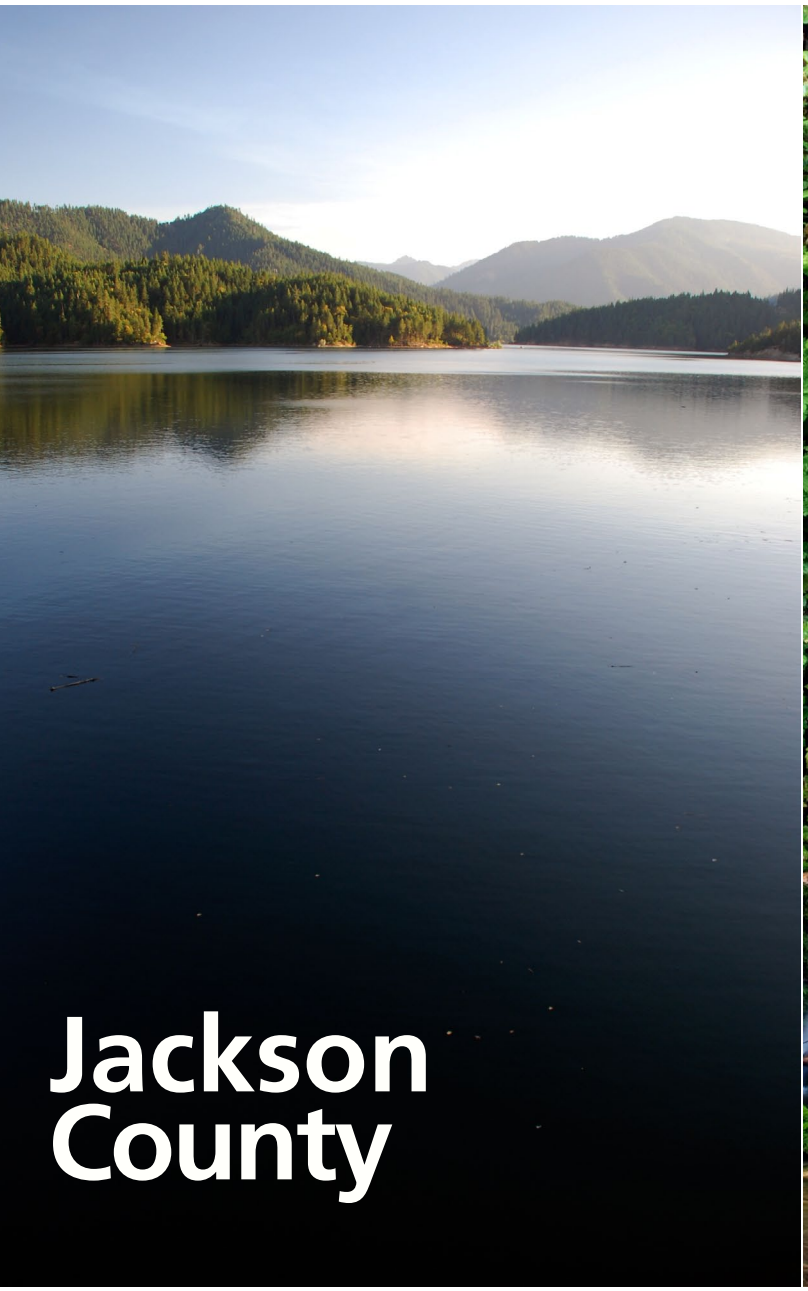
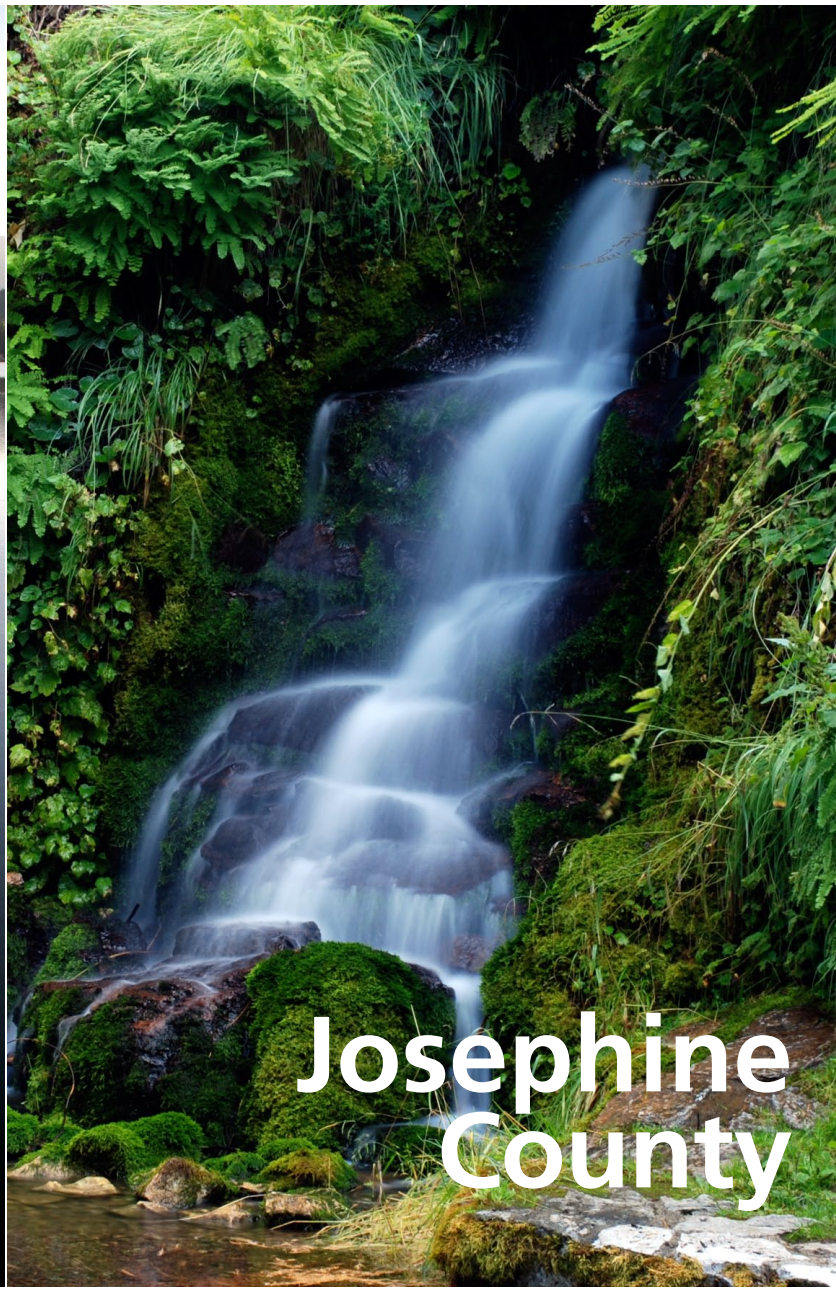
# Community Health Assessment
## 2013

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Jackson Care Connect

PrimaryHealth of Josephine County
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# Acknowledgements


***A special thanks to:***

***George Adams***
***Don Bruland***
***Larry Gershowitz***
***Diane Hoover***
***Sandi Larsen***
***Laura McKeane***
***Meadow Martell***
***Rich Rohde***
***Ed Smith-Burns***
***Caryn Wheeler***
***Cynthia Ackerman***
***Shannon Cronin***
***Bevin Hansell***
***Heidi Hill***
***Jennifer Lind***
***Maggie Rollins***
***Belle Shepherd***
***Kari Swoboda***

***Primary Consultant, Technical Writer***

***Vanessa A Becker, M.P.H., Principal. V Consulting & Associates Inc.***

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# Introduction

The ***purpose*** of the Community Health Assessment (CHA) is to provide a macro view of community health issues in Josephine and Jackson Counties. It completes this by cataloging and reviewing applicable data related to the health of the community at a county level. ***The process of the CHA is as important and vital to the community as the document that is produced.*** The ***document*** assists Coordinated Care Organizations in planning and prioritizing efforts that ultimately improve health outcomes, the health of individuals and communities and reduce health care costs. The ***process*** serves to engage community members in identifying trends and opportunities to improve the health of their community. The ***primary audience*** of the process and the resulting CHA document is the CCO Community Advisory Council (CAC) membership.

Three Coordinated Care Organizations (CCOs) came together in January of 2013 to collaborate on a single, collective community health assessment over two counties in Southwestern Oregon. Pooling resources, reducing duplication of effort and meeting funding mandates motivated the three organizations to secure a contract with a consultant to lead and facilitate a community health assessment. The Josephine and Jackson Community Health Assessment was completed to meet the needs for AllCare Health Plan, PrimaryHealth and Jackson Care Connect.

The Mobilizing for Action through Planning and Partnerships (MAPP) model was the basis of the Community Health Assessment ***process***. The MAPP process is a national best practice and recognized by the Oregon Health Authority (OHA) as a process for community health assessment. Due to the resources and time required for a thorough MAPP process, the collaborative agreed upon a modified MAPP model with a time line of January 2013-December 2013.

Data used in the community health assessment included ***secondary data*** sets, those data sets that were collected by another organization or group. These included needs assessments, census and other demographic data, epidemiology data on incidence, prevalence and percentages of health status at local, county, state and national population groups. ***Primary data,*** collected by those leading the Jackson and Josephine County Community Health Assessment, was also collected via key informant interviews and several focus groups across both counties.

The CHA document begins by outlining the process that was completed in 2013, then proceeds to list notable demographic trends in each county, identify individual and community health status issues and ends with a summary of community perceptions of health. Suggestions for next steps for the Community Health Improvement Plan (CHIP) are found at the end of each county section.

Although the full document separates both counties into their own reports, health status data, demographic trends and focus group data were similar across both counties. Focus group and key informant data were also fairly consistent with the demographic and epidemiological picture of the counties, with few distinct differences.

The Community Health Assessment is not meant to be a static document or an all-inclusive document. It is designed to complement other community efforts, plans and assessments and will be added to and changed over the next several years as community health and perceptions of health change. The CHA is not intended to be a rigorous research study, a catalog of service gaps, nor is it designed to extensively evaluate the efficacy and validity of existing community data. Instead, it is intended to provide a macro view of available community data and help to identity community trends to assist with planning.

***"I appreciate that all three CCOs are working together on this—it's hopeful. I'm super glad they are listening. —Focus Group Participant***

# *Community Health Assessment (CHA) Process*
## *Josephine and Jackson Counties 2013*

| Process | Activity | Timeline |
|---|---|---|
| **Preliminary data collection:** Identify previous community assessments<br>Secondary quantitative data collection | Web based search<br>Key informant interviews | Winter/Spring 2013 |
| **Analysis of secondary data for themes:** Review and prioritize health status data | Health status data review | Spring 2013 |
| **Collection of primary data:** Collect qualitative data | Community focus groups<br>Site champions (from CACC) work w/ consultant to complete focus groups<br>Key informant interviews of professionals in health sector<br>Review by consultant, CACC (Committee of reps from all 4 CACs working on CHA) | September 2013 |
| **Final inventory and analysis:** Incorporate health status data priorities, focus group data, key informant interviews | Review by Consultant, CACC for themes, prioritization of what to present and needs for future data collection | October 2013 |
| **Write and share:** Community Health Assessment document | Document presented for approval by:<br>1. CACC, to<br>2. CACs to<br>3. CCO Boards | November 2013 |

# Process

The Jackson and Josephine county Community Health Assessment synthesizes several months of collecting, cataloging and reviewing data related to the health of residents living in Jackson and Josephine county. The process represents collaboration with three Coordinated Care Organizations (CCOs) and spans two counties in Southwestern Oregon. It is the first step in an ongoing process of community health assessment, planning and improvement.

The purpose of the Community Health Assessment (CHA) is to provide a macro view of community health issues in the county. This is accomplished by cataloging and reviewing applicable community health status data and gathering additional data from the community about their health priorities and perceptions. The process serves to engage community members in identifying trends and opportunities to improve the health of their community. The resulting CHA document assists organizations in planning and prioritizing efforts that ultimately lead to the triple aim of improving health outcomes, improving individual and community health, and reducing costs.

Community Health Assessments are required for Coordinated Care Organizations. Three CCOs came together in January of 2013 and decided to collaborate on a single, collective community health assessment. The Josephine and Jackson County Community Health Assessment was designed to meet the needs for AllCare Health Plan, PrimaryHealth and Jackson Care Connect Coordinated Care Organizations and their four Community Advisory Councils (CACs).

## Framework and Process

A desire to pool resources, reduce duplication of effort and meet mandates motivated the collaborative orgainzations to secure a contract with a consultant to lead and facilitate the community health assessment. A contract was secured with V Consulting & Associates to lead the process and provide technical writing.

The Mobilizing for Action through Planning and Partnerships (MAPP) model was then chosen as the basis of the Community Health Assessment process. The MAPP process is a national best practice and recognized by the Oregon Health Authority (OHA) as a process for community health assessment. MAPP enables enhanced understanding of the complex influences on community health, through thoughtful and deliberate data collection and analysis. Due to the resources and time required for a thorough MAPP process, the collaborative group agreed upon a modified MAPP model with a time line of January 2013-December 2013.

The work of the CHA was completed by the consultant and a workgroup of representatives from all four CACs. The workgroup was titled the Community Advisory Council CHA Committee (CACC). CACC members provided leadership to the process, assisted with primary data collection and focus groups, and were advocates for the process to their CCO Board of Directors and the larger community. Engagement of the CAC members (via the CACC) was vital to the process, providing an opportunity for the CAC to meet Oregon Administrative Rules (OAR) requirements for overseeing the Community Health Assessment, increase individual knowledge about community health and health care transformation.

The CACC reviewed and edited the first preliminary draft of the CHA document. The four CAC's were then given an opportunity to review the document and then recommend the document be accepted and submitted to the Oregon Health Authority by the CCO Board of Directors by their January 1, 2014 deadline.

# *Plans and Processes requiring Community Health Assessments*

## CHNA

Community Health Needs Assessment

Required by IRS

Focus is to identify and assess access and needs of community the hospital is serving.

Documentation must include written report.

See Patient Protection and Affordable Care Act requirements for 501(c)3 hospitals.
Led by hospital

Every 3 years

## CCO

Coordinated Care Organization

Required by Oregon Health Authority

Purpose is to assess entire community served by CCO, not just Medicaid population. Tied to responsibility of CCO in creating the Triple Aim: Better care, better health and reduced costs.

Led by CCO, with CAC involvement.

Proposed to be every 3 years

## Public Health Accreditation

Required by Public Health Accreditation Board (PHAB)

Collaborative process resulting in a comprehensive community health Assessment.

Led by County Public Health with collabrative partners.

Every 5 years
(could be on a 3 year cycle)

## BIP

Biennial Improvement Plan

Required by Oregon Health Authority

Collaborative process resulting in a comprehensive community health Assessment.

Led by County Public Health with collabrative partners.

Every 5 years
(could be on a 3 year cycle)

### *Data Assumptions and Priorities*

The large volume of available data sets necessitated setting priorities about what data to collect and analyze. Collecting and cataloging data was completed with the following assumptions and priorities.

- Data accessible online was preferable—particularly if able to save in PDF or another readable/printable format
- Collect data on entire community, not just on Medicaid/Oregon Health Plan population, identify county specific data when available
- Collect epidemiology data on health status, prevalence, incidence of disease
- Collect data on social determinants of health-such as poverty, unemployment, homelessness
- Collect data on services related to health
- Collect data within the last seven years, the newer the data the better
- Older data was allowed if there was lack of data in that particular type of data
- Data on chronic disease, mental and behavioral health and addictions were emphasized
- Data updated regularly and/or part of a larger, reliable data system/ tracking effort

Data assumptions and priorities were established at the onset of the MAPP process in January 2013. The initial data collection and analysis (meta-analysis) took place from January to May of 2013. Results from the meta-analysis were presented to the CACs and CCO boards in May. All data that was collected was cataloged into a spreadsheet titled the "data sources." The data sources document was and will be continually added to and serve as a community resource of available health status data. PDF versions of all available data sets and assessments were organized in a series of online folders—ensuring accessibility for all leadership team and CAC members.

### *Types of Data*

The community health assessment included secondary data sets, those data sets that were collected by another organization or group. These included existing needs assessments, epidemiology data on incidence, prevalence and percentages of health status at local, county, state and national population groups. Secondary data at the local (zip code) and county level was utilized when available. Primary data, data collected by those leading the CHA, was also collected via key informant interviews and focus groups across Jackson and Josephine county.

### *Limitations*

The Community Health Assessment is not meant to stand on its own, but is a process and document designed to complement other community efforts, plans and assessments. It is not a complete collection of all community health needs or health data. It relies heavily on secondary data assessments and there are many notable gaps in readily available local, county, state and national data. The CHA is also not a rigorous research study, nor is it designed to extensively evaluate the efficacy and validity of existing community data. While the CHA identifies many critical health issues, it is not inclusive of every possible health-related issue. Instead, it is intended to provide a macro view of available community data, help to identify community trends, and help to illustrate the need for more detailed local data.

The CHA document is a dynamic and changing document and will be added to and changed over the next several years as community health and perceptions of health change.

# Contents

**Introduction** iii

*Process*

Framework and Process

Data Assumptions and Priorities

Types of Data

*Jackson County: People and Place* 8

*Location and Physical Characteristics*

*Demographic Trends & Population Characteristics*

Migration and Growth

Growth in Elderly Population

Poverty

Homelessness

Education

Disabilities

Crime

**Health Status: Individual and Community Health** 18

*County Health Rankings*

*Morbidity & Mortality in Jackson County*

Chronic Disease & Conditions

Mental Health

Addictions

*Maternal & Child Health*

*Health Behavior & Lifestyle Factors*

Tobacco

Obesity

*Additional Social Determinants of Health*

Food Insecurity

*Health System*

Access to Medical Care

**Community Perceptions of Health** 36

*Focus Groups*

*Key Informant Interviews: System of Care Strengths and Opportunities*

Key Informant Questions

Themes

*The Community Health Improvement Plan & Next Steps*

Utilizing the CHA for Planning

***Josephine County People and Place*** ***54***

*Location and Physical Characteristics*

*Demographic Trends and Population Characteristics*

Migration and Growth

Growth in Elderly Population

Poverty

Homelessness

Education

Disabilities

Race and Ethnicity

Crime

***Health Status: Individual and Community Health*** ***62***

*County Health Rankings*

Morbidity & Mortality in Josephine County

Chronic Disease & Conditions

Mental Health

Addictions

Maternal & Child Health

Health Behavior & Lifestyle Factors

Obesity

Physical Activity & Nutrition

*Additional Social Determinants of Health*

Food Insecurity

*Health System*

Access to Medical Care

***Community Perceptions of Health*** ***79***

*Focus Groups*

*Key Informant Interviews: System of Care Strengths and Opportunities*

Key Informant Questions

Themes

*The Community Health Improvement Plan & Next Steps*

Utilizing the CHA for Planning

***Appendix*** ***95***

*Josephine County Community Health Assessment Data Sources*

Sampling of Available Data Sources 2012-2013

*Jackson County Community Health Assessment Data Sources*

Sampling of Available Data Sources 2012-2013

*Focus Group Guide & Questions*

# Community Health Assessment

## 2013

# Jackson County

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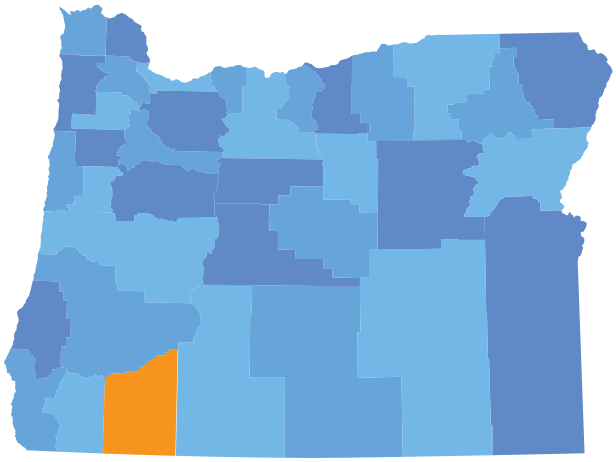
# Jackson County: People and Place

## Location and Physical Characteristics



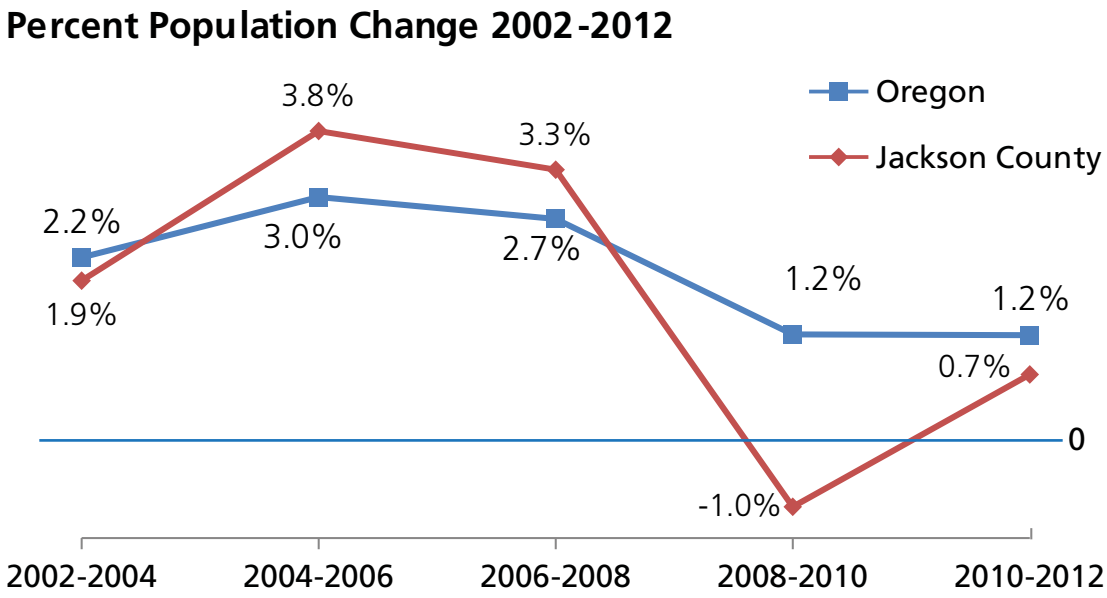
Jackson County is a county located in Southwestern Oregon along the border with California. It is considered one of the more rugged parts of the state with multiple climates and geography within its 2,081 square miles. The terrain and geography is diverse including large broad valleys, deep river valleys and sparsely populated mountainous areas. There are hundreds of hills, valleys and waterways including the Rogue River and Bear Creek.

Interstate 5 (I-5) runs through the county and the only urban areas lie along the I-5 corridor, in the broader valley areas of Medford and Ashland. The total population in Jackson County is 206,412 (2012). The population centers in Jackson County include Medford, Ashland, Phoenix, Central Point and Talent. These centers account for 60% of the total county population, with the remaining 40% of the county population living in many thinly populated rural areas. There are 11 incorporated cities in Jackson County and 34 unincorporated communities. The largest incorporated city is the county seat of Medford.

## Demographic Trends & Population Characteristics

### Migration and Growth

Jackson County exceeded the average state growth from 2004-2008. However, from 2008-2010, during the economic downturn the county saw the growth trend change to the negative as many residents out-migrated from the county to find jobs out of state or in the larger urban areas of the state in the Willamette Valley. Like many Southwestern Oregon counties, local population statistics began showing that younger families were leaving the area for more metropolitan counties to find jobs shortly after the downturn.



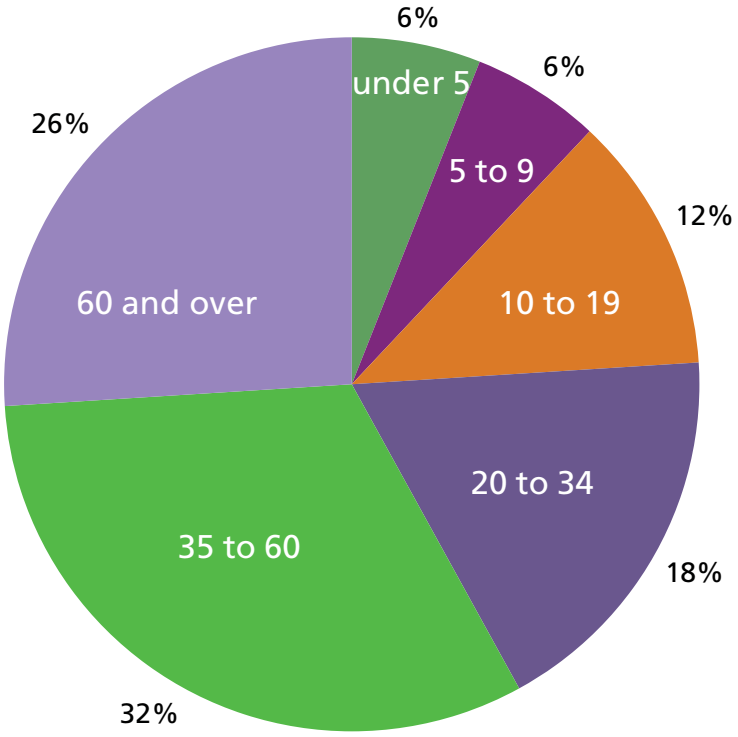

Source: PSU Population Research Center

At the same time, the county continued to see a steady influx of seniors to the county, largely from out of state. Both the exodus of younger and often higher socioeconomic level populations and the influx of older demographic groups in the county ultimately influences the health status and burden for care on the community. The percentage of 60 and over is expected to continue to rise within the county, while percentages of younger ages continues to diminish.

### *Growth in Elderly Population*

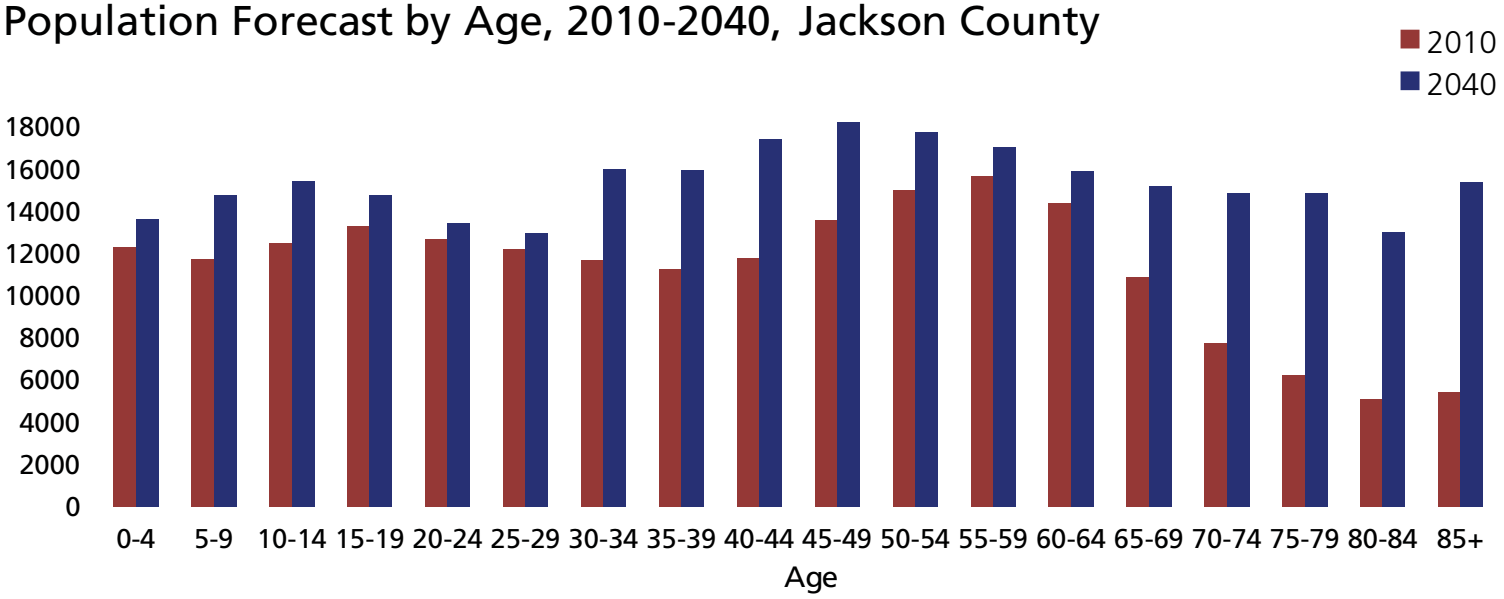
According to 2012 census data, 18.8% of the county population is over 65-years-old, higher than the state average of 14.9%. Jackson County joins many other counties in Southern Oregon with distinctly higher average ages and higher percentages of elderly living in the county than more metropolitan counties.

Age Distribution Jackson County 2012




Source: 2012 US Census

Population Forecast by Age, 2010-2040, Jackson County




Source: Office of Economic Analysis, Department of Administrative Services, State of Oregon

## *Poverty*

Nearly one in four children in Jackson County live in poverty, creating significant challenges to their overall health and long-term development.

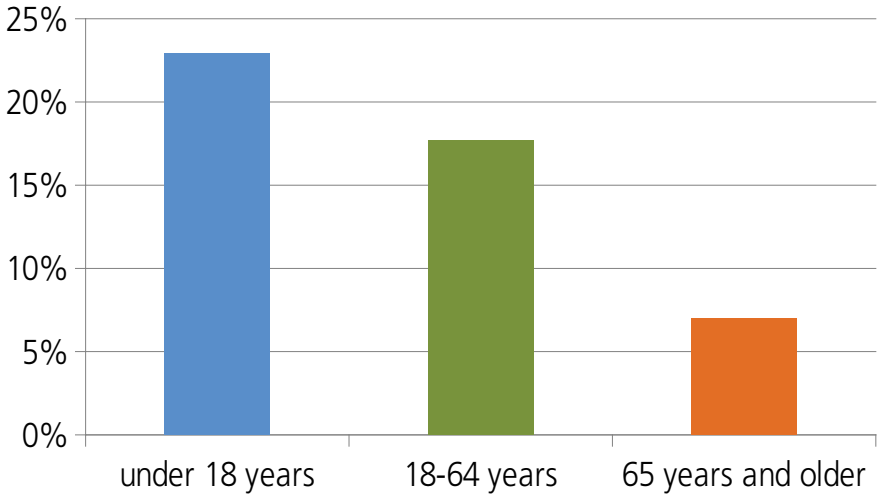
15.8% of the total county population lives in poverty (2008-2011), slightly higher than the state average of 14.8%.

Poverty has tremendous impact on individual and community outcomes and was consistently brought up in the community focus groups related to access to health care services, housing, access to healthy food and nutrition.

***"I think the health of the people in our community varies from very healthy to poor health. Some groups are very physically active and health conscious with good incomes and other sub-groups are impacted by very low incomes, inadequate housing and childcare, which produces high levels of stress and negatively impacts health."—Focus Group Participant***

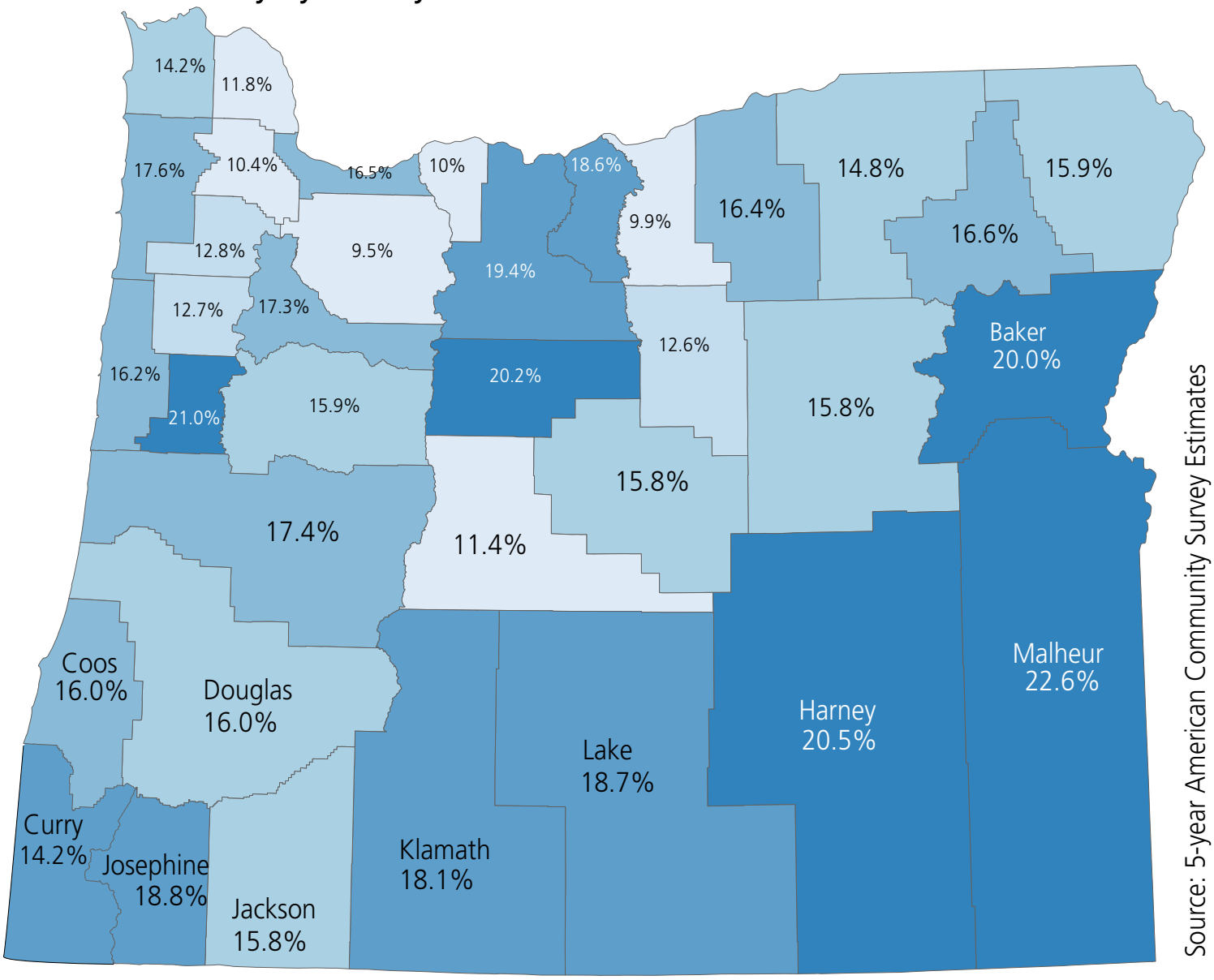
Percent living below poverty level by age

*Jackson County 2009-2011*




*Source: U.S. Census Bureau, 2009-2011 American Community Survey 3-Year Estimates*

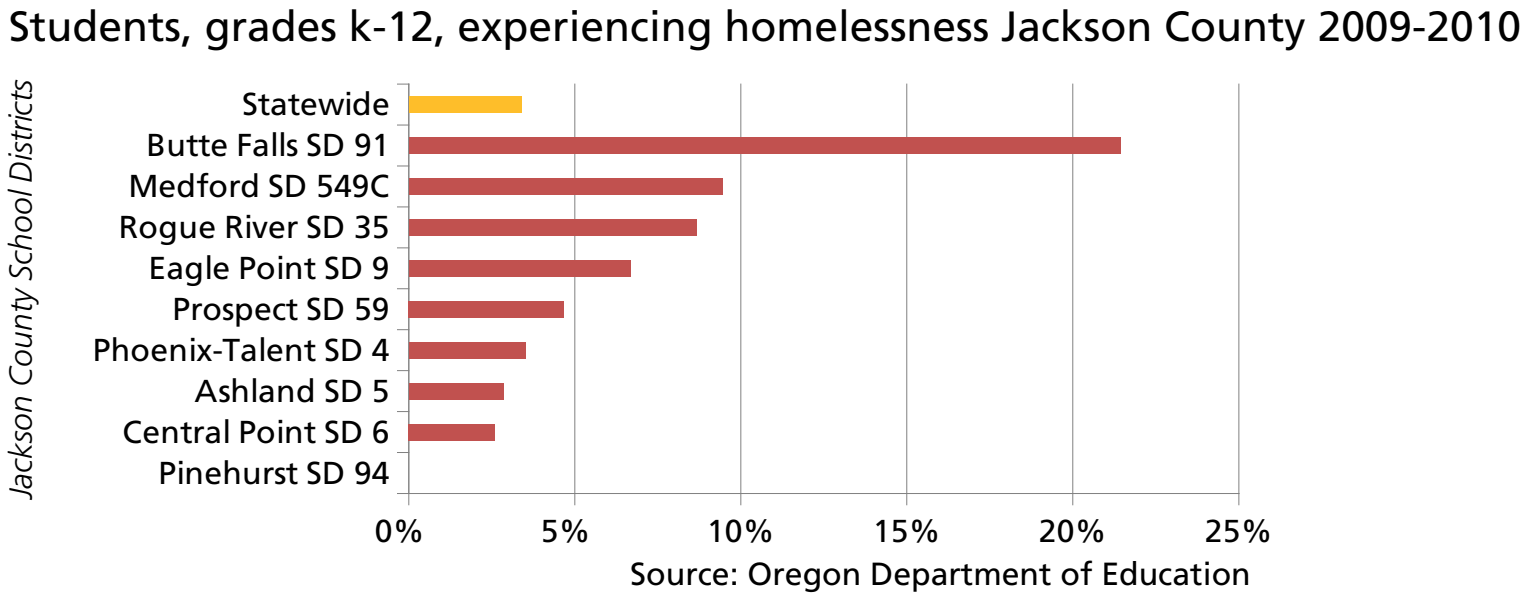
## Percent In Poverty By County




Source: 5-year American Community Survey Estimates

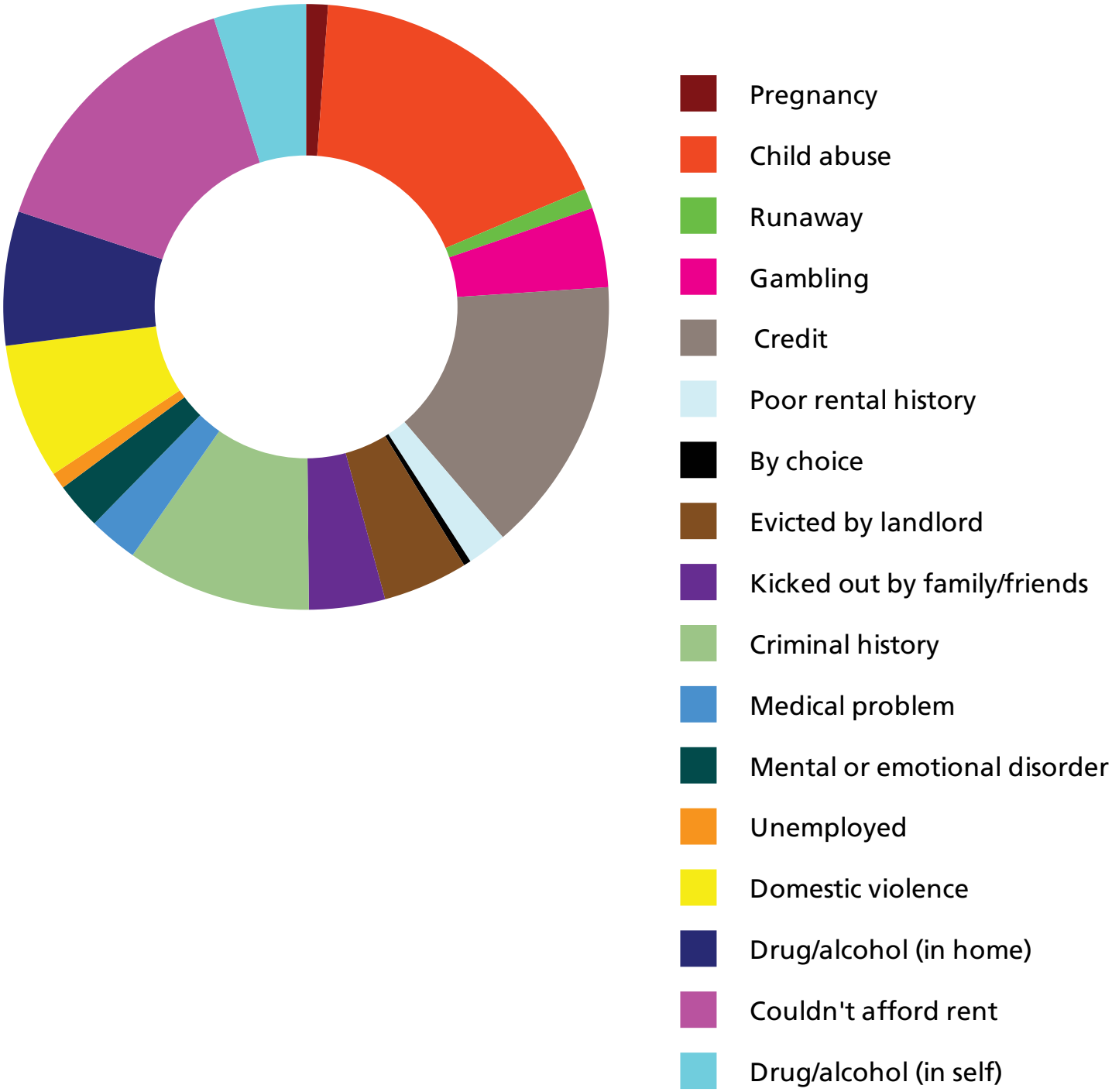
## *Homelessness*

Homelessness continues to be a challenge for many living in Jackson County. Causes of homelessness vary, they include drug and alcohol abuse, high rents, domestic violence and unemployment.




Children who experience homelessness are more likely to be at risk for violent crime, lower educational outcomes and higher rates of substance abuse. Nearly all districts in Jackson County listed K-12 grade students experiencing homelessness with most districts far exceeding the state average.

## Causes of Homelessness Jackson County 2013



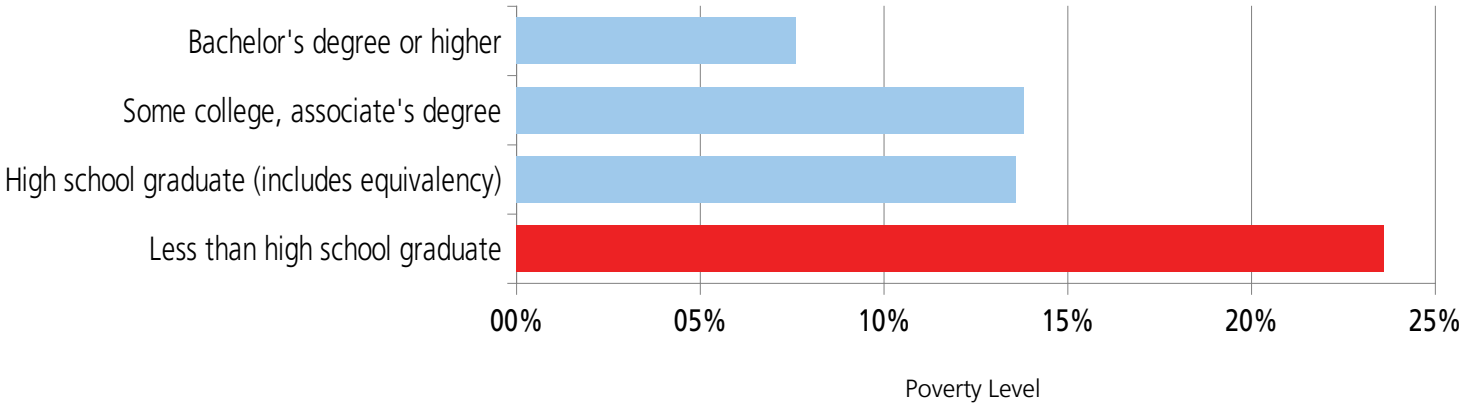

*Source: One Night Homeless Count 2011-2013, Jackson County Homeless Task Force*

## *Education*

High school graduation rates at the county level are similar to state averages, typically showing 88-89% of the population being a high school graduate or higher.

