this clinic. • Legacy Clinic Northwest: Please visit the Legacy Clinic page to get contact information for this clinic.
- NCM Pettygrove Classical Chinese Medicine Clinic: Pettygrove Classical Chinese Medicine Clinic offers a full-spectrum of Oriental medicine therapies, including acupuncture. The Chinese

medicine formulary provides herbal medicines. Sliding scale discounts are available to patients below FPL, proof of FPL may be required. Please inquire.

- NCNM at Chinese Consolidated Benevolent Association Native Asian Community Support Center.
- NCNM at PCC Capitol Formerly known as Homestreet, serves Hillsboro, Aloha and surrounding neighborhoods such as Washington County.
- ZoomCare is a resource for affordable primary care, urgent care, lab test and same-day medical procedures.

NORTHEAST PORTLAND

- Legacy Clinic Northeast: Please visit the Legacy Clinic page to get contact information for this clinic.
- NCNM at PCC Workforce Clinic: This Clinic services minority women and children, community members and dislocated workers training to re-enter the workforce.
- NCNM at In-Act Clinic: Located in Downtown Portland providing services for court mandated offenders with drug and/or alcohol addictions. Community members welcome.
- NCNM at Hooper Detox: Short term inpatient care for adults and teens with alcohol and drug addiction.
- East County Community Clinic Operates out of Multnomah County Health Clinic facility, provides for migrant farm workers, Latinos and the general community.
- Providence Clinics: Please visit the Providence Clinic page to get contact information for the NE Portland clinics.
- Planned Parenthood
- Working Class Acupuncture Traditional Chinese medicine and Western medicine. Sliding scale fees.

SOUTHWEST PORTLAND

- Legacy Clinic Bridgeport: Please visit the Legacy Clinic page to get contact information for this clinic.
- Legacy Clinic Lake Oswego: Please visit the Legacy Clinic page to get contact information for this clinic.
- NCNM Natural Health Center on First Ave: Natural Health Center focuses on all facets of naturopathic medicine. Providing primary care for acute and chronic disease. The clinic includes

a comprehensive natural medicine pharmacy as well as a licensed, full-service laboratory. Sliding scale discounts are available to patients below FPL, proof of FPL may be required.

- NCNM at PCC Sylvania Clinic: Only community health center on campus. Provides services to staff, students, community members in the neighborhood.
- NCNM at In-Act Clinic Court mandated persons for addiction and recovery, but open to the community.
- Men's Wellness Center: The Men's Wellness Center, part of the Cascade AIDS Project, offers free rapid HIV testing as well as a variety of other health services for men.
- Ninety Nine West Urgent Care & Health is a resource for uninsured or under-insured patients suffering from non-life-threatening injuries or illness.
- OHSU Community Health Centers provide low-cost primary and urgent care for uninsured patients.
- Providence Clinics Please visit the Providence Clinics page to get contact information for the SW
- Southwest Community Health Center A safety-net clinic providing basic, high quality health care services to low income, uninsured and underinsured residents of SW Portland.
- Shriner's Hospital for Children Acceptance, for children up to age 18, is based solely on a child's medical needs. Income or insurance status is not an issue for a child's acceptance as a patient.
- Good News Community Health Center Good News provides care for uninsured patients.
- OHSU Richmond Clinic A teaching clinic of OHSU primarily serving SE Portland.
- Rosewood Family Health Center Comprehensive medical care in SE Portland.
- NCNM at Asian Health and Service Center Part of NCNM focuses on Chinese Classical Medicine.
- NCNM at Immune Enhancement Program Immune Compromised.
- Providence Clinics: Please visit the Providence Clinics page to get contact information for the SE Portland clinic.
- Balanced Life Health Care Provides free women's health & family planning services to eligible patients.
- Low Cost Primary Care: Primary health care, including mental health care, for \$60 a visit. Please call (503)231-2994 for more information or to schedule an appointment.

- Planned Parenthood
- Oregon College of Oriental Medicine Traditional Chinese medicine. Sliding scale fees.

GRESHAM

- Gresham Urgent Care: Treatment of non-life-threatening injury and illness. No appointment necessary.
- Legacy Clinic Mount Hood: Please visit the Legacy Clinic page to get contact information for this clinic.
- Providence Clinics: Please visit the Providence Clinic page for contact information for the Gresham clinics.
- Wallace Medical Concern General Medicine. Basic urgent medical care and specialty podiatry and dermatology care at clinics located in Gresham and Downtown Portland.

