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2018 Community Health Assessment of Jackson and Josephine Counties

Jefferson Regional Health Alliance

Health Resources in Action
Advancing Public Health and Medical Research

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Acronym List

Adverse Childhood Experiences	(ACEs)
Asset Limited, Income Constrained, Employed	(ALICE)
Behavioral Risk Factor Surveillance System	(BRFSS)
Biennial Implementation Plan	(BIP)
Community Advisory Councils	(CAC)
Community Health Assessment	(CHA)
Community Health Improvement Plan	(CHIP)
Community Mental Health Programs	(CMHP)
Coordinated Care Organizations	(CCO)
Federally Qualified Health Centers	(FQHC)
Forces of Change Assessment	(FOCA)
Health Resources and Services Administration	(HRSA)
Health Resources in Action	(HRiA)
Jefferson Regional Health Alliance	(JRHA)
Local Public Health System Assessment	(LPHSA)
Mobilizing for Action through Planning and Partnerships	(MAPP)
National Association of County and City Health Officials	(NACCHO)
Public Health Accreditation Board	(PHAB)
Supplemental Nutrition Assistance Program	(SNAP)
Years of Potential Life Lost	(YPLL)

EXECUTIVE SUMMARY

INTRODUCTION

Jefferson Regional Health Alliance is a collaboration of regional community leaders from all sectors learning and working together to improve the health and health care resources of Southern Oregonians. The vision of JRHA is a) that the organizations and individuals responsible for the health of the community are interconnected, promoting health and health care transformation together, b) current systems are transformed, reducing economic, cultural and system barriers to health and health care access while reducing the costs of health care services, and c) relationships and resources are leveraged through collaboration to implement best practices and ensure a sustainable health care system.

To advance the vision of JRHA and create a healthy community for Jackson and Josephine Counties, in 2018 JRHA undertook a collaborative community health assessment (CHA). Many of JRHA's partners have state, federal, or accreditation requirements as stated below:

- The Public Health Accreditation Board (PHAB) sets the standards that public health departments need to meet in order to achieve and maintain accredited status. Included in these standards are requirements to work collaboratively with community partners to produce both a CHA and a community health improvement plan (CHIP) every 5 years.
- Section 501(r) of the Internal Revenue Service Code was added in 2012 by the 2010 enactment of the Affordable Care Act and requires tax-exempt 501(c)(3) organizations that operate one or more hospital facility to conduct a community health needs assessment (CHNA) at least once every 3 years.
- The Oregon Health Authority requires Coordinated Care Organizations (CCO) to create a CHIP every 5 years. The CHIP is derived from the most recent CHA.
- Community Mental Health Programs (CMHP) are required to have a Biennial Implementation Plan (BIP) informed by this CHA
- Department of Health and Human Services – Health Resources and Services Administration (HRSA) requires Federally Qualified Health Centers (FQHC) to complete Form 9: Need for Assistance Worksheet every 3 years which makes use of the most recent CHA.

This 2018 community health assessment for Jackson and Josephine Counties aims to meet the requirements of partners as well as develop a shared understanding of community health in order to guide collaborative community health improvement efforts.

In January 2018, JRHA hired Health Resources in Action (HRiA), a non-profit public health organization, as a consultant to provide strategic guidance and technical assistance for the community health assessment process, and to collect, analyze, and report the data for the final CHA deliverables.

APPROACH AND METHODS

This CHA aims to identify the health-related needs and strengths of Jackson and Josephine Counties through a social determinants of health framework, which defines health in the broadest sense and recognizes numerous factors—from employment to housing to access to care—that have an impact on the community's health. Social, economic, and health data were drawn from existing data sources, such as the U.S. Census, Oregon Health Authority, and both Jackson and Josephine County Public Health, among others. In addition to an online and paper community survey that engaged over 1,100 residents, approximately 170 individuals from multi-sector organizations, residents, and community stakeholders

participated in community forums, focus groups and interviews to gather feedback on community strengths, challenges and priority health concerns.

Through the process of compiling, analyzing and synthesizing quantitative and qualitative data, a list of fifteen key themes emerged. This list was then prioritized by key stakeholders, resulting in the following six priority key themes:

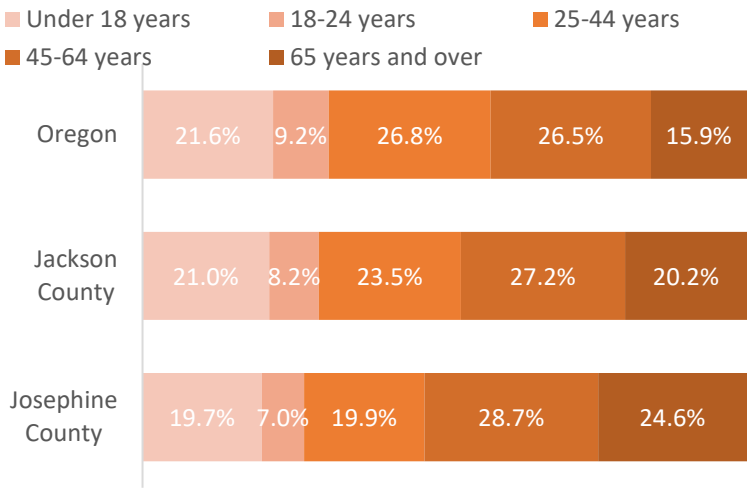
- Substance use
- Affordable housing
- Mental health and well-being
- Poverty and employment
- Parenting and life skills
- Education and workforce development