For those that have less than a high school degree (or equivalent) poverty is markedly higher—they are twice as likely than those with some college to live in poverty.

Poverty rate for Jackson County residents 25-years and over by educational attainment, 2009-2011

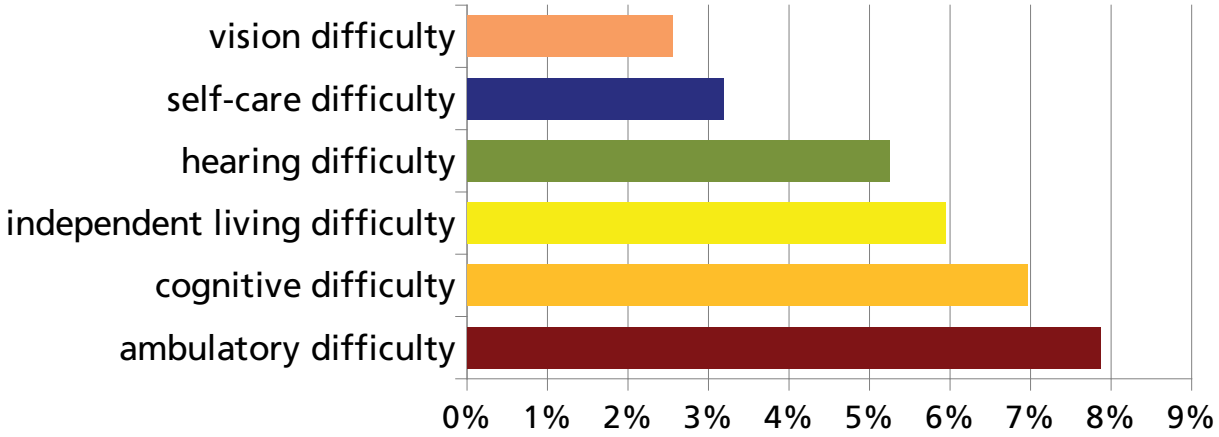



Source: 2009-2011 American Community Survey 3-Year Estimates

## *Disabilities*

Jackson County has an estimated 29,079 adults with disabilities according to the recent ***Area Agency on Aging*** 2013-2016 plan. Types of disabilities are varied, with ambulatory difficulty being the highest, cognitive being a close second.

Percentage adults with a disability Jackson County 2011



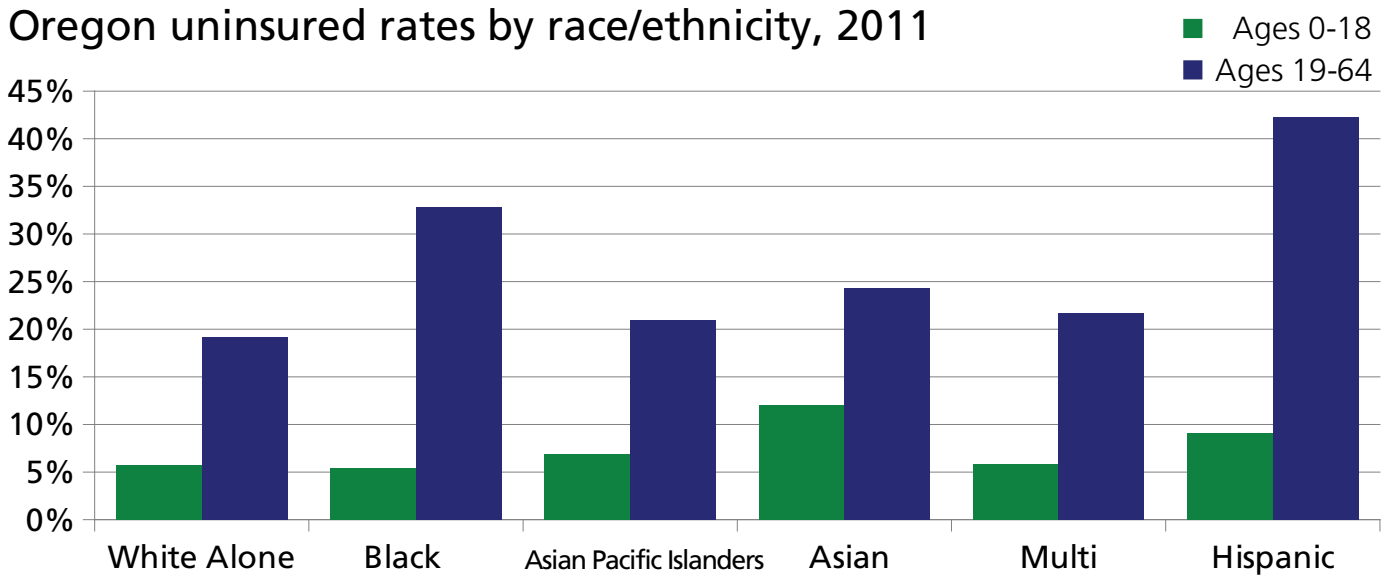

*Source: 2011 American Community Survey 1-Year Estimates*

## *Race & Ethnicity*

Jackson County demographics for race and ethnicity are quite similar to state averages, with over 17% of residents identifying as a minority population. Hispanic or Latino represent 11.4% of the population in the county, followed by people identifying as being from two or more ethnic groups.

Public school enrollment statistics are similar to census numbers in most districts. The Phoenix-Talent School District shows the highest numbers of minorities, followed by Medford and Eagle Point.

Health outcomes for racial and ethnic minorities continue to be worse, and percentages of insured minorities are also lower. Although specific county-level data for uninsured by race/ethnicity is not currently available, it is important to note that Hispanic groups have significantly higher chances of being uninsured statewide. Every minority race and ethnic group has higher rates of uninsurance when compared with Caucasian populations, presenting significant barriers to accessing health care and health disparities. It is interesting to note that outside the Portland Metro area, Jackson County has some of the highest percentages of race and ethnic diversity in the state.




*Source: 2011 Oregon Health Insurance Survey*

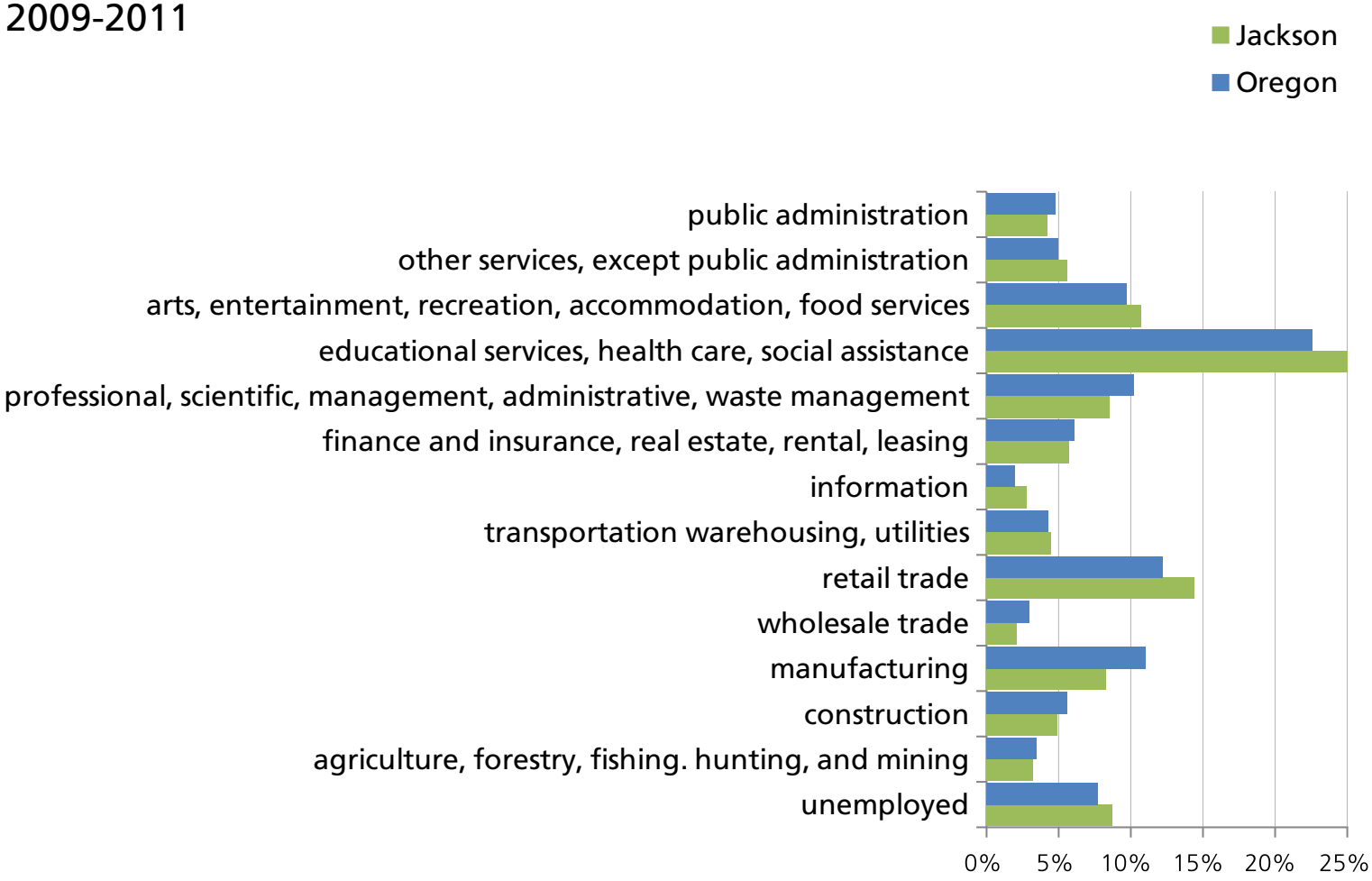
### *Employment*

Unemployment in Jackson County continues to be higher than state and national averages. Although the trend shows slight decreases in the seasonally adjusted unemployment rates from the Oregon Employment Department, they continue to hover around 10% annually, nearly 3% higher than the national average.

Residents of Jackson County work predominantly in educational services, health care, social assistance, and retail.

Unemployment and its effects on poverty and health continue to be felt by county residents and it was discussed frequently in focus groups.

Percent employed by business sector Jackson County and Oregon 2009-2011




*source: 2009-2011 american community survey 3-year estimates*

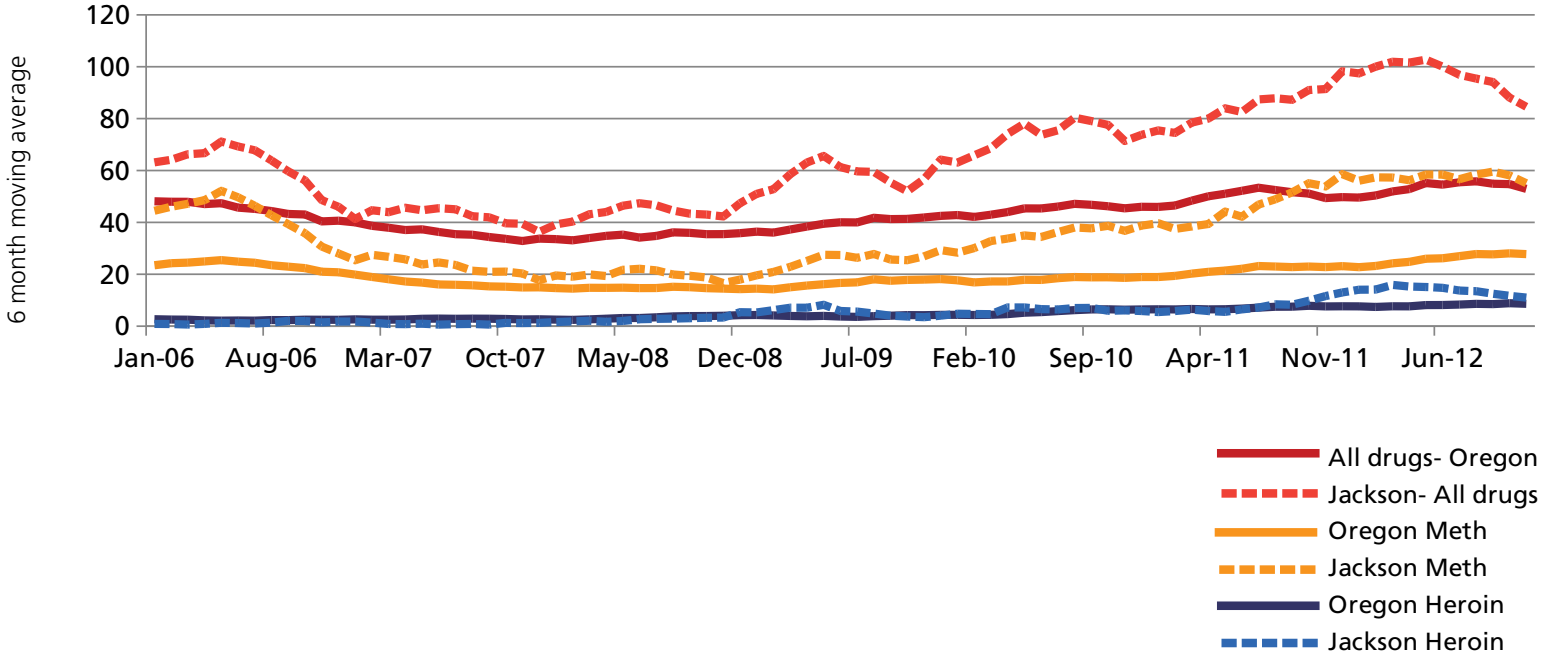
***"Multiple families are living under one roof since the economy went downhill, it affects everyone's health." —Focus Group participant***

## *Crime*

Crime continues to be a challenge for residents living in Jackson County. The *Report of Oregon Offenses Known to Law Enforcement* lists Jackson County as fourth highest in the state for property crimes (out of 36), ninth for person crimes and eleventh for behavior crimes in 2010. Drug arrests continue to outpace state averages of arrests for all drug categories, but notably higher for methamphetamine.

***"Meth use is high and scares me because of all the robberies, stealing, dirty needles and stuff." —Focus Group participant***

Drug Arrests- Oregon State and Jackson County




*Source: Criminal Justice Commission, Statistical Analysis Center*

# Health Status: Individual and Community Health

## County Health Rankings

The County Health Rankings is a collaborative project supported by the Robert Wood Johnson Foundation. The rankings evaluate counties based on causes of death (mortality), types of illnesses (morbidity) and those factors that lead to poor health outcomes. The rankings provide a measurement tool to compare county-to-county, as well as comparison to state and national benchmarks.

The most recent rankings were released in March 2013 and rankings are available for nearly every county in the United States. The rankings look at a variety of measures that affect health. Although released annually, some of the data sets that are used in the development of the rankings are older so it is important to not look at county rankings exclusively when evaluating the health status of Jackson County.

**Jackson County** was ranked in the middle percentile, ranking 13th out of 33 ranked Oregon Counties (health outcomes category), this was improved by two positions in 2012. Mortality (death) was ranked 10th out of 32, morbidity (disease) was ranked at 18th out of 32.

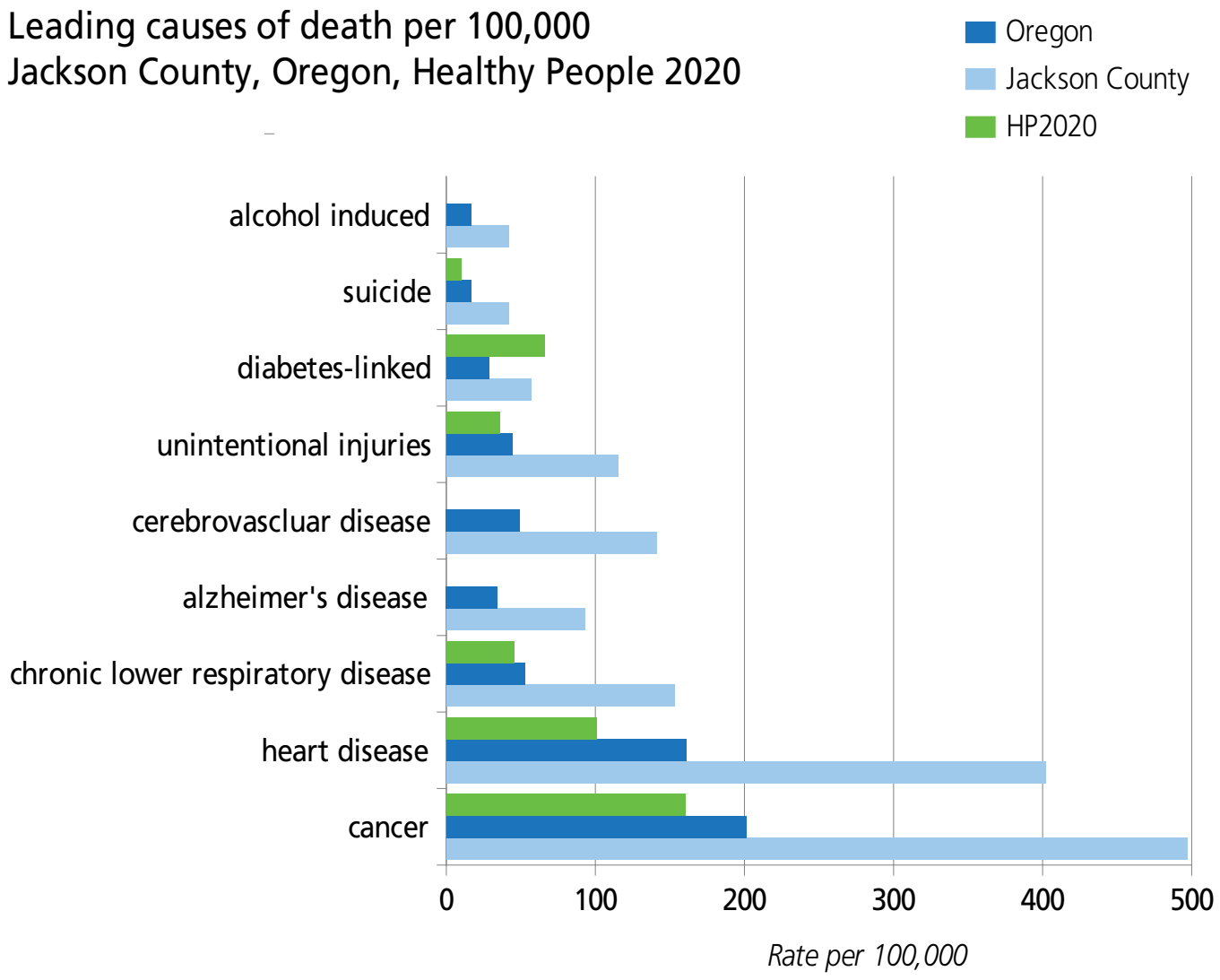
## Morbidity & Mortality in Jackson County

Mortality (death) and causes of death have changed in Jackson County over the last 75 years, consistent with state and national trends. Many advances in science, medicine, living and working conditions have contributed to changes in causes of death and life expectancy. The major causes of premature death in Jackson County are chronic conditions, consistent with a nationwide epidemic of chronic disease and conditions.

### Health Outcomes Oregon Counties 2013

| County | Rank |
|---|---|
| Baker | 33 |
| Benton | 2 |
| Clackamas | 5 |
| Clatsop | 12 |
| Columbia | 19 |
| Coos | 28 |
| Crook | 8 |
| Curry | 26 |
| Deschutes | 7 |
| Douglas | 30 |
| Gilliam | not ranked |
| Grant | 1 |
| Harney | 20 |
| Hood River | 3 |
| Jackson | 13 |
| Jefferson | 32 |
| Josephine | 29 |
| Klamath | 31 |
| Lake | 22 |
| Lane | 17 |
| Lincoln | 24 |
| Linn | 23 |
| Malheur | 10 |
| Marion | 14 |
| Morrow | 16 |
| Multnomah | 15 |
| Polk | 9 |
| Sherman | not ranked |
| Tillamook | 25 |
| Umatilla | 27 |
| Union | 21 |
| Wallowa | 18 |
| Wasco | 11 |
| Washington | 4 |
| Wheeler | not ranked |
| Yamhill | 6 |

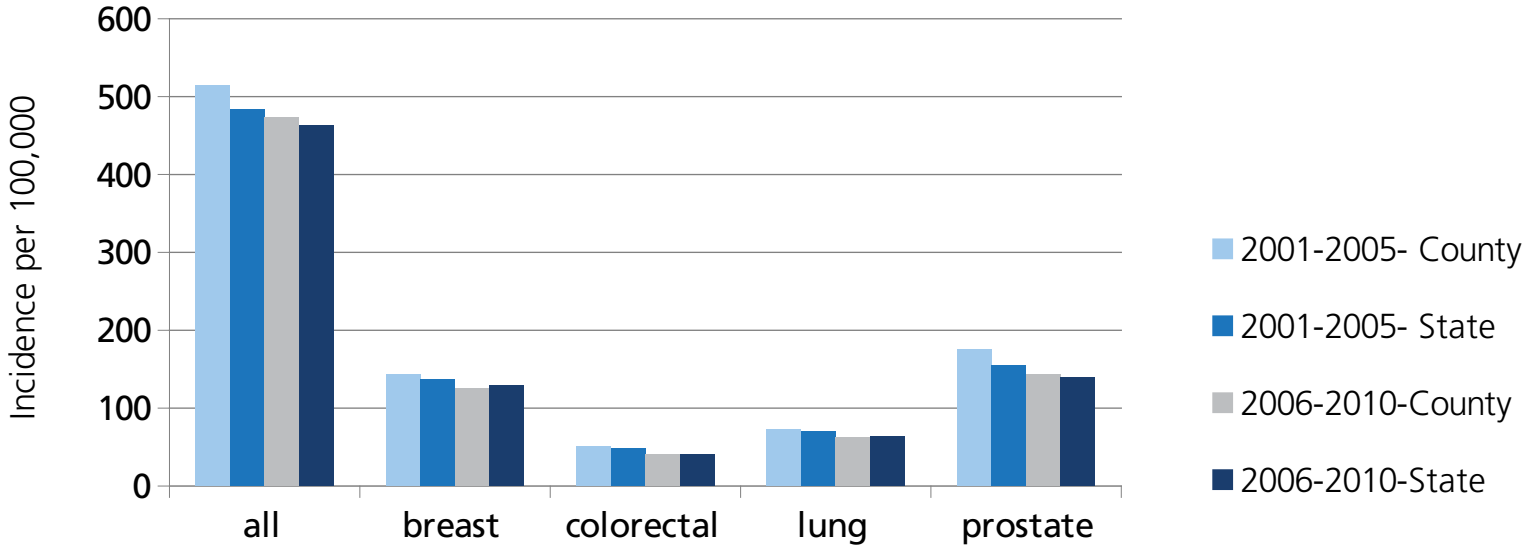
Death from cancer, heart disease and lower respiratory disease is significantly higher in Jackson County than the state or Healthy People 2020 goal. Rates of suicide and unintentional injuries are three times higher in Jackson County than national goals and double the state average. Healthy People 2020 provides national benchmark goals for communities and organizations that create and administer health improvement plans. They are evidence-based national objectives designed to help communities monitor progress and evaluate success. Jackson County rates are at least double that of the Healthy People benchmark goals in cancer, heart disease and chronic respiratory disease.




*Sources: Oregon Health Division County Data Book 2011, Healthy People 2020*

Jackson County joins many of its neighboring counties with high incidences of cancer. Breast Cancer, Prostate, Lung and Colorectal cancers continue to be the leading types of cancer in Jackson County, a consistent trend for the last decade.

## Leading types of cancer, Jackson County 2001-2010

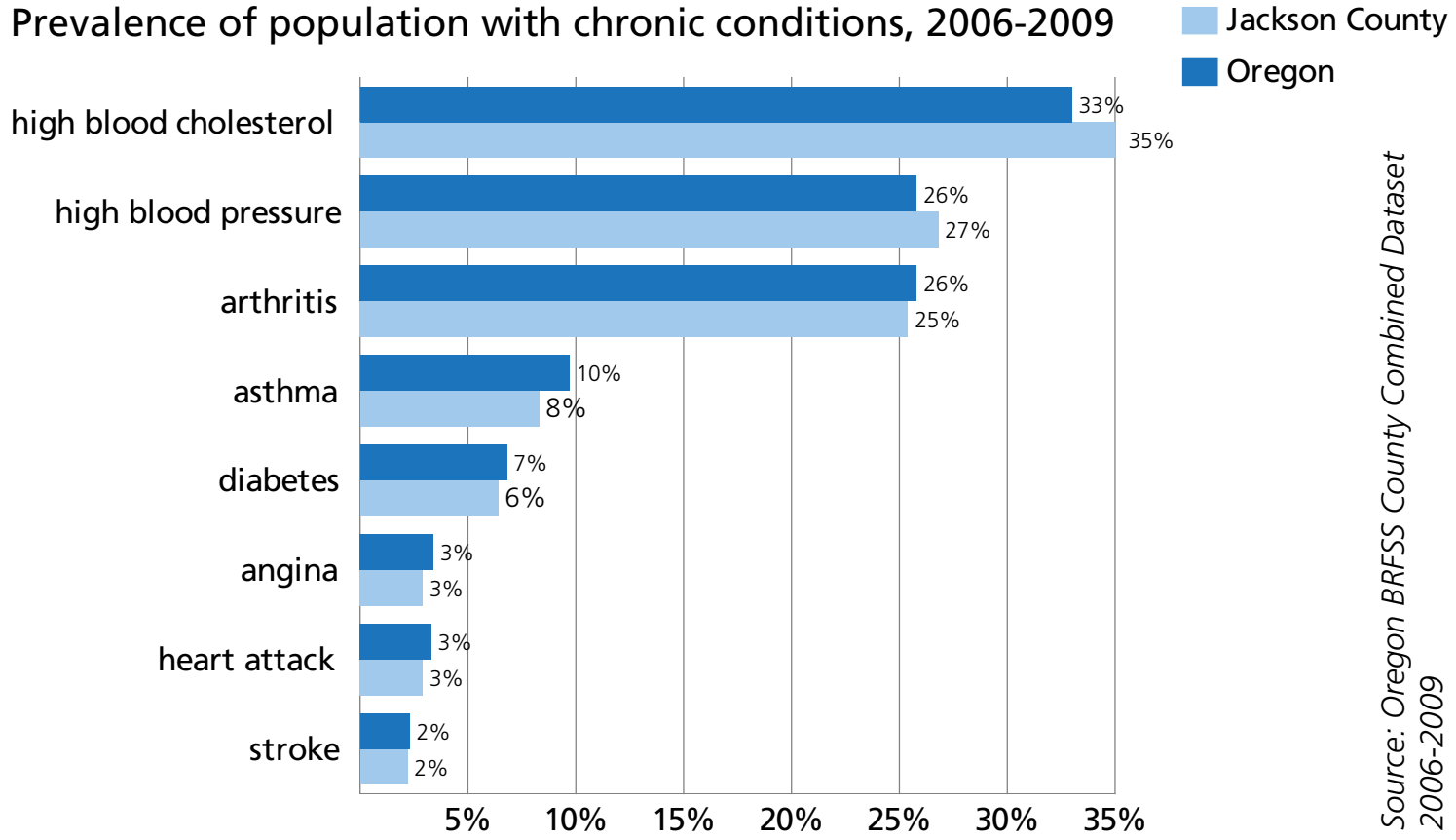



*Source: Oregon Public Health Authority, Cancer in Oregon report, 2010*

### *Chronic Disease & Conditions*

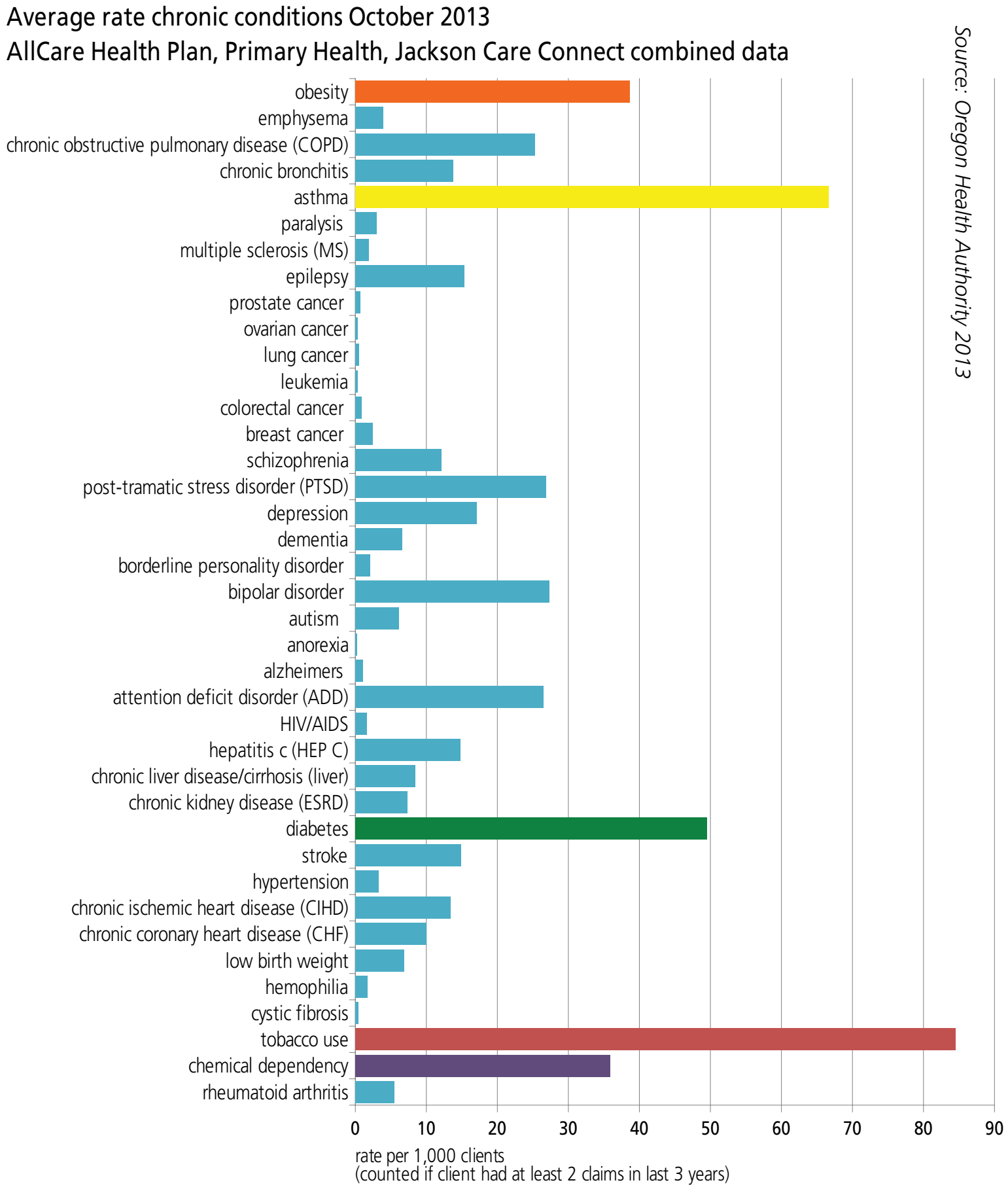
Prevalence of chronic conditions in Jackson County are close to many state averages. The County age-adjusted population data shows a high burden of high blood cholesterol, high blood pressure and arthritis in the county.

## Prevalence of population with chronic conditions, 2006-2009



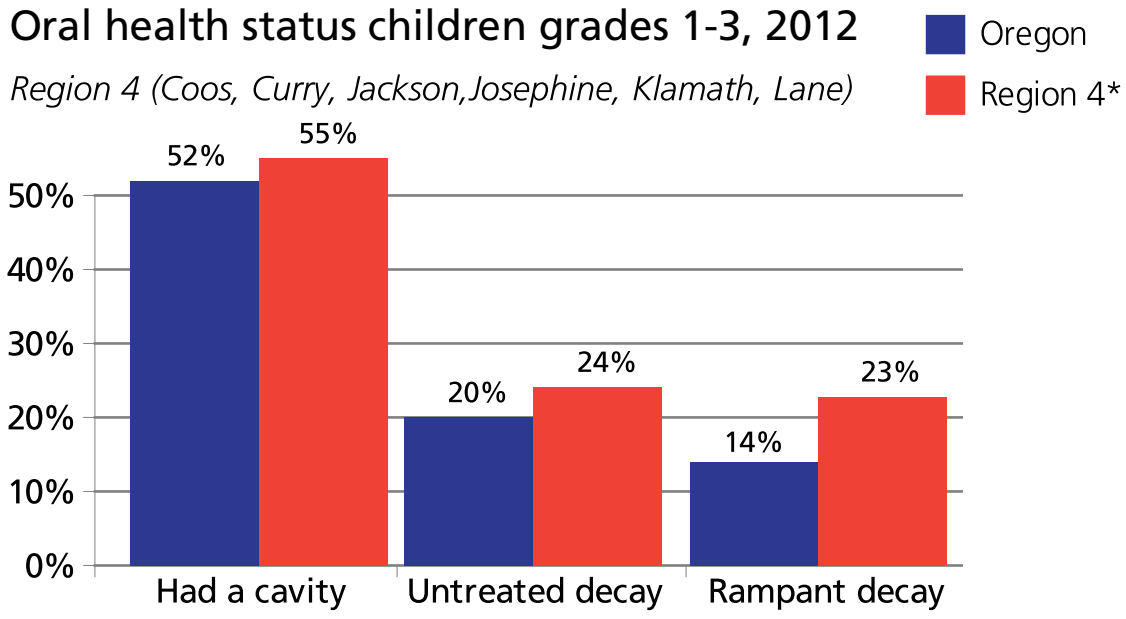

*Source: Oregon BRFSS County Combined Dataset 2006-2009*

The burden of chronic conditions for those on Oregon insurance programs, such as the Oregon Health Plan, show a similar pattern as the county population. Oregon Health Plan patients, enrolled in one of the three CCO's in Josephine and Jackson Counties, show high rates of tobacco use, diabetes, asthma, obesity and chemical dependency.

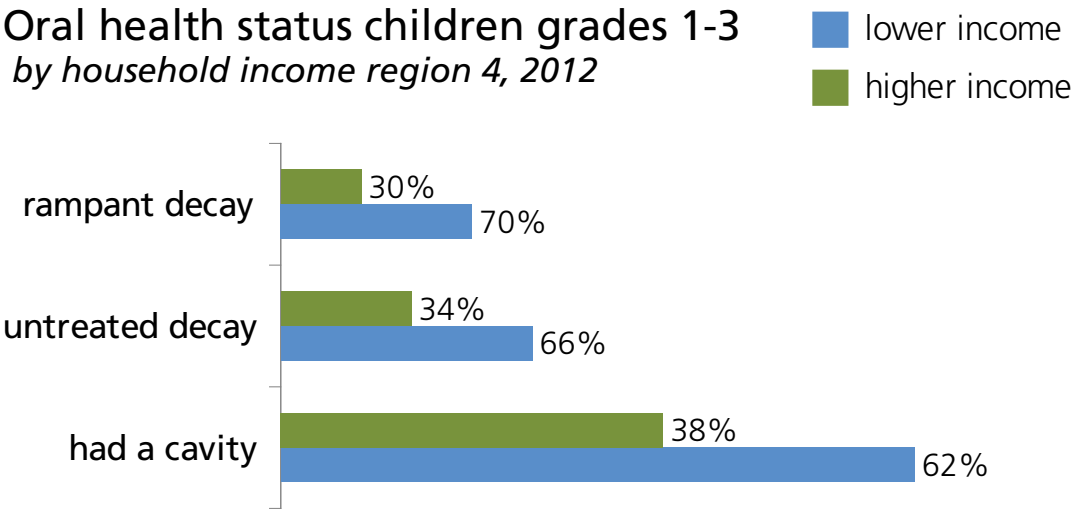


## *Oral and Dental Health*

National and state level data show that tooth decay is five times more common than asthma in Oregon children. Dental health should be a priority concern for the County and State. In Oregon, oral disease is on the rise and is not limited by socio-economic status, race or ethnicity, or age according to a recent resources scan and needs assessment commissioned by the Oregon Community Foundation.




*Source: Oregon Smile Survey 2012*




*Source: Oregon Smile Survey 2012*
*Region 4 includes Coos, Curry, Douglas, Jackson, Josephine, Klamath, Lane*

The 2012 Oregon Smile Survey grouped counties into regions, Jackson County being in Region 4 with Coos, Curry, Josephine, Klamath, Lane, and Douglas. The region has higher percentages of cavities, untreated decay and rampant decay in children.

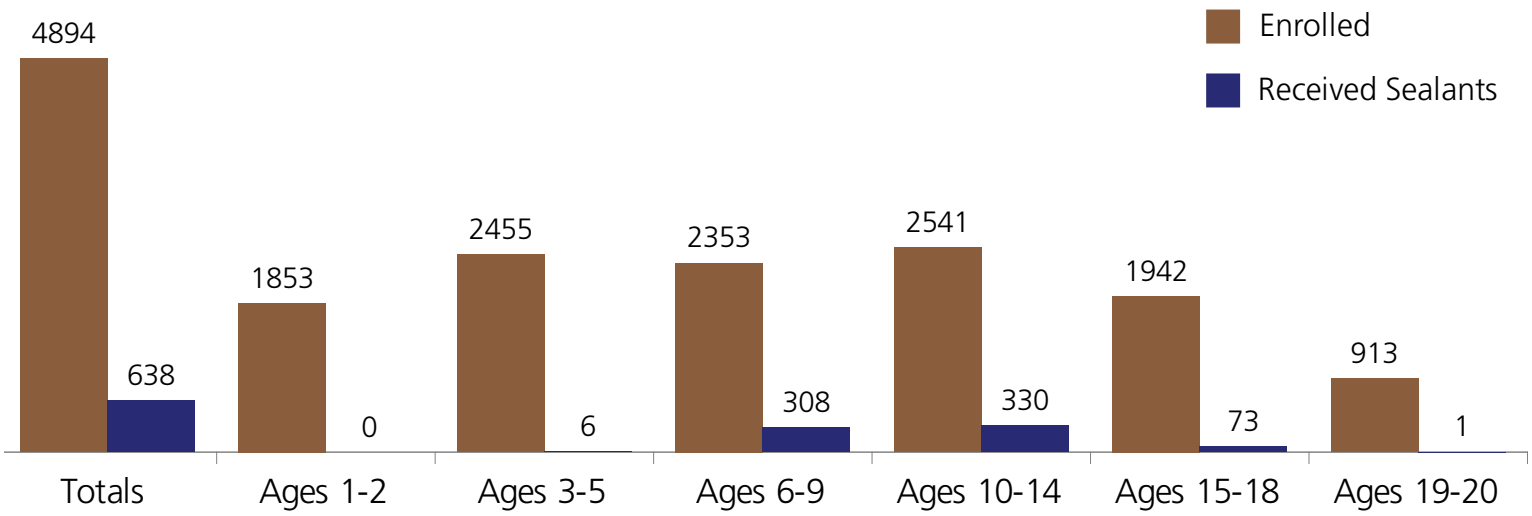
Although the rise in oral disease is not limited to socio-economic status, the dental health of children in the region was far worse for those with lower incomes.

Dental prevention and access to dental care was consistently mentioned in all focus groups in the county. Of those children enrolled in Medicaid in the county, the majority did not have sealants (a common preventive dental practice).

***"We see kids with swollen faces from abscesses and dental problems—their parents are like, 'I don't know what to do, won't it just heal?' It affects their ability to be at school and learn." —Focus Group Participant***

## Youth Medicaid Population with Dental Coverage and Sealants

*Jackson County 2010-2011*



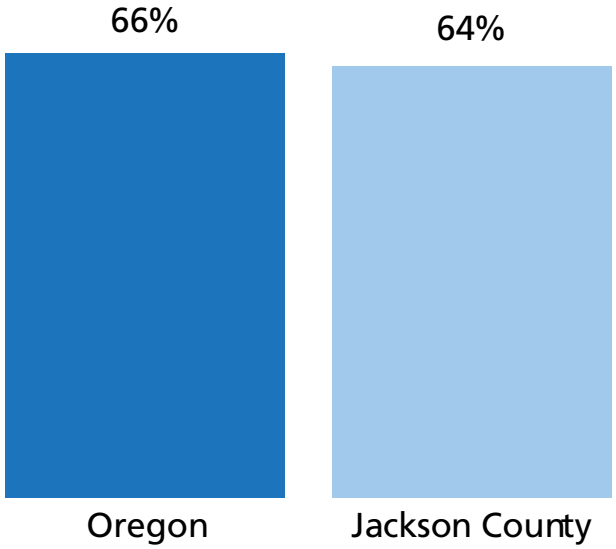

*Source: EPSDT Measure, DCO Performance Measurement 2010-2011*

### *Mental Health*

Close to 65% of residents in Jackson County describe themselves as having good mental health. Although that is close to the state average, it still shows that close to 1 in 3 people don't consider themselves as having good mental health. When people don't feel as though their mental health is good, health-related quality of life is reduced.