- Planned Parenthood

SW WASHINGTON

- Free Clinic of SW Washington The Free Clinic of SW Washington serves uninsured, low-income Washington residents who do not have health insurance or state medical assistance.
- Legacy Clinic Salmon Creek: Please visit the Legacy Clinic page to get contact information for this clinic.
- New Heights Clinic provides primary care for uninsured and state insured individuals and follows clients until they receive their own coverage.
- Sea Mar Community Health Centers offer primary care and basic dental care on a sliding fee scale.
- Clinica de Salud Familiar Primary care services

- Planned Parenthood

CLACKAMAS

- Providence Sunnyside Family Medicine, Obstetrics & Internal Medicine.
- Willamette Falls Immediate Care is a resource for urgent medical needs.
- Oregon City Health Clinic
- Planned Parenthood

Clinics in Multnomah County

These private, primary care clinics offer low-cost or sliding fee payment options for uninsured clients.

Clinics

- Balanced Life Health Care
- Good News Community Health Center
- Dr. Michael Horowitz
- Salvia Medica 318 319

Mental Health Resources

From NAMI 2015 Mental Health Resource Guide

<http://namimultnomah.org/wp-content/uploads/2015/04/nami-resource-guide-2015.pdf>

Please go to NAMImultnomah.org for additional Addiction/Substance Abuse Programs in their Resource Guide

Trauma Informed Oregon

Resources for Implementing Trauma Informed Care

Find the resources you need as you implement trauma informed care. Browse state, local, and national resources on trauma informed care including materials and databases for health and behavioral health care providers. We've also included resources for community partners, family and youth organizations, and individuals and families.

Trauma Informed Oregon is a collaboration of university, public and private partners, individuals with lived experience, youth and family members that are committed to creating and sustaining a trauma informed system of care in Oregon.

Trauma Informed Oregon

Regional Research Institute for Human Services,
Portland State University 1600 SW 4th Ave. Suite 900 Portland, OR 97201

Phone:

503-725-9618

Email: info@traumainformedoregon.org

Appendix D

Data Sources

Agingstats-Federal Interagency Forum on Aging-Related Statistics

<https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf>

Alzheimer's Association

225 N. Michigan Ave., Fl. 17

Chicago, IL 60601-7633

<https://www.alz.org/media/HomeOffice/Facts%20and%20Figures/facts-and-figures.pdf>

American Academy of Allergy, Asthma & Immunology

555 East Wells Street Suite 1100, Milwaukee, WI 53202-3823

<https://www.aaaai.org/conditions-and-treatments/allergies>

American Cancer Society

1-800-227-2345

<http://www.cancer.org/Cancer/BreastCancer/DetailedGuide/breast-cancer-key-statistics>

American Diabetes Association

1701 North Beauregard Street

Alexandria, VA 22311

800-DIABETES

<http://www.diabetes.org/>

American Factfinder

U.S. Census Bureau

<http://www.census.gov/>

American Foundation for Suicide Prevention

120 Wall Street

29th Floor

New York, NY 10005

<https://afsp.org/about-suicide/suicide-statistics/>

American Community Survey

<http://www.census.gov/acs/www/>

American Heart Association

7272 Greenville Ave.

Dallas, TX 75231 1-800-AHA-USA1

www.heart.org

Mental Health America | Formerly known as the National Mental Health Association.

500 Montgomery Street, Suite 820

Alexandria, VA 22314

<http://www.mentalhealthamerica.net/issues/mental-health-america-glossary-and-citations>

National Association of Counties

660 North Capitol Street NW | Suite 400 | Washington, DC | 20001 | Phone: 202.393.6226

<http://www.naco.org>

National Alliance on Mental Illness

3803 N. Fairfax Dr., Ste. 100

Arlington, VA 22203

800-950-9264

<http://www.nami.org/>

National Institutes of Health

9000 Rockville Pike, Bethesda, Maryland 20892

<https://newsinhealth.nih.gov/2014/10/cold-flu-or-allergy>

NAMI Multnomah

524 NE 52nd Ave

Portland, OR 97213

503-228-5692

Anxiety and Depression Association of America (ADAA)

8701 Georgia Avenue

Suite #412

Silver Spring, MD 20910

Phone: 240-485-1001 <https://adaa.org/>

Centers for Disease Control and Prevention

1600 Clifton Road, Atlanta, GA 90333

800-232-4636

Community Commons

Community Commons | Data, tools, and stories to improve communities and inspire change.