KEY FINDINGS

DEMOGRAPHICS AND HEALTH STATUS

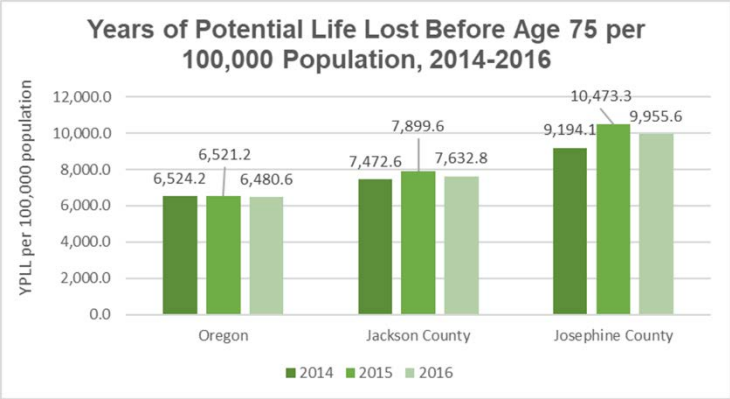
Jackson and Josephine Counties are experiencing population growth, especially among the Hispanic/Latino population. Compared to Oregon overall, the region has a higher proportion of residents who identify as White and those who are aged 65 and over.

Age Distribution, by State and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

According to the BRFSS, a nation-wide survey that asks residents about their health-related risk behaviors, health conditions, and use of preventive services, over 80% of adults reported their general health status to be good, very good, or excellent across all geographies, with adults slightly less likely to report as such in Josephine County (Figure 5). While self-reported health status is high, more local data from the community survey indicated that only 46.5% of respondents felt that the general health status of the community within which they live was good, very good or excellent.



Mortality statistics help us understand health and how it can be improved. In 2017, the mortality rates for Josephine and Jackson Counties (847.4 deaths per 100,000 population and 756.4 deaths per 100,000 population, respectively) were higher than that for Oregon (717.5 deaths per 100,000 population). Years of potential life lost (YPLL) is an estimate of the average years a person would have lived if he or she had not died prematurely. It is, therefore, a measure of premature mortality. As an alternative to death rates, it is a method that gives more weight to deaths that occur among younger people. According to the Oregon Health Authority, the YPLL before age 75 was higher in both Josephine (9,706.2 per 100,000 population) and Jackson Counties (7,486.9 per 100,000 population) compared to the statewide rate (6,432.7 per 100,000 population).

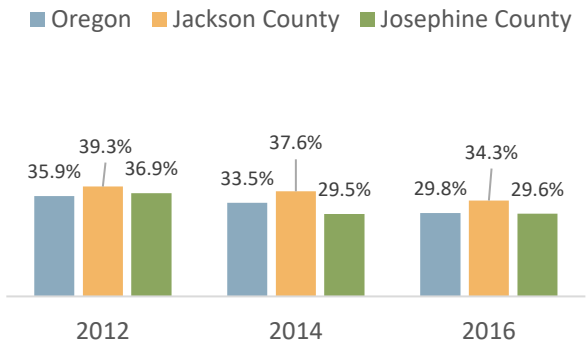
SUBSTANCE USE

Substance use and abuse is a critical public health issue that affects not only the individual, but also has serious direct and indirect impacts on families, communities and society as whole. The causes of substance use disorders are multi-faceted and include biological, social and environmental factors.[1]

"Opioids are what we're seeing. The amount of heroin that runs through here – it affects so much of the population"

Substance use is prevalent among youth and adults in Jackson and Josephine, resulting in trauma and crime. As seen across all the data sources for this assessment, substance use emerged as a top issue. Looking at the community survey conducted as part of this assessment, substance use was the third most frequently selected health issue having the largest impact on the community (59.6%). Respondents were most concerned about meth use, opioid abuse, and drug use among youth. Current alcohol and marijuana use among Jackson County 11th graders as well as current cigarette use among Josephine County adults stand out. Additionally, opioid overdose hospitalization rates are higher in the two counties compared to the state.