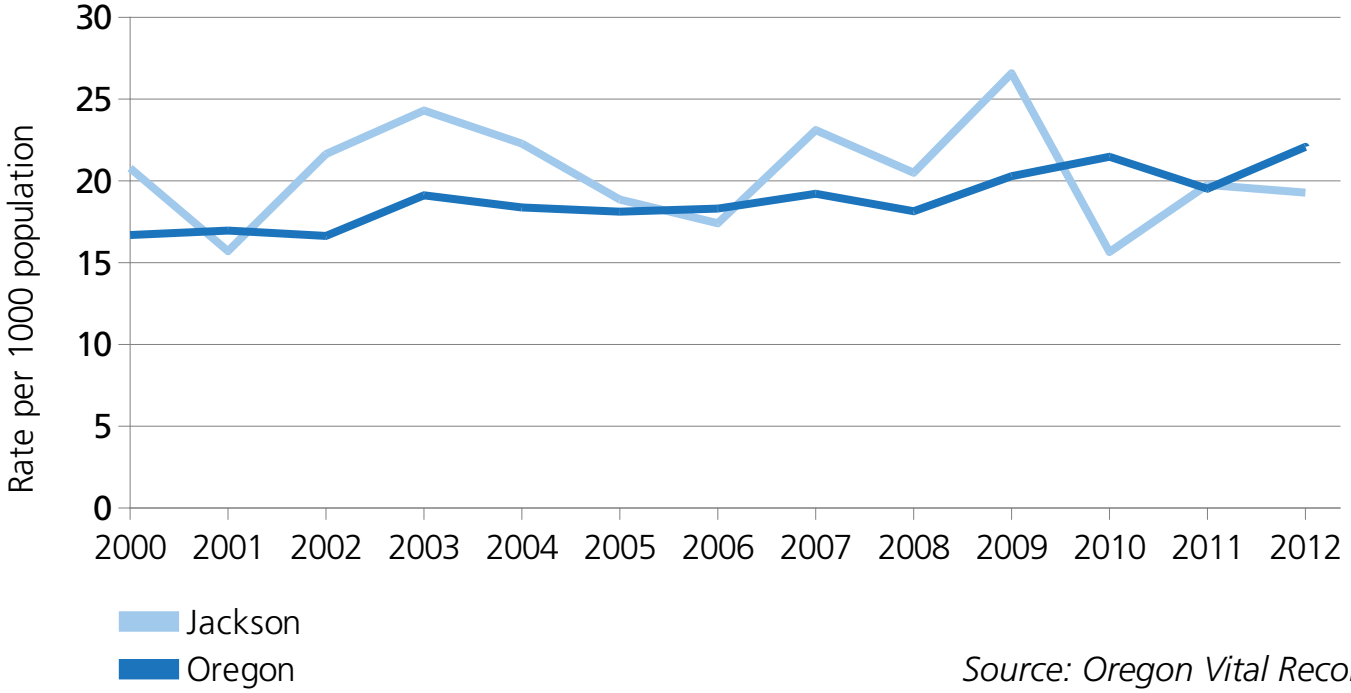
## Oregon Adults in Good Mental Health

*Jackson County and Oregon, 2006-2009*




*Source: Oregon Behavioral Risk Factor Surveillance System*

## Rate of suicide deaths, all ages 2000-2012 — Jackson County




*Source: Oregon Vital Records*

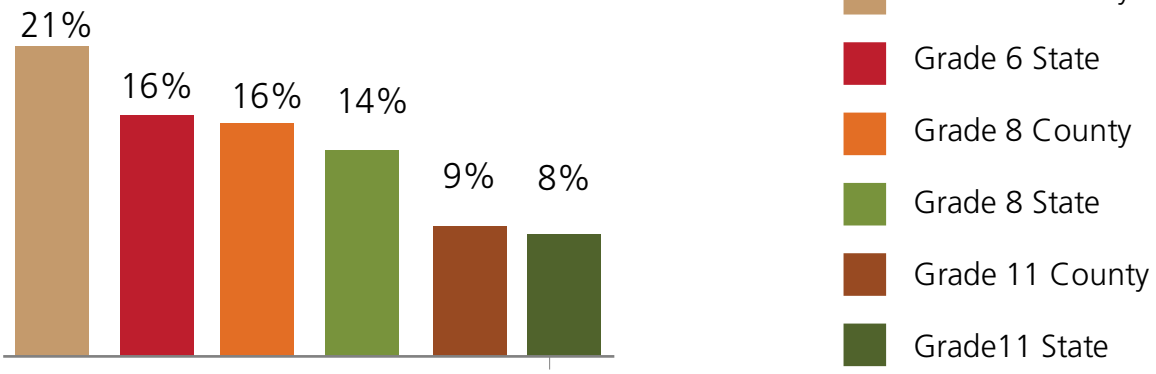
Rates of suicide deaths have been typically been higher than the state rate, with the highest rate being 26.6 deaths per 100,000. Suicide is highly correlated with depression, intimate partner violence and several mental health disorders.

Suicide, depression and harassment in youth is also higher in Jackson County than state averages. Bullying and harassment of youth was another reoccurring theme in the focus groups.

***"Bullying is destroying our future." —Focus Group Participant***

## Youth Harassment Multiple Grades

*Josphine County 2012*

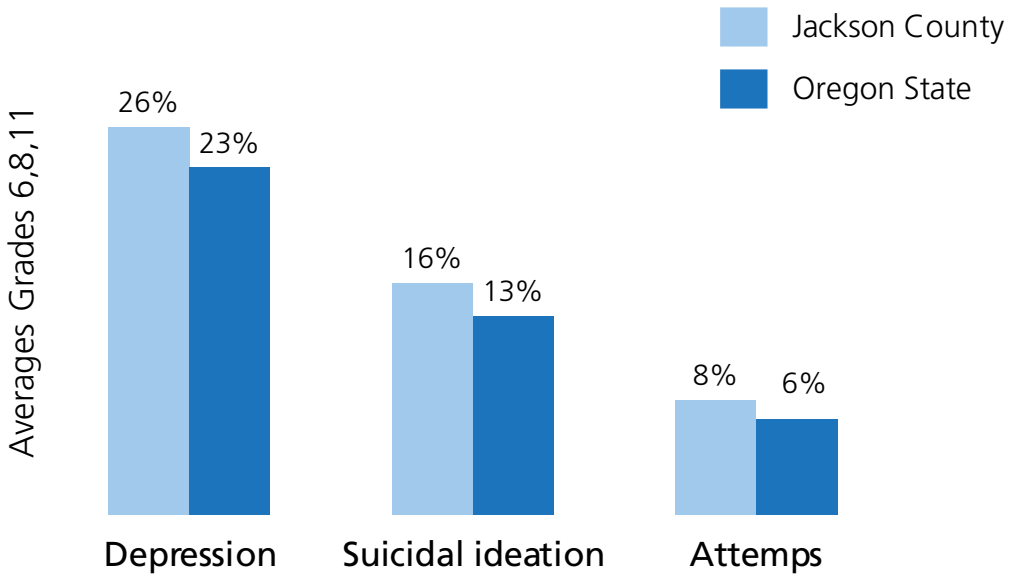



Harassment because "someone said that you were gay, lesbian, bisexual or transgender"

*Source: Oregon Student Wellness Survey, 2012*

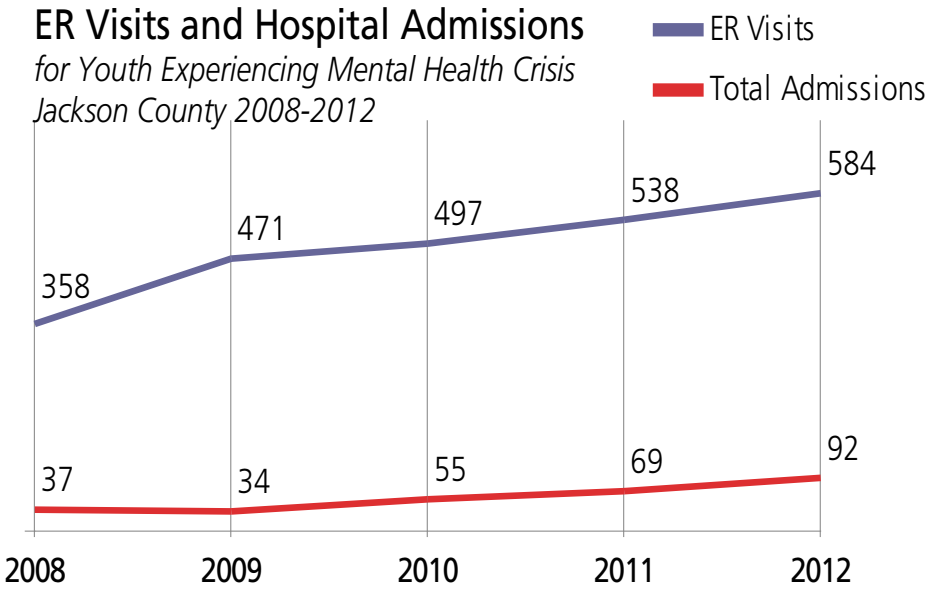
## Youth Depression, Suicide Ideation, and Attempts

*Jackson County*



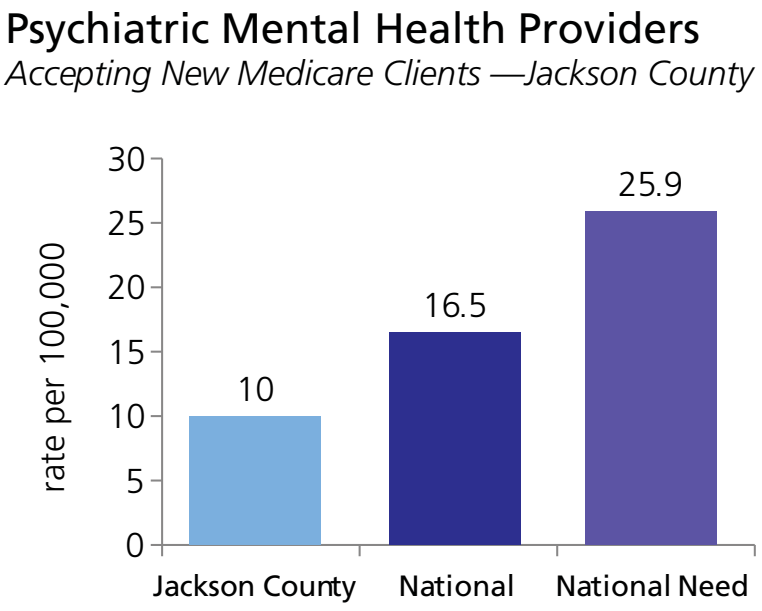

*Source: 2012 Oregon Student Wellness Survey*

Youth experiencing mental health crisis is increasing in the county, as evidenced by increasing ER visits and hospital admissions.




*Source: Rouge River Medical Center*

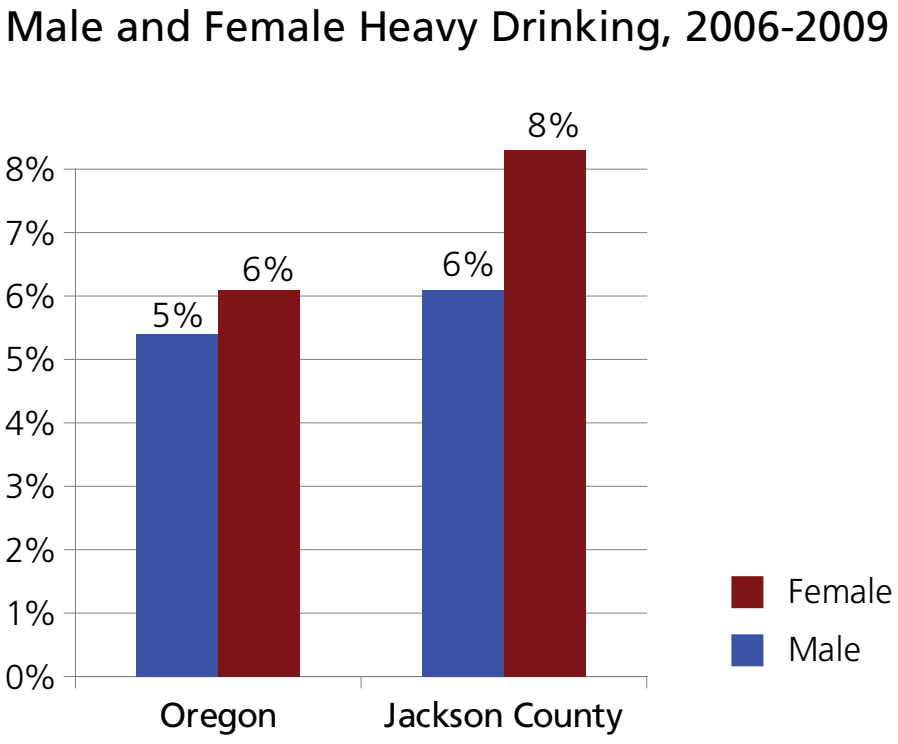
Seniors in the county are also challenged in accessing psychiatric services. The rate of Psychiatric Mental Health Providers accepting new Medicare clients is very low compared to the national need.



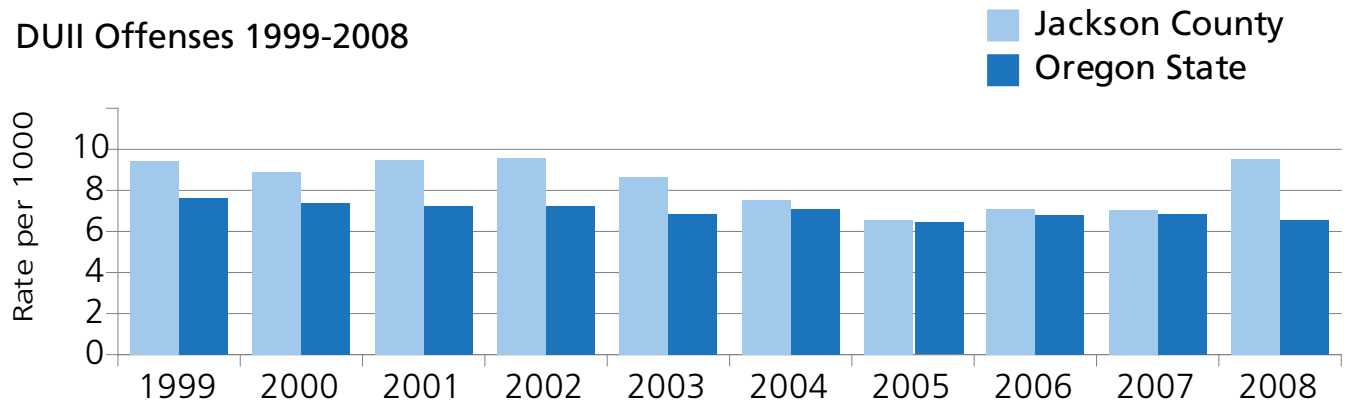

*Source: Jackson County Suicide Prevention Coalition, 2013*

## *Addictions*

Jackson County residents have significant issues with addictions to alcohol, tobacco, other drugs and gambling. Binge drinking, in both genders is higher than state averages, and higher than neighboring counties. Excessive heavy alcohol consumption can contribute to chronic health issues, including heart disease, cirrhosis of the liver, high blood pressure, stroke, coma and death. 15% of Jackson County adults drink excessively, twice the national benchmark of 7%. Heavy or excessive drinking is defined as adults consuming more than one (women) or two (men) beverages per day on average.




*Source: Oregon Behavioral Risk Factor Surveillance System*

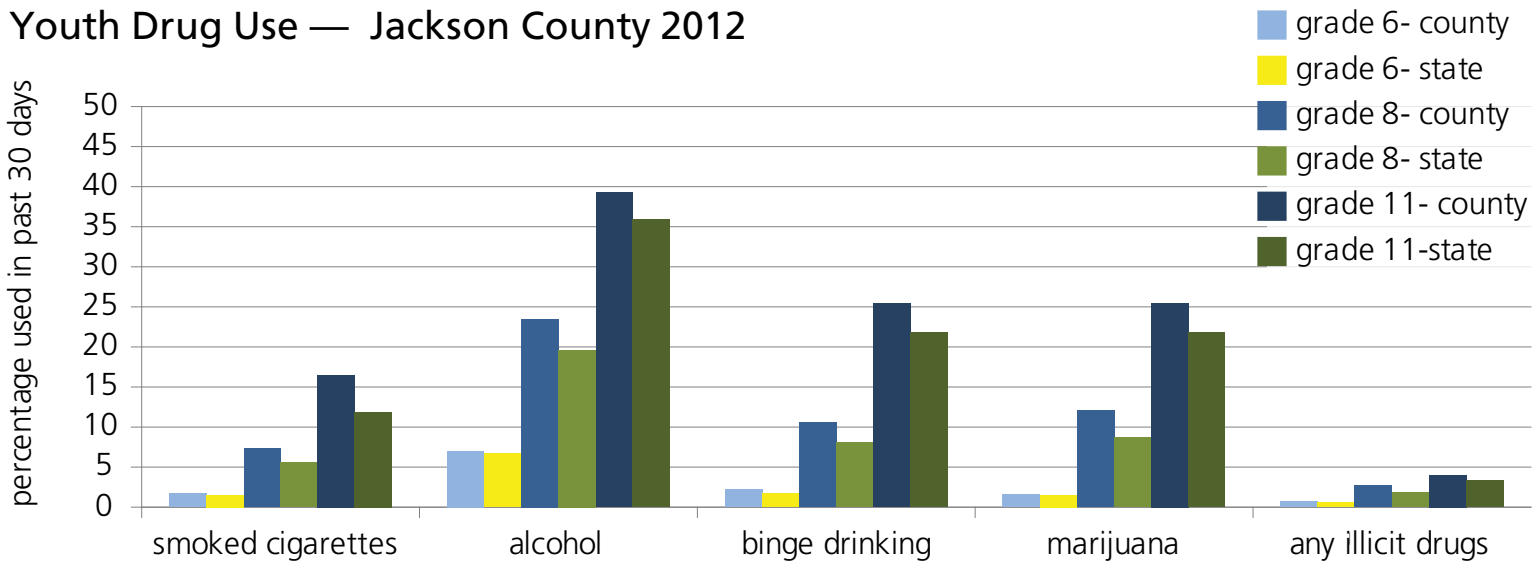



*Source: DUII Data Book for Oregon Counties, 1999-2008*

The rate of DUII (driving under the influence of intoxicants) is a data set reviewed when evaluating impact of addictions on a community. For well over a decade, rates of DUII has been higher in Jackson County than the state average.

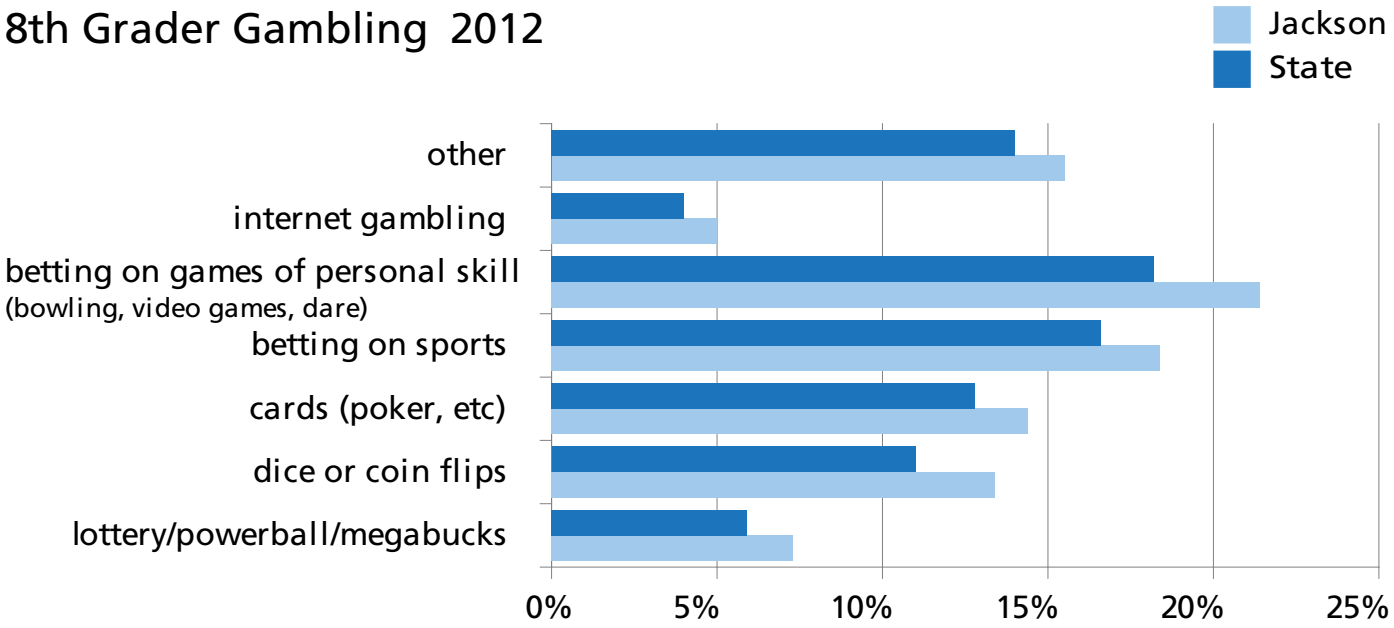
Drug and alcohol use is not a problem exclusively in adults. Jackson County shows youth reporting higher rates of cigarette, alcohol, binge drinking, marijuana and illicit drug use than state averages, for grade school through high school.

***"Kids come back from lunch [at my school] visibly high—having smoked their parents' stash at lunch. Everybody knows who the smokers are here, but there isn't much that we can do about it." —Focus Group Participant***




*Source: 2012 Oregon Student Wellness Survey*

## 8th Grader Gambling 2012



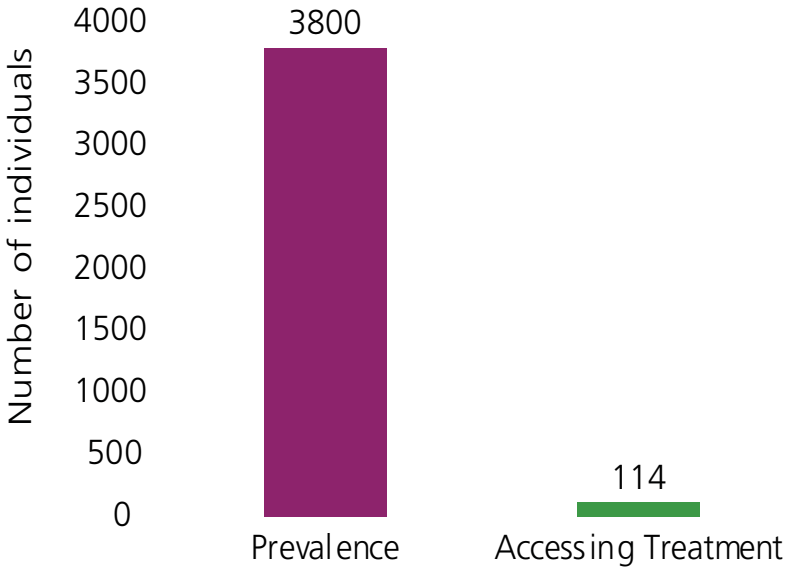

*Source: Oregon Student Wellness Survey 2012*

Gambling, a type of addiction, also presents challenges to both adults and youth in Jackson County. The county has higher percentages of eighth graders reporting gambling of every type, than the state average.

The prevalence of problem gambling is considerably higher than those accessing treatment in Jackson County. It is important to note that only 3% of those Jackson County residents experiencing problem gambling are accessing treatment.
For all drug categories, Jackson County continues to outpace State average drug

### Prevalance of Problem Gambling

*Jackson County 2012*

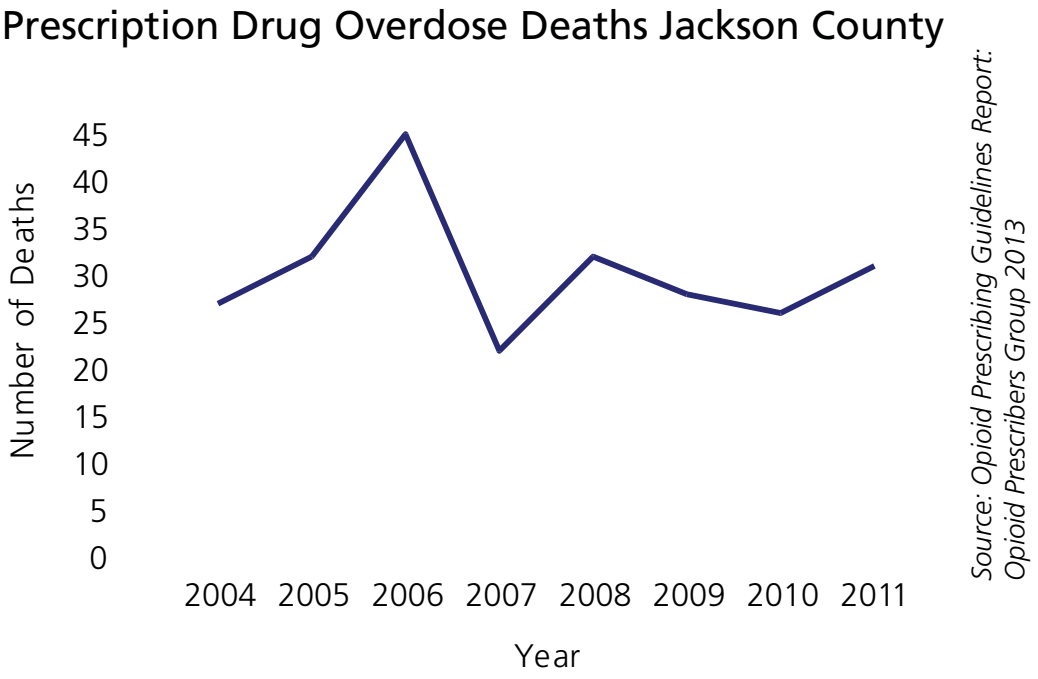



*Source: Oregon gambling treatment programs evaluation update 2012*
*Oregon Health Authority, Addictions and Mental Health Division*

arrests; most notably methamphetamine and heroin. (See People and Place section) It is important to note that declines in drug arrests are more likely attributed to reductions in funding for local law enforcement than reductions in drug use and trafficking.

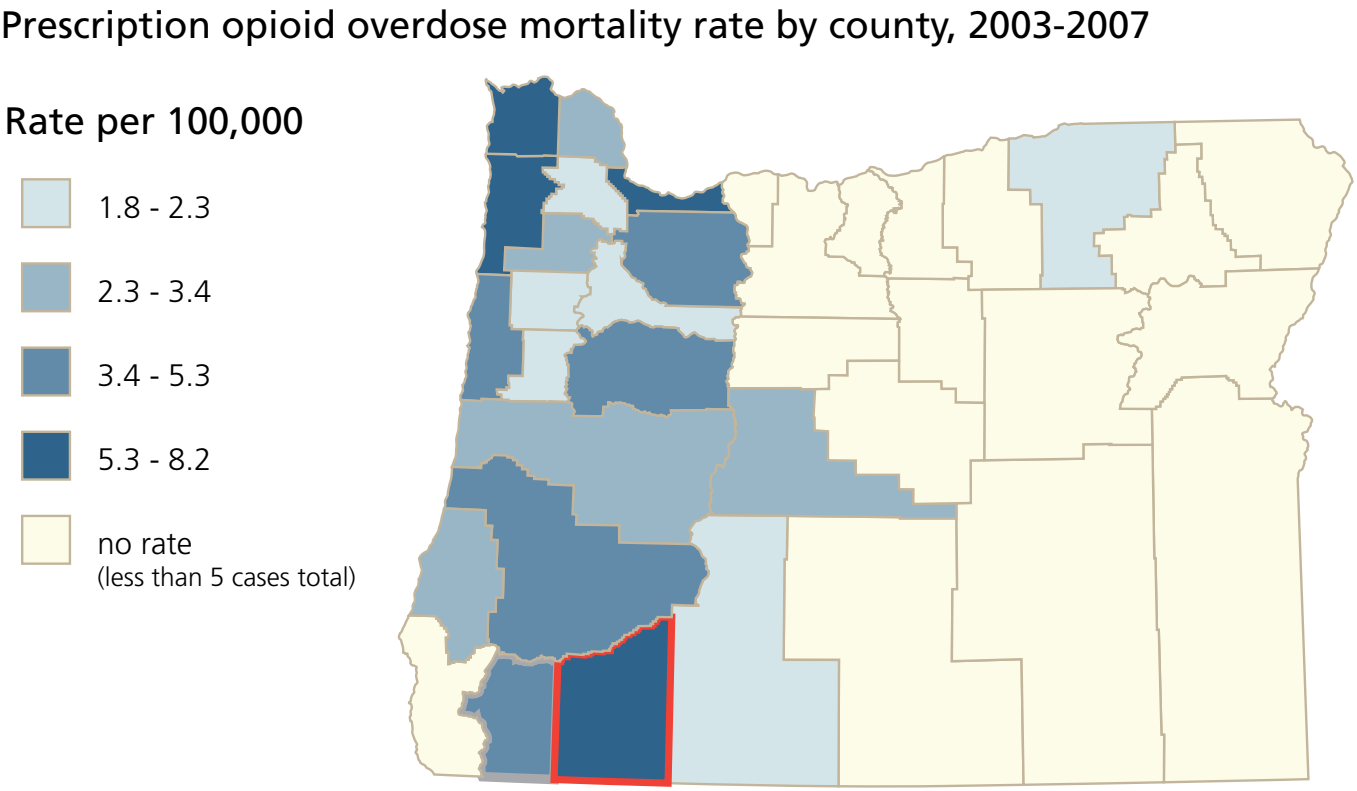
***"Just about everyone I know has an addiction. People with addictions are more sick, can't get to the doctor, don't have insurance and are embarrassed." —Focus Group Participant***

Jackson County has one of the highest opioid death rates in the State, and the number of annual opioid deaths is on the rise (deaths from drugs such as codeine, oxycodone, morphine and methadone). The morbidity and mortality associated with inappropriate use of opiate drugs has a negative impact on the health of the community. At the same time, people in focus groups commented that their pain was not well managed and discussed the added burden that chronic pain presented when suffering from chronic conditions. Focus group comments and the high rate of opioid death suggest systemic problems in the management of chronic pain in the county.




## *Maternal & Child Health*

Causes of

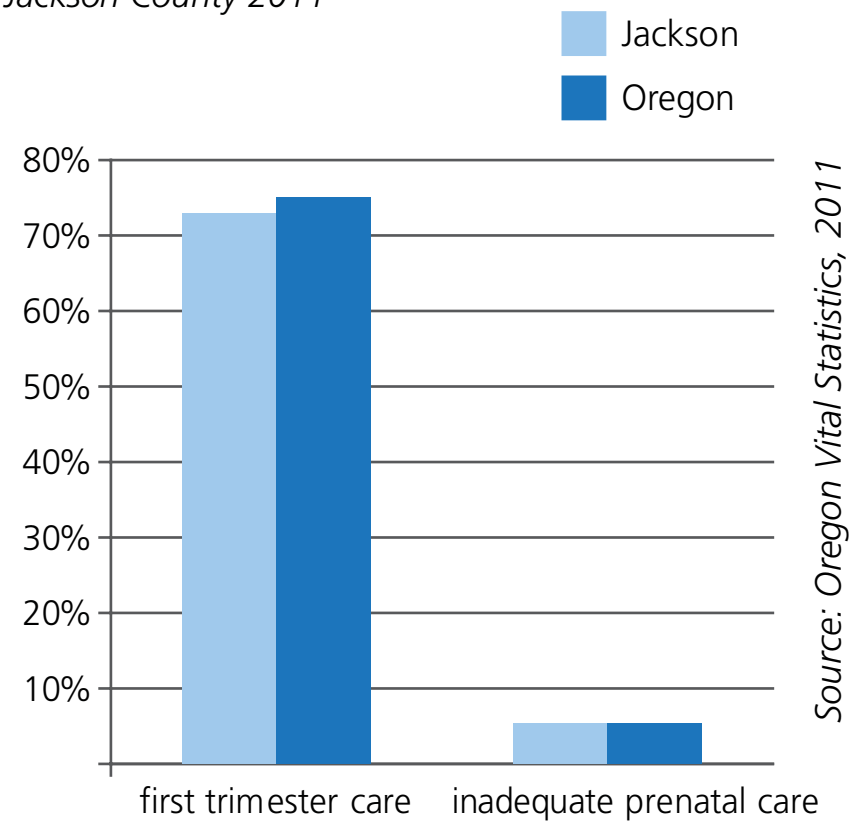



*Source: Jackson County Response to Prescription*

low birth weight include tobacco use, alcohol and other drug use, socioeconomic factors such as education level and poverty as well as maternal and fetal medical conditions. Babies born with low birth weight (considered 1500-2499 grams at birth) typically have more long-term disabilities and developmental issues, including cerebral palsy, learning disabilities, impairment of sight, hearing and/or lung functioning. The percentage of low birthweight babies in Jackson County is 6%, close to the state percentage of 6.1% and just meeting the national benchmark of 6%.

## Percentage receiving prenatal care

*Jackson County 2011*

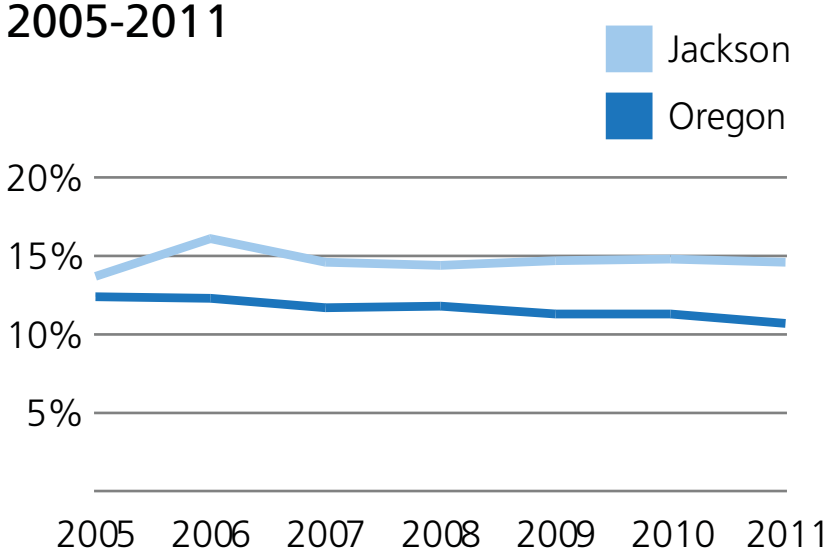



Women who access care while they are pregnant are more likely to have healthy pregnancies and better child outcomes and less likely to have low birth weight babies. Prenatal care includes a myriad of services, including: education about healthy choices and body changes while pregnant, prenatal testing and counseling, treating medical conditions/complications (such as anemia and gestational hypertension), oral health assessment and treatment, screening for intimate partner violence and tobacco use and substance abuse.

Although pregnancy risk factors are high (such as maternal tobacco use) in Jackson County, utilization of prenatal care is moderate but below the state average, with 73% of mothers in the county receiving prenatal care in the first trimester. Those women receiving prenatal care in Jackson County, have a marked reduced rate of low birth weight babies compared to those without prenatal care.

A primary risk factor for low birth weights and child outcomes is maternal smoking. Maternal smoking is currently higher than the state average and has been for several years.

## Percentage of Maternal Tobacco Use 2005-2011

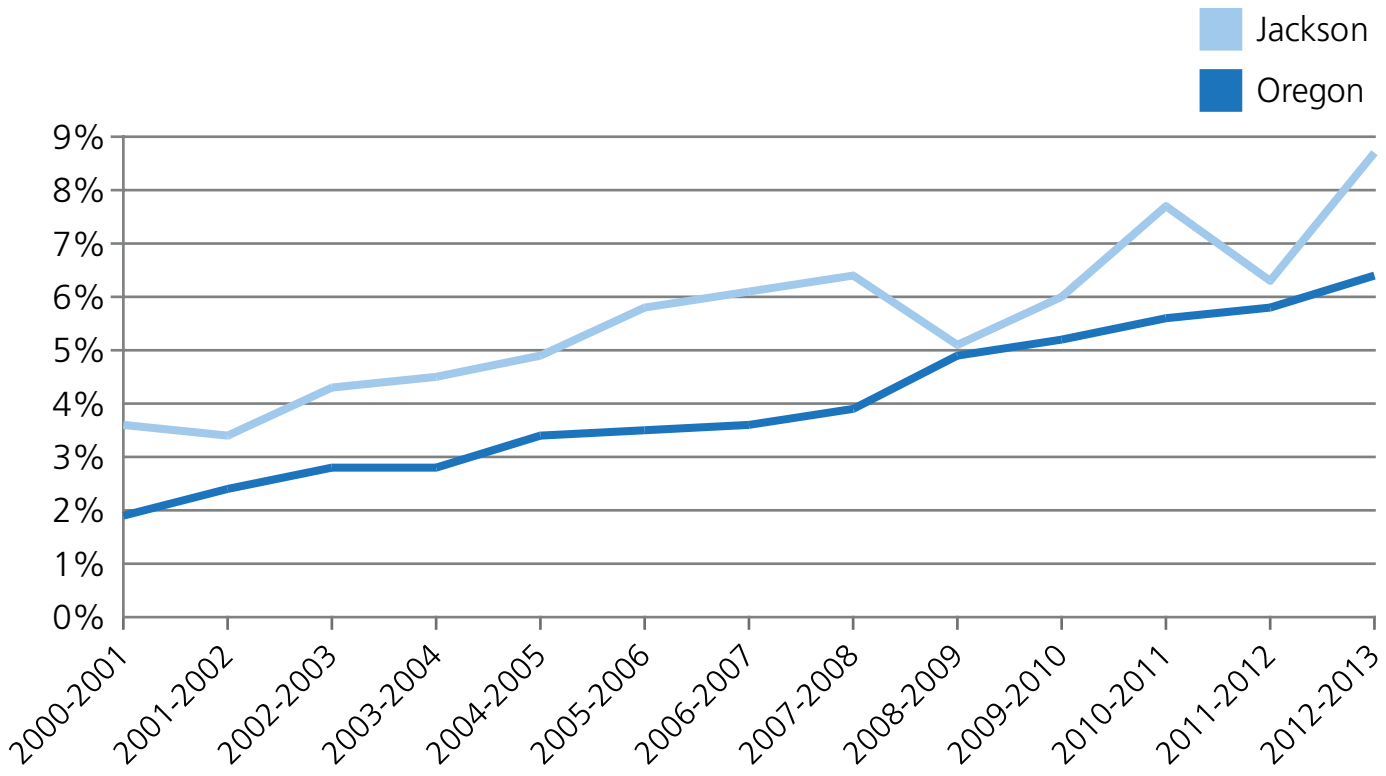



*Source: Oregon Health Authority Center for Health Statistics*

The teen birth rate in Jackson County is higher than the state average and national benchmark. Jackson County's teen birth rate per 1,000 females ages 15-19 is 37. The Oregon rate is 33 per 1,000, the national benchmark is 21 per 1,000.

Immunization is an effective tool for preventing disease and death. Vaccinating children, according to the Centers for Disease Control and Prevention recommended immunization schedules, is varied by county. Those parents choosing not to vaccinate claiming religious exemption has been higher in Jackson County than state average for over a decade. The trend of those requesting exemption continues to increase annually.

Religious exceptions from immunizations by school year Jackson County




*Oregon Health Authority, Immunization Program*

## *Health Behavior & Lifestyle Factors*

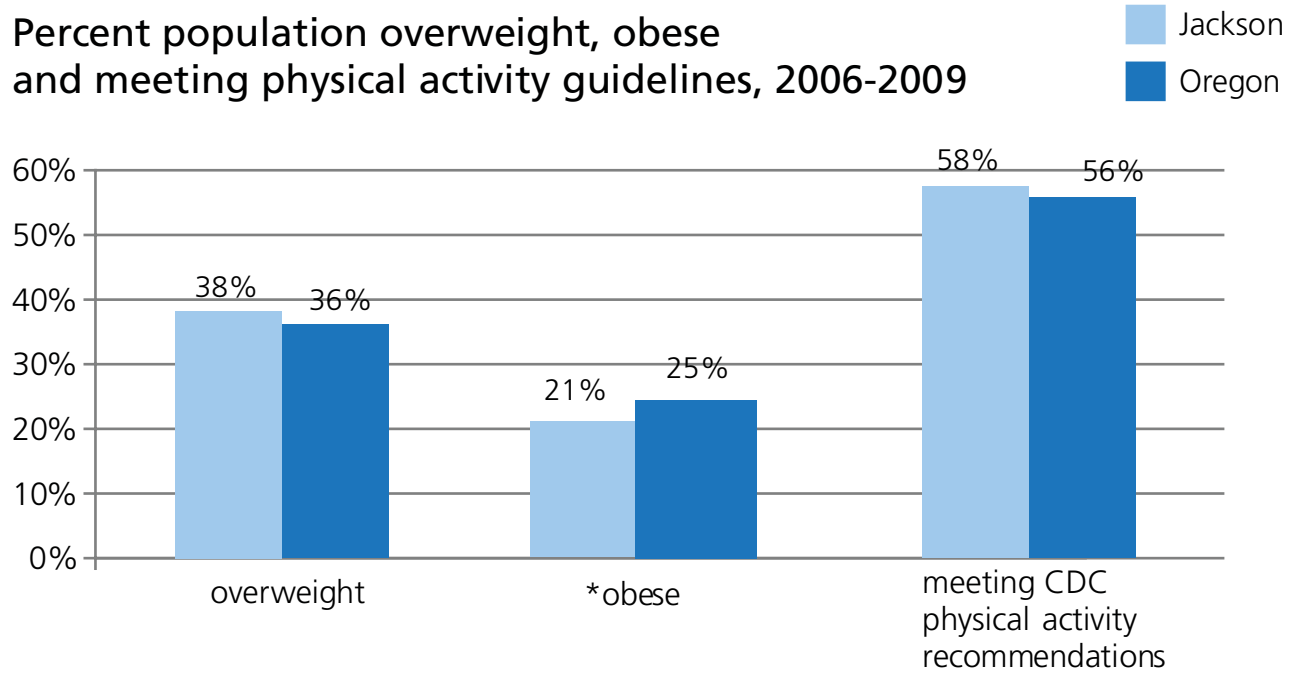
Modifiable behaviors related to health status such as tobacco use, inadequate physical activity and nutrition have significant influence on the health of individuals and communities. The leading cause of preventable death in Jackson County, as it is in Oregon, is tobacco use. A close second is obesity.

### *Tobacco*

Tobacco usage has remained high in Jackson County for many years. Roughly 1 in 5 adults in the county smoke cigarettes, considerably higher than the state average of 17.1%. Of grave concern are the 15% of birth mothers, in 2009, who reported smoking while pregnant.

According to the 2013 County Tobacco Fact Sheet, Jackson County spent an estimated $83.8 million on medical care related to tobacco use.

2012 Oregon Student Wellness Survey data indicates that 7.3% of 8th graders, and 16.5% of 11th graders in Jackson County used cigarettes. One-third of these kids have started an addiction that will eventually kill them. Eighty percent of adult smokers in Oregon started before the age of 18.




*Source: Oregon BRFSS County Combined Dataset 2006-2009*

### *Obesity*

Obesity is a modifiable risk factor for several chronic conditions. Overweight is defined as a body mass index of 25 or higher, obesity is defined as a BMI of 30 or higher. BMI is calculated by using both height and weight. Research has shown that overweight and obesity are associated with increased risk of coronary heart disease, type 2 diabetes, cancer, high blood pressure, stroke, liver and gallbladder disease. Approximately 2/3 of adults in Jackson County are either obese or overweight, putting them at increased risk of chronic disease and increased morbidity.

### *Physical Activity & Nutrition*

Regular physical activity and a healthy diet reduce the risk for chronic disease and obesity.

The percentage of adults consuming at least five servings of fruits and vegetables a day in Jackson County from 2006-2009 was 33.2%, exceeding the state average of 27%. The proportion of fast food establishments in the county, at 44%, is almost twice the national benchmark.

> ***"Access to resources to live a healthy lifestyle is hard. Food access here is bad, small stores in small communities have mostly processed foods, they can't afford to bring in fresh out of town produce. That's made worse by the fact that those with SNAP use their food stamps for processed food, the money goes farther with processed food."***
> ***— Focus Group Participant***

## *Additional Social Determinants of Health*

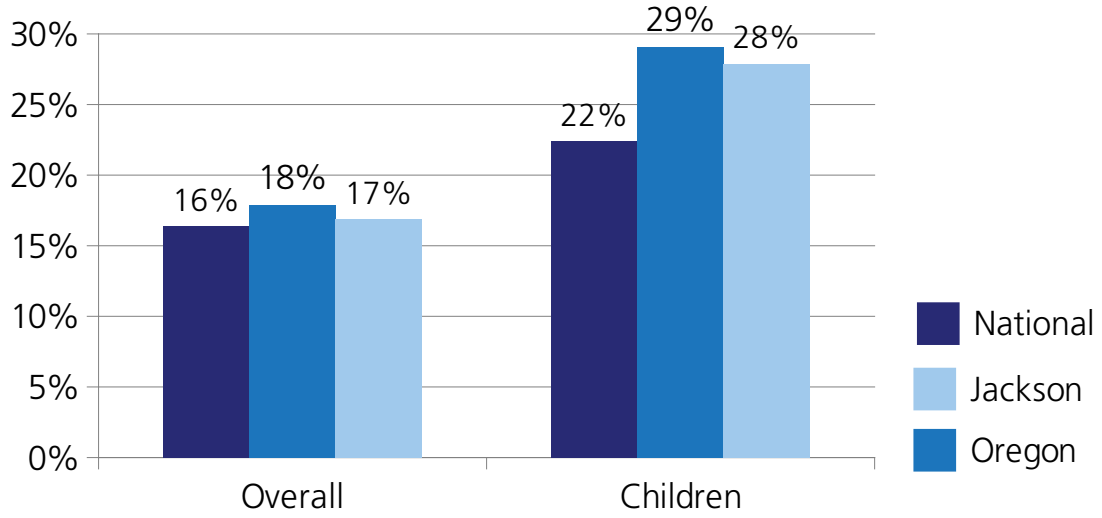
### *Food Insecurity*

The USDA defines food insecurity as lack of access to enough food for all members in a household and limited or uncertain availability of nutritionally adequate foods. Over 16% of Jackson County households, or approximately 34,260 people are food insecure. 75% of the food-insecure households in the county have incomes below the poverty level. Additionally, 22.4% of children in Jackson County households experienced food insecurity in 2011. It is estimated that an additional 15 million dollars would have been needed to meet food needs of those living with food insecurity in Jackson County in 2011.