Healthy Columbia Willamette Collaborate

<https://multco.us/healthy-columbia-willamette-collaborative/reports>

Data USA

<https://datausa.io/about/>

Deloitte Insights

<https://www2.deloitte.com/insights/us/en/economy/issues-by-the-numbers/march-2018.html>

Department of Numbers

<https://www.deptofnumbers.com/unemployment/oregon/>

FierceHealthcare

3 Speen Street, Suite 300, Framingham, MA 01701

<https://www.fiercehealthcare.com/payer/industry-voices-why-are-we-treating-social-determinants-health-as-another-healthcare-fad>

Henry J. Kaiser Family Foundation

<https://www.kff.org/state-category/demographics-and-the-economy/?state=OR>

IHME

Institute for Health Metrics and Evaluation 2301 Fifth Ave., Suite 600

Multnomah County: Joint Office of Homeless Services**National Cancer Institute**

U.S. Department of Health and Human Services

National Institutes of Health

Cancer Statistics - National Cancer Institute

National Center for Health Statistics

CDC - NCHS - National Center for Health Statistics

National Center for Chronic Disease Prevention and Health Promotion Behavioral Risk Factor Surveillance System (BRFSS)**National Institute on Drug Abuse**

Office of Science Policy and Communications

Public Information and Liaison Branch

6001 Executive Boulevard

Room 5213, MSC 9561

Bethesda, Maryland 20892

National Institute of Mental Health

NIMH » Any Mental Illness (AMI) Among U.S. Adults

National Survey of Children's Health

<http://www.nschdata.org/Content/Default.aspx>

National Health and Nutrition Examination Survey

<http://www.cdc.gov/nchs/nhanes.htm>

Multnomah County Health Department

426 SW Stark Street

Portland, OR 97204

503-988-3674

<http://web.multco.us/health>

Office of National Drug Control Policy

800-666-3332

<http://www.whitehousedrugpolicy.gov/> 330

Open Data Network

https://www.opendatane트워크.com/entity/0500000US41005-0500000US41051/Clackamas_County_OR

Oregon Association of Hospitals and Health Systems

4000 Kruse Way Place, Building 2, Suite 100

Lake Oswego, OR 97035

503-636-2204

<http://www.oahhs.org>

Oregon Center for Public Policy

204 North First, Suite C

Silverton, OR 97381

503-873-1201

www.ocpp.org

The Oregon Community Foundation

1221 SW Yamhill St., Suite 100

Portland, OR 97205

503-227-6846

<https://www.oregoncf.org>

Oregon Department of Human Services

Oregon Food Bank

7900 N.E. 33rd Drive

Portland, OR 97238-5370

503-282-0555

<http://www.oregonfoodbank.org/>

OFB Network Stats | Oregon Food Bank

Oregon Health Authority

Public Health Division

500 Summer Street, NE, E-20 Salem, OR 97301-1097

503-947-2340

<http://www.oregon.gov/OHA/>

Substance Abuse and Mental Health Services Administration (SAMHSA)

<http://www.oas.samhsa.gov/>

Co-occurring Disorders | SAMHSA

The Trauma Informed Care Project

808 5th Avenue Des Moines, IA 50309

Phone:(515) 244-2267

FAX: (515) 244-1922

galvarez@orchardplace.org

University of Wisconsin

School of Public Health

County Health Rankings & Roadmaps

<http://www.countyhealthrankings.org/app/oregon/2019/overview>

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

National Center for Health Statistics

U.S. Bureau of Labor Statistics

https://www.bls.gov/regions/west/summary/blsummary_portland_or_wa.pdf

The U.S. Department of Housing and Urban Development

OFFICE OF COMMUNITY PLANNING AND DEVELOPMENT

<https://www.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf>

Appendix E-Additional Ranking Information

The ranking below was determined by the individual votes per category and the level of perceived need. 10 would represent the highest level of need and 1 the lowest.