Percent 11th Grade Students Reported Current Alcohol Consumption, by State and County, 2012, 2014, and 2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

AFFORDABLE HOUSING

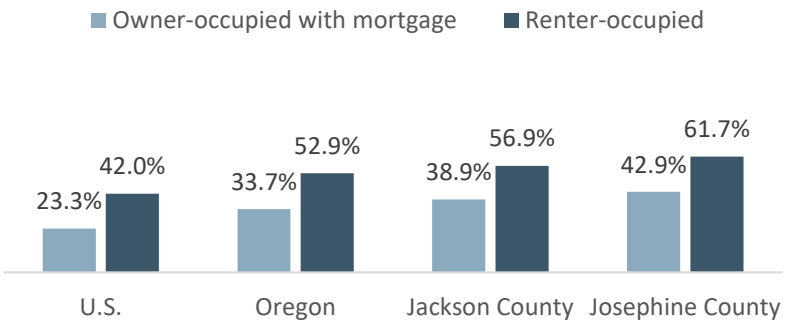
Affordability, quality and stability are important characteristics that directly impact an individual's ability to access safe and healthy

[1] US Department of Health and Human Services, Office of the Surgeon General. Facing Addiction in America The Surgeon General's Report on Alcohol, Drugs, and Health. 2016.

housing.[2] Unstable housing and homelessness can lead to stress, isolation, chronic disease, substance use, mental health issues and violence.[3] While housing itself is an important factor in an individual's health, it can also be a cost burden and result in compromises to health in other areas – i.e. foregoing prescription medications – due to cost. The supply of affordable housing does not meet the demand among residents, particularly renters, within Jackson and Josephine counties, resulting in housing insecurity, homelessness and stress, among other health issues.

Affordable housing was the top issue that emerged from focus group and interview discussions. Renters in the region are particularly burdened by the high cost of housing and the high percentage of income spent on housing. Housing is a regional issue that is also connected to workforce shortages in some professions, such as health care, which has implications not only for providers but also community members needing care.

Percent Households where Housing Costs are 30% or More of Income, by U.S., State, and County, 2012-2016

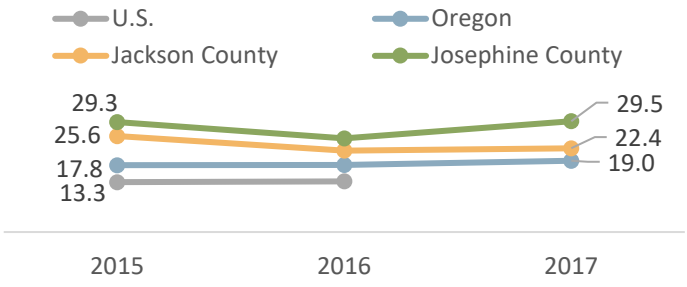


DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

MENTAL HEALTH AND WELL-BEING

Mental health is essential to overall well-being and is closely connected to physical health. Mental health issues, such as anxiety and depression, can arise from genetic factors and/or from a number of individual and societal factors – incidence of trauma, poor nutrition and poverty. [4] Mental illness affects people's ability participate in health-promoting behaviors, and thus affects their ability to maintain good physical health. Mental illness can also impact other areas of life including attending and focusing at school, obtaining and maintaining a job, finding and keeping housing, and having relationships with friends and family.[5]

Depression and anxiety were noted as prevalent across the lifespan in Jackson and Josephine Counties. Mental health of youth was especially concerning to assessment participants, who explained that trauma at home and peer pressure were primary issues facing youth. For working age adults, mental health was discussed in the context of experiencing stress related to high cost of living and raising a family. Social isolation was the most commonly cited stressor for seniors.



[2] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.
[3] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.
[4] Tulchinsky TH, et al. Editorial: Mental Health as a Public Health Issue. Public Health Reviews. 2012; 34, 2.
[5] Mental health and mental disorders. Healthy People 2020. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed on: October 30, 2018

Many mental illnesses can lead to an increased risk of suicide. Between 2015 and 2017, the suicide rate in Jackson and Josephine Counties was consistently higher than Oregon and the U.S.

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017
NOTE: 2017 data not publicly available for the U.S.

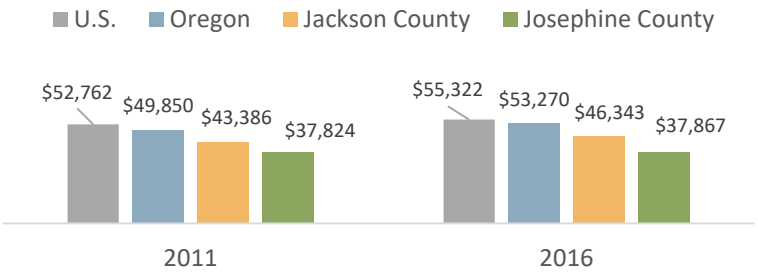
"Young people here who are beginning their work life or family life… they're distressed because there are not enough jobs with sufficient pay."

POVERTY AND EMPLOYMENT

Poverty and employment are linked to health[6] – an individual's employment and income level directly impacts their ability to afford access to health care, healthy food, and housing, all of which influence myriad health outcomes. Individuals who are unemployed or underemployed experience higher rates of depression, stress and stress-related conditions, such as stroke, heart attack, heart disease, arthritis.[7]

Despite declining and low unemployment, assessment participants indicated that it is a challenge for community members to make a living in the area, given the limited jobs available and the low pay for those opportunities that do exist. Median household income is lower and rates of poverty are higher in Jackson and Josephine Counties, especially