The percentage of K-12 students eligible for free/reduced lunches in 2012-2013 was nearly 60%, indicating significant child poverty levels and access to food concerns for the youth of Jackson County.

Percent with food insecurity

*Jackson County, Oregon, National, 2011*

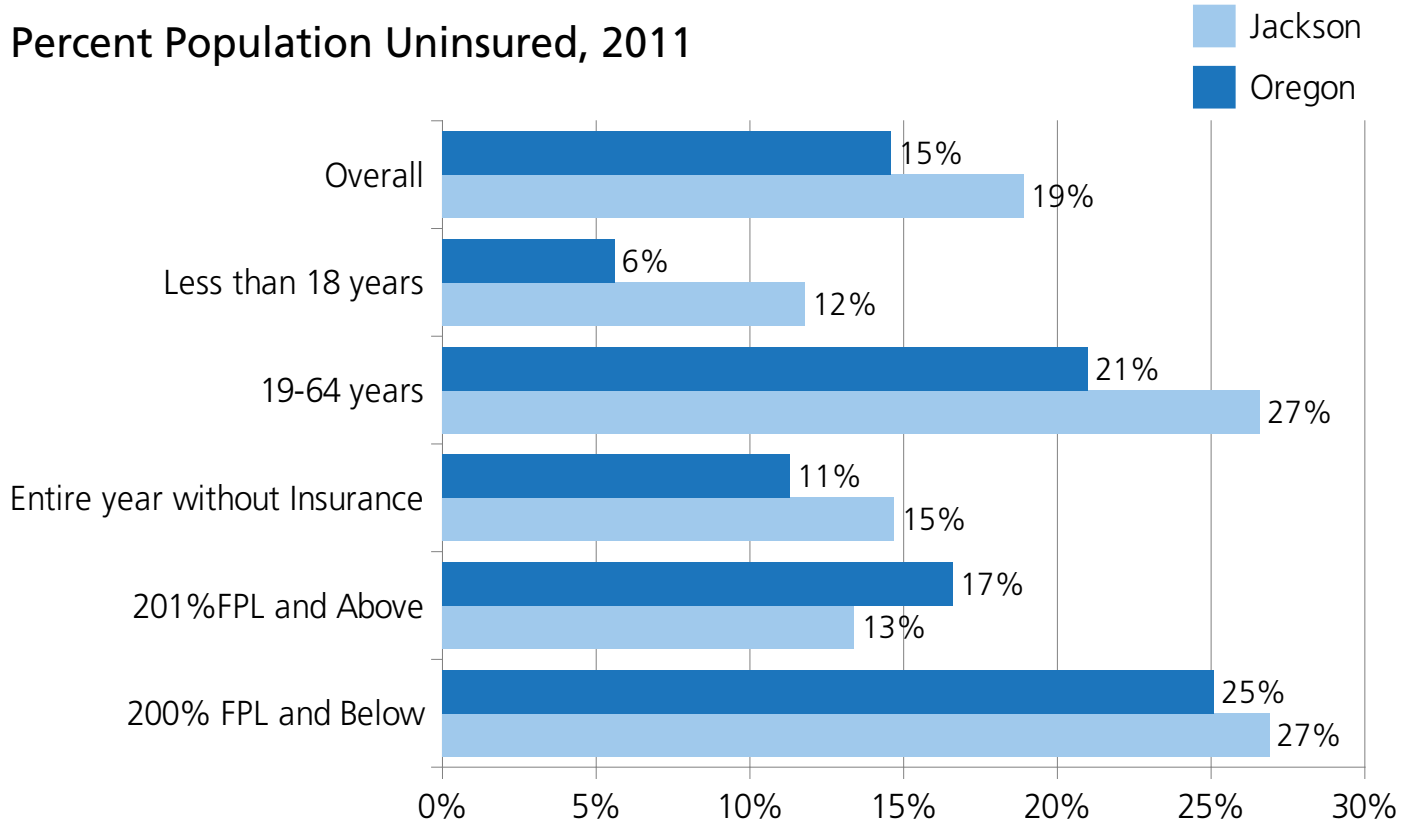



*Source: Map the Meal Gap, Food Insecurity in your County, Feedingamerica.org*

# Health System

## Access to Medical Care

Lack of health insurance coverage continues to be a significant barrier to accessing needed health and medical care. Uninsured people are likely to experience more adverse physical, mental and financial outcomes than those with insurance. Jackson County far exceeds the national benchmark of 11% and state percentages in all age groups. 26.6% adults 19-64 in Jackson County were uninsured in 2011. This number is expected to change after January 1st, 2014. It is expected that the majority of new enrollees after January 1 will be adults.



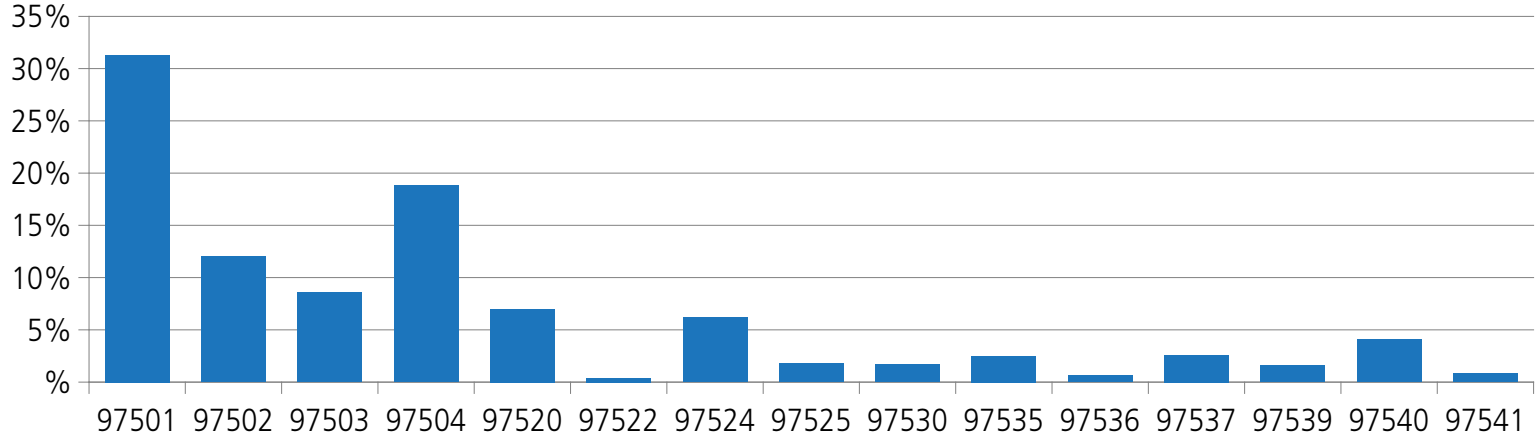

*Source: 2011 Oregon Health Insurance Survey*

Although the number and demographics of enrollees will change January 1, it is helpful to understand the current population of CCO enrollees. Enrollees are spread out across the county, with the higher percentages living in Medford, Central Point, and White City.

Close to 65% of the current CCO enrollees in Jackson County are under the age of 18, higher than Josephine County (53% are under 18). Access to health care was a consistent theme in focus groups and key informant interviews. Insurance costs, transportation (getting to appointments), availability of specialists, accessibility of clinics for people with disabilities, language barriers, primary care physicians not taking specific insurance plans, and health literacy regarding how to negotiate insurance were all listed as access concerns for residents living in Jackson County.

## Percent CCO Enrollees By Select Zip Codes

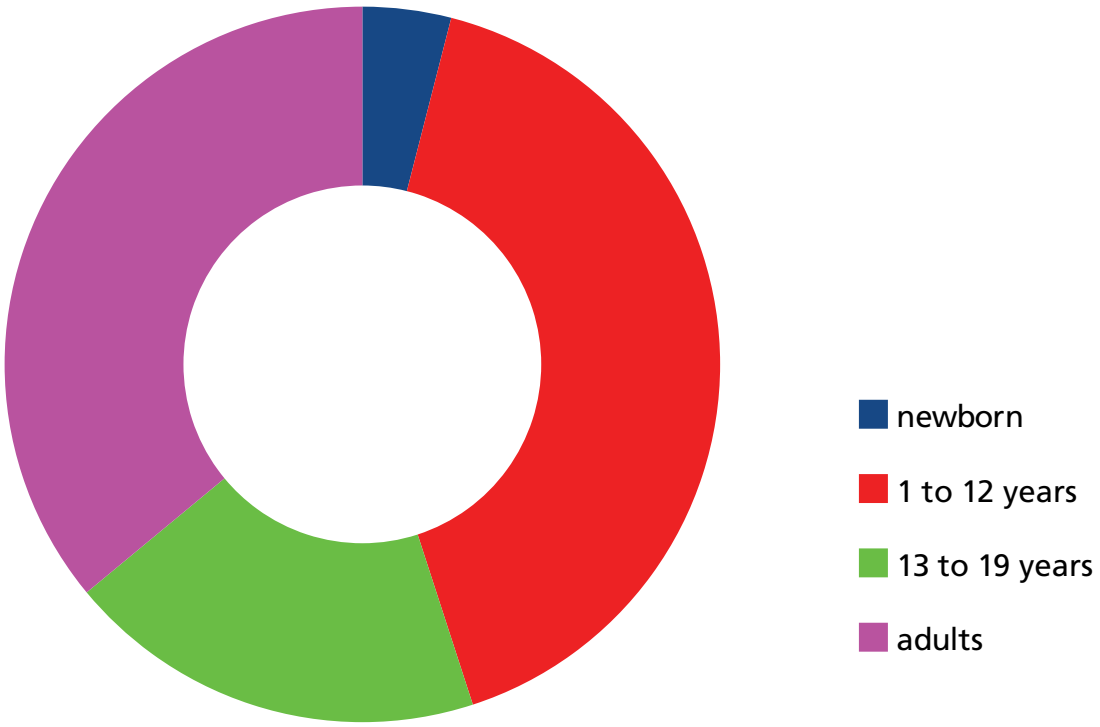
*Jackson County 2013*




***"I've seen patients that said they were surprised that they couldn't use their brother's insurance card and didn't know what a copay, co-insurance or deductibles were. Health literacy and access to health care is more than just having insurance and that will only become more apparent after January 1st."—Key Informant***

## CCO enrollee by age

*Jackson County 2013*



# Community Perceptions of Health

## Focus Groups

This report presents summary findings from five focus groups, conducted in Jackson County as part of the 2013 Community Health Assessment. The purpose of the Community Health Assessment was to learn what people in the county believe are most important issues affecting their health and that of their families and communities. The purpose of the focus groups was to gather primary qualitative data on community perceptions and increase community engagement in setting priorities for individual and community health.

The focus groups were part of a larger community health assessment process, following a modified Mobilizing for Action through Planning and Partnerships (MAPP) model. The focus groups were all facilitated by a consultant and assisted by Community Advisory Council (CAC) members and Coordinated Care Organization (CCO) staff.

Five focus groups were completed through Jackson County during September 2013. Thirty-six (36) community members participated in the groups, representing several different populations. A subcommittee of the CAC, titled the CACC, began by prioritizing populations and locations for focus groups. Lengthy discussion about what groups to select for focus groups included two face-to-face CACC meetings, an online survey given to the CACC members.

It is also important to note that there are limitations to the focus group data. Focus group data should not stand on its own but complement the health status and epidemiology data presented earlier in the Community Health Assessment. Focus groups were not intended to be a representative of all individuals in the entire county but rather, a process to gain specific insight into health concerns and solutions of specific populations. The populations chosen were driven by the Community Advisory Councils.

The limited time frame (one month) to complete focus groups was recognized as a challenging aspect of the process and the CACC had several intentional conversations about the need to prioritize due to the time constraints. Due to the January 1, 2014 deadline for submission of the final CHA, the CACC worked within the one-month parameter and chose five groups per county, with the caveat that additional groups and time would be added into the process for the next CHA.

### Prioritized Populations for Jackson County Focus Groups

- Latino/Spanish-Speaking
- Addictions
- Uninsured/Underinsured
- Dental
- Rural/Unincorporated
- Chronic Pain
- Chronic Disease

The CACC also discussed and guided the selection of data and questions to gather at the focus groups. The focus group guide, including the specific questions asked, is attached in the Appendices. A "site champion" was chosen from the CACC for each focus group. The role of the site champion was to lead recruitment, coordination of focus group location, selection of incentives for participants and introduction of the consultant to the participants at the group.

Data was gathered during the groups via open-ended questions and instant feedback polling questions. The instant feedback polling questions utilized Turning Technology "clickers," capturing instant demographic data and polling on health priorities and perceptions. The use of multiple feedback collection methodologies ensured 100% participation of focus group attendees.

Light refreshments and $10 gift cards were provided to focus group participants as incentives. The focus groups were completed within two hours, and averaged 6 participants per group.

### *Focus Group Schedule-Jackson County*

| Group | Date | Location |
|---|---|---|
| Rural/Unincorporated | 9-30 | Prospect |
| Latino/Spanish Speaking | 9-4 | Sacred Heart Church |
| Uninsured and Dental | 9-16 | Library Medford |
| Addictions | 9-17 | Addictions Recovery Center inpatient |
| Chronic Disease/Chronic Pain | 9-25 | Central Point |

## *Demographics of Participants*

Focus group participants answered demographic questions about gender, age, ethnicity, martial status and education with Turning Technology clickers. The use of the clicker technology provided anonymity and increased participation and engagement in the group process. The total number of participants was thirty-six. Please note that not all participants chose to fill out demographic information, so totals on the demographic categories are varied.

### *Jackson County Focus Group Participant Demographics*

| Characteristic | Response |
|---|---|
| Age | |
| 25 or under | 11% |
| 26-39 | 17% |
| 40-54 | 31% |
| 55-64 | 19% |
| 65 or over | 22% |
| Sex | |
| Female | 58% |
| Male | 42% |
| Ethnicity | |
| African American/Black | 3% |
| Pacific Islander | 0% |
| Hispanic/Latino | 14% |
| Native American | 0% |
| White/Caucasian | 83% |
| Other | 0% |
| Marital Status | |
| Married or co-habitating | 58% |
| Not married, single, divorced or widowed | 42% |
| Highest Level of Education | |
| Less than HS Diploma | 11% |
| HS diploma or GED | 22% |
| Some college or degree | 61% |
| Other | 6% |
| Household income | |
| Less than $20,000 | 36% |
| $20,000-29,999 | 22% |
| $30,000-49,000 | 11% |
| Over $50,000 | 31% |

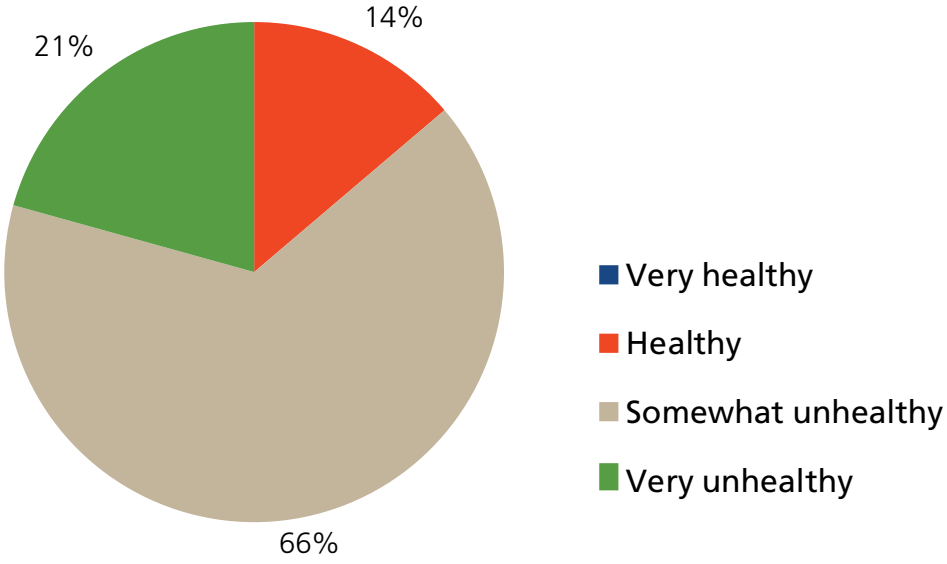
## *Community Perceptions*

Focus group participants also answered questions about their personal health, the community health and ranked their top health problems, risk factors and conditions that influenced a healthy community. The following data were also collected with the Turning Technologies clicker system.

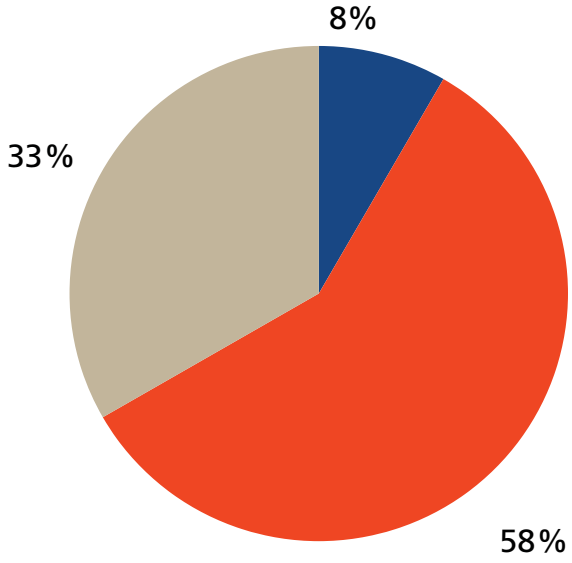
A majority of participants (87%) described their community as unhealthy. Counter to that, was that the majority (66%) of participants described themselves as healthy.

Participants were then asked to select the three most important health problems, perceived risk factors and conditions that influenced a healthy community.

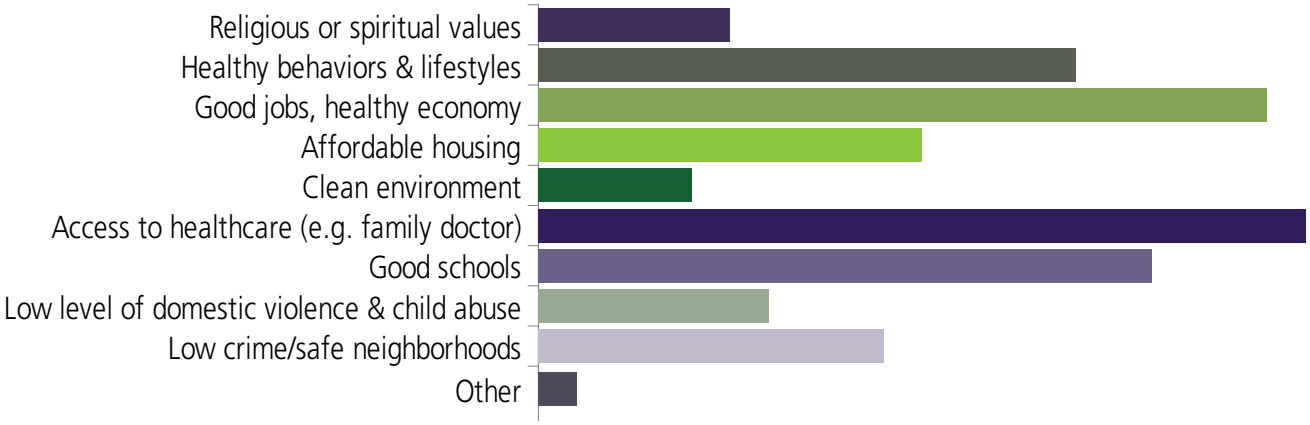
### Community Health



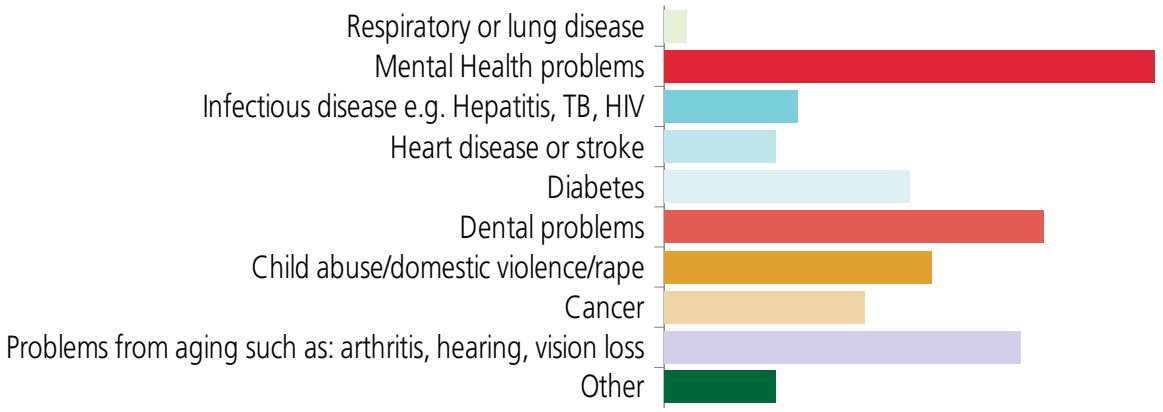

### Personal Health



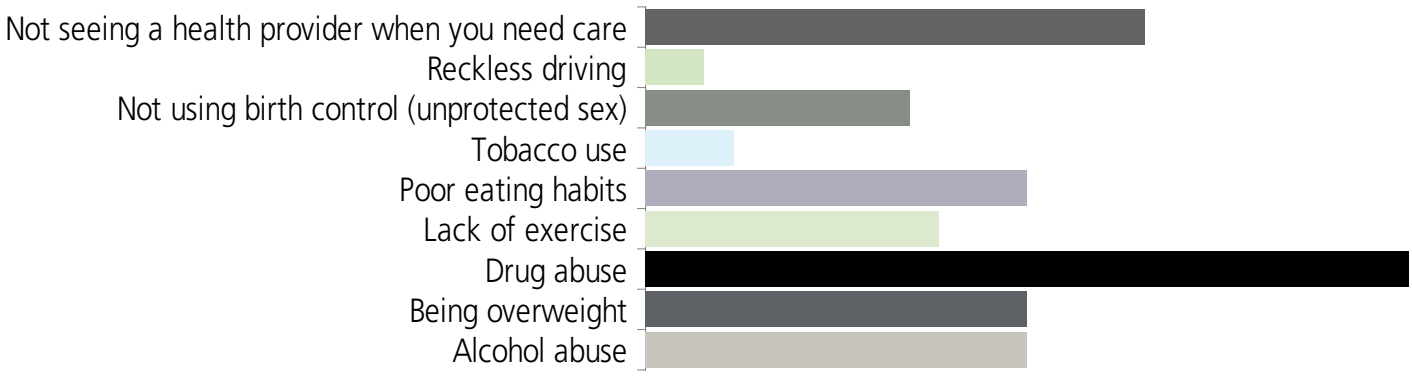

### *What do you think are the three most important ingredients for a healthy community?*



### *What do you think are the three biggest health problems in your community?*




### *What do you think are the three biggest risk factors for health in your community?*




### *Participant Commentary*

The second portion of the groups consisted of open-ended dialog questions, asking participants to discuss individual and community health needs. Several hundred narrative comments were collected during the five focus groups. The CACC workgroup reviewed all comments and upon analysis, recognized several universal themes. The comments listed below were reviewed, categorized and selected by the CACC to be included in the CHA. Focus group participants' responses are presented in seven categories. All comments below were transcribed verbatim. Comments are intentionally written out as they were spoken in the group.

1. Access to and quality of health services
2. Mental Health and addictions
3. Lifestyle: Exercise, Obesity, Nutrition and access to food
4. Dental and/or Vision health
5. Poverty and the economy
6. Chronic disease and/or aging issues
7. Crime, domestic violence and child abuse

### *Access to and Quality of Health Services*

Focus group participants consistently brought up barriers to accessing health and medical services. Insurance (or lack of), paying for health care services, physically getting to a health care provider (transportation), language barriers, having providers available and the relationship with providers were all common themes in every focus group.

*"Insurance needs to be more cost effective for us—I don't want it for free, but it needs to be more affordable so that we don't have to choose between feeding my kids or getting medical care."*

*"Some clinics don't want to treat all issues at the same time, they only treat one issue at a time—they ask for multiple appointments—but that requires more paying,deductibles, or copays.*

*"For years, I've been trying to get on OHP but I am over income—so I have to save for emergencies and just deal with my pain."*

*"[My biggest concern is] access to healthcare, being able to go to the doctor when you need to, not always going to emergency room."*

*"Availability of healthcare—up to a week ago I had no health insurance—I skipped a few doctor appointments which made my chronic conditions worse and cost [more] in the long run."*

*"Availability—getting into the doctor or specialists took me six months. You could be dead by then. Even when you have insurance getting in is not always easy."*

*"Continuity of care—not all docs on the same page, they all treat differently—not coordinated at all."*

*"Negative: Cost of healthcare, even with insurance, is a barrier. Positive: Availability of quality healthcare in our community."*

*"Most of the time, we just get over the counter medications or share each others prescription medications and then it gets worse. We can't afford to get the labs/tests to determine what is wrong too, so it just gets worse."*

*"Access isn't just about insurance—we need more services, access on many different levels. More of all services are needed, addictions, prenatal, all services are needed."*

*"Transportation—even those that have chronic diseases—must have insurance but getting to the provider is super difficult."*

*"A woman at the gas station told me she was happy to see a clinic start in Butte Falls—and that it will save peoples' lives on the road. Older people were driving and either waiting too long or getting in an accident—she told me, in tears, about several that she knew [that] died after leaving the gas station to get to Medford."*

*"Somebody might want to get to a workshop but they have no transportation, transportation is a huge need."*

### *Mental Health and Addictions*

Challenges with mental illness and addictions weighed heavily on all groups. The effects of both on the individual and community were prevalent in many conversations about what concerned participants and what solutions they wanted to improve their health and the health of their community.

*"Mental health problems, people don't think they can be healthy so they turn into negative thinking. If you are healthy mentally you are less prone to do drugs."*

*"The biggest factor is lack of a continuum of mental health supports and services. Services seem to be focused on meeting crisis needs rather than prevention and community support due to lack of funding."*

*"Mental illness and substance abuse are huge and costly. Also, the criminalization of mentally ill and addicted individuals is an ineffective and costly approach to dealing with these issues."*

*"Just about everyone I know has had an addiction. People with addictions are more sick, can't get to the doctor, don't have health insurance and are embarrassed."*

*"We need clean needles. I see needles laying around all over the place, in the street, on the sidewalk, its disgusting and I was a user."*

*"I am diabetic and used to supply all of Hawthorne Park with hypodermic needles, I got over 200 a month and didn't need them all. I'm here now (inpatient treatment) so I don't know who is giving out clean needles."*

*"People are scared now—because of more homeless people are in the woods and the drug culture they bring."*

*"Substance abuse is another serious issue in our community across all economic levels. Also a lack of adequate mental health services is a big problem."*

*"We need less probation-focused treatment."*

*"Pot, heroin, pills and prescription pills. People have gotten pretty creative. Like snorting Excedrin migraine in their nose (in my high school)."*

*"Two years ago we had a huge problem with inhalants—kids were doing them at football games—whipits with whip cream inhalants. My nephews were killed last year from doing whipits and getting in a car accident."*

*"Kids come back from lunch (at my school) visibly high—having smoked their parents' stash at lunch. Everybody knows who the smokers are here, but there isn't much we can do about it."*

*"Lack of resources [is a problem] they are out there but they are always broken. Bus passes, food banks, etcetera are broke. It's hard to get to resources. Not a lot of help for women with no children. Jackson County Mental Health only has 12 visits a year—that's not enough, it's like you just start getting into your problems and have to stop."*

*"Homelessness, limited help for young single people. Hard if you don't have parents to help you."*

*"Out of fifteen of my preschoolers—four were raised by grandparents last year. They aren't always healthy [the grandparents]—and their health affects the kids and the grandparents. Plus, its stressful to raise your grandkids."*

*"Bullying is destroying our future, education systems are atrocious, our country is at the bottom of education scales, (writing, math, science and reading) and it affects our health."*

### *Lifestyle: Exercise, Obesity, Nutrition and Access to Food*

The need for lifestyle changes, including diet and exercise were clearly recognized in all groups. Participants were quick to recognize their own challenges with lifestyle change while also making suggestions for solutions such as community gardens, walking groups or farmers markets.

*"Habits are hard to break and start from our family going way back. I do what my parents did, and food and life has changed, so should our habits."*

*"Unhealthy food seems to be more convenient."*

*"Access to resources to live a healthy lifestyle is hard. Food access here is bad—small stores in small communities have mostly processed foods, they can't afford to bring in fresh out of town produce. That's made worse with the fact that those with SNAP use their food stamps for*

*processed food-the money goes farther with processed food."*

*"It costs $20 gas to get to Eagle Point [out of rural town] to a grocery store with good produce, there is no public transit except "'the thumb .'" (hitchhiking)*

*"Part of the problem is the lack of real education around nutrition and disease prevention."*

*"With no grocery store with produce here, sometimes I call the local café and ask them for a head of lettuce when I need it."*

*"As a family—lack of consistent exercise for entire family affects our health—life is busy, exercise becomes last on the list of priorities."*

*"Kids don't play outside—they sit in front of video games."*

### *Dental and Vision Health*

Access to dental care and the negative effects of not having both preventive and crisis dental care was a consistent theme among all groups and demographics. Vision health was also mentioned in approximately 60% of the groups, related those living in poverty and not being able to acquire glasses or contacts.

*"[There are] lots of dental issues here—all they do is pull your teeth. When you don't have teeth you lose self esteem."*

*"Dental appointments are still 2-3 weeks out even when in pain, what if I have a bad infection? People can die without help."*

*"We see kids with swollen face from abscesses and dental problems—their parents are like, "I don't know what to do, won't it just heal?" It affects their ability to be at school and learn even when they are there."*

*"Vision services—glasses are expensive and if you can't see you probably can't work—half the people that we serve at the food bank can't see the line to sign for their food box."*

*"Lack of affordable dental care—if you don't have teeth, you can't eat—it's expensive to get care—fillings, root canals which can lead to other chronic conditions. If it costs you $170-200 to get your teeth cleaned, you probably won't do it if you can already barely make it."*

*"Homeless people don't have the freedom to eat well, they eat whatever they can get, which is usually not healthy food. Canned chili should not be a staple of anyone's diet."*

*"The homeless can't get glasses because of [not having] ID for the Lions Club. 'Free' glasses—they aren't free."*

### *Poverty and the Economy*

Poverty and the economy influences individual, family and community health. All groups consistently discussed their influence on health, having lengthy conversations about how improving the economy, jobs and not living in poverty would help improve health.

*"No, [we are not healthy] because of homelessness. It's embarrassing to go to doctor's office and they ask for address and I don't have one."*

*"I am very concerned at the growing numbers of families needing emergency food who are food insecure, and the lack of affordable housing which is the number one need reported by the families in my program."*

*"We are not healthy enough. We have too much poverty, uninsured, lack of public health programs, no affordable housing, too many homeless and jobless."*

*"Multiple families are living under one roof since the economy went downhill-it affects everyone's health."*

*"Childcare—hard to get benefits for it if you work and it's expensive."*

*"I think the health of the people in our community varies from very healthy to poor health. Some groups are every physically active and health conscious with good incomes and other sub-groups are impacted by very low incomes, inadequate housing and childcare, which produces high levels of stress and negatively impacts health."*

### *Chronic Disease and Aging Issues*

61% of focus group participants noted that they were currently living with a chronic condition. Several participants also discussed challenges of managing chronic pain, particularly in light of many programs to reduce opioid use in the county.

*"I have MS and my husband has diabetes—I bring home preschool kids'colds from work and it affects our health. In small towns you see small epidemics of flu, it goes through the entire town and shuts us down. We can't function with the flu like big cities do."*

*"As our population ages—they have more chronic conditions and can't get the right medical and support services."*

*"Caregiver fatigue—there is not a lot of money for caregivers so family often does it, they get tired and they have their own health issues like depression, stress, etc."*

*"The disabled— the entire group that just fell off Medicare that now won't get care—hospice care is narrowing and becoming highly medical focused."*

### *Crime, Domestic Violence and Child Abuse*

Crime and concern about community and individual safety rated as a high concern in nearly all focus groups. Concern about child abuse and domestic violence and their connection to health were noted in all groups.

*"Public safety. Cutting Sheriff's Department. Criminals know public safety is last priority."*

*"Need more counseling services and support to help families and dependents with trauma."*

### *Community Engagement in Solutions*

All focus groups ended with a question about solutions to the challenges, problems and needs identified in the prior questions. Specifically, the facilitator asked "what do you think we (as a community) can do to enhance the health of our community?" The focus was directed at what solutions participants wanted to be engaged in to address the problems discussed earlier.

All groups, regardless of demographic or location expressed a strong sense of concern about their community and how they could contribute to improving problems. Several solutions and positive comments were stated in every group, some of those comments are as follows:

### *Suggestions*

*"Embrace that we are all in this together—find things that help more than myself, but my larger community too."*

*"We have a community kitchen, but my problem is awareness and getting them there. I made apple sauce one time and a lady said 'oh, you can make apple sauce?' People want to know how to improve their life, they just don't know how."*

*"[We need] education for professionals on addictions, being addicted is a disease, we aren't all bad people."*

*"Make sure I get prenatal care and take care of my baby now so she's not a drain on the community later."*

*"I will stay clean, be a productive citizen in the community, volunteer work to help others with addictions."*

*"We need more opportunities to keep young people [get] active in good ways instead of getting into trouble."*

*"[We need] more things at schools to give youth direction. Now that I'm clean and sober, I realize I wasted 44 years in my life-now I want to help and develop myself with education."*

*"The meth commercial where they chase the addict like we are a horrible pople, that makes us more separate. Instead, maybe the commercial should be a hand reaching out to help us with problems. Reach out to the addict, don't chase us."*

*"Education is key. sometimes it's about breaking cycles and learning new ways. Education can be many different levels."*

*"I appreciate that all three CCOs are working together for this, it's hopeful. I am really glad that they are listening."*

*"Develop creative affordable ways to provide community service supports to those suffering from mental illness to reduce isolation, support recovery, and prevent re-hospitalization."*

*"Build and initiate pubic health programs that have community buy-in. Involve public in CCO process."*

## *Key Informant Interviews: System of Care Strengths and Opportunities*

Several community leaders working in the health care sector were interviewed to gain additional insight into the strengths and weaknesses of the health system of care in Jackson County.

Individuals and organizations were recommended to the consultant by members of the CACC and CCO staff. All key informant interviews were completed by the consultant and anonymity of name and title was provided. Key Informants were recommended based on their organization affiliation, role in providing medical, mental, behavioral or addictions treatment to Jackson county residents.

### *Organizations represented in the key informant interviews*

| |
|---|
| Addictions Recovery Center |
| Jackson County Health and Human Services |
| La Clinica |
| Southern Oregon Head Start |
| Jackson County Public Health |
| Asante |
| Oregon Health Authority |
| HASL Center for Independent Living |
| Jackson County Mental Health |
| Jefferson Regional Health Alliance |

### *Key Informant Questions*

All key informants were asked the following questions:

1. ***What are your organization's major contributions to the local health system of care?***
2. ***What challenges do you see that may affect your work (upcoming changes in legislation, funding, technology, new collaborations, etc.)?***

### *Themes*

Key informants universally talked about unmet needs of their communities, changing partnerships, increased complexity of administration, changing paradigms to improve care, a desire to reduce barriers to care and prevention activities when discussing their organization's contributions to the community and system of care.

> ***"Sometimes you know you have a great service that is meeting tremendous need for real people, but if you can't bill and get paid for the staff doing it, you can't keep doing it." —Key Informant***

While the desire for integration and improving patient outcomes was strong, the challenges that come with changing payment systems, legislative pressures and changes, the unmet needs of many patients, and consistently poor health status of patients and the community at large were listed by key informants.

> ***"There are so many metrics of success and pieces interrelated in our transformation, it is very, very complex. Local, state and federal changes are happening very quickly. We are really seeing how interrelated the system is as we push one place and the result comes out somewhere else. Relationships and communication are more important to improve our health system, than ever before. Some of our communities will succeed at this and some will not. " —Key Informant***

# *The Community Health Improvement Plan & Next Steps*

## *Utilizing the CHA for Planning*

The Jackson County Community Health Assessment (CHA) draws attention to numerous opportunities for health improvement at the individual and community level. While the CHA identifies many critical health issues, it is not inclusive of every possible health-related issue. Instead, it was intended to provide a macro view of available community data and help to identify community trends. The CHA was successful in that purpose as well as engaging new community members in prioritizing what health status issues were important and where additional focus and data was needed.

The CHA was the first step in an ongoing process of community health assessment, planning and improvement. The natural progression of the community planning process is to **prioritize** health status issues and implement strategies to improve them. The prioritization process and document is titled the Community Health Improvement Plan (CHIP).

***"Pick the top three health problems in my community?! How can I only pick three, they are all important!" –Focus Group Participant***

Prioritizing future efforts to address individual and community health is imperative. Individuals, organizations and communities in Jackson County do not have unlimited resources to change all health status problems at once. Prioritizing efforts that are most likely to succeed and have the biggest positive impact on individual and community health must happen first. Strategies that are most likely to improve health outcomes, improve health of individuals and reduce health care costs ties the CHIP to the CCO Triple Aim. The prioritization conversation will not be one time process but will be dynamic.

The next step of the CCO community health process will entail community discussion about the community health assessment findings followed by establishing short term, intermediate and long-term strategies to address prioritized individual and community health problems. The prioritization process should be based on the quantitative and qualitative data presented in the community health assessment document and complemented with additional community input.

### Top 3 Health Problems: Focus Groups Jackson County 2013

1. Mental Health Problems
2. Dental Problems
3. Problems from Aging

### Top 3 Ingredients for A Healthy Community Jackson County 2013

1. Access to health care
2. Good jobs and a healthy economy
3. Good schools

### Top 3 Risk Factors/Behaviors Related to a Healthy Community Jackson County 2013

1. Drug Abuse
2. Not seeing a health care provider when you needed to (access)
3. Alcohol abuse, overweight, poor eating habits

Strategies for addressing health problems, behaviors related to health or ingredients for building a health community should be based on best practice/standards, potential community impact, cost and feasibility. Additionally, strategies for health improvement should be linked to indicators that are already being tracked in the community, to better enable the evaluation of progress and success of the chosen strategies. This will aid in reducing duplication of effort and provide a mechanism for more consistent and continuous measurement of progress. CCO metrics and local, state and national public health indicators are suggested possible indicators.

Identifying additional data needs and working with local, state and federal organizations to meet those needs will also need to be considered in the CHIP. County specific data on health status by race and ethnicity is an example of a continuing data need. Dental access and outcomes is another area of data needs, among many others. Having adequate data to understand problems in the community is imperative in planning appropriate strategies and solutions. Advocating for access to county level data that is helpful for CCO and CAC planning will need to be a continuing strategy in the CHIP.

Engagement of the CAC will continue to be instrumental in the process, as will listening to community member priorities and concerns. The work of improving the health of people in Jackson County will happen with collaborative and adaptable efforts as we move forward through health care transformation and integration.

AllCare® HEALTH PLAN

Jackson Care Connect

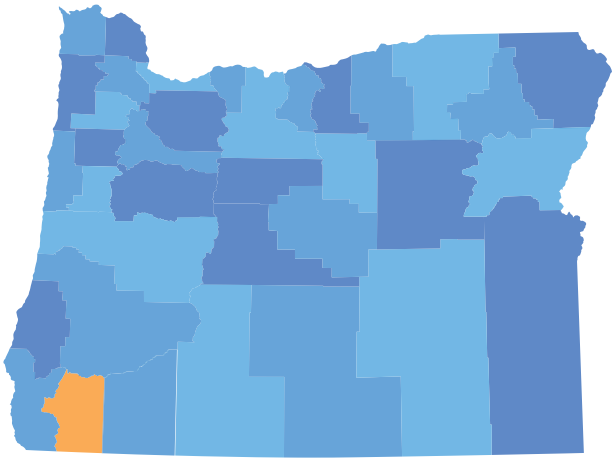
PrimaryHealth of Josephine County
Your Community Health Plan

# Community Health Assessment

## Josephine County 2013

# Josephine County People and Place

## Location and Physical Characteristics



Josephine County is located in Southwestern Oregon. It is a rugged part of the state with multiple climates and geography within its 1,640 square miles. The diverse terrain includes large broad valleys, deep river valleys and sparsely populated mountainous areas. There are hundreds of hills, valleys and waterways including the Rogue River and its tributaries such as the Illinois River.

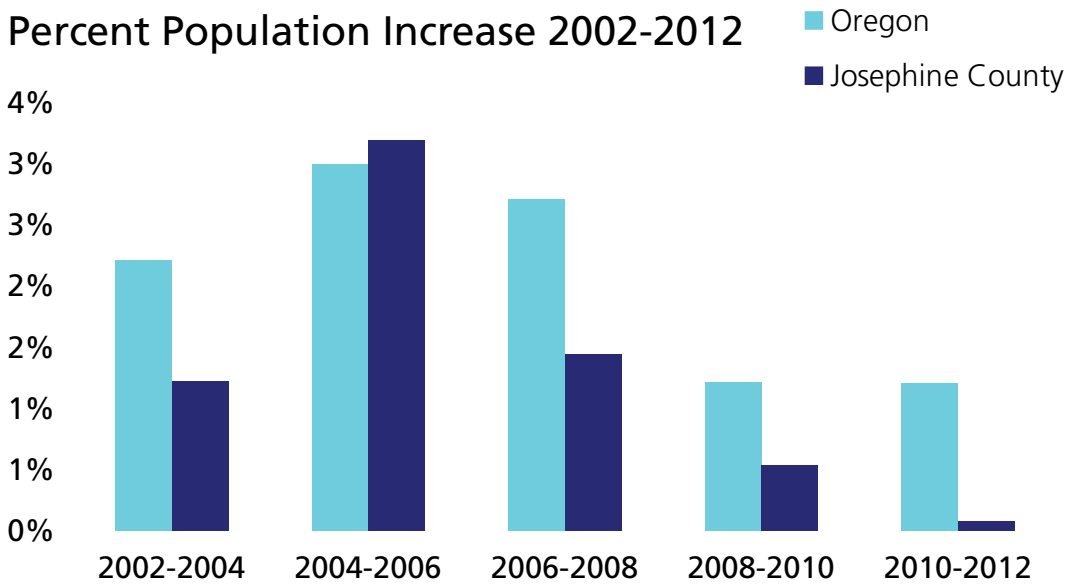
Josephine County has only two incorporated cities and the county is designated as rural by the Oregon Office of Rural Health. The total population in Josephine County is 82,930 (2012). The two incorporated cities are Grants Pass and Cave Junction. Grants Pass is the county seat and had a population of 34,805 in 2012. The majority of residents live in over 24 unincorporated areas, creating geographic barriers to accessing medical care, services and in some communities, access to exercise facilities, grocery stores and fresh foods.