Criteria Grid for Priority Areas for AHP to Address - Based on 2020-2022 CHNA											
Count of Entries***	1	2	3	4	5	6	7	8	9	10	Total
Racial and Ethnic Health Disparities*	0	0	0	0	5	0	0	0	27	50	82
General Aging	1	0	0	4	10	0	7	0	9	0	31
Diabetes	0	0	0	0	5	0	7	8	45	20	85
Obesity	0	0	3	0	0	0	0	16	18	50	87
Heart Disease	0	0	0	0	0	0	0	24	36	20	80
Stroke	0	0	0	0	5	0	14	40	9	0	68
COPD/Asthma/Allergies	0	2	0	4	5	0	14	16	9	0	50
Access to Care-barriers**	2	0	0	0	0	6	21	16	0	70	115
Cancer- Screenings	0	0	0	0	0	0	7	0	0	0	7
Breast Cancer	0	0	0	0	10	0	7	24	27	10	78
Colon Cancer	0	0	0	0	10	0	21	0	18	0	49
Skin cancer	0	0	0	4	0	6	21	8	9	0	48
Prostate Cancer	0	0	0	0	0	0	14	16	0	0	30
Mental Health - Anxiety/Stress	0	2	0	8	0	0	7	8	27	40	92
Mental Health- Alzheimer's	0	0	0	4	5	0	14	0	18	10	51
Mental Health- Depression	0	0	3	0	5	0	14	8	27	20	77
Mental Health- Suicide	0	0	0	4	0	0	21	8	36	40	109

Sorted by Highest to Lowest	Total values	Priority Area	Rank
Access to Care-barriers**	115.0	SD	1
Mental Health- Suicide	109.0	BH	2
Alcohol & Drug Misuse	98.0	BH, CD	3
Housing/Homelessness	95.0	SD	4
Mental Health - Anxiety/Stress	92.0	BH	5
Obesity	87.0	CD	6
Diabetes	85.0	CD	7
Racial and Ethnic Health Disparities*	82.0	All	8
Hunger/Food Access	82.0	SD	9
Heart Disease	80.0	CD	10
Breast Cancer	78.0	CD	11
Mental Health- Depression	77.0	BH	12
Stroke	68.0	CD	13
Mental Health- Alzheimer's	51.0	BH	14
Tobacco	51.0	BH, CD	15
COPD/Asthma/Allergies	50.0	CD	16
Colon Cancer	49.0	CD	17
Skin cancer	48.0	CD	18
Sexually Transmitted D.	40.0	CD	19
Transportation	38.0	SD	20
Safety	37.0	SD	21
Affordability	36.0	SD	22
General Aging	31.0	CD	23
Prostate Cancer	30.0	CD	24
Mental Health Services	26.0	BH	25
Hep C	25.0	CD	26
Wages	23.0	SD	28
Vaccination	22.0	CD	29
Poor eating habits	20.0	SD, CD	30
Accidents	16.0	SD	31
Trauma	9.0	SD	32
Cancer- Screenings	7.0	SD	33

The thirty-two categories above were determined based on specific health outcomes data such as diabetes or cancer as well as poor quality of life indicators such as homelessness and poverty as identified in this and previous reports.

Core Areas of Concern	
Racial and Ethnic Health Disparities* has a significant impact in all areas	
CD- Chronic Disease	Total values
Heart Disease/Stroke (Combined)	148.0
Obesity	87.0
Diabetes	85.0
Breast Cancer	78.0
Sexually Transmitted Diseases	40.0
BH- Behavioral Health	Total values
Mental Health- Suicide	109.0
Alcohol & Drug Misuse	98.0
Mental Health - Anxiety/Stress	92.0
Mental Health- Depression	77.0
Mental Health-Alzheimer's	51.0
SD- Social Determinates of Health	Total values
Access to Care-barriers**	115.0
Housing/Homelessness	95.0
Hunger/Food Access	82.0
Transportation	38.0
Safety	37.0
**Access to care and resources, Cultural and language barriers, Racism and prejudice, Community support	



Adventist Health Portland

2019 CHNA approval

This community health needs assessment was adopted on 10/17/19 by the Adventist Health System/West Board of Directors. The final report was made widely available on December 31, 2019.

CHNA/CHIS contact:

Ed Hoover, Manager, LivingWell/Community Wellness
Adventist Health Portland
10123 S. E. Market Street Portland, OR 97216

Phone: (503) 251-6201

Email: HooverEL@ah.org

To request a copy, provide comments or view electronic copies of current and previous community health needs assessments or community benefit implementation strategies, please visit the Community Benefits section on our website at <https://www.adventisthealth.org/about-us/community-benefit/>