***"We are far away from medical centers and services, it affects the elderly. Transportation, social and food services are a major problem here." —Focus Group Participant***

## Demographic Trends and Population Characteristics

### Migration and Growth

Josephine County has consistently lagged behind average state growth rates and has experienced a migration pattern in and out of the county similar to many other rural Oregon counties. Although the percentage growth has not dipped into the negative percentage, like Jackson County, the patterns of migration are important to note. Like many other rural counties, Josephine has experienced outmigration of younger populations while seeing an influx of older populations at the same time. This migration pattern has kept the overall annual growth close to zero but presents changes in workforce, service needs and health care utilization patterns. Like many Southwestern Oregon counties, local population statistics began showing that younger families were leaving the area for more metropolitan counties to find jobs shortly after the economic downturn.



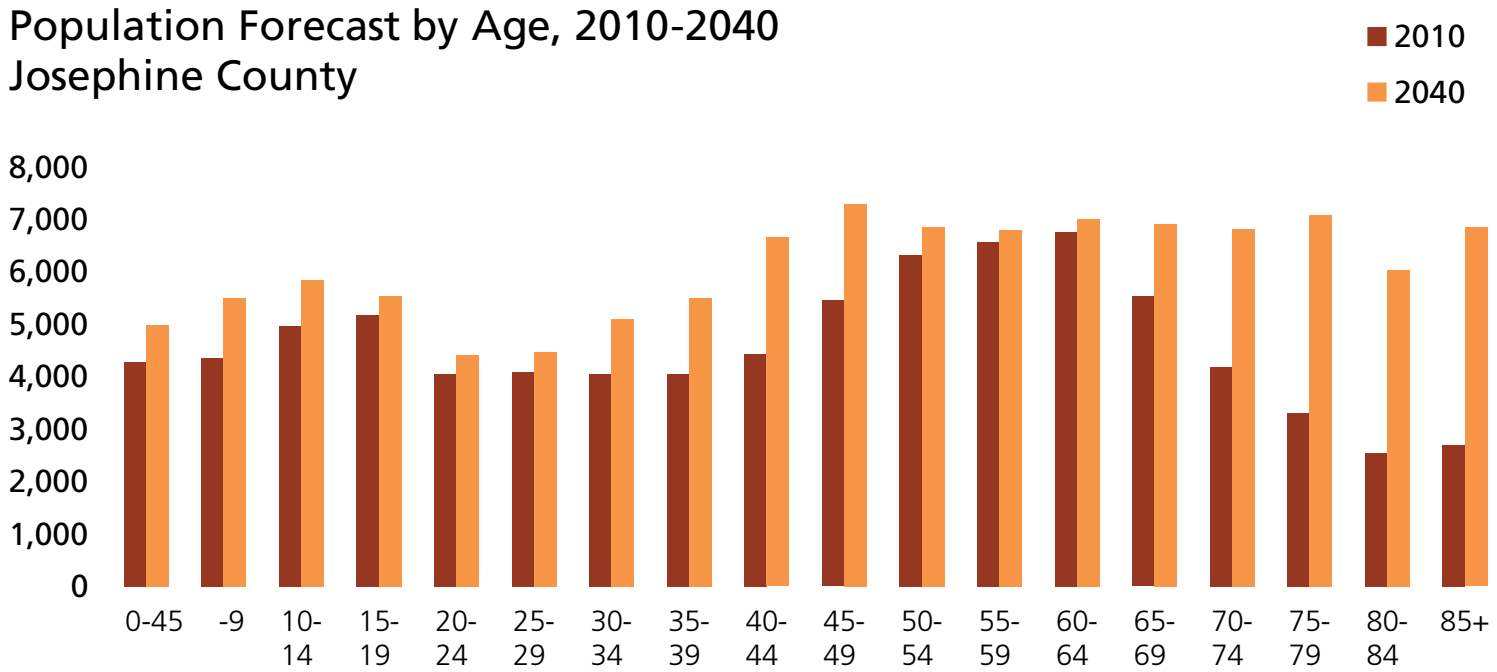

*Source: PSU Population Research Center*

At the same time, the county continued to see a steady influx of seniors to the county, largely from out of state.

Both the exodus of younger and often higher socioeconomic level populations and the influx of older demographic groups in the county ultimately influences the health status and burden for care on the community. The percentage of 60 and over is expected to continue to rise within the county, while percentages of younger ages continues to diminish.

### *Growth in Elderly Population*

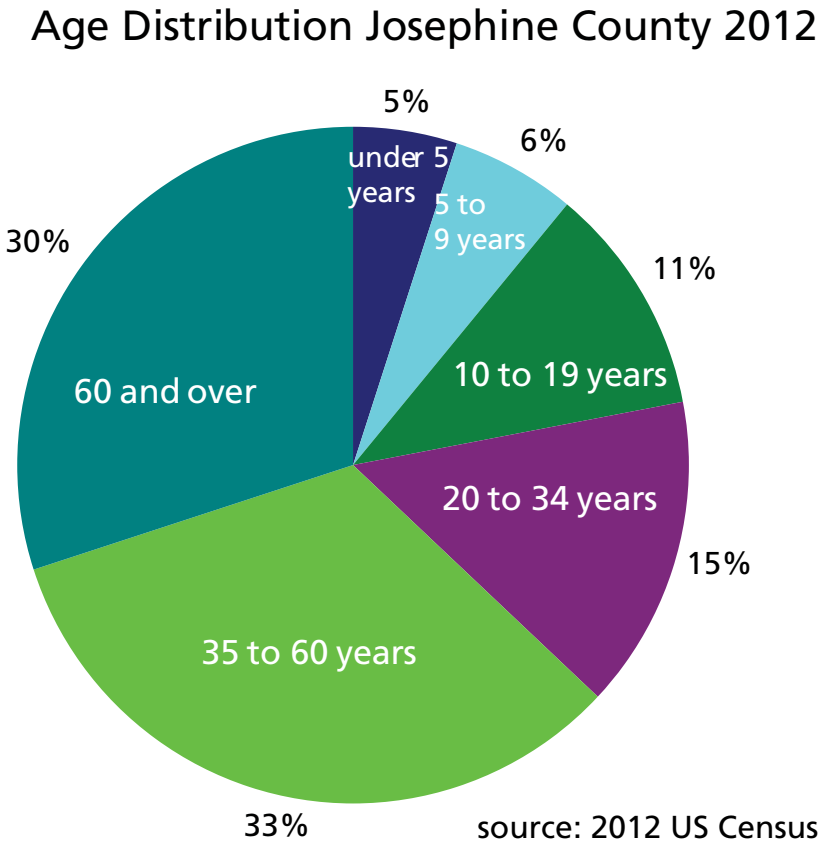
According to 2012 census data, 23.6% of the county population is over 65 years old. That is nearly double the state average of 14.9% and still higher than Jackson County at 18.8%.




*Source: Office of Economic Analysis, Department of Administrative Services, State of Oregon*

Josephine County joins many other counties in Southern Oregon with distinctly higher average ages and higher percentages of elderly living in the county than more metropolitan counties. The more isolated rural communities in Josephine County have higher percentages of residents over age 60 than Grants Pass, the county seat.

***"People here are old, they don't have anyone to help them anymore, they get isolated [out here] and the group of them is getting bigger."***
***—Focus Group Participant***



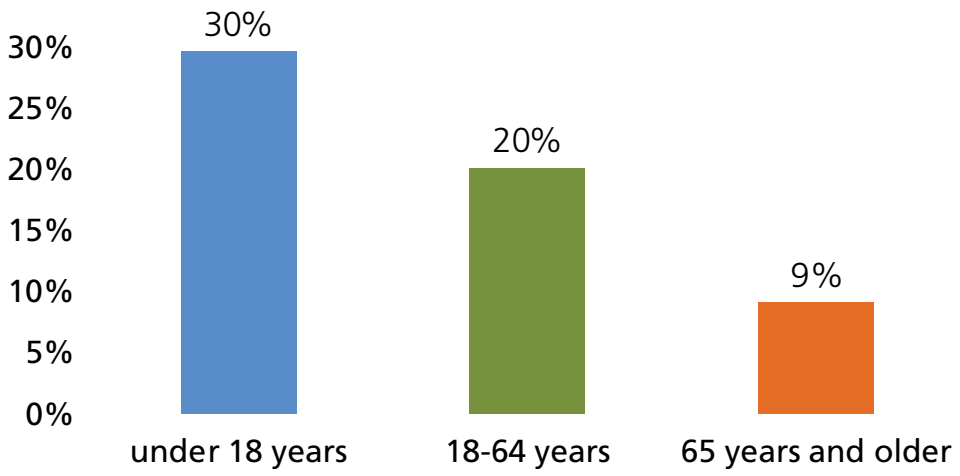
## *Poverty*

Nearly one in three children in Josephine County live in poverty, creating significant challenges to their overall health and long-term development.

18.8% of the total county population lives in poverty (2007-2011), higher than the state average of 14.8%.

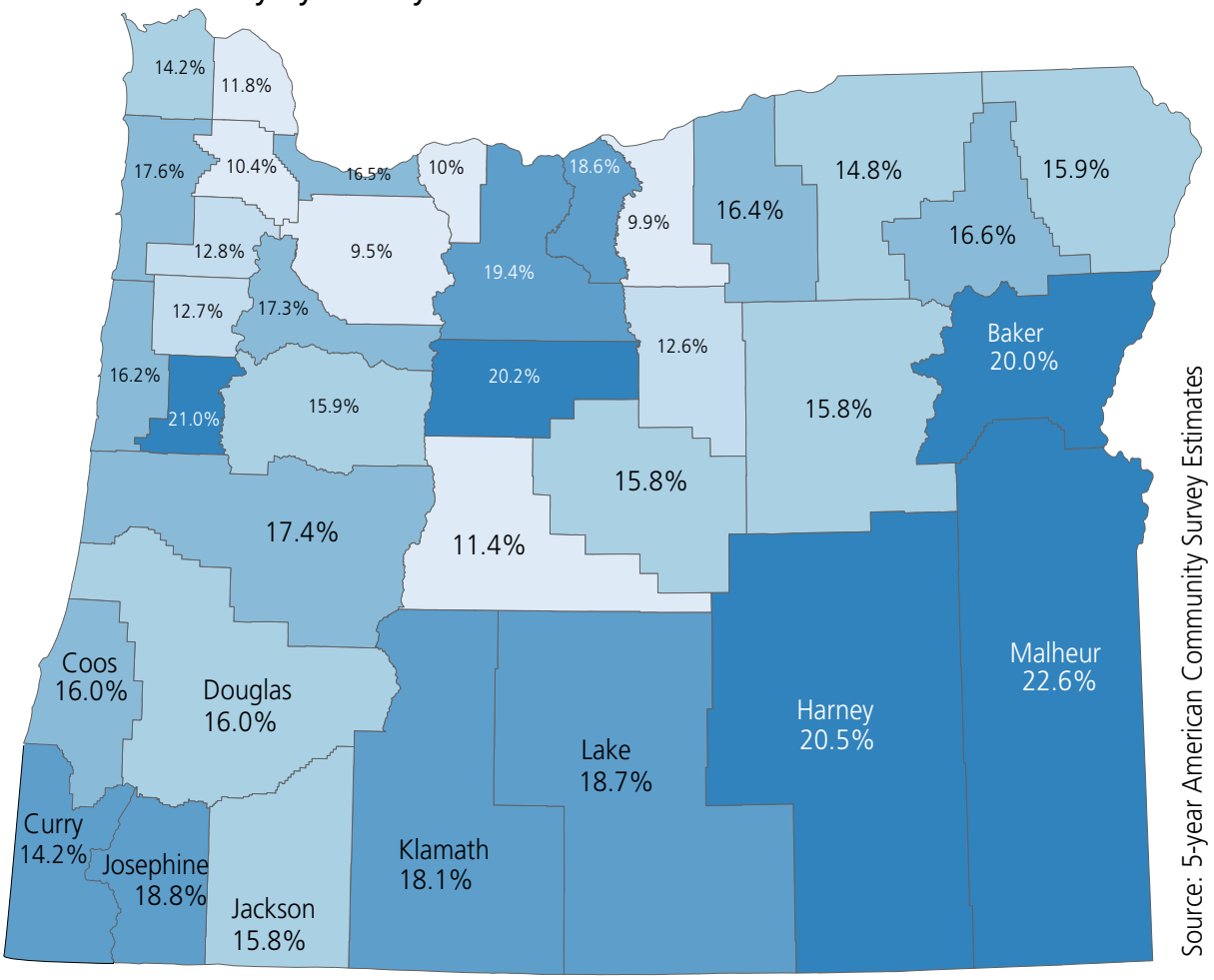
Poverty has tremendous impact on individual and community outcomes and was consistently brought up in the community focus groups related to access to health care services, housing, access to healthy food and nutrition.

Percent living below poverty level by age
Josephine County




***"Your health here depends on your income—if you can't afford good food you eat garbage and you can't see the doctor when you need to." —Focus Group Participant***

Percent In Poverty By County

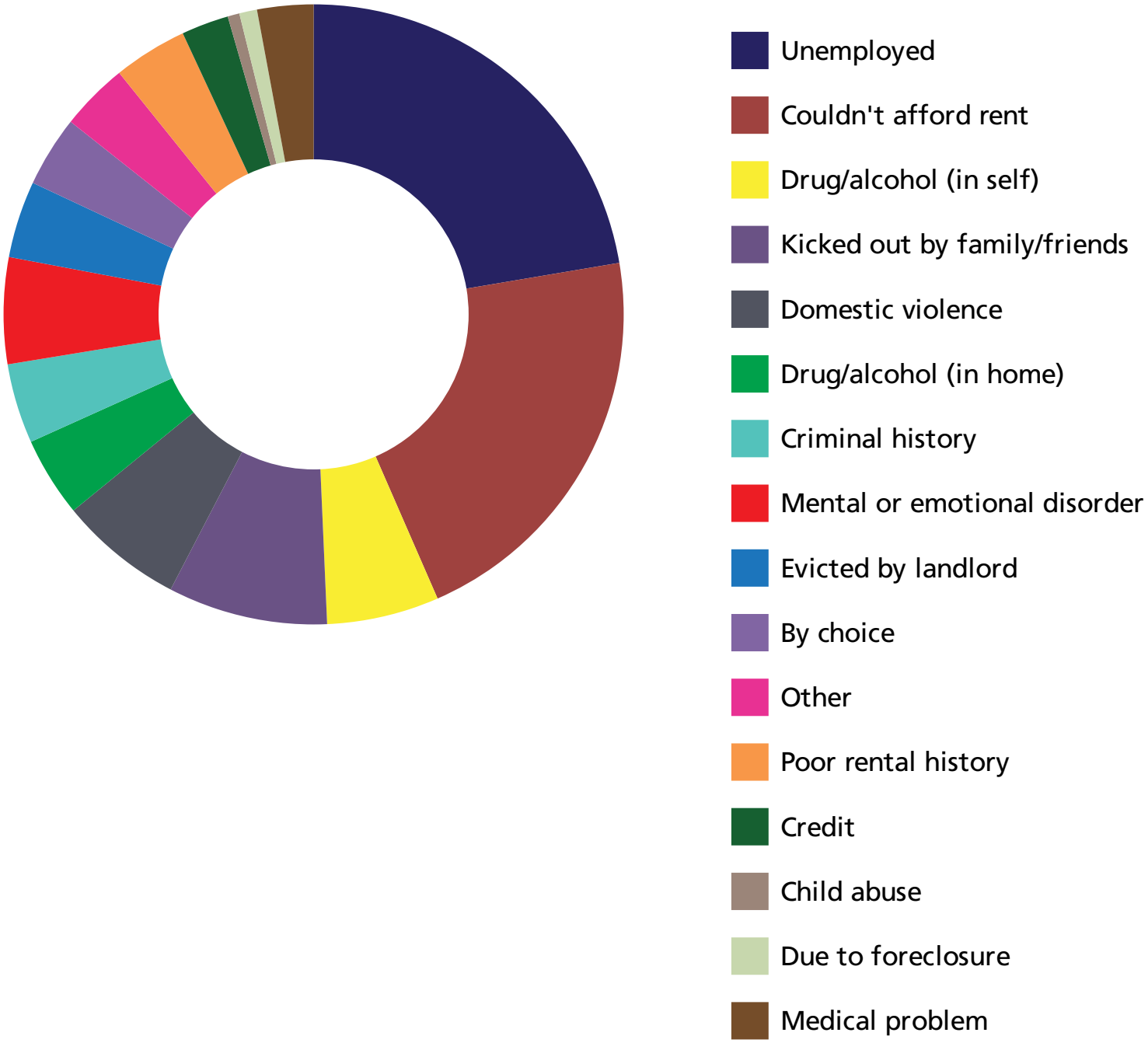



Source: 5-year American Community Survey Estimates

## *Homelessness*

Homelessness continues to be a challenge for many living in Josephine County. Causes of homelessness are varied, they include drug and alcohol abuse, high rents, domestic violence and unemployment.

### Causes of Homelessness Josephine County 2013



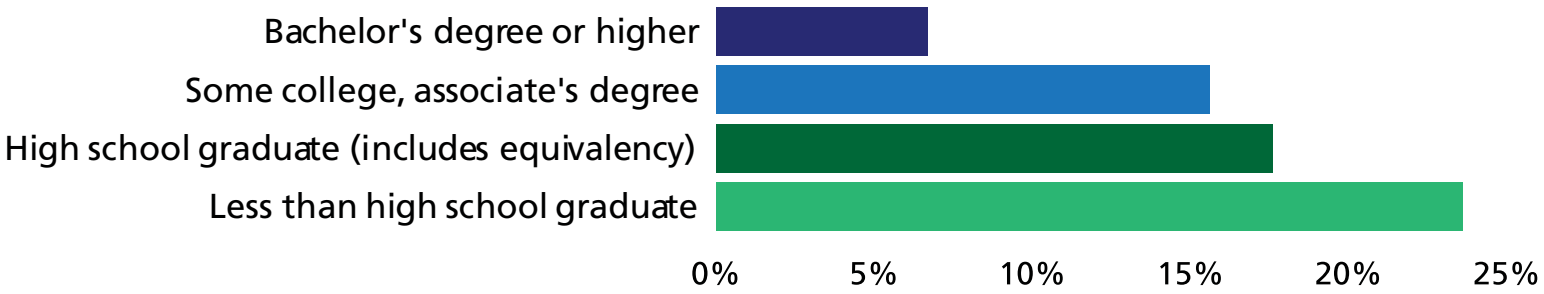

*Source: One Night Homeless Count 2011-2013, Josephine County Homeless Task Force*

## *Education*

High school graduation rates at the county level are similar to State averages, typically showing 87% of the population being a high school graduate or higher.

For those with less than a high school degree (or equivalent), poverty is markedly higher—they are twice as likely than those with some college to live in poverty.

### Poverty rate for population 25 years and over by educational attainment Josephine County, 2009-2011

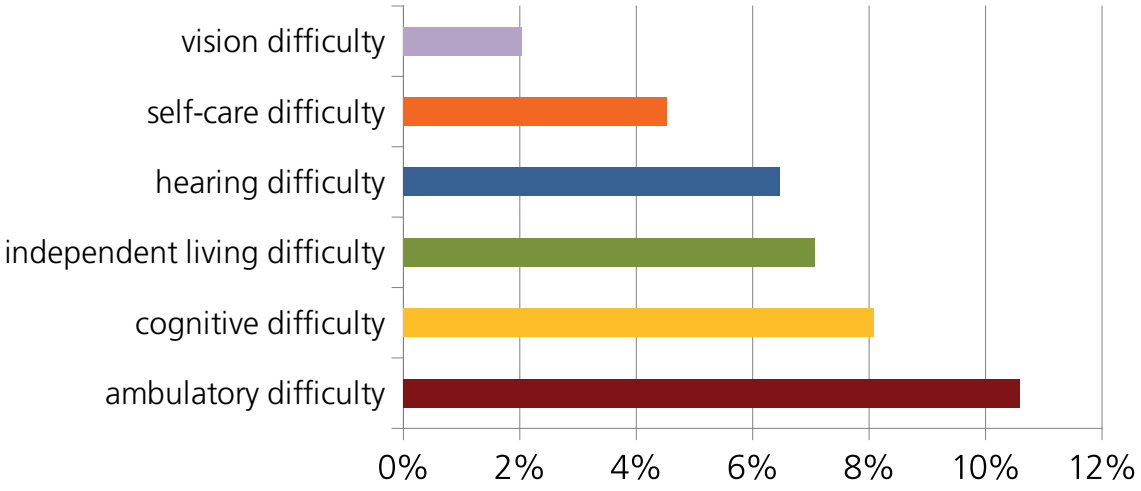



*Source: 2009-2011 American Community Survey 3-Year Estimates*

## *Disabilities*

In Josephine County there are an estimated 12,555 adults with disabilities according to the recent Area Agency on Aging 2013-2016 plan. Types of disabilities are varied, with ambulatory difficulty being the highest, cognitive being a close second.

### Percentage of people with a disability Josephine County 2011



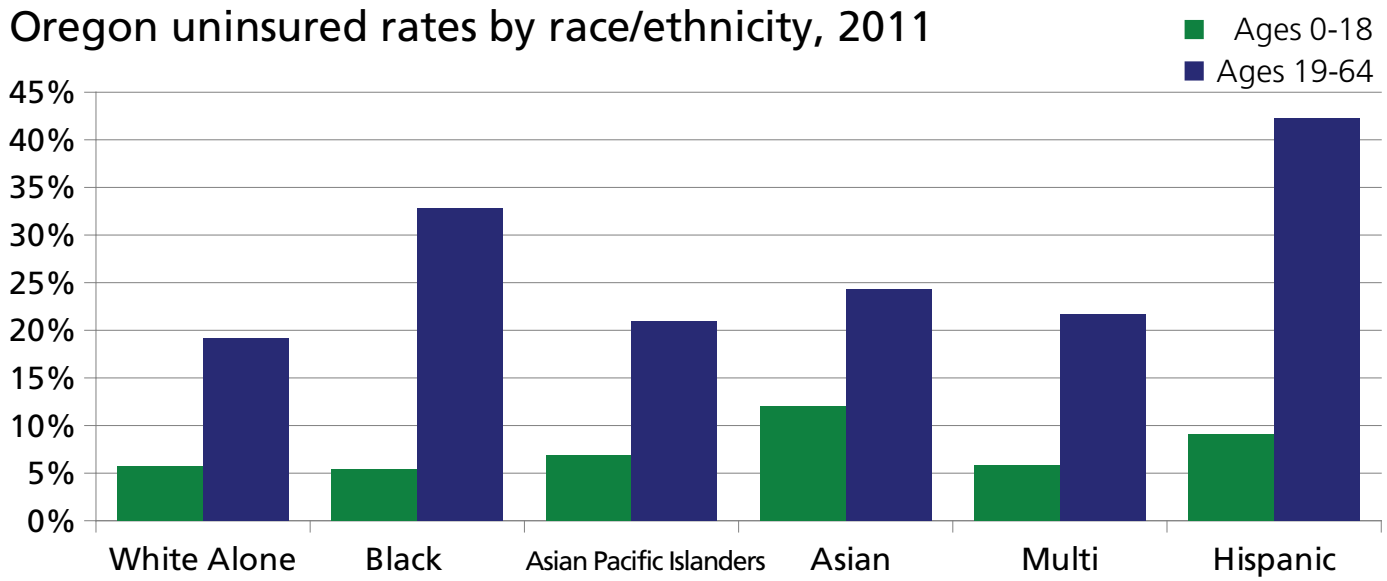

Source: 2011 American Community Survey 1-Year Estimates

## *Race and Ethnicity*

Josephine County has had consistently low percentages of ethnic minorities. Although the percentages have increased over the last decade, they have not increased significantly. 2012 Census statistics show that 11.8% of the population in the county identify as being a minority. Hispanic or Latino represents a 6.6% minority of the population in the county, followed by people identifying as being from two or more races at 3.1%.

Public school enrollment statistics are slightly different from census numbers, showing higher percentages of minorities. Grants Pass School District shows 12.84% Hispanic students, which is nearly double the census number of 6.6%. The districts are still below the state average for minority populations, but the school enrollment numbers suggest growing ethnic minorities in Josephine County.

Health outcomes for racial and ethnic minorities continue to be lower, while percentages of those insured are also lower in minority groups. Although specific county-level data for uninsured by race/ethnicity is not currently available, it is important to note that Hispanic groups have significantly higher chances of being uninsured statewide. Every minority race and ethnic group has higher rates of uninsurance as compared to Caucasian populations, presenting significant barriers to accessing health care and health disparities.

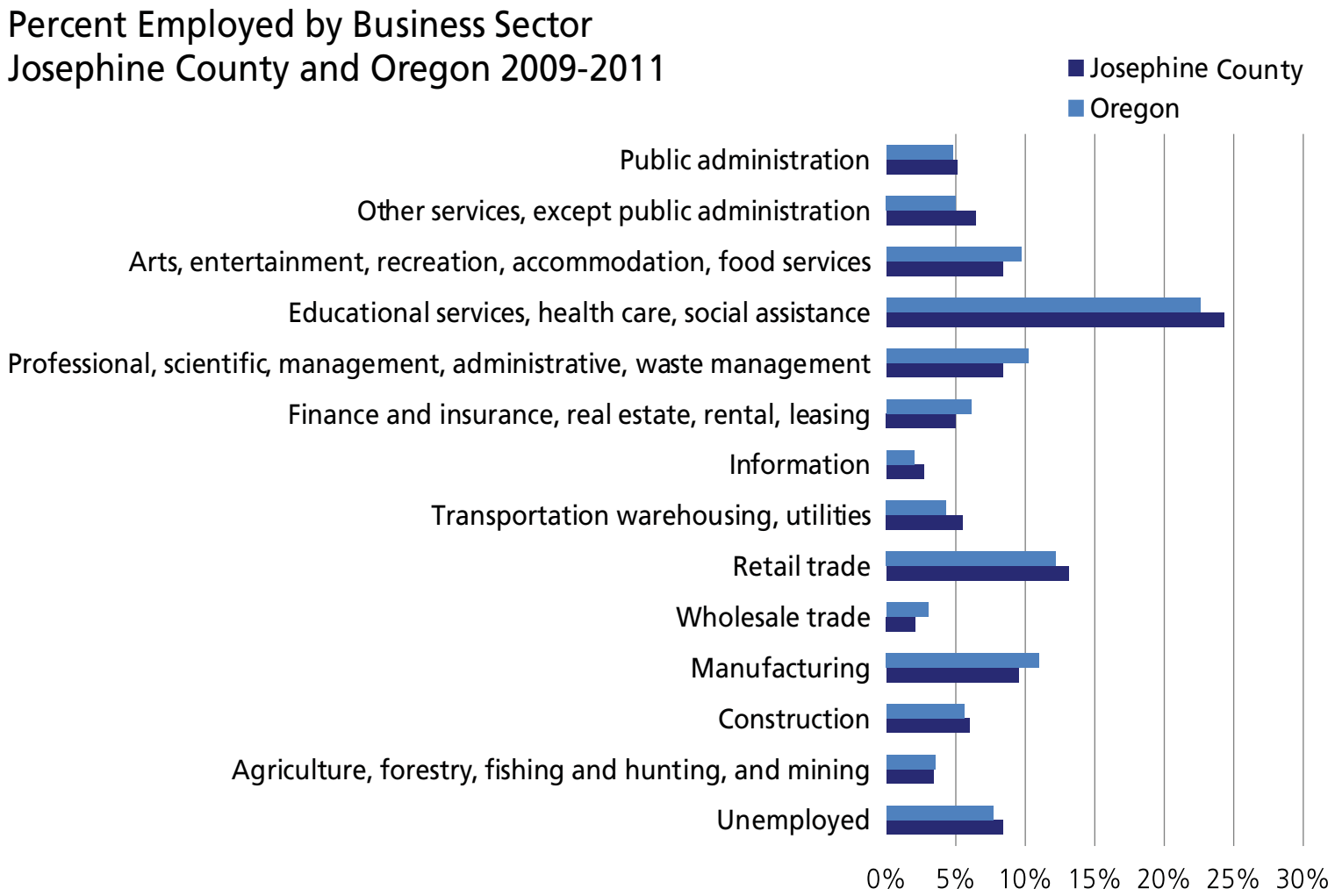



*Source: 2011 Oregon Health Insurance Survey*

## *Employment*

Unemployment in Josephine County continues to be higher than state and national averages. Although the trend shows slight decreases in the seasonally adjusted unemployment rates from the Oregon Employment Department, they continue to hover around 11.2-11.3% annually, 4% higher than the national average and higher than Jackson, Curry and Douglas counties.

Residents of Josephine County work predominantly in education services, health care, social assistance and retail.




*Source: 2009-2011 American Community Survey 3-Year Estimates*

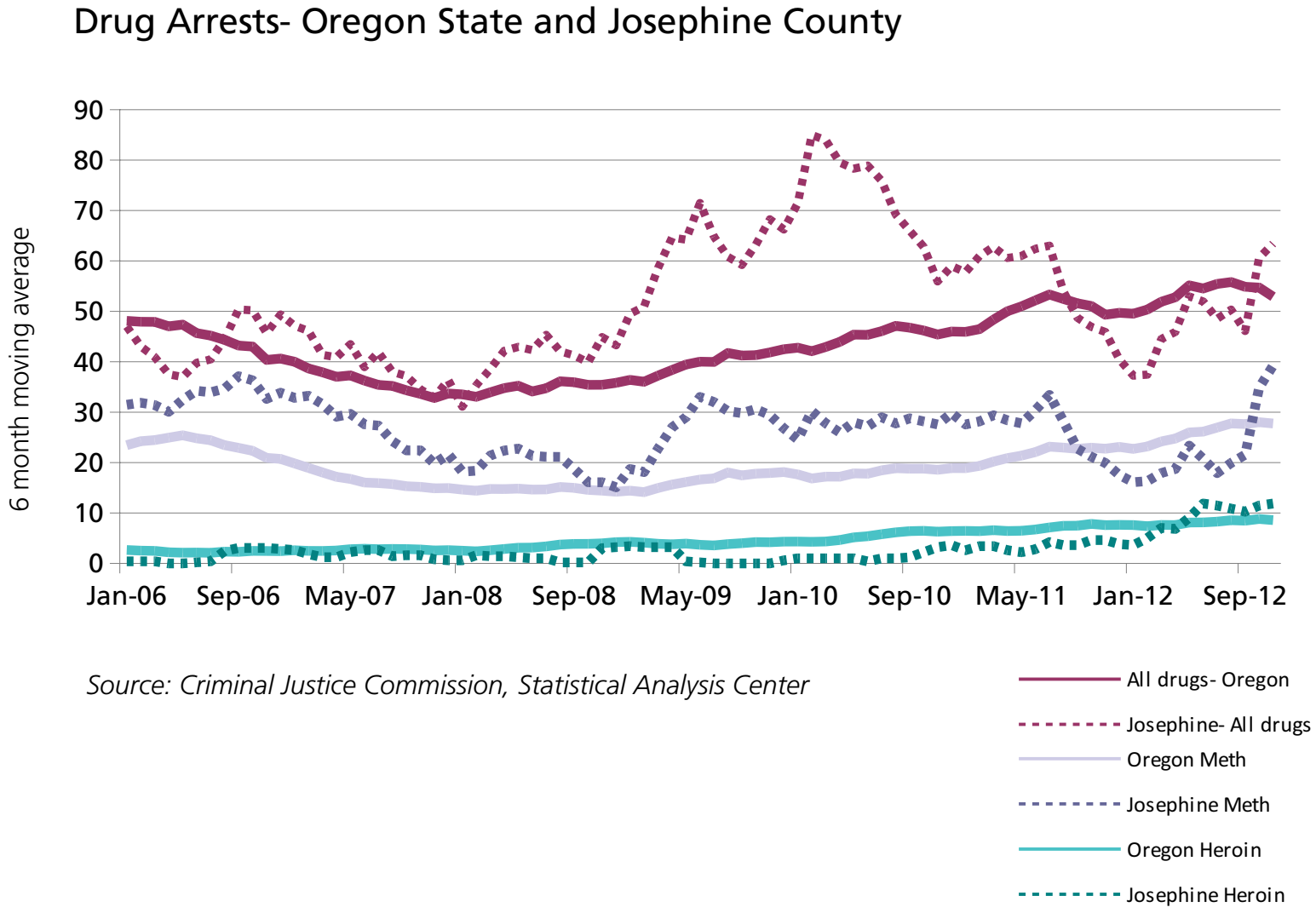
Unemployment and its effects on poverty and health continue to be felt by county residents and was discussed frequently in focus groups.

***"I've not been able to find work in the area—and without work there is no money. Without money we have to sell our house. Huge fear, we live in huge fear, even though we have strong beliefs, I still can't provide." —Focus Group Participant***

## *Crime*

Crime continues to be top of mind for residents living in Josephine County. The ***Report of Oregon Offenses known to Law Enforcement*** lists Josephine County as 14th highest in the state for property crimes (out of 36), 14th for person crimes and 23rd for behavior crimes in 2010. Drug arrests for heroin and methamphetamine surpassed state averages beginning in 2012 and continue to be on an increasing trend line.

***"When you are surrounded by drugs you can't be healthy." —Focus Group participant***




*Source: Criminal Justice Commission, Statistical Analysis Center*

# Health Status: Individual and Community Health

## County Health Rankings

The County Health Rankings is a collaborative project supported by the Robert Wood Johnson Foundation. The rankings evaluate counties based on causes of death (mortality), types of illnesses (morbidity) and those factors that lead to poor health outcomes. The rankings provide a measurement tool to compare county-to-county, as well as comparison to state and national benchmarks.

The most recent rankings were released in March 2013 and rankings are available for nearly every county in the United States. The rankings look at a variety of measures that affect health. Although released annually, some of the data sets that are used in the development of the rankings are older so it is important to not look at county rankings exclusively when evaluating the health status of Josephine County.

**Josephine County** was one of the worst in the state, raking 29th out of 33 Oregon counties (health outcomes category) a second year in a row. Mortality (death) was also ranked 29th out of 32, morbidity (disease) was ranked slightly better at 18th out of 32.

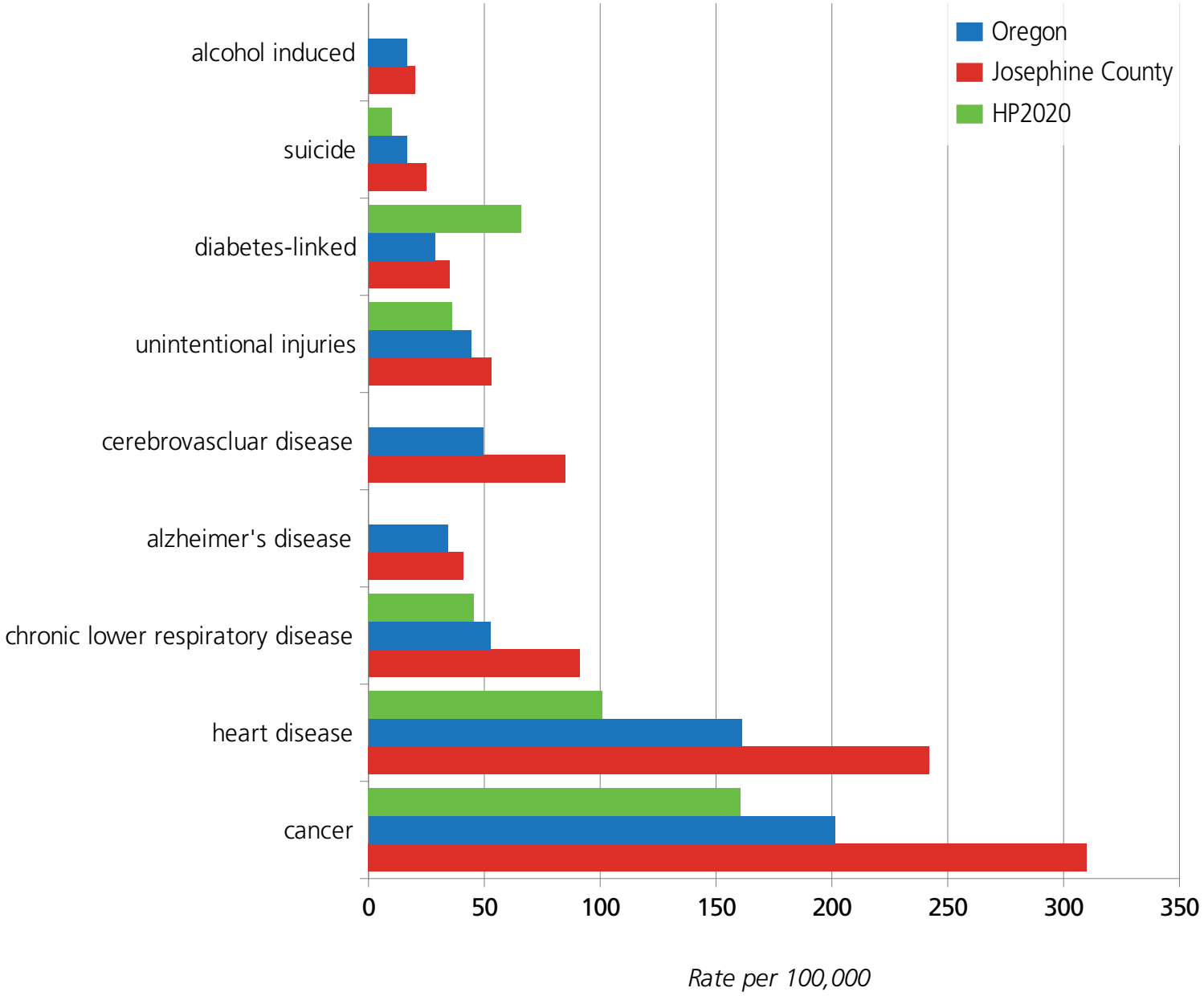
### *Morbidity & Mortality in Josephine County*

Mortality (death) and causes of death have changed in Josephine County over the last 75 years, consistent with state and national trends. Many advances in science, medicine, living and working conditions have contributed to changes in causes of death and life expectancy. The major causes of premature death in Josephine County are chronic conditions, consistent with a nationwide epidemic of chronic disease and conditions.

## Health Outcomes Oregon Counties 2013

| County | Rank |
|---|---|
| Baker | 33 |
| Benton | 2 |
| Clackamas | 5 |
| Clatsop | 12 |
| Columbia | 19 |
| Coos | 28 |
| Crook | 8 |
| Curry | 26 |
| Deschutes | 7 |
| Douglas | 30 |
| Gilliam | not ranked |
| Grant | 1 |
| Harney | 20 |
| Hood River | 3 |
| Jackson | 13 |
| Jefferson | 32 |
| Josephine | 29 |
| Klamath | 31 |
| Lake | 22 |
| Lane | 17 |
| Lincoln | 24 |
| Linn | 23 |
| Malheur | 10 |
| Marion | 14 |
| Morrow | 16 |
| Multnomah | 15 |
| Polk | 9 |
| Sherman | not ranked |
| Tillamook | 25 |
| Umatilla | 27 |
| Union | 21 |
| Wallowa | 18 |
| Wasco | 11 |
| Washington | 4 |
| Wheeler | not ranked |
| Yamhill | 6 |

## Leading causes of death per 100,000
*Josephine County, Oregon, Healthy People 2020*




*Sources: Oregon Health Division County Data Book 2011, Healthy People 2020*

Death from cancer, heart disease and lower respiratory disease is significantly higher in Josephine County than the state or Healthy People 2020 goal. Healthy People 2020 provides national benchmark goals for communities and organizations that create and administer health improvement plans. They are evidence-based national objectives designed to help communities monitor progress and evaluate success. Josephine County rates are almost double that of the Healthy People benchmark goals in cancer, heart disease and chronic respiratory disease.

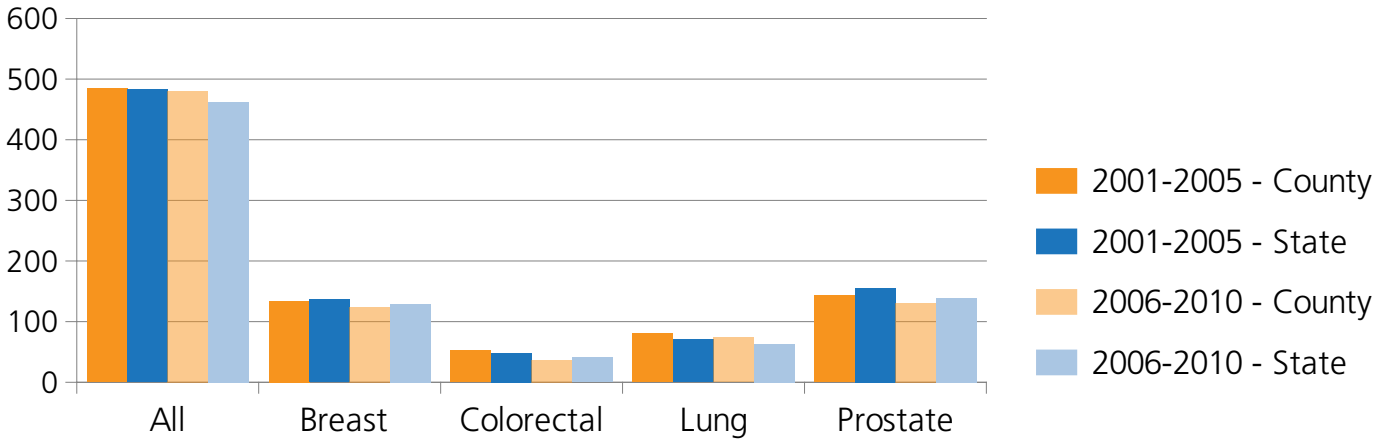
Josephine County joins many of its neighboring counties with high incidences of cancer. Breast cancer, prostate, lung and colorectal cancers continue to be the leading types of cancer in Josephine County, a consistent trend for the last decade.

## *Chronic Disease & Conditions*

Prevalence of chronic conditions in Josephine County are close to many state averages with the exception of high blood cholesterol and high blood pressure. The county age-adjusted population data shows a high burden of high blood cholesterol, high blood pressure, asthma and arthritis in the county.

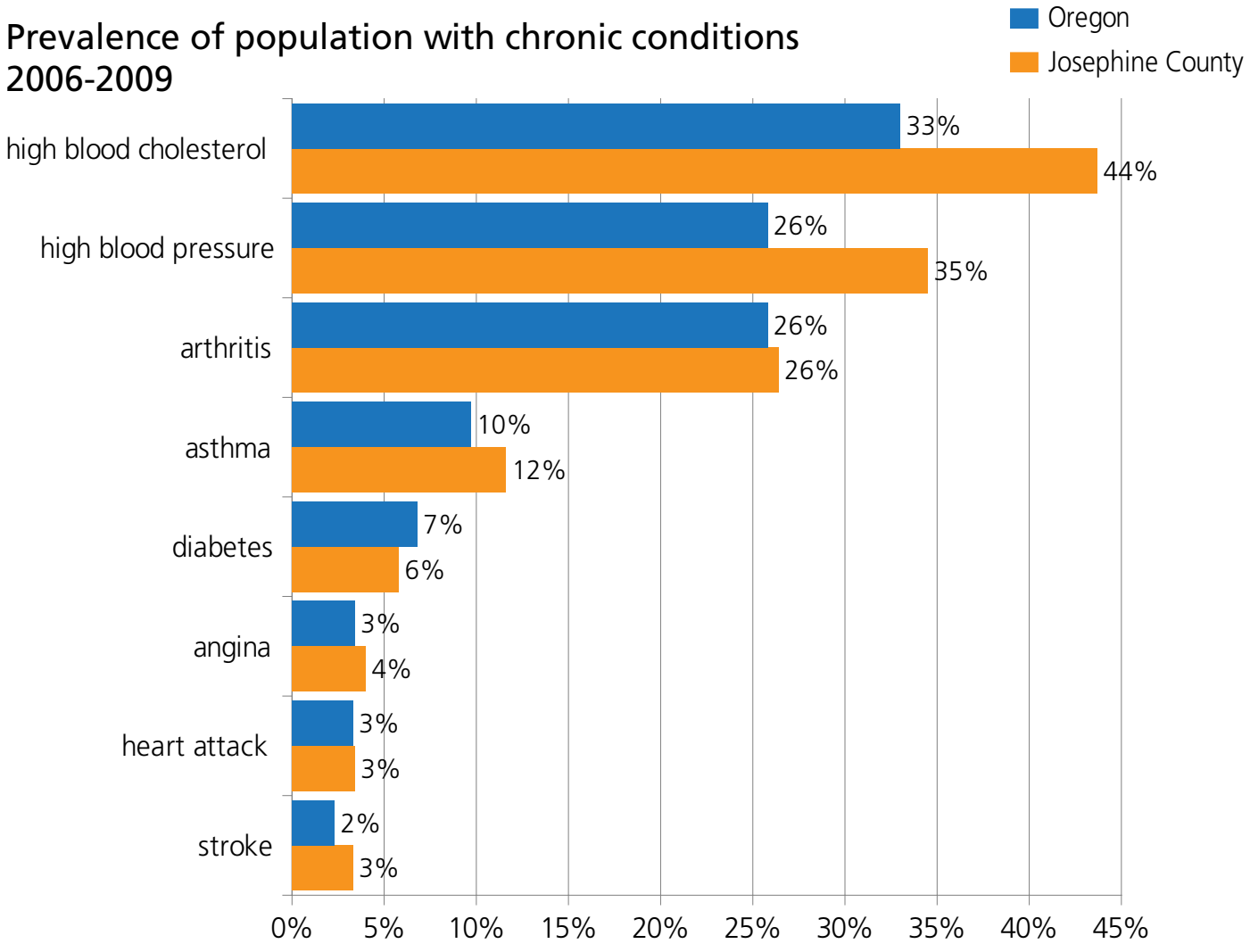
### Leading types of cancer

*Josephine County 2001-2010*



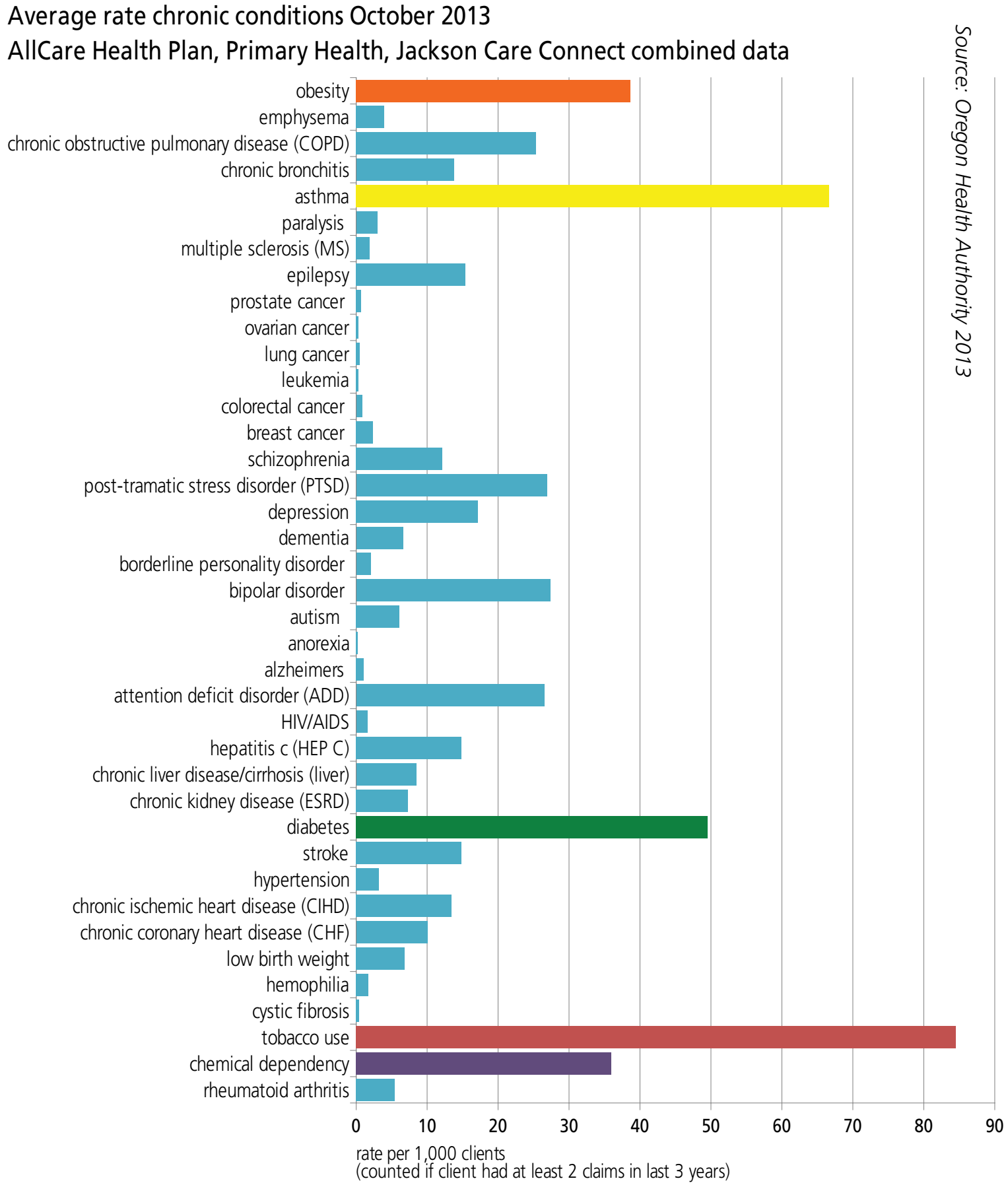

*Oregon Public Health Authority, Cancer in Oregon report, 2010*

### Prevalence of population with chronic conditions 2006-2009



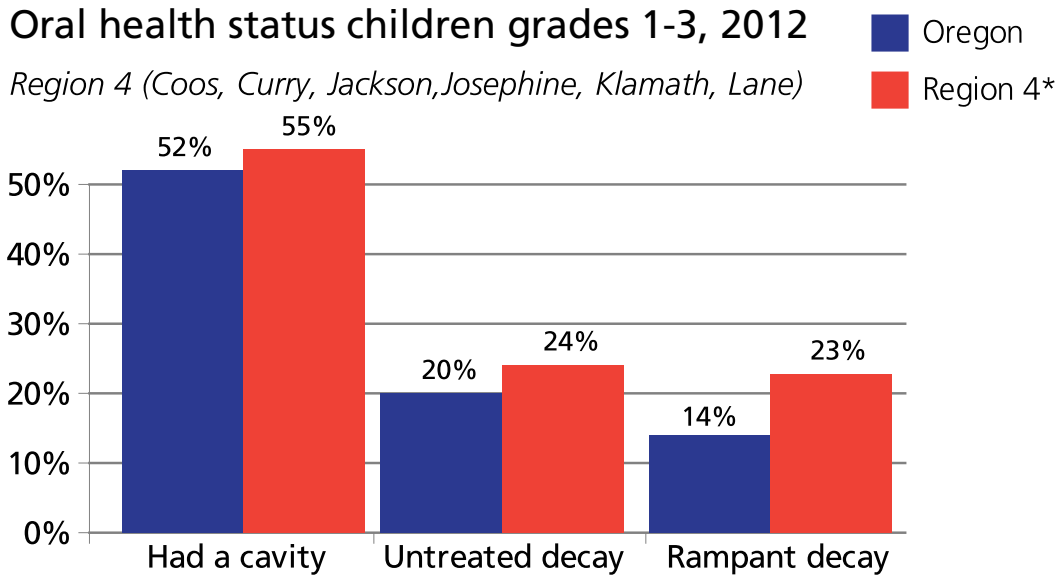

*Source: Oregon BRFSS County Combined Dataset 2006-2009*

The burden of chronic conditions for those on Oregon insurance programs, such as the Oregon Health Plan, show a similar pattern as the county population. Oregon Health Plan patients, enrolled in one of the three CCO's in Josephine and Jackson Counties, show high rates of tobacco use, diabetes, asthma, obesity and chemical dependency.



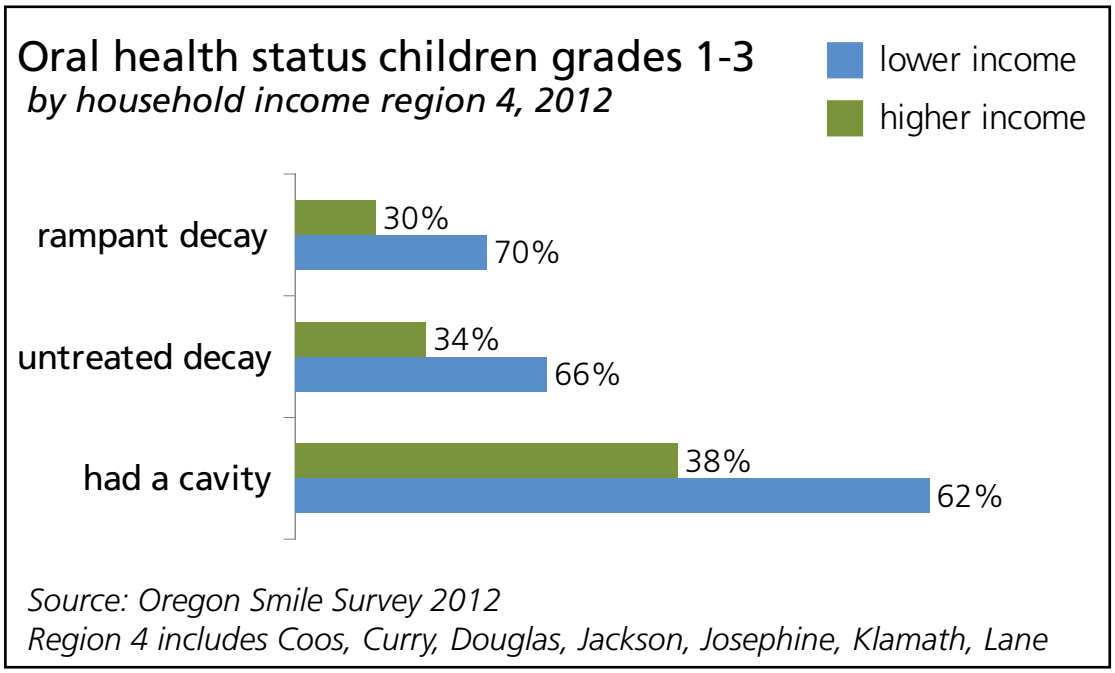
## *Oral and Dental Health*

National and state level data shows that tooth decay is five times more common than asthma in Oregon children, making dental health a priority concern for the County and State. In Oregon, oral disease is on the rise and is not limited by socio-economic status, race or ethnicity, or age according to a recent resources scan and needs assessment commissioned by the Oregon Community Foundation.




*Source: Oregon Smile Survey 2012*

The 2012 Oregon Smile Survey grouped counties into regions, Josephine County being in Region 4 with Coos, Curry, Klamath, Lane, Douglas and Jackson. The region has higher percentages of cavities, untreated decay and rampant decay in children. Although the rise in oral disease is not limited to socio-economic status, the dental health of children in the region was far worse for those with lower incomes.



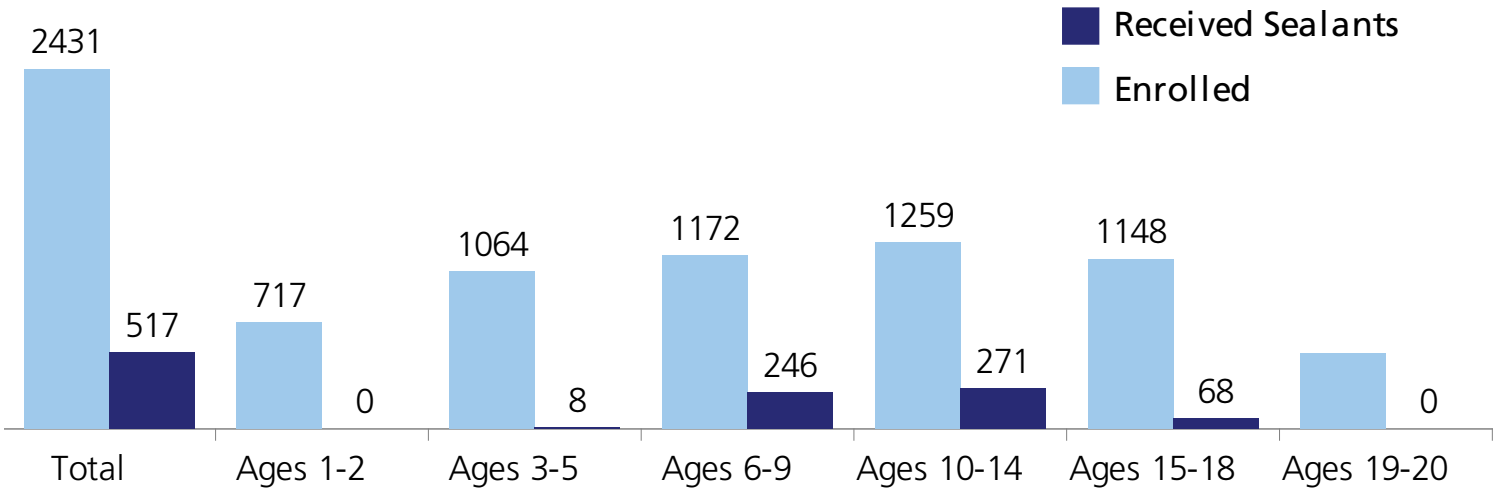

*Source: Oregon Smile Survey 2012*
*Region 4 includes Coos, Curry, Douglas, Jackson, Josephine, Klamath, Lane*

***"Dental care and issues are huge—dental affects so many other health issues, we have insurance and I still can't afford dental care—it affects more than people would think."***
***—Focus Group Participant***

Dental prevention and access to dental care was consistently mentioned in all focus groups in the county. Of those children enrolled in Medicaid in the county, the majority did not have sealants (a common preventive dental practice).

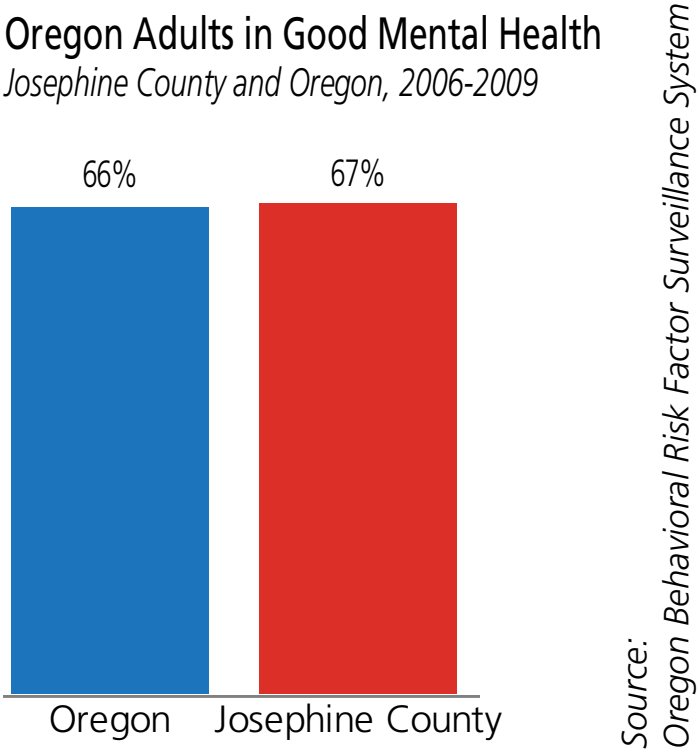
## Youth Medicaid Population with Dental Coverage and Sealants

*Josephine County 2011-2012*



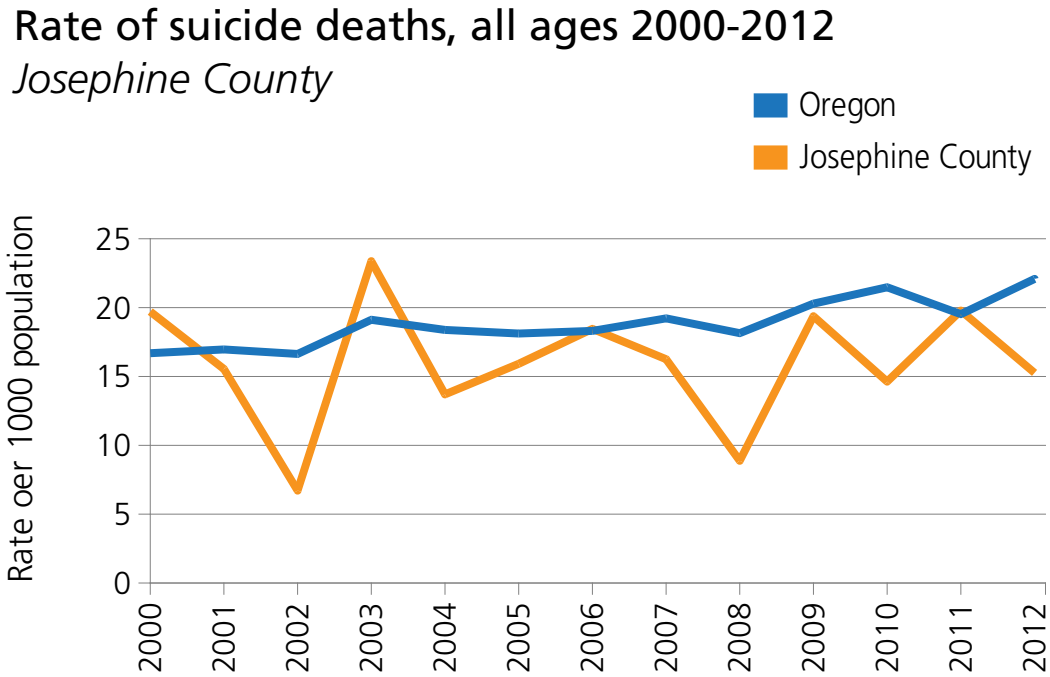
## *Mental Health*

67% of residents in Josephine County describe themselves as having good mental health. Although that is close to the state average, it still shows that close to 1 in 3 people don't consider themselves as having good mental health. When people don't feel as though their mental health is good, health-related quality of life is reduced.




Rates of suicide deaths have been varied in Josephine County over the last decade. Suicide is highly correlated with depression, intimate partner violence and several mental health disorders.

Suicide, depression and harassment in youth in Josephine County is close to state averages but still high.

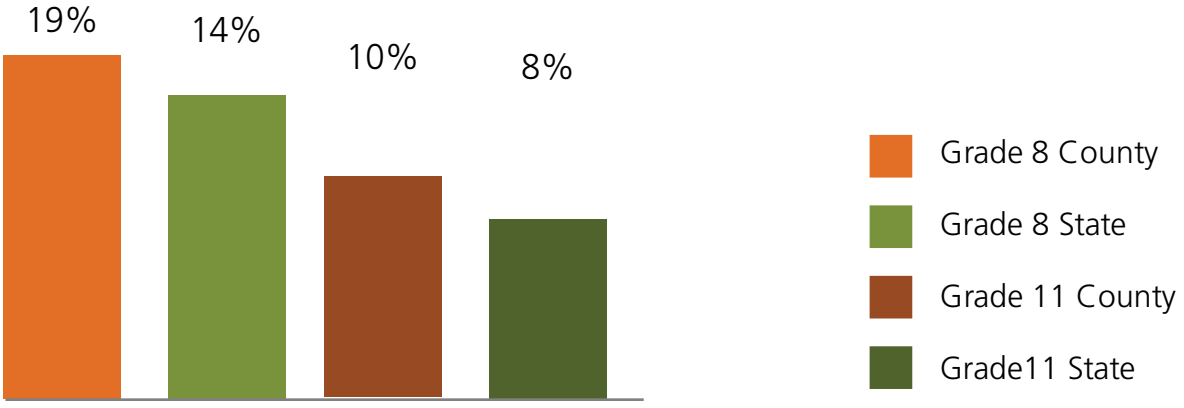



*Source: Oregon Vital Records*

Bullying and harassment of youth was another reoccurring theme in the focus groups. Youth identifying as gay, lesbian, bisexual or transgender were more likely to experience harassment and bullying in the county.

## Youth harassment multiple grades

*Josephine County 2012*

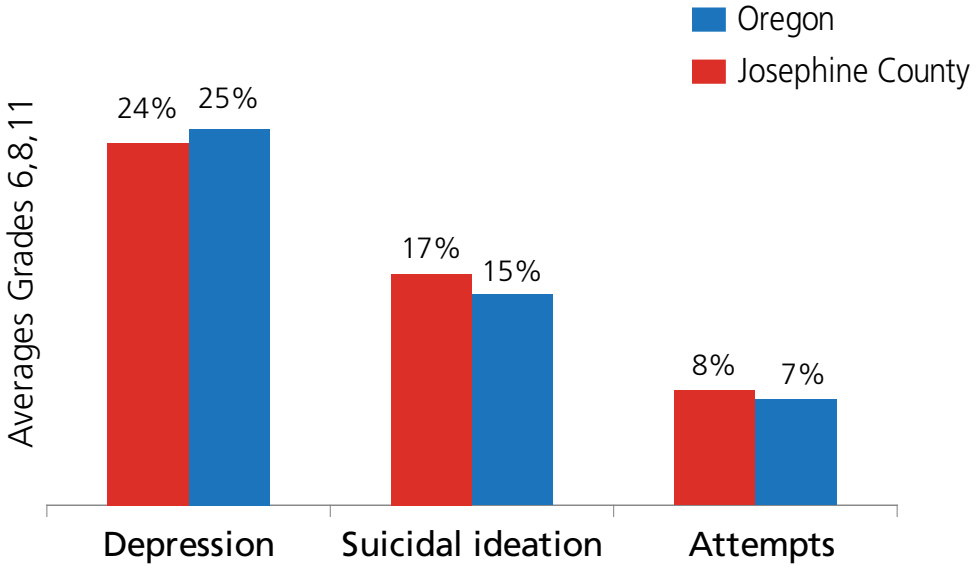



harassment because "someone said that you were gay, lesbian, bisexual or transgender"

*Source: Oregon Student Wellness Survey, 2012*

## Youth Depression, Suicide Ideation, and Attempts

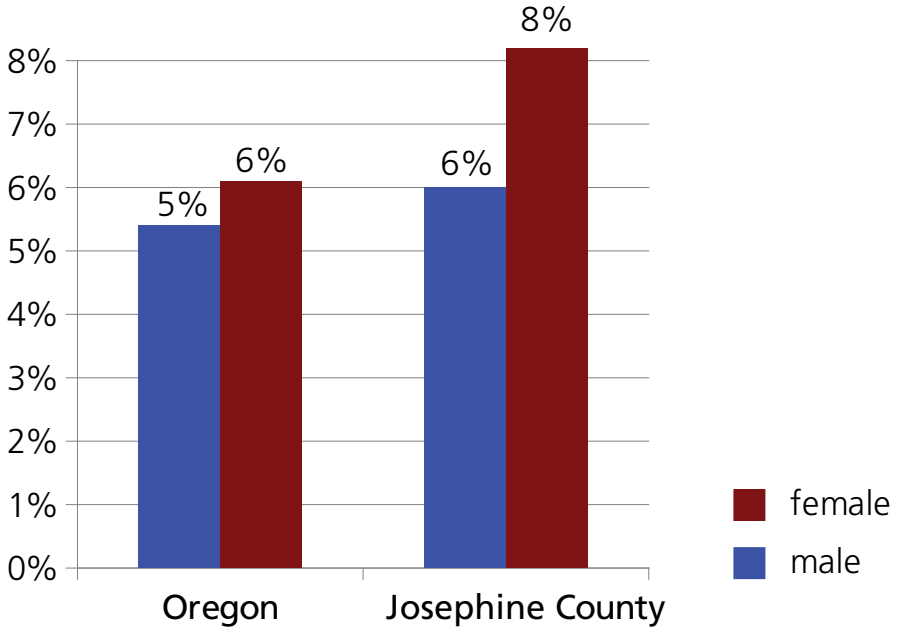
*Josephine County*




*Source: 2012 Oregon Student Wellness Survey*

Data from the 2012 Oregon Student Wellness Survey indicate that 1 in 4 Josephine County youth experienced depression, 17% experienced suicidal ideation, and 7% attempted suicide.

## Male and female heavy drinking, 2006-2009



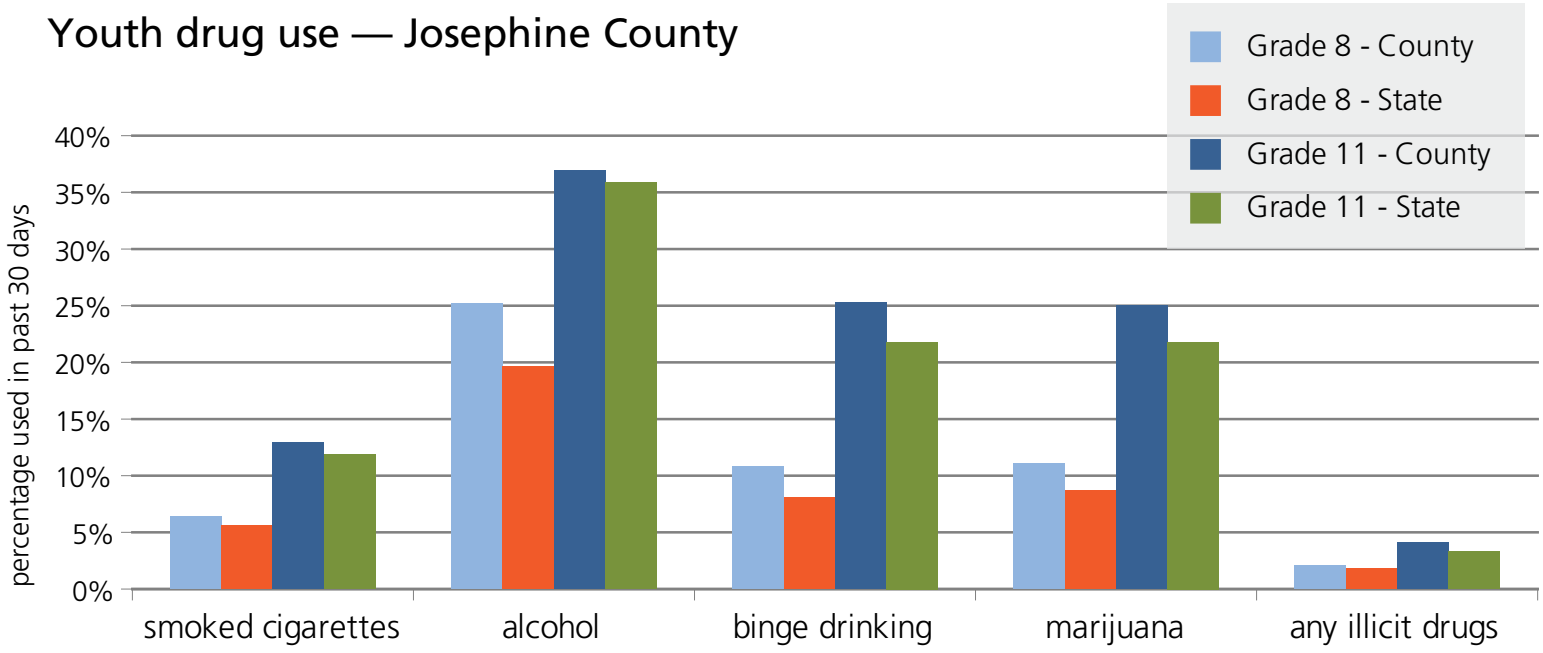

*Source: Oregon Behavioral Risk Factor Surveillance System*

### *Addictions*

Josephine County residents have significant issues with addictions of alcohol, tobacco, other drugs and gambling. Binge drinking, in women, is higher than state averages, and higher than neighboring counties. Excessive heavy alcohol consumption can contribute to chronic health issues, including heart disease, liver cirrhosis, high blood pressure, stroke, coma and death. 14% of Josephine County adults drink excessively, twice the national benchmark of 7%. Heavy or excessive drinking is defined as adults consuming more than one (women) or two (men) beverages per day on average.

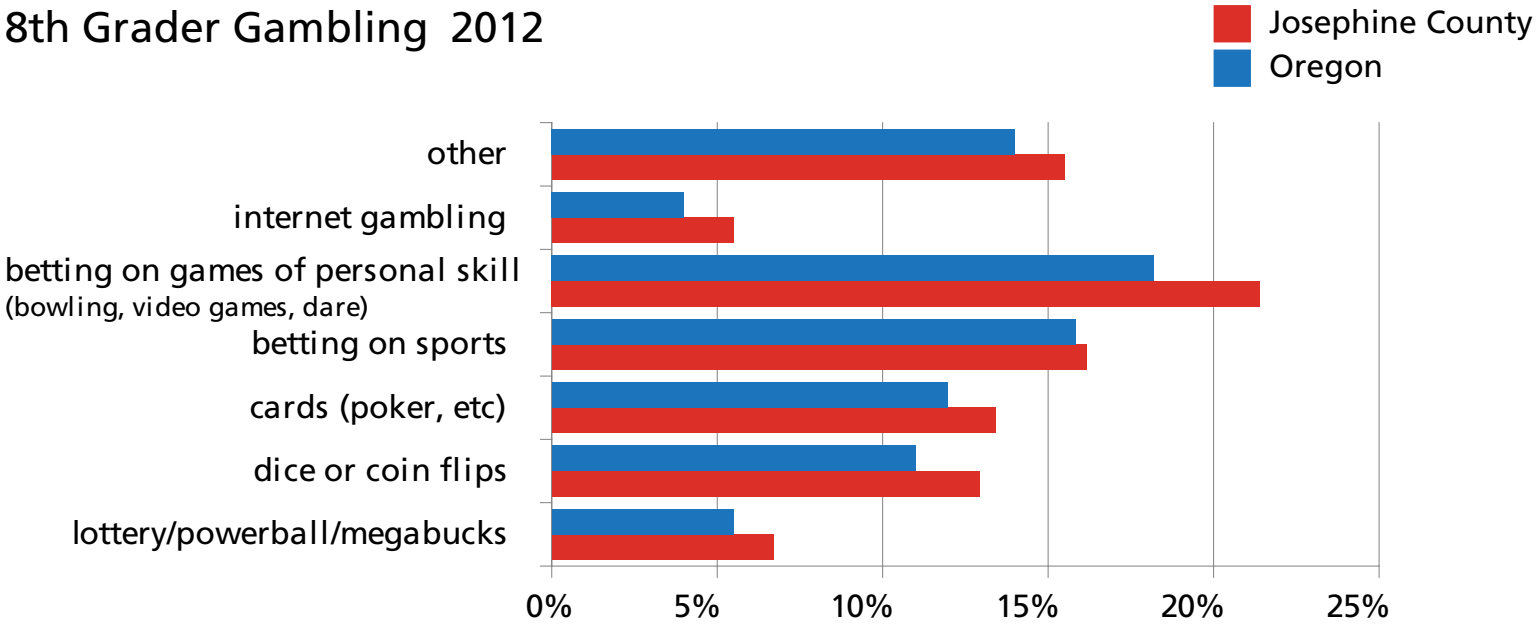
***"Unfortunately my addictions have affected the entire community, so my choice to be clean will too."—Focus Group Participant***

## Youth drug use — Josephine County




*Source: 2012 Oregon Student Wellness Survey*

## 8th Grader Gambling 2012



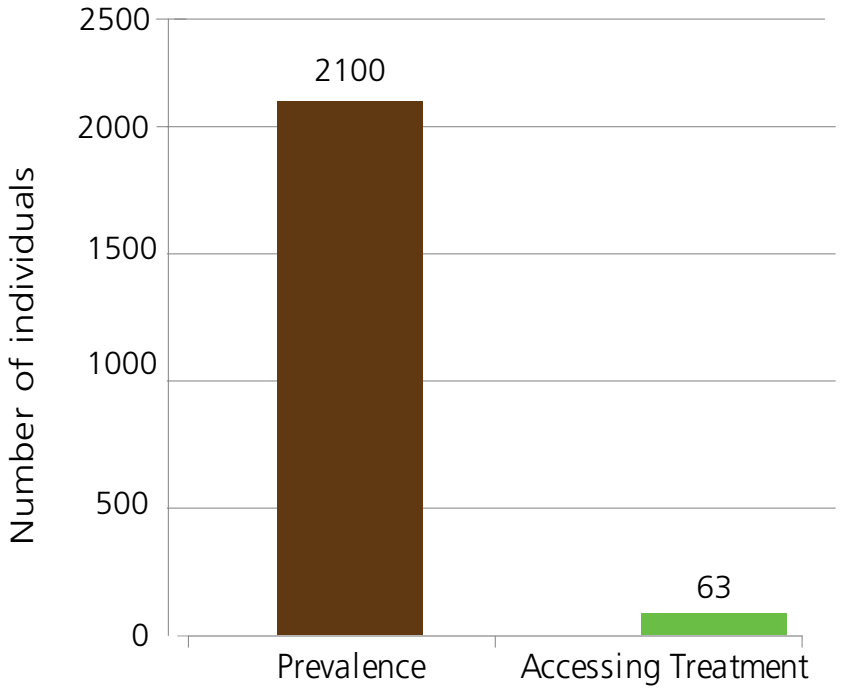

*Source: Oregon Student Wellness Survey 2012*

Drug and alcohol use is not a problem exclusively in adults. Eighth and eleventh grade students in Josephine County reported higher than State average binge drinking, and use of cigarettes, alcohol, marijuana and illicit drugs.

Gambling, a type of addiction, also presents challenges to both adults and youth in Josephine County. The county has higher percentages of eighth graders reporting gambling of every type, than the state average.

## Prevalance of Problem Gambling

*Josephine County 2012*




*Source: Oregon gambling treatment programs evaluation update 2012*
*Oregon Health Authority, Addictions and Mental Health Division*

The prevalence of problem gambling is considerably higher than those accessing treatment in Josephine County. It is important to note that only 3% of those with problem gambling in the county are accessing treatment.

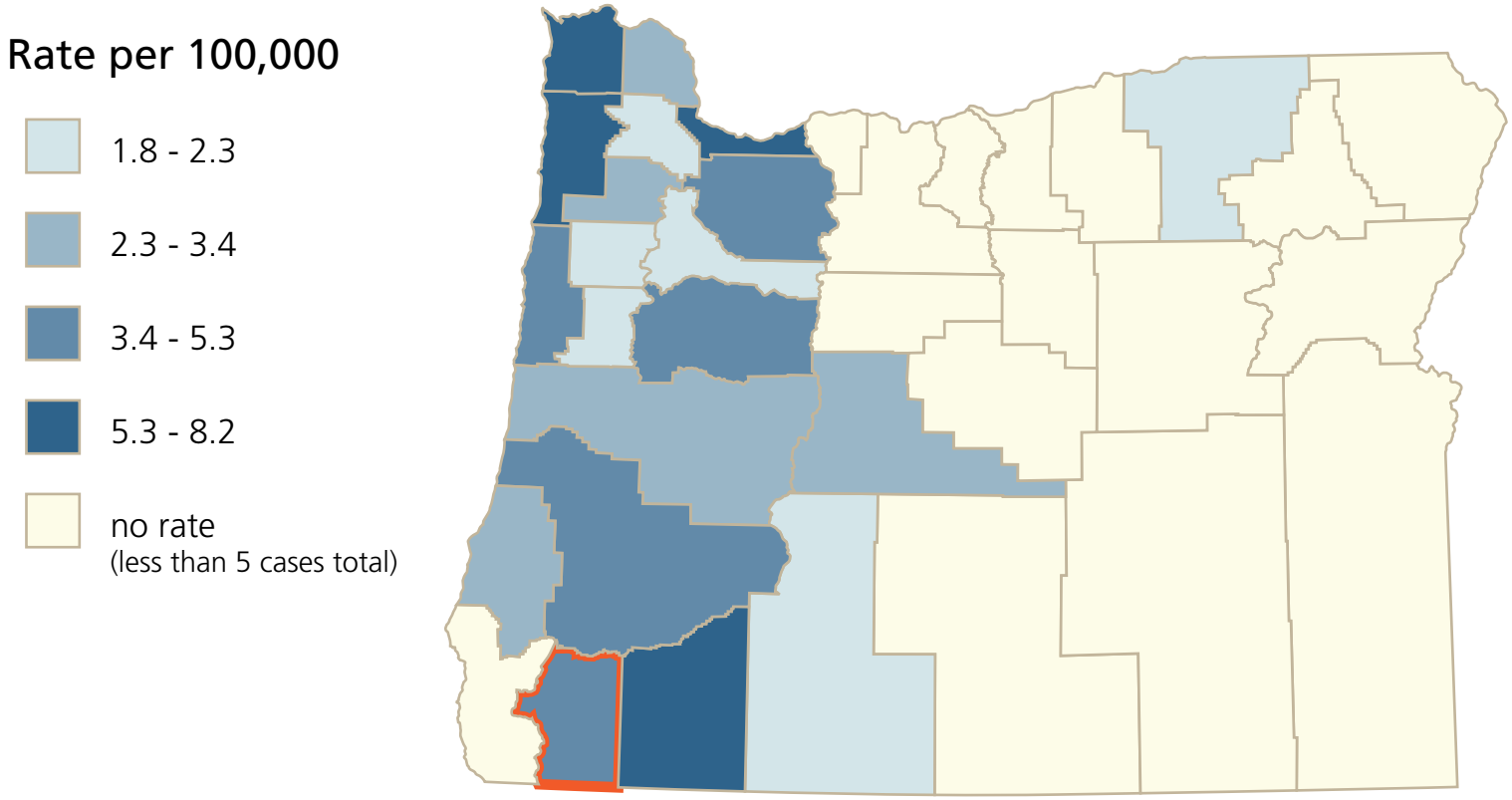
Arrests for drug offenses are mentioned in the People and Place section, but show higher averages arrests in Josephine County for all drug categories while also showing higher averages for heroin and methamphetamine.

***"Drugs (are the number one problem). To me it's a core problem that affects and creates broken families, abuse, crime, is a vicious cycle. We have good programs here but it's just so common, we need to break the cycle in people, families and communities."***
***—Focus Group Participant***

The rise in opioid overdose deaths presents a challenge for both providers and the community. (Deaths from drugs such as codeine, oxycodone, morphine and methadone). The morbidity and mortality associated with inappropriate use of opiate drugs has a negative impact on the health of the community. Josephine County has one of the highest opioid death rates in the state and the number of yearly deaths due to opioids is on the rise. At the same time, people in focus groups commented that their pain was not well managed and discussed the added burden that chronic pain presented when suffering from chronic conditions. Focus group comments and the high rate of opioid death suggest systemic problems in the management of chronic pain in the county.

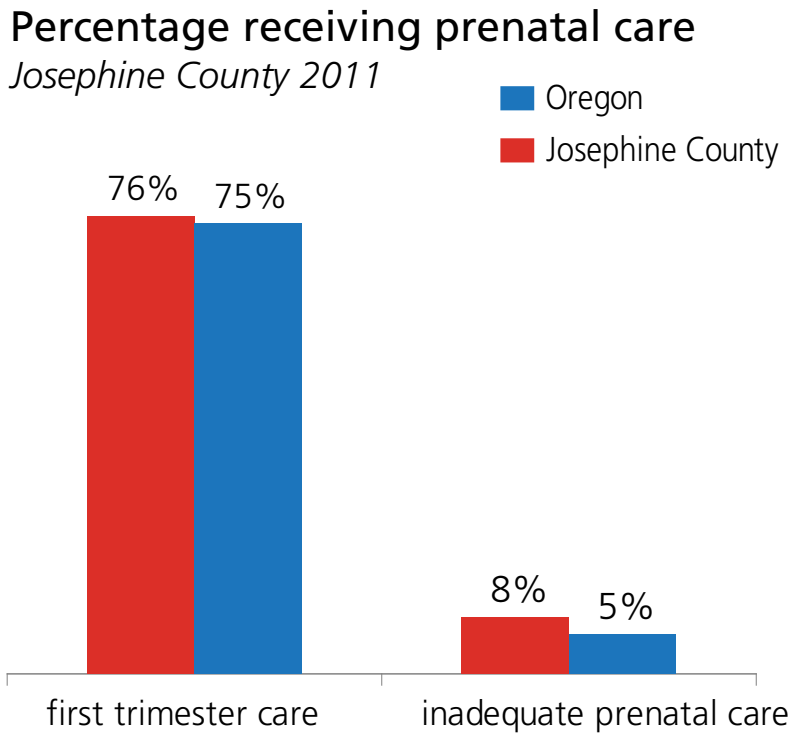
***"I don't see anyone speaking for those who need opiates for their chronic pain and are unable to get meds because doctors won't prescribe them." —Focus Group Participant***

Prescription Opioid overdose mortality rate by county, 2003-2007



## *Maternal & Child Health*

Causes of low birth weight include tobacco use, alcohol and other drug use, socioeconomic factors such as education level and poverty as well as maternal and fetal medical conditions. Babies born with low birth weight (considered 1500-2499 grams at birth) typically have more long-term disabilities and developmental issues, including cerebral palsy, learning disabilities, impairment of sight, hearing and/or lung functioning. The percentage of low birthweight babies in Josephine County is 5.5%, close to the state percentage of 6.1% and better than the national benchmark of 6%.



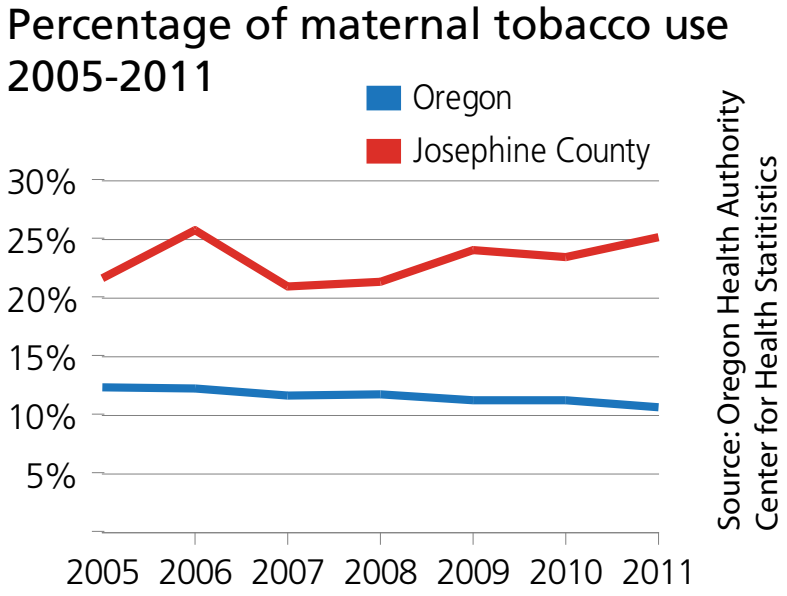

*source: oregon vital statistics, 2011*

Women who access care while they are pregnant are more likely to have healthy pregnancies and better child outcomes, and also less likely to have low-birth-weight babies. Prenatal care includes a number of services, including: education about healthy choices and body changes while pregnant, prenatal testing and counseling, treatment for medical conditions/complications (such as anemia and gestational hypertension), oral health assessment and treatment, screening for tobacco use, substance abuse, and intimate partner violence.

Although pregnancy risk factors are high (e.g. maternal tobacco use) in Josephine County, utilization of prenatal care is moderate and slightly exceeds the state average, with 76.2% of mothers in the county receiving prenatal care (2011) in the first trimester. Women receiving prenatal care in Josephine County have a markedly reduced rate of low birth weight babies compared to those without prenatal care.

A primary risk factor for low birth weights and poor child health outcomes is maternal smoking. Maternal smoking in Josephine County is currently higher than the state average and has been for several years.

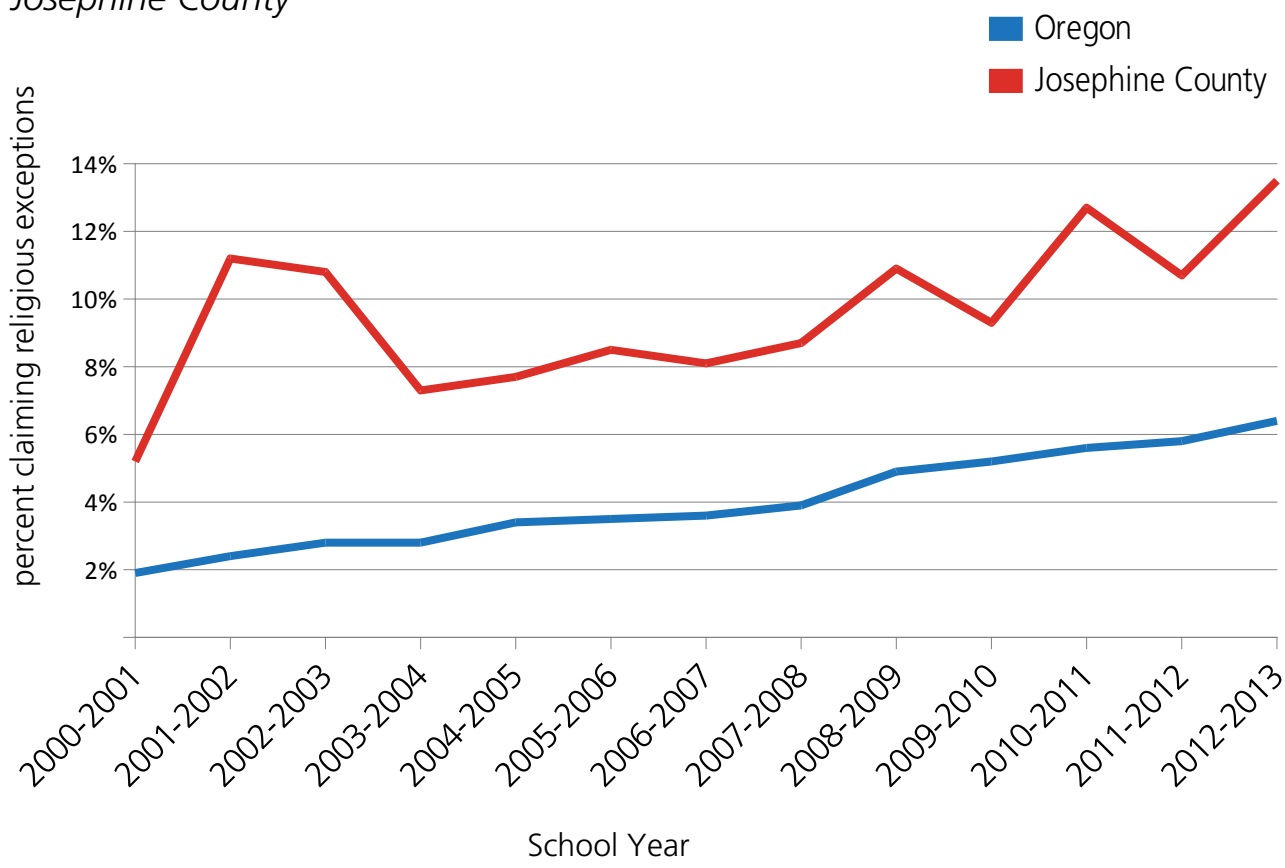
The teen birth rate in Josephine County is higher than the state average and national benchmark. Josephine County's teen birth rate per 1,000 females ages 15-19 is 36, higher than the Oregon rate of 33 and the national benchmark of 21.



Immunization is an effective tool for preventing disease and death. Vaccinating children, according to the Centers for Disease Control and Prevention recommended immunization schedules, is varied by county. Parents choosing not to vaccinate claiming religious exemption has been higher than state average in Josephine County for over a decade. The number of parents requesting exemptions continues to increase annually.

## Religious Exceptions from Immunizations

*Josephine County*




*Oregon Health Authority, Immunization Program*

## *Health Behavior & Lifestyle Factors*

Modifiable behaviors related to health status such as tobacco use, inadequate physical activity and nutrition have significant influence on the health of individuals and communities. Tobacco is the leading cause of preventable death in Josephine County, as it is in Oregon;  a close second is obesity.

### Tobacco

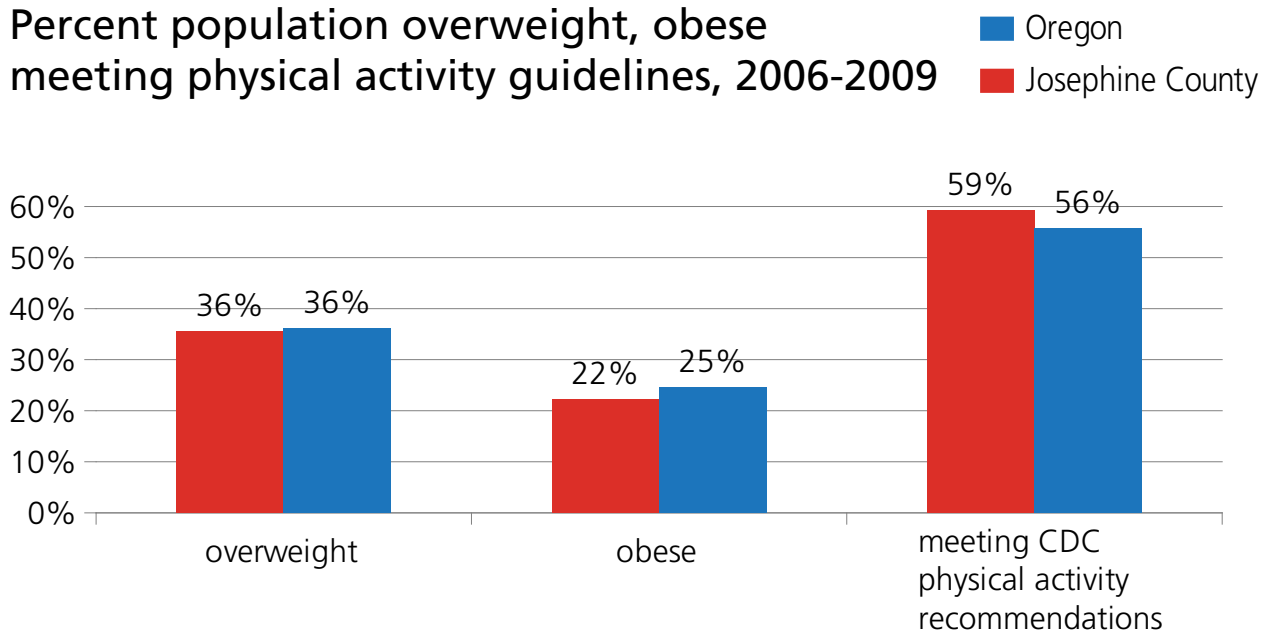
Tobacco usage has remained high in Josephine County for many years. Roughly 1 in 5 adults in the county smoke cigarettes, considerably higher than the state average of 17.1%.  Of grave concern are the 23% of birth mothers, in 2009, who reported smoking while pregnant.

According to the 2013 County Tobacco Fact Sheet, residents in Josephine County spent an estimated $50.8 million on medical care related to tobacco use.

2012 Oregon Student Wellness Survey data indicates that 6.4% of 8th graders, and 12.9% of 11th graders in Josephine county used cigarettes. One-third of these kids have started an addiction that will eventually kill them.  Eighty percent of adult smokers in Oregon started before the age of 18.

### *Obesity*

Obesity is a modifiable risk factor for several chronic conditions. Overweight is defined as a body mass index of 25 or higher, obesity is defined as a body mass index (BMI) of 30 or higher. BMI is calculated by using both height and weight. Research has shown that overweight and obesity are associated with increased risk of coronary heart disease, type 2 diabetes, cancer, high blood pressure, stroke, liver and gallbladder disease. Approximately two-thirds of adults in Josephine County are either obese or overweight, putting them at increased risk of chronic disease, cancer, and premature death.




*Source: Oregon BRFSS County Combined Dataset 2006-2009*

### *Physical Activity & Nutrition*

Regular physical activity and a healthy diet reduce the risk for chronic disease and obesity. Nearly one in four (22%) Josephine County residents are defined as being physically inactive. Physical inactivity is defined for adults 20 years and over reporting no leisure time physical activity.

The percentage of adults consuming at least five servings of fruits and vegetables a day in Josephine County from 2006-2009 was 22.7%, below the state average of 27%. The proportion of restaurants in the county that are fast food establishments is high, at 40%, almost twice the national benchmark.

> ***"The fast food restaurant ratio to healthy food choices is bad, there is a lot of fast food here." —Focus Group Participant***

## *Additional Social Determinants of Health*

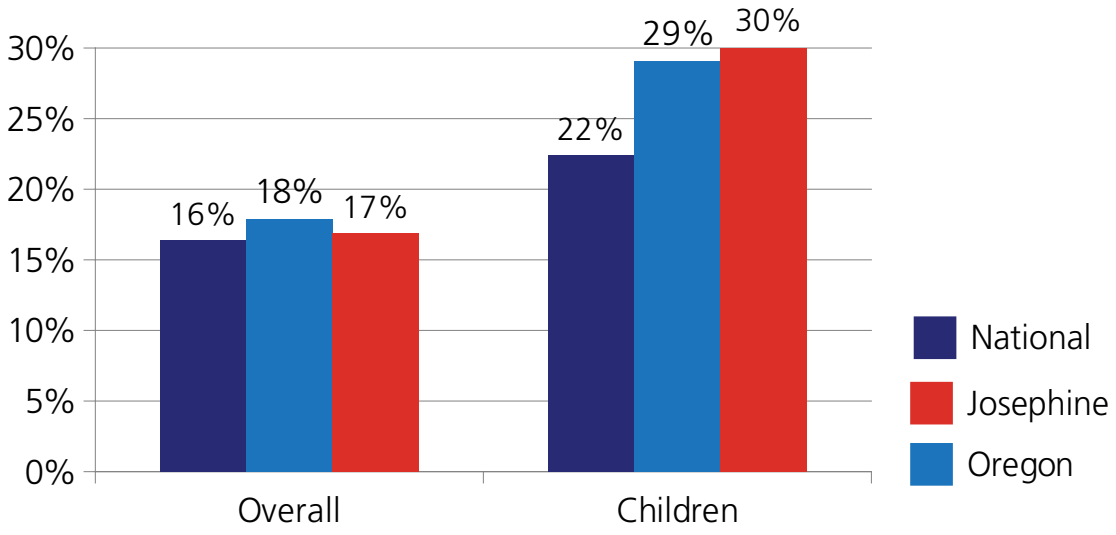
### *Food Insecurity*

The USDA defines food insecurity as lack of access to enough food for all members in a household and limited or uncertain availability of nutritionally adequate foods. Over 17.8% of Josephine County households, or approximately 14,650 people are food insecure. 78% of the food-insecure households in the county have incomes below the poverty level. Additionally, one in three children in Josephine County households experienced food insecurity in 2011. It is estimated that in 2011 an additional six million dollars would have been required to meet food needs of Josephine County residents experiencing food insecurity.

The percentage of K-12 students eligible for free/reduced lunches in 2012-2013 was 63.8%, indicating significant child poverty levels and access to food concerns for the youth of Josephine County.

Percent with food insecurity

*Josephine County, Oregon, National, 2011*



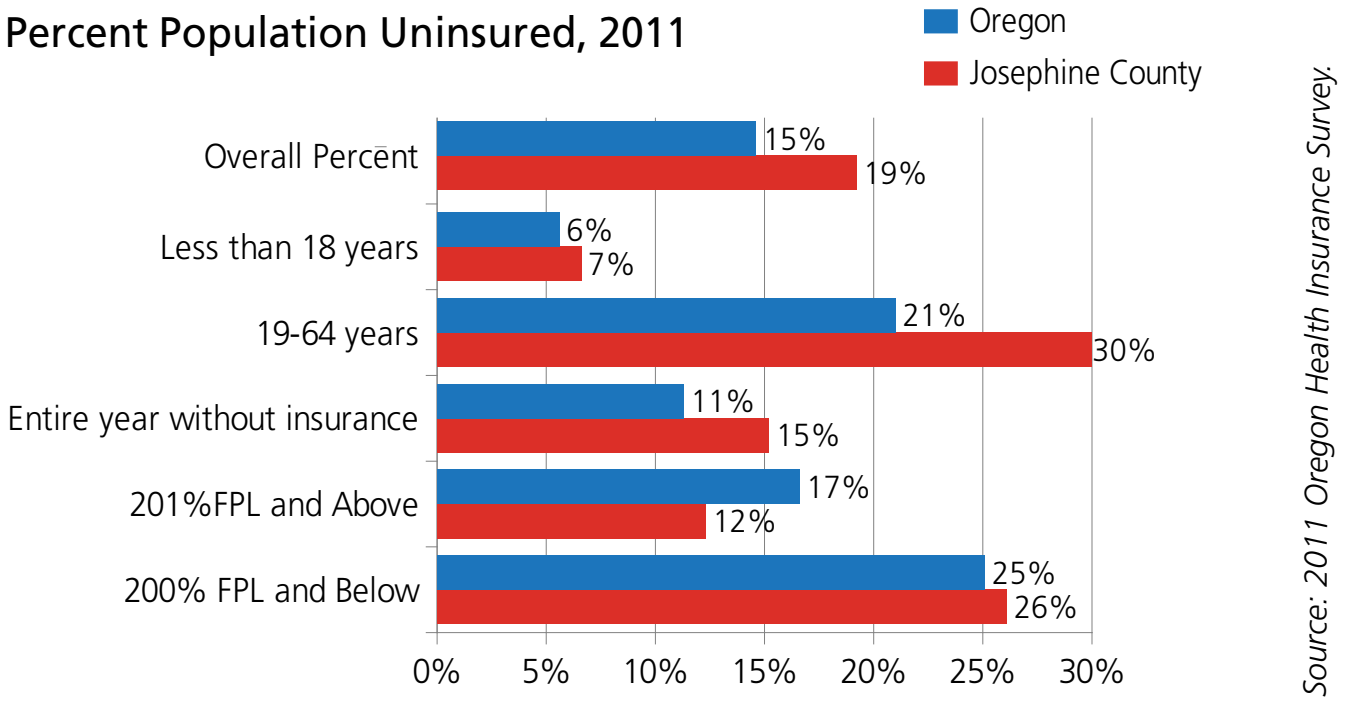

*Source: Map the Meal Gap, Food Insecurity in your County, Feedingamerica.org*

# Health System

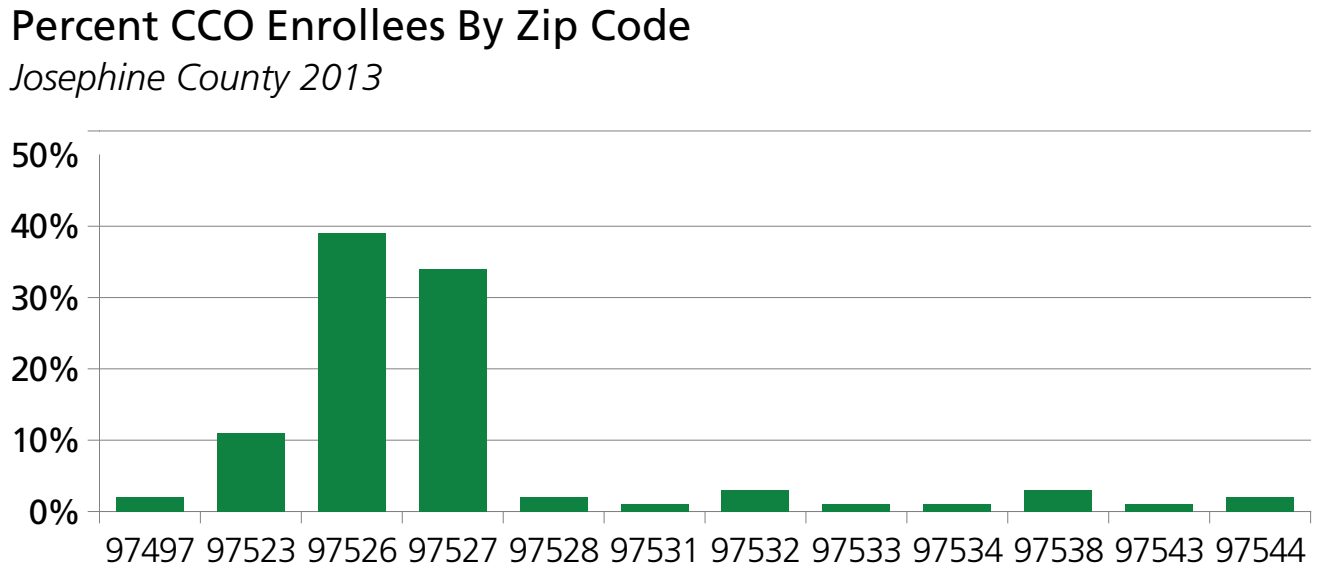
## Access to Medical Care

Lack of health insurance coverage continues to be a significant barrier to accessing needed health and medical care. Uninsured people are likely to experience more adverse physical, mental and financial outcomes than those with insurance. Josephine County far exceeds the national benchmark of 11% and state percentages in all age groups. 29.7% of adults 19- to 64-years-old in Josephine County were uninsured in 2011.

This number is expected to change after January 1st, 2014. It is expected that the majority of new enrollees after January 1 will be adults.

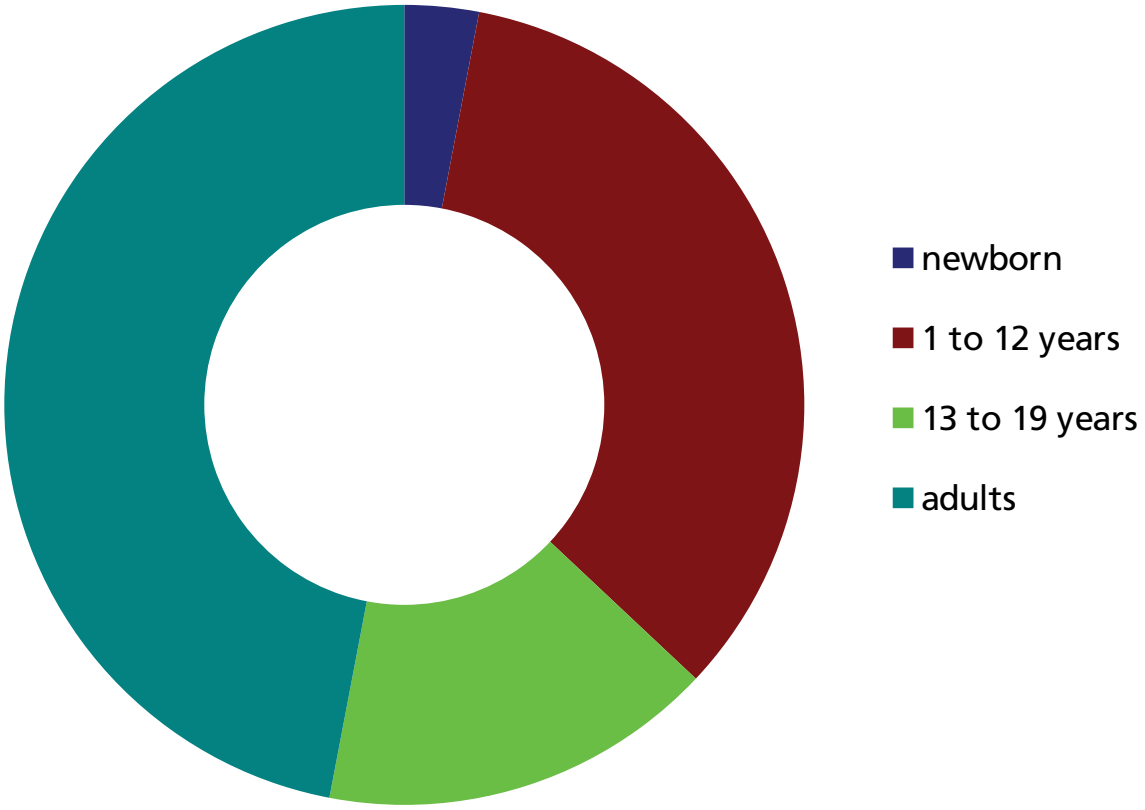



Although the number and demographics of enrollees will change January 1, it is helpful to understand the current population of CCO enrollees. Enrollees are spread out across the county, with the majority living in Grants Pass and Cave Junction.



## CCO enrollees by age group

*Josephine County 2013*




Close to 55% of the current CCO enrollees in Josephine County are under the age of 18.

Access to health care was a consistent theme in focus groups and key informant interviews. Insurance costs, transportation (getting to appointments), availability of specialists, accessibility of clinics for people with disabilities, language barriers, primary care physicians not taking specific insurance plans, and health literacy regarding how to negotiate insurance were all listed as access concerns for residents living in Josephine County.

# Community Perceptions of Health

## Focus Groups

This report presents summary findings from five focus groups, conducted in Josephine County as part of the 2013 Community Health Assessment (CHA). The purpose of the CHA was to learn what people in the county believe are most important issues affecting their health and that of their families and communities. The purpose of the focus groups was to gather primary qualitative data on community perceptions and increase community engagement in setting priorities for individual and community health.

The focus groups were part of a larger community health assessment process, following a modified Mobilizing for Action through Planning and Partnerships (MAPP) model. The focus groups were all facilitated by a consultant and assisted by Community Advisory Council (CAC) members and Coordinated Care Organization (CCO) staff.

Five focus groups were conducted throughout Josephine County during September 2013. Forty-eight (48) community members participated in the groups, representing several different populations. A subcommittee of the CAC, titled the CACC, began by prioritizing populations and locations for focus groups. Lengthy discussion about what groups to select for focus groups included two face-to-face CACC meetings, and an online survey given to the CACC members.

The limited time frame (one month) to complete focus groups was recognized as a challenging aspect of the process and the CACC had several intentional conversations about the need to prioritize due to the time constraints. Due to the January 1, 2014 deadline for submission of the final CHA, the CACC worked within the one-month parameter and chose five groups per county, with the caveat that additional groups and time would be added into the process for the next CHA.

It is also important to note that there are limitations to the focus group data. The focus group data should not stand on its own but complement the health status and epidemiology data presented earlier in the Community Health Assessment. The focus groups were not intended to be a representative of all individuals in the entire county but rather, a process to gain specific insight into health concerns and solutions of specific populations. The populations chosen were driven by the CACs.

### Prioritized Populations for Josephine County Focus Groups

CACC Priorities for 2013 CHA

- Rural/Unincorporated
- Seniors
- Uninsured/Underinsured
- Dental
- Addictions
- Chronic Pain
- Chronic Disease

The CACC also discussed and guided the selection of data and questions to gather at the focus groups. The focus group guide, including the specific questions asked, is attached in the Appendices. A "site champion" was chosen from the CACC for each focus group. The role of the site champion was to lead recruitment of focus group participants, coordinate a location, select incentives for participants, and introduce the consultant to the focus group.

Data was gathered during the groups via open-ended questions and instant feedback polling questions. The instant feedback polling questions utilized Turning Technology "clickers,"capturing instant demographic data and polling on health priorities and perceptions. The use of multiple feedback collection methodologies ensured 100% participation of focus group attendees.

Focus groups were all facilitated by the same consultant and assisted by the Community Advisory Council (CAC) members and Coordinated Care Organization (CCO) staff. Light refreshments and $10 gift cards were provided to focus group participants as incentives. The focus groups were completed within two hours and averaged 6 participants per group.

### *Focus Group Schedule-Josephine County*

| Group | Date | Location |
|---|---|---|
| Rural/Unincorporated | 9-26 | Cave Junction |
| Seniors | 9-04 | Seniors Dining Site Grants Pass |
| Uninsured and Dental | 9-25 | Grants Pass |
| Addictions | 9-16 | OnTrack Inpatient |
| Chronic Disease/Chronic Pain | 9-09 | Grants Pass |

## *Demographic of Participants*

Focus group participants answered questions about gender, age, ethnicity, martial status and education with Turning Technology clickers. The use of the clicker technology provided anonymity and increased participation and engagement in the group process. The total number of participants was fourty-eight. Please note that not all participants chose to fill out demographic information, so totals on the demographic categories are varied.

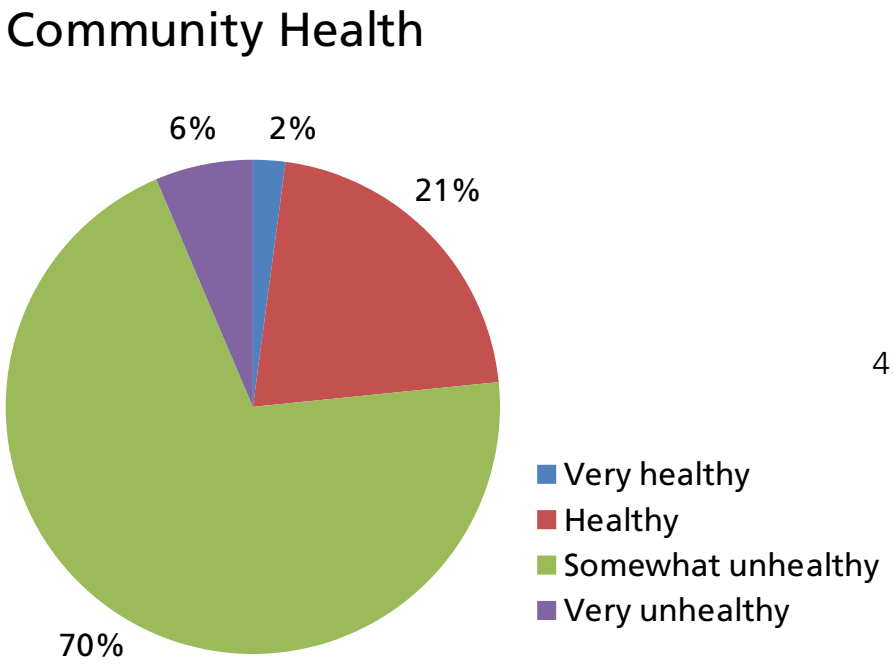
### *Josephine County Focus Group Participant Demographics*

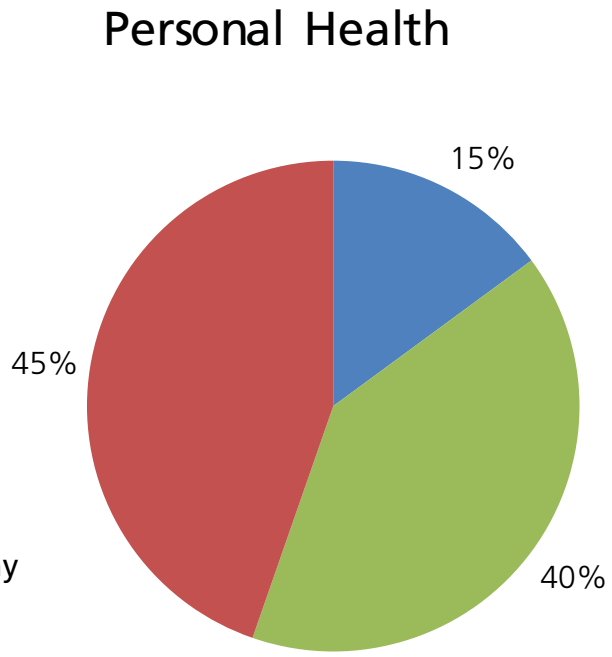
| Characteristic | Response |
|---|---|
| **Age** | |
| 25 or under | 6% |
| 26-39 | 15% |
| 40-54 | 23% |
| 55-64 | 15% |
| 65 or over | 42% |
| **Sex** | |
| Female | 61% |
| Male | 39% |
| Ethnicity | |
| African American/Black | 6% |
| Pacific Islander | 2% |
| Hispanic/Latino | 4% |
| Native American | 0% |
| White/Caucasian | 85% |
| Other | 0% |
| Marital Status | |
| Married or co-habitating | 70% |
| Not married, single, divorced or widowed | 30% |
| Highest Level of Education | |
| Less than HS Diploma | 7% |
| HS diploma or GED | 39% |
| Some College or degree | 50% |
| Other | 4% |
| Household income | |
| Less than $20,000 | 30% |
| $20,000-29,999 | 22% |
| $30,000-49,000 | 13% |
| Over $50,000 | 13% |
| I don't know | 17% |
| | |

## *Community Perceptions*

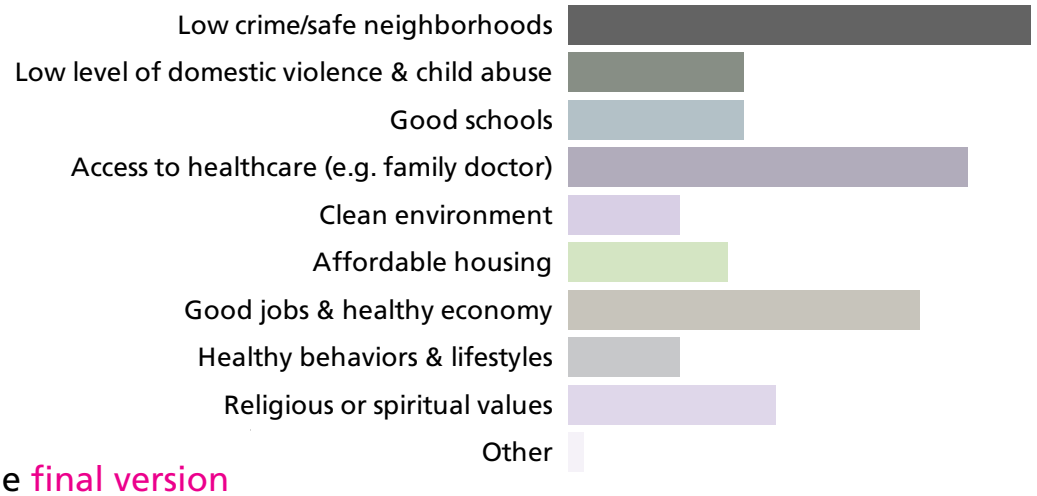
Focus group participants answered questions about their personal health and their community's health. Additionally, participants were asked to rank health problems, risk factors and conditions that influenced a healthy community. The following data were also collected with the Turning Technologies clicker system.

A majority of participants (76%) described their community as unhealthy. Counter to that, the majority (60%) of participants described themselves as healthy.

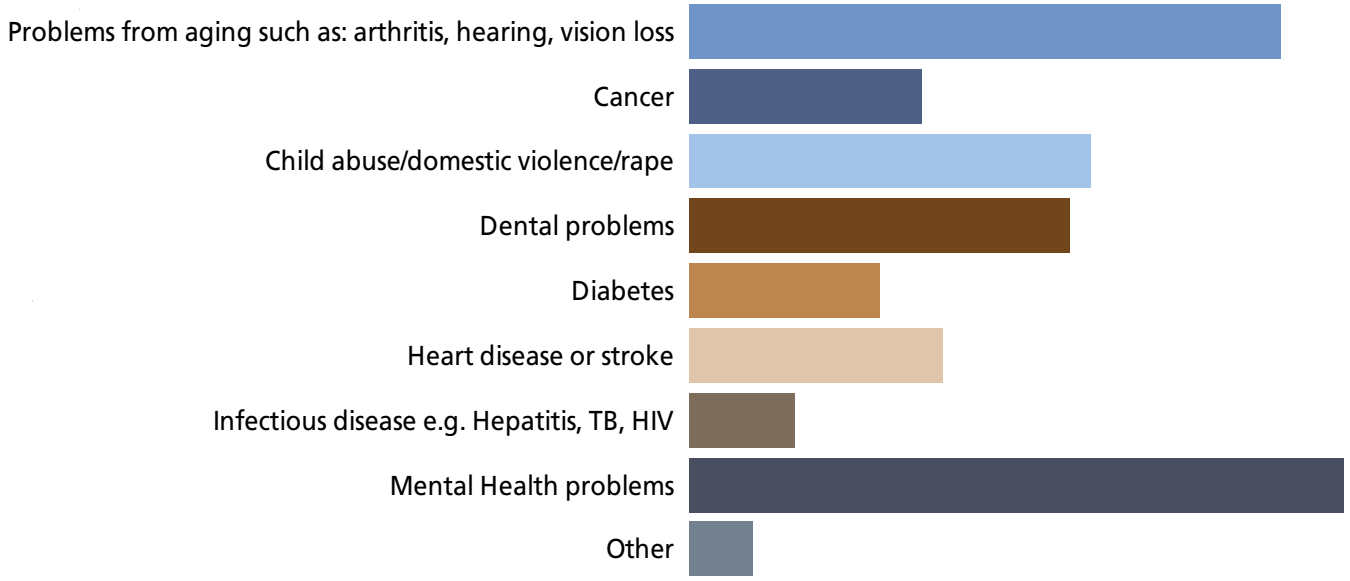


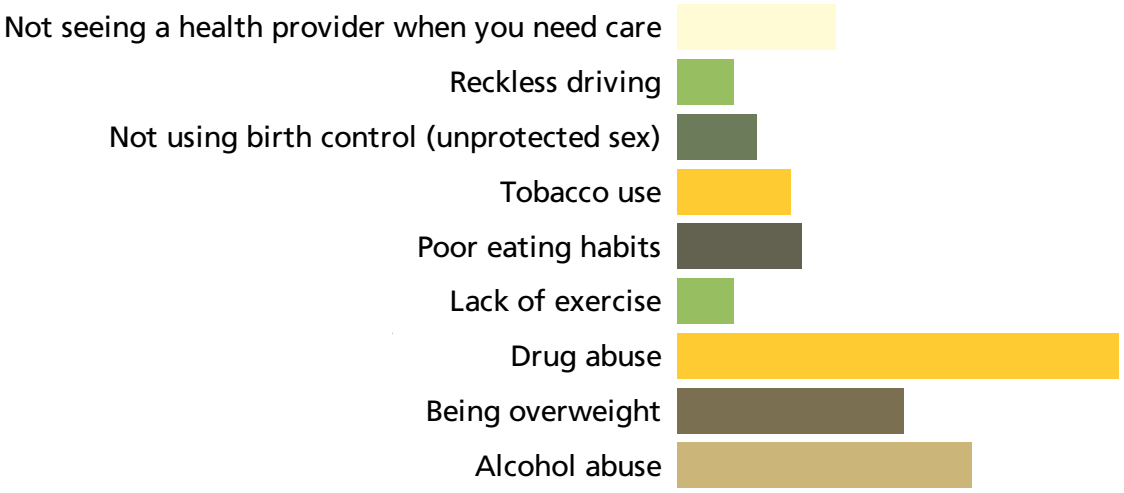

### *What do you think are the three most important ingredients for a healthy community?*



## *What do you think are the three biggest health problems in your community?*




## *What do you think are the three biggest risk factors for health in your community?*




### *Participant Commentary*

The second portion of the groups consisted of open-ended dialog questions, asking participants to discuss individual and community health needs. Several hundred narrative comments were collected during the five focus groups. The CACC workgroup reviewed all comments and upon analysis, recognized several universal themes. The comments listed below were reviewed, categorized and selected by the CACC to be included in the CHA.

Focus group participants' responses are presented in seven categories. All comments below were transcribed verbatim. Comments are intentionally written out as they were spoken in the group.

1. Access to and quality of health services
2. Mental health and addictions
3. Lifestyle: exercise, obesity, nutrition and access to food
4. Dental and/or vision health
5. Poverty and the economy
6. Chronic disease and/or aging issues
7. Crime, domestic violence and child abuse

## *Access to and Quality of Health Services*

Participants in groups consistently brought up barriers to accessing health and medical services. Insurance (or lack of), paying for health care services, physically getting to a health care provider (transportation), language barriers, having providers available and the relationship with providers were common themes in every focus group.

*"We only have major medical, so dental and eye visits have been pushed to "as needed" as opposed to "routine." And for our major medical benefits, the deductibles on our plan has made it tough for both my husband and to get care in the same year. We've had to choose who's health issues are more threatening and that person goes to the doctor and uses the money budgeted for co-insurance."*

*"I had to go off meds and withdrawls were crazy because I couldn't pay for the doctors appointment to get it refilled."*

*"We are far away here from medical center and services, it affects the elderly. Transportation, social, and food services are a major problem."*

*"Healthcare shouldn't just be 'see the doctor and get a prescription and go home.' We need holistic approaches. We need lifestyle changes. Alcohol and drug abuse have to be included."*

*"A lot of healthcare plans won't pay for a Naturopath; it's the only place my wife will go."*

*"[I have] depression from not having money for care—problems get added to the pile and my depression gets worse—its easy to get hopeless."*

*"Providers won't talk to me—only want to know one issue or complaint. I do know my body."*

*"A lot of physicians that won't take Medicare patients, it's a small town. Where are we going to go?"*

*"Providers and doctors don't always give you credit for your intuition about your health, they don't want to listen, they only want one…complaint per visit."*

*"Transportation is a challenge—getting to where we need to go is almost impossible sometimes."*

### *Mental Health and Addictions*

**Challenges with mental illness and addictions weighed heavily on all groups. The effects of both on the individual and community were prevalent in many conversations about what concerned participants and what solutions they wanted to improve their health and the health of their community.**

*"When you are surrounded by drugs you can't be healthy."*

*"I see a lot of mental health problems with homeless people—I've seen a lot of homeless and it's a notable increase."*

*"Mental health is a disaster area—my adopted daughter has been in 15 facilities in 5 years and she has very little hope for her future, it's sad even when your parents cannot advocate for you."*

*"Mental disabilities, lack of staffing and services and they wander the street. Not taking meds and/or can't afford it. There is nowhere for them to go or they can't get transportation to get there."*

*"Meth and Heroin are our biggest drug problems, [they] cause broken families, effect safety, education."*

*"My addiction caused me to go into heart attack—that caused issues for family on top of my addiction problem."*

*"My alcoholism is from a lack of treatment of my depression—it wasn't being treated and alcohol is what I turned to."*

*"Drugs [are our number one problem]. To me it's a core problem that affects and creates broken families, abuse, crime, is a vicious cycle. We have good programs here but it's just so common, we need to break the cycle in people, families and communities"*

*"Inadequate or negligent prescribing of drugs with dangerous side effects, like anti-depressants, methadone can be worse than the disease."*

*"Unfortunately my addictions have affected the entire community so my choice to be clean will too."*

### *Lifestyle: Exercise, Obesity, Nutrition and Access to Food*

The need for lifestyle changes, including diet and exercise were clearly recognized in all groups. Participants were quick to recognize their own challenges with lifestyle change while also making suggestions for solutions such as community gardens, walking groups or farmers markets.

*"Obesity is a big problem of all ages here."*

*"I feel the biggest health concern is obesity. I know for a small county the meth issue and now heroin is huge but as a whole I think people are morbidly obese which brings on a whole other onset of health problems."*

*"The fast food restaurant ratio to healthy food choices is bad, there is a lot of fast food here."*

*"Drastic increase in Diabetes—starting in grade school, not just caused by diet and exercise, but sugary carbonated drinks too."*

*"Carbonated, sugary drinks are too available and too many."*

### *Dental and Vision Health*

Access to dental care and the negative effects of not having both preventive and crisis dental care was a consistent theme among all groups and demographics. Vision health was also mentioned in 40% of the groups, related those living in poverty and not being able to acquire glasses or contacts. Only 45% of focus group participants noted that they had received dental services when they needed them in the last 12 months.

*"Dental care and issues are huge—dental affects so many other health issues—we have insurance and still can't afford dental care, it affects more than people would think."*

*"Not having quality dental has affected mine and my wife's health—they either pull teeth or do nothing at all."*

*"My bulimia has messed up my teeth, when I had dental insurance it wasn't so much a issue as it is now."*

### *Poverty and the Economy*

Poverty and the economy influence individual, family, and community health. All focus group participants consistently discussed their influence on health. Participants were largely of the opinion that improving the economy, jobs and not living in poverty would help improve health.

*"Economy and drug abuse effects everyone, in one way or another."*

*"Those that can afford to be healthy, are. Unfortunately, we have too many poor and unemployed living on junk food. Too much obesity for young people."*

*"Not being able to find work in the area—and without work there is no money. Without money we have to sell our house. Huge fear, we live in huge fear, even though we have strong beliefs I still can't provide"*

*"We are grateful for programs like OHP, UCAN, food stamps. OHP paying for my other meds is huge help. But I'd like to be able to stand on my own two feet someday soon, I am tired."*

*"Unemployment rate are going up. People are idle and don't have insurance. Poverty scale is different for healthcare than other benefits—I'm not quite poor enough for help but I still need help."*

*"We need more jobs, and better health education, and better law enforcement to get rid of the drugs."*

*"High unemployment results in higher non or underinsured, increased alcohol use and abuse, increased domestic tensions, and increased crime."*

### *Chronic Disease and Aging Issues*

51% of focus group participants noted that they were currently living with a chronic condition. Several participants also discussed challenges of managing chronic pain, particularly in light of many programs to reduce opioid use in the county.

*"A lot of us are past retirement and with that comes a lot of health problems. I hate to go to the doctor and hear that I should expect it because I'm old and just get used to it—its discrimination and its not right."*

*"I don't see anyone speaking for those who need opiates for their chronic pain. I'm unable to get meds because doctors won't prescribe them to me because they are afraid of getting in trouble. But I'm still in pain."*

*"Chronic pain effects both me and my wife—doing what we can do to manage pain to do everyday tasks like mowing the lawn. Long-term we try to stay cheerful, but at times we get sad and hopeless—is this as good as it gets? That's a big drag that affects all aspects of life. We used to go dancing, but not anymore, we are lucky to just get through the day."*

*"We have insurance but it doesn't cover medication for my chronic pain-when something breaks in the house, it stays broken. I have to save money to pay for my medication to help with my pain."*

*"People here are old, they don't have anyone to help them anymore, they get isolated (out here) and the group of them is getting bigger."*

### *Crime, Domestic Violence and Child Abuse*

Crime and concern about community and individual safety rated as a high concern in nearly all focus groups. Concern about child abuse and domestic violence and their connection to health were noted in all groups.

*"I normally feel safe here, but the police protection is horrible."*

*"I called 911 and it took 20 minutes for them to respond, I don't feel safe."*

*"My community [of domestic violence workers and clients] are very unhealthy—a lot of drug use, alcohol, sexual assault—a lot of violence unreported that our community doesn't see."*

*"Domestic violence was in my household and has affected me and my kids with PTSD and depression—I wonder how it will affect my kids long term."*

*"[We need to] increase public awareness of the impact of stress and trauma on children and our future."*

## *Community Engagement in Solutions*

All focus groups ended with a question about solutions to the challenges, problems and needs identified in the prior questions. Specifically, the facilitator asked "what do you think we (as a community) can do to enhance the health of our community?" The focus was directed at what solutions participants wanted to be engaged in to address the problems discussed earlier.

All groups, regardless of demographic or location expressed a strong sense of concern about their community and how they could contribute to improving problems. Several solutions and positive comments were stated in every group, some of those comments are as follows:

## *Suggestions*

*"We need to build opportunities for multi-generations to share skills like gardening, sewing, community gardens-would help to teach and provide food and skills."*

*"Church and social groups—support them. We need to do these skills again and not rely on others to do them for us."*

*"Change attitudes that we hold helping and doing something, improving something every day. This has to start young. Striving for self-sufficiency starts young."*

*"[We need] community gardens—teach to grow and preserve."*

*"[We should] educate children about importance of healthy food and exercise. change life styles. Could we do a community walk your child to school day? Like the nationalwalktoschool.org in October."*

*"[We must] recognize that community health is a systems issue and that every cog in the wheel (law enforcement, school systems, health care, housing affordability) all impact the health of a community. People in this community just want to hunker down and ignore our problems, blame the government for their woes and not accept personal responsibility as citizens for positive change.*

## *Key Informant Interviews: System of Care Strengths and Opportunities*

Several community leaders working in the health care sector were interviewed to gain additional insight into the strengths and weaknesses of the health system of care in Josephine County.

Individuals and organizations were recommended to the consultant by members of the CACC and CCO staff. All key informant interviews were completed by the consultant and anonymity of name and title was provided. Key Informants were recommended based on their organization affiliation, role in providing medical, mental, behavioral or addictions treatment to Josephine county residents.

### *Organizations represented in the key informant interviews*

| |
|---|
| Southern Oregon Head Start |
| OnTrack Addiction Recovery Programs and Services |
| Three Rivers Community Hospital |
| Asante |
| Oregon Health Authority |
| Rogue Medicine |
| Options for Southern Oregon |
| Siskiyou Health Center |
| Josephine Public Health |
| Josephine County Board of Commissioners |
| HASL Center for Independent Living |

### *Key Informant Questions*

All key informants were asked the following questions:

1. What are your organization's major contributions to the local health system of care?

2. What challenges do you see that may affect your work (upcoming changes in legislation, funding, technology, new collaborations, etc.)?

### *Themes*

Key informants universally talked about unmet needs of their communities, changing partnerships, increased complexity of administration, changing paradigms to improve care, a desire to reduce barriers to care and prevention activities when discussing their organization's contributions to the community and system of care.

***"Finding and keeping high quality staff is very difficult here. Our pay is less than bigger areas and our problems more challenging. Many providers are getting ready to retire, who is going to move here to lead us into the future? We are tired."—Key Informant***

While the desire for integration and improving patient outcomes was strong, the challenges that come with changing payment systems, legislative pressures and changes, the unmet needs of many patients, and consistently poor health status of patients and the community at large were listed by key informants.

# The Community Health Improvement Plan & Next Steps

## Utilizing the CHA for Planning

The Josephine County Community Health Assessment (CHA) draws attention to numerous opportunities for health improvement at the individual and community level. While the CHA identifies many critical health issues, it is not inclusive of every possible health-related issue. Instead, it was intended to provide a macro view of available community data and help to identify community trends. The CHA was successful in that purpose, as well as engaging new community members in prioritizing what health status issues were important, and where additional focus and data was needed.

The CHA was the first step in an ongoing process of community health assessment, planning and improvement. The natural progression of the community planning process is to prioritize health status issues and implement strategies to improve them. The prioritization process and document is titled the Community Health Improvement Plan (CHIP).

> ***"Pick the top three health problems in my community?! How can I only pick three, they are all important!" –Focus Group Participant***

Prioritizing future efforts to address individual and community health is imperative. Individuals, organizations and communities in Josephine County do not have unlimited resources to change all health status problems at once. Prioritizing efforts that are most likely to succeed and have the biggest positive impact on individual and community health must happen first. Strategies that are most likely to improve health outcomes, improve health of individuals and reduce health care costs ties the CHIP to the CCO Triple Aim. The prioritization conversation will not be one time process but will be dynamic.

The next step of the CCO community health process will entail community discussion about the community health assessment findings followed by establishing short term, intermediate and long-term strategies to address prioritized individual and community health problems. The prioritization process should be based on the quantitative and qualitative data presented in the community health assessment document and complemented with additional community input.

### *Top 3 Health Problems: Focus Groups Josephine County 2013*

1. Mental Health Problems
2. Problems from Aging
3. Domestic violence and child abuse

### *Top 3 Ingredients for A Healthy Community Josephine County 2013*

1. Low Crime and safe communities
2. Access to health care
3. Good jobs and economy

### *Top 3 Risk Factors/Behaviors Related to a Healthy Community Josephine County 2013*

1. Drug Abuse
2. Alcohol abuse
3. Being overweight

Strategies for addressing health problems, behaviors related to health or ingredients for building a health community should be based on best practice/standards, potential community impact, cost and feasibility. Additionally, strategies for health improvement should be linked to indicators that are already being tracked in the community, to better enable the evaluation of progress and success of the chosen strategies. This will aid in reducing duplication of effort and provide a mechanism for more consistent and continuous measurement of progress. CCO metrics and local, state and national public health indicators are suggested possible indicators.

Identifying additional data needs and working with local, state and federal organizations to meet those needs will also need to be considered in the CHIP. County specific data on health status by race and ethnicity is an example of a continuing data need. Dental access and outcomes is another area of data needs, among many others. Having adequate data to understand problems in the community is imperative in planning appropriate strategies and solutions. Advocating for access to county level data that is helpful for CCO and CAC planning will need to be a continuing strategy in the CHIP.

Engagement of the CAC will continue to be instrumental in the process, as will listening to community member priorities and concerns. The work of improving the health of people in Josephine County will happen with collaborative and adaptable efforts as we move forward through health care transformation and integration.

# Appendix

## Josephine County Community Health Assessment Data Sources

### Sampling of Available Data Sources 2012-2013

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| Alcohol & Other Drugs | Oregon Student Wellness Survey 2012 | http://www.oregon.gov/oha/amh/2012%20Student%20Wellness/Josephine.pdf |
| | *Epidemiological Data on Alcohol, Drugs and Mental Health 2000 to 2012 | http://www.oregon.gov/oha/amh/ad/data/josephine.pdf<br><br>Adult Alcohol Use Fact Sheet: http://www.oregon.gov/oha/amh/ad/josephine-adult.pdf |
| | National Survey on Drug Use and Health State Rankings-Prescription Drug Use | http://www.samhsa.gov/data/2k12/NSDUH115/sr115-nonmedical-use-pain-relievers.htm |
| | 2011 National Survey on Drug use & Health All drugs | http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf |
| | *Oregon Justice Commission Statistical Analysis Center- county level crime and drug data | http://www.oregon.gov/CJC/Pages/SAC.aspx (best viewed on-line) |
| Behavioral Health | Oregon's Healthy Future: A Plan for Empowering communities 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority5-substanceabuseandbehavioralhealth.pdf |
| | Suicides in Oregon: Trends and Risk Factors 2012 Report | http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/Suicide%20in%20Oregon%202012%20report.pdf |
| | *Specific 2000-2012 Epidemiology Alcohol, Drugs, MH (also included in Alcohol & Drugs) | http://www.oregon.gov/oha/amh/ad/data/josephine.pdf |
| | SAMHSA Oregon State Brief | http://www.samhsa.gov/data/StatesInBrief/2k9/OREGON_508.pdf |
| | SAMHSA Adolescent Behavioral Health Brief-State | http://www.samhsa.gov/data/StatesInBrief/2k9/OASTeenReportOR.pdf |
| | SAMHSA Data Sources-various reports and search functions, some state, some sub-state | http://www.samhsa.gov/data/States_In_Brief_Reports.aspx |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Children/ Youth** | Kindergarten Readiness | 2008 Results- No link, electronic copy in files Assessment revised 2010-12 and will be used starting in 2013-14 school year. Updates at: http://www.ode.state.or.us/search/page/?id=3908 |
| | *Children First for Oregon report 2011 | http://www.cffo.org/images/pdf_downloads/county_data_books/Josephine%20County.pdf |
| | Free & Reduced Lunch ODE | http://www.ode.state.or.us/sfda/reports/r0061Select.asp |
| | Youth Suicide Attempts in Oregon Adolescent Data System 2007 Data Report | Fact Sheet: http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Documents/factsheet.pdf (2007 data)<br><br>Full 2007 report- No link, electronic copy in files |
| | Suicide, Suicide Attempts, and Ideation among Adolescents in Oregon, Oregon Health Authority, March 2012 | http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/Suicide%2csuicide%20Attempts%2c%20and%20ideation%20among%20Adolescents%20in%20Oregon%202010.pdf |
| | *Oregon Student Wellness Survey 2012(duplicate) | http://www.oregon.gov/oha/amh/2012%20Student%20Wellness/Josephine.pdf |
| | National Survey of Children's Health (CDC)- LOTS of state specific data- Oregon Children's Profile Included as PDF | http://www.cdc.gov/nchs/slaits/nsch.htm |
| | *Kids Count Data Book 2012-Oregon data | http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=OR&group=Grantee&loc=5359&dt=1%2c3%2c2%2c4 |
| | Oregon Child Health 2010 Data & resource guide | http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/Documents/oregon-child-health-2010-data-and-resource-guide.pdf |
| | *Child Welfare Data Book | http://www.oregon.gov/dhs/abuse/pages/publications/children/index.aspx |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Community Assessments & Plans** | Oregon Public Health Community Health Assessment Clearinghouse | http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/communityhealthassessmentclearinghouse/pages/index.aspx |
| | *Public Health Annual Plan | http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Documents/Annual%20Plans/AnnualPlan2012-2013/Josephine_County_2012_Annual_Plan.pdf (2012-13) |
| | FY 2012 PRC Community Health Needs Assessment (Asante Health System) | http://www.asante.org/app/files/public/1603/2012-Community-Health-Needs-Assessment.pdf |
| | Providence Health and Services-Summary of the Community Needs Assessment and Community Benefit Plan (3-1-2011) | http://oregon.providence.org/ptkattachments/FormsInstructions/CHNA-FINALfull_appendix.pdf<br><br>Southern OR Summary (2011), no link, electronic copy in files |
| | Oregon Health Improvement Plan 2010-2020 | http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/OregonHealthImprovementPlan/Documents/hip_plan.pdf |
| | Oregon State Health Profile 2012 | http://public.health.oregon.gov/About/Documents/oregon-state-health-profile.pdf |
| **Crime** | Oregon Annual Uniform Crime Reports-County Specific Tables throughout | http://www.oregon.gov/osp/CJIS/docs/2010/2010_annual_report.pdf |
| | *County Criminal Justice Fact Sheet-Oregon Criminal Justice Commission 9-2-2010 | http://www.oregon.gov/CJC/docs/josephine_co_cj_fact_sheet.pdf |
| | *DUII Data Book for Oregon Counties, 1999-2008 | http://library.state.or.us/repository/2009/200906301527262/1999-2008.pdf (Josephine 26) |
| | *Oregon Justice Commission Statistical Analysis Center- county level crime and drug data | http://www.oregon.gov/CJC/Pages/SAC.aspx |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Chronic Disease** | Oregon Living Well Data Report-2012- note, data just on study participants, not general population | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Documents/Reports/statedata12.pdf |
| | *Oregon Behavioral Risk Factor Surveillance System (BRFSS) County Level Data 2008-2011- limited data on chronic disease, preventable health screening, and modifiable risk behaviors among adults | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Pages/pubs.aspx#data<br><br>Chronic Conditions: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20I.pdf<br><br>Health protective and risk factors among adults, by race and ethnicity, http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/table_3_race_oversample_2010-2011.pdf<br><br>Preventable Health Screenings: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20III.pdf<br><br>Tobacco Prevalence: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20IV.pdf |
| | *Keeping Oregonians Healthy: Preventing Chronic Diseases by reducing tobacco, diet, promoting physical activity & preventive screenings 2007- GREAT TABLES pages 132-148 | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/healthor.pdf |
| | *Asthma-Oregon Asthma Surveillance Data 2010- county specific maps throughout | No link, electronic copy in files |
| | *The Burden of Asthma in Oregon: 2013 Oregon Asthma Program | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Asthma/Pages/burdenrpt.aspx |
| | Oregon Environmental Public Health Tracking Program - Asthma Report 2000 – 2011 | http://public.health.oregon.gov/HealthyEnvironments/TrackingAssessment/EnvironmentalPublicHealthTracking/Documents/Reports/AsthmaReport.pdf |
| | Oregon Arthritis Report 2011 – County Specific Data throughout report | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Arthritis/Documents/arthrpt11.pdf |
| | Diabetes Atlas- National Data | http://www.idf.org/diabetesatlas/ |
| | *Heart Disease & Stroke in Oregon 2010- Pages 7-10, County Specific Tables | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/HeartDiseaseStroke/Documents/heartstroke_update2010.pdf |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Communicable Disease** | *Communicable Disease Summary 2011- great county level maps of infection throughout report | http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/AnnualReports/arpt2011/Documents/ACD_report2011forWEB.pdf |
| | Flu/CD DHS Pandemic Influenza Emergency Management Plan 2008 | http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Influenza/Documents/panfluplan.pdf |
| **Compilations** | *Oregon Behavioral Risk Factor Surveillance System(BRFSS) Survey 2006-2009 (ALL DATA) | https://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/county/index/Pages/index.aspx |
| | *Oregon Health Authority Data Sets/ Reports (data DHS client data, health data etc.) | http://www.oregon.gov/oha/pages/data/index.aspx |
| | DHS January 2013 County Quick facts | http://www.oregon.gov/dhs/aboutdhs/dhsbudget/Documents/county-quick-facts-2013.pdf |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| Demographic | *Census Quick Facts-2010 April | http://quickfacts.census.gov/qfd/states/41/41033.html |
| | *Oregon Vital Statistics County Data 2011 | http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/cdb2011/Pages/index.aspx |
| | School Enrollment Data: Student Ethnicity 2011-2012 School Year (by district) | http://www.ode.state.or.us/sfda/reports/r0067Select2.asp |
| | Census: by zip code 2010 | http://www.oregon.gov/dhs/spwpd/sua/docs/demographic/2010-state-zipcode-pop.xls |
| | *Oregon Office of Rural Health-Annual Report and community reports- 2009 | http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/publications/upload/2009-Year-End-Report-Printable.pdf<br><br>Community Reports in electronic files |
| | Household composition-By County. PSU Population Research Center | http://mkn.research.pdx.edu/2011/09/whos-home-a-look-at-households-and-housing-in-oregon/ |
| | Migration & the economy trends Oregon & county. PSU Population Research Center 2011 | http://mkn.research.pdx.edu/2011/05/slow-economy-tempered-oregon-population-growth-over-decade/ |
| | Most recent Oregon Population Reports by county: PSU 2012 | http://www.pdx.edu/prc/annual-oregon-population-report |
| | **Communities Reporter: Oregon- Best Viewed ON-LINE | http://oe.oregonexplorer.info/rural/CommunitiesReporter/ |
| | Josephine County Community Conditions (11-13-12) | No link- in electronic files |
| | Snapshot of Jackson and Josephine Counties (7-12-2012) | No link- in electronic files |
| | Southern Oregon Regional Profile | http://www.oregoncf.org/Templates/media/files/regional_profiles/southern_or_profile_2011.pdf |
| Environmental Health | Public water systems-online data- | http://170.104.63.9/ |
| | Adult Blood Lead Reporting in Oregon 2006-2010 | https://public.health.oregon.gov/HealthyEnvironments/WorkplaceHealth/Documents/9563-AdultLeadReport-FINAL-web_version.pdf |
| | Oregon Department of Environmental Quality Air Quality Annual Report (city specific) | http://www.deq.state.or.us/aq/forms/2011AirQualityAnnualReport.pdf |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Health Equity** | Oregon's Healthy Future: A Plan for Empowering communities 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority1-healthequity.pdf |
| | *NW Health Foundation State of Equity report 2011 | http://nwhf.org/images/files/Oregon_State_of_Equity_Report.pdf |
| | OHA Health Equity Report 2012 | No link, electronic copy in files |
| | CHI Advancing equity in Health Care Reform Implementation 11-2012 | No link, electronic copy in files |
| | National Academy for State Health Policy- State Policymakers' Guide for Advancing Health Equity Through Health Reform Implementation- August 2012 | http://www.nashp.org/sites/default/files/advancing.equity.health.reform.pdf |
| | *Institute of Medicine Unequal Treatment: Confronting Racial & Ethnic Disparities in HC: Administrators Brief | http://www.iom.edu/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/DisparitiesAdmin8pg.pdf |
| **Health Rankings** | Oregon Benchmarks 2009 | http://benchmarks.oregon.gov/BMCountyData.aspx |
| | *County Health Rankings 2013 | http://www.countyhealthrankings.org/app/oregon/2013/josephine/county/outcomes/overall/snapshot/by-rank |
| **Intimate Partner Violence & Child Abuse** | Costs of Intimate Partner Violence in Oregon 2005 | http://alliancetoendviolenceagainstwomen.org/wp-content/uploads/2012/07/IPVCosts.pdf |
| | Oregon Violence Against Women Violence Prevention Plan 2005 | No link, electronic copy in files |
| | *IPV Deaths-OHA report 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/intimpartnerviolence.pdf |
| | Oregon DHS Child Welfare 2010 Data Book- Page 28-38, County Specific Data (duplicate) | http://www.oregon.gov/dhs/abuse/pages/publications/children/index.aspx |
| **Injury** | Oregon Health Authority Trauma Registry 2010-2011- Page 22, County level data | http://public.health.oregon.gov/providerpartnerresources/emstraumasystems/traumasystems/pages/registry.aspx |
| | State Injury Prevention Policy Report 2012 | http://healthyamericans.org/reports/injury12/release.php?stateid=OR |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Obesity, Physical Activity & Nutrition** | Oregon's Healthy Future: A Plan for Empowering communities 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority3-obesity.pdf |
| | *Oregon Overweight, Obesity, Physical activity & Nutrition(PAN) Facts, 2012 DHS- county specific table on pages 50-57 | http://public.health.oregon.gov/PreventionWellness/PhysicalActivity/Documents/Oregon_PANfactst_2012.pdf |
| | Healthy Active Oregon: Statewide Physical Activity & Nutrition Plan 2007-2012 | http://public.health.oregon.gov/PreventionWellness/PhysicalActivity/Documents/PAN_rpt_07.pdf |
| | Oregon DMV Records Report: Obesity Surveillance 2012 (cool report) | http://public.health.oregon.gov/HealthyEnvironments/TrackingAssessment/EnvironmentalPublicHealthTracking/Documents/Reports/EPHT_DMV_obesity_tracking.pdf |
| | Leightman Maxey Foundation Nutrition Education Symposium Strategic Roadmap Project Final Report (8-16-11) | No link- in electronic files |
| **Occupational Injury** | Occupational Health in Oregon 2009 | https://public.health.oregon.gov/HealthyEnvironments/WorkplaceHealth/Documents/OPHP_Occupational%20health%20in%20Oregon.pdf |
| | Oregon Occupational Health Indicators 2000-2009 data | http://public.health.oregon.gov/HealthyEnvironments/WorkplaceHealth/Documents/OHI_2000_2009.pdf |
| **Oral Health/Dental** | Oregon's Healthy Future: A Plan for Empowering communities 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority4-oralhealth.pdf |
| | Oregon Smile Survey 2012 | https://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/Oral-Health-Publications.aspx |
| | Pew States Report on Dental Sealants 2013 | http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Pew_dental_sealants_report.pdf |
| | Burden of Oral Disease in Oregon 2006 | No link- in electronic files |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Poverty** | 2011 Report on Poverty-Oregon Housing & Community Services | http://www.oregon.gov/ohcs/isd/ra/docs/2011_oregon_poverty_report.pdf (page 36) |
| | Ending Homelessness-10-year plan to end Homelessness in Oregon | http://www.oregon.gov/ohcs/pdfs/2011_ehac_annual_report.pdf |
| | Key Workforce Challenges: More Severe in Oregon's Rural Areas November 2012 | http://www.qualityinfo.org/olmisj/ArticleReader?itemid=00008442 |
| **Prenatal/ Maternal Health** | Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) 1998-2008 data by topic- state data | https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/topics.aspx |
| | Oregon Perinatal Data Book 2007 | http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/PerinatalDataBook/Pages/index.aspx |
| | *Oregon Home Visiting Needs Assessment Report 2012-County Specific starts on page 50 | http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Documents/Josephine.pdf |
| | Women, Infant and Children (WIC) Program County Specific Fact Sheets | http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Documents/annual/annual_josephine.pdf |
| | ALERT Childhood Immunization Rates- 2 year old completion(County Specific) | http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Documents/county/Josephine.pdf |
| **Rural Health Care Access** | OHA Report: Oregon's Uninsured Analysis 2011. County Level Data, Pages 10-14 | http://www.oregon.gov/oha/OHPR/RSCH/docs/uninsured/oregonuninsured_2009finalreport.pdf |
| | Oregon Health Plan Managed Care Enrollment Reports-Monthly by County-View On-line | http://www.oregon.gov/oha/healthplan/pages/data_pubs/enrollment/main.aspx |
| | OHA Economically Disadvantaged & Uninsured Populations 2012 | No link- in electronic files |
| | Oregon Federally Qualified Rural Health Clinic Report 2011 | http://www.ohsu.edu/xd/outreach/oregon-rural-health/clinics/upload/2011-RHC-Report-for-the-web.pdf |
| | *Oregon Office of Rural Health 2012 Areas of Unmet HC Need in Rural Oregon Report- County Specific Tables throughout | http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/2012-Unmet-Need-Report.pdf |
| | Oregon Office of Rural Health Community Profiles | No link- in electronic files |
| | *SUMMARY- 2012 MUA, HPSA and Unmet Need report Oregon by city/county | http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/Designations-of-Health-Care-Shortage-Report.pdf |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Seniors** | Rogue Valley Council of Governments Area Agency on Aging 2013-2016 Area Plan | http://www.rvcog.org/ftp/2013-2016_RVCOG_Area_Agency_on_Aging_Four-Year_Area_Plan/2013-2016_RVCOG_AAA_Area_Plan.pdf |
| **Tobacco** | Oregon Tobacco Facts & Laws 2011 | http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tobfacts.pdf |
| | OHP Tobacco Cessation Services Report 2012 | http://www.oregon.gov/oha/healthplan/DataReportsDocs/2012%20Tobacco%20Cessation%20Services%20Survey.pdf |
| | Oregon Tobacco Quit Line Data | https://www.box.com/quitlinereports/ |
| | *Oregon County Tobacco Fact Sheet | http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/countyfacts/josefac.pdf |
| | Oregon Quit line Utilization Dashboard County Report-NOVEMBER 2012 report | all months site link: http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx#quitlinedashboard |
| | Burden of Tobacco among Medicaid clients in Oregon | http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/medicaidburden.pdf |
| | *Vital Signs: Current Cigarette Smoking Among Adults Aged >18 Years with Mental Illness- United States 2009-2011 | http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a2.htm?s_cid=mm6205a2_w<br><br>4 page consumer fact sheet: http://www.cdc.gov/VitalSigns/pdf/2013-02-vitalsigns.pdf |
| **Transportation** | Report on Existing Conditions, United We Ride Plan, for Rogue Valley 2012 | http://www.ammatransitplanning.com/clientp01/client01sub1/UWR_Existing%20Conditions_071312.docx |

# Jackson County Community Health Assessment Data Sources

## Sampling of Available Data Sources 2012-2013

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Alcohol & Other Drugs** | Oregon Student Wellness Survey 2012 | http://www.oregon.gov/oha/amh/2012%20Student%20Wellness/Jackson.pdf<br><br>Underage Drinking: http://www.oregon.gov/oha/amh/ad/jackson-underage.pdf |
| | *Epidemiological Data on Alcohol, Drugs and Mental Health 2000 to 2012 | http://www.oregon.gov/oha/amh/ad/data/jackson.pdf<br><br>Adult Alcohol Use Fact Sheet: http://www.oregon.gov/oha/amh/ad/jackson-adult.pdf |
| | National Survey on Drug Use and Health State Rankings-Prescription Drug Use | http://www.samhsa.gov/data/2k12/NSDUH115/sr115-nonmedical-use-pain-relievers.htm |
| | 2011 National Survey on Drug use & Health All drugs | http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf |
| | *Oregon Justice Commission Statistical Analysis Center- county level crime and drug data | http://www.oregon.gov/CJC/Pages/SAC.aspx |
| **Behavioral Health** | Oregon's Healthy Future: A Plan for Empowering communities 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority5-substanceabuseandbehavioralhealth.pdf |
| | Barriers to Effective Suicide Prevention-Jackson County Suicide Prevention Coalition- June 2013 | No link, electronic copy in files |
| | Suicides in Oregon: Trends and Risk Factors 2012 Report | http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/NVDRS/Suicide%20in%20Oregon%202012%20report.pdf |
| | Jackson County Mental Health and Addiction Services Biennial Implementation Plan 2013-2015 | http://www.oregon.gov/oha/amh/CountyPlans/Jackson%20County%20BIP%202013-2015.pdf |
| | *Specific 2000-2012 Epidemiology Alcohol, Drugs, MH (also included in Alcohol and Drugs) | http://www.oregon.gov/oha/amh/ad/data/jackson.pdf |
| | Jackson County's Implementation Plan for 2009-11 (focus on services) | http://www.localcommunities.org/lc/029/FSLO-1218048324-50029.pdf |
| | Jackson County Community Crisis Response Project 2008-Jefferson Regional Health Alliance (JRHA) Report | http://www.jeffersonregionalhealthalliance.org/My%20Web%20Files/Community%20Crisis%20Response%20Foundations%20Presentation%20Final.pdf |
| | JRHA Behavioral Health Initiative Mapping Project 2006 | http://www.jeffersonregionalhealthalliance.org/My%20Web%20Files/JRHA%20Mapping%20Project%200313-1606.pdf |
| | SAMHSA Oregon State Brief | http://www.samhsa.gov/data/StatesInBrief/2k9/OREGON_508.pdf |
| | SAMHSA Adolescent Behavioral Health Brief-State | http://www.samhsa.gov/data/StatesInBrief/2k9/OASTeenReportOR.pdf |
| | SAMHSA Data Sources-various reports and search functions, some state, some sub-state | http://www.samhsa.gov/data/States_In_Brief_Reports.aspx |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Children/ Youth** | Kindergarten Readiness Assessment | 2008 Results- No link, electronic copy in files Assessment revised 2010-12 and will be used starting in 2013-14 school year. Updates at: http://www.ode.state.or.us/search/page/?id=3908 |
| | *Children First for Oregon report 2011 | http://www.cffo.org/images/pdf_downloads/county_data_books/Jackson%20County.pdf |
| | Free & Reduced Lunch ODE | http://www.ode.state.or.us/sfda/reports/r0061Select.asp |
| | Youth Suicide Attempts in Oregon Adolescent Data System 2007 Data Report | Fact Sheet: http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Documents/factsheet.pdf (2007 data)<br><br>Full 2007 report- No link, electronic copy in files |
| | Suicide, Suicide Attempts, and Ideation among Adolescents in Oregon, Oregon Health Authority, March 2012 | http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/Suicide%2csuicide%20Attempts%2c%20and%20ideation%20among%20Adolescents%20in%20Oregon%202010.pdf |
| | Oregon Plan for Youth Suicide Prevention (data old, use mainly for strategies) | http://public.health.oregon.gov/PreventionWellness/SafeLiving/SuicidePrevention/Documents/YSuicide.pdf |
| | *Oregon Healthy Teen Survey-County Specific data 2007-2008 | http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2007/county/Documents/jackson8.pdf (8th grade)<br><br>http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2007/county/Documents/jackson11.pdf (11th grade) |
| | *Oregon Student Wellness Survey 2012(duplicate) | http://www.oregon.gov/oha/amh/2012%20Student%20Wellness/Jackson.pdf |
| | National Survey of Children's Health (CDC)- LOTS of state specific data- Oregon Children's Profile Included as PDF | http://www.cdc.gov/nchs/slaits/nsch.htm |
| | *Kids Count Data Book 2012-Oregon data | http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=OR&group=Grantee&loc=5357&dt=1%2c3%2c2%2c4 |
| | Oregon Child Health 2010 Data & resource guide | http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/Documents/oregon-child-health-2010-data-and-resource-guide.pdf |
| | *Child Welfare Data Book | http://www.oregon.gov/dhs/abuse/pages/publications/children/index.aspx |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Community Assessments & Plans** | Oregon Public Health Community Health Assessment Clearinghouse | http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/communityhealthassessmentclearinghouse/pages/index.aspx |
| | *Public Health Annual Plan | http://public.health.oregon.gov/ProviderPartnerResources/LocalHealthDepartmentResources/Documents/Jackson_County_Annual_Plan_2013_update.pdf (2013-14) |
| | FY 2012 PRC Community Health Needs Assessment (Asante Health System) | http://www.asante.org/app/files/public/1603/2012-Community-Health-Needs-Assessment.pdf |
| | Jackson County Oregon Community Needs Assessment 2011 | http://www.accesshelps.org/Files/2011%20Community%20Needs%20Assessment.pdf |
| | Providence Health and Services- Community Health Needs Assessment 2011-13 | http://oregon.providence.org/ptkattachments/FormsInstructions/CHNA-FINALfull_appendix.pdf<br><br>Southern OR Summary (2011), no link, electronic copy in files |
| | Oregon Health Improvement Plan 2010-2020 | http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/OregonHealthImprovementPlan/Documents/hip_plan.pdf |
| | Oregon State Health Profile 2012 | http://public.health.oregon.gov/About/Documents/oregon-state-health-profile.pdf |
| | Oregon Child Development Coalition Community Assessment- Migrant Seasonal Head Start Program 2009 | http://www.ocdc.net/Live/content/downloads/JACKSONCOUNTY_CA.pdf |
| **Crime** | Oregon Annual Uniform Crime Reports- County Specific Tables throughout | http://www.oregon.gov/osp/CJIS/docs/2010/2010_annual_report.pdf |
| | *County Criminal Justice Fact Sheet- Oregon Criminal Justice Commission 9-2-2010 | http://www.oregon.gov/CJC/docs/jackson_co_cj_fact_sheet.pdf |
| | *DUII Data Book for Oregon Counties, 1999-2008 | http://library.state.or.us/repository/2009/200906301527262/1999-2008.pdf (Jackson on Page 24) |
| | *Oregon Justice Commission Statistical Analysis Center- county level crime and drug data | http://www.oregon.gov/CJC/Pages/SAC.aspx |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| Chronic Disease | Oregon Living Well Data Report-2012- note, data just on study participants, not general population | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Documents/Reports/statedata12.pdf |
| | *Oregon Behavioral Risk Factor Surveillance System (BRFSS) County Level Data 2008-2011- limited data on chronic disease, preventable health screening, and modifiable risk behaviors among adults | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Pages/pubs.aspx#data<br><br>Chronic Conditions: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20I.pdf<br><br>Health protective and risk factors among adults, by race and ethnicity, http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/table_3_race_oversample_2010-2011.pdf<br><br>Preventable Health Screenings: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20III.pdf<br><br>Tobacco Prevalence: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20IV.pdf |
| | *Keeping Oregonians Healthy: Preventing Chronic Diseases by reducing tobacco, diet, promoting physical activity & preventive screenings 2007- GREAT TABLES pages 132-148 | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/healthor.pdf |
| | *The Burden of Asthma in Oregon: 2013 Oregon Asthma Program | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Asthma/Pages/burdenrpt.aspx |
| | Oregon Environmental Public Health Tracking Program - Asthma Report 2000 – 2011 | http://public.health.oregon.gov/HealthyEnvironments/TrackingAssessment/EnvironmentalPublicHealthTracking/Documents/Reports/AsthmaReport.pdf |
| | Oregon Arthritis Report 2011 – County Specific Data throughout report | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Arthritis/Documents/arthrpt11.pdf |
| | Diabetes Atlas- National Data | http://www.idf.org/diabetesatlas/ |
| | *Heart Disease & Stroke in Oregon 2010- Pages 7-10, County Specific Tables | http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/HeartDiseaseStroke/Documents/heartstroke_update2010.pdf |
| Communicable Disease | *Communicable Disease Summary 2011- great county level maps of infection throughout report | http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/AnnualReports/arpt2011/Documents/ACD_report2011forWEB.pdf |
| | Flu/CD DHS Pandemic Influenza Emergency Management Plan 2008 | http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Influenza/Documents/panfluplan.pdf |

| Category | Title<br>*particularly good source document | Source |
|---|---|---|
| **Compilations** | *Oregon Behavioral Risk Factor Surveillance System(BRFSS) Survey 2006-2009 (ALL DATA) | https://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/county/index/Pages/index.aspx |
| | *Oregon Health Authority Data Sets/ Reports (data DHS client data, health data etc.) | http://www.oregon.gov/oha/pages/data/index.aspx |
| | DHS January 2013 County Quick facts | http://www.oregon.gov/dhs/aboutdhs/dhsbudget/Documents/county-quick-facts-2013.pdf |
| **Demographic** | *Census Quick Facts-2010 April | http://quickfacts.census.gov/qfd/states/41/41029.html |
| | *Oregon Vital Statistics County Data 2011 | http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/cdb2011/Pages/index.aspx |
| | School Enrollment Data: Student Ethnicity 2011-2012 School Year (by district) | http://www.ode.state.or.us/sfda/reports/r0067Select2.asp |
| | Census: by zip code 2010 | http://www.oregon.gov/dhs/spwpd/sua/docs/demographic/2010-state-zipcode-pop.xls |
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| | Household composition-By County. PSU Population Research Center | http://mkn.research.pdx.edu/2011/09/whos-home-a-look-at-households-and-housing-in-oregon/ |
| | Migration & the economy trends Oregon & county. PSU Population Research Center 2011 | http://mkn.research.pdx.edu/2011/05/slow-economy-tempered-oregon-population-growth-over-decade/ |
| | Most recent Oregon Population Reports by county: PSU 2012 | http://www.pdx.edu/prc/annual-oregon-population-report |
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| | Adult Blood Lead Reporting in Oregon 2006-2010 | https://public.health.oregon.gov/HealthyEnvironments/WorkplaceHealth/Documents/9563-AdultLeadReport-FINAL-web_version.pdf |
| | Oregon Department of Environmental Quality Air Quality Annual Report (city specific) | http://www.deq.state.or.us/aq/forms/2011AirQualityAnnualReport.pdf |
| | JACKSON COUNTY ENVIRONMENTAL PUBLIC HEALTH DIVISION ANNUAL REPORT | http://www.co.jackson.or.us/Page.asp?NavID=3746 |
| **Health Equity** | Oregon's Healthy Future: A Plan for Empowering communities 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority1-healthequity.pdf |
| | *NW Health Foundation State of Equity report 2011 | http://nwhf.org/images/files/Oregon_State_of_Equity_Report.pdf |
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| | Oregon Violence Against Women Violence Prevention Plan 2005 | No link- in electronic files |
| | *IPV Deaths-OHA report 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/intimpartnerviolence.pdf |
| | Oregon DHS Child Welfare Data Book (duplicate) | http://www.oregon.gov/dhs/abuse/pages/publications/children/index.aspx |
| **Injury** | Oregon Health Authority Trauma Registry 2010-2011- Page 22, County level data | http://public.health.oregon.gov/providerpartnerresources/emstraumasystems/traumasystems/pages/registry.aspx |
| | State Injury Prevention Policy Report 2012 | http://healthyamericans.org/reports/injury12/release.php?stateid=OR |

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| **Obesity, Physical Activity & Nutrition** | Oregon's Healthy Future: A Plan for Empowering communities 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority3-obesity.pdf |
| | *Oregon Overweight, Obesity, Physical activity & Nutrition(PAN) Facts, 2012 DHS-county specific table on pages 50-57 | http://public.health.oregon.gov/PreventionWellness/PhysicalActivity/Documents/Oregon_PANfactst_2012.pdf |
| | Healthy Active Oregon: Statewide Physical Activity & Nutrition Plan 2007-2012 | http://public.health.oregon.gov/PreventionWellness/PhysicalActivity/Documents/PAN_rpt_07.pdf |
| | Oregon DMV Records Report: Obesity Surveillance 2012 (cool report) | http://public.health.oregon.gov/HealthyEnvironments/TrackingAssessment/EnvironmentalPublicHealthTracking/Documents/Reports/EPHT_DMV_obesity_tracking.pdf |
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| | Oregon Occupational Health Indicators 2000-2009 data | http://public.health.oregon.gov/HealthyEnvironments/WorkplaceHealth/Documents/OHI_2000_2009.pdf |
| **Oral Health/ Dental** | Oregon's Healthy Future: A Plan for Empowering communities 2012 | http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority4-oralhealth.pdf |
| | *Oregon Smile Survey 2012 | https://public.health.oregon.gov/PreventionWellness/oralhealth/Pages/Oral-Health-Publications.aspx |
| | Pew States Report on Dental Sealants 2013 | http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Pew_dental_sealants_report.pdf |
| | Burden of Oral Disease in Oregon 2006 | No link- in electronic files |
| **Poverty** | 2011 Report on Poverty-Oregon Housing & Community Services | http://www.oregon.gov/ohcs/isd/ra/docs/2011_oregon_poverty_report.pdf (page 32) |
| | Ending Homelessness-10-year plan to end Homelessness in Oregon<br><br>Jackson County Report | http://www.oregon.gov/ohcs/pdfs/2011_ehac_annual_report.pdf<br><br>http://www.co.jackson.or.us/files/10 Year_Plan_to_End_Homelessness.pdf |
| | Key Workforce Challenges: More Severe in Oregon's Rural Areas November 2012 | http://www.qualityinfo.org/olmisj/ArticleReader?itemid=00008442 |

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| **Prenatal/ Maternal Health** | Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) 1998-2008 data by topic- state data | https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/topics.aspx |
| | Oregon Perinatal Data Book 2007 | http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/PerinatalDataBook/Pages/index.aspx |
| | *Oregon Home Visiting Needs Assessment Report 2012-County Specific starts on page 50 | http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Documents/Jackson.pdf |
| | Women, Infant and Children (WIC) Program County Specific Fact Sheets | http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Documents/annual/annual_jackson.pdf |
| | ALERT Childhood Immunization Rates- 2 year old completion(County Specific) | http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Documents/county/Jackson.pdf |
| **Rural Health Care Access** | OHA Report: Oregon's Uninsured Analysis 2011. County Level Data, Pages 10-14 | http://www.oregon.gov/oha/OHPR/RSCH/docs/uninsured/oregonuninsured_2009finalreport.pdf |
| | Oregon Health Plan Managed Care Enrollment Reports-Monthly by County-View On-line | http://www.oregon.gov/oha/healthplan/pages/data_pubs/enrollment/main.aspx |
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| | *Oregon Office of Rural Health 2012 Areas of Unmet HC Need in Rural Oregon Report-County Specific Tables throughout | http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/2012-Unmet-Need-Report.pdf |
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| **Seniors** | Rogue Valley Council of Governments Area Agency on Aging 2013-2016 Area Plan | http://www.rvcog.org/ftp/2013-2016_RVCOG_Area_Agency_on_Aging_Four-Year_Area_Plan/2013-2016_RVCOG_AAA_Area_Plan.pdf |

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| | OHP Tobacco Cessation Services Report 2012 | http://www.oregon.gov/oha/healthplan/DataReportsDocs/2012%20Tobacco%20Cessation%20Services%20Survey.pdf |
| | Oregon Tobacco Quit Line Data | https://www.box.com/quitlinereports/ |
| | *Oregon County Tobacco Fact Sheet | http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/countyfacts/jackfac.pdf |
| | Oregon Quit line Utilization Dashboard County Report-NOVEMBER 2012 report | all months site link: http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx#quitlinedashboard |
| | Burden of Tobacco among Medicaid clients in Oregon | http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/medicaidburden.pdf |
| | *Vital Signs: Current Cigarette Smoking Among Adults Aged >18 Years with Mental Illness- United States 2009-2011 | http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a2.htm?s_cid=mm6205a2_w<br><br>4 page consumer fact sheet: http://www.cdc.gov/VitalSigns/pdf/2013-02-vitalsigns.pdf |
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# Community Health Assessment
## *Focus Group Guide & Questions*

We asked you to come here today to provide input to the Josephine Jackson County community health assessment project. The purpose of the focus group is to learn from you what you think about health and what, in your opinion, affects your, your family's, and your community's health and wellness.

AllCare, PrimaryHealth and Jackson Care Connect are sponsoring these groups, and the information will be used to increase our understanding of community health issues and for planning our programs and services so that they fit the needs of the community. There will be lots of questions today, most that we won't be able to answer today. We will record your questions and they will be included in our report.

Once we hear from our other groups, we can send information about what we learned and what we are doing with the information to anyone who is interested. We will also have a final report and action plan that details everything we hear during these meetings.

Polling Questions

1. In the following list, what do you think are the three most important ingredients for a "Healthy Community?" (Those factors which most improve the quality of life in a community.)

Rank the top three (1 = greatest impact on health):
___ Good place to raise children
___ Low level of child abuse/domestic violence
___ Good schools
___ Access to health care (e.g., family doctor)
___ Parks and recreation
___ Clean environment
___ Affordable housing
___ Good jobs and healthy economy
___ Healthy behaviors and lifestyles
___ Religious or spiritual values
___ Other_____

2. In the following list, what do you think are the three most important "health problems" in our community? (Those problems which have the greatest impact on overall community health.)

Rank the top three (1 = greatest impact on health):
___ Problems from aging such as (e.g., arthritis,hearing/vision loss, etc.)
___ Cancer
___ Child abuse /domestic violence/rape
___ Dental problems
___ Diabetes
___ Heart disease and stroke
___ Infectious Diseases (e.g., hepatitis, TB, etc.)
___ Mental health problems
___ Respiratory / lung disease

___ Other _____

3. In the following list, what do you think are the three most important "risky behaviors" in our community? (Those behaviors which have the greatest impact on overall community health.)

Rank the top three (1 = greatest impact on health):
___ Alcohol abuse
___ Being overweight
___ Drug abuse
___ Lack of exercise
___ Poor eating habits
___ Tobacco use
___ Not using birth control (unprotected sex)
___ Reckless driving
___ Not seeing a health provider when you need care
___ Other____

4. How would rate our community as a "Healthy Community?"

___ Very unhealthy ___ Unhealthy ___ Somewhat healthy ___ Healthy ___ Very healthy

5. How would you rate your personal health?

___ Very unhealthy ___ Unhealthy ___ Somewhat healthy ___ Healthy ___ Very healthy

6.. How do you pay for most of your health care?

___ Pay cash (no insurance)
___ Health insurance (e.g., private insurance, Blue Shield, HMO)
___ Medicaid (OHP)
___ Medicare
___ Veterans' Administration
___ Indian Health Services
___ Other _____

7. Have you had a dental exam/teeth cleaning in the last 12 months?

_____Yes
_____ No

8. I currently live with a chronic disease like Diabetes, Asthma, Heart Disease, Arthritis, COPD or other chronic condition.

___ Yes
___No

9. I have received health care services when I needed them in the last 12 months.

Strongly agree
Agree
Somewhat agree
Neutral
Somewhat disagree
Disagree
Strongly disagree

10. What county do you live in?

Josephine
Jackson

11. What is your age?

25 or under 26-39 40-54 55-64 65 or over

12. What is your sex?

Female
Male

13. Which ethnic group do you most identify with?

African American/Black
Asian/Pacific Islander
Hispanic/Latino
Native American
White/Caucasian
Biracial/more than one
Other

14. What is your marital status?

Married or living with somebody
Not married, dating, single, widowed or divorced

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

Less than high school diploma
High school diploma or GED
College degree or certificate
Advanced Degree (masters or more)
Other

16. What is your approximate annual household income?

Less than $20,000
$20,000 to $29,999
$30,000 to $49,000
$50,000-$75,000
Over $75,000
I don't know

Discussion Questions:
Do you think people in your community are healthy? Why? Why not?
What affects the health of you & your family the most?
Tell me about your biggest health concern in your community?
What do you think we (as a community) can do to enhance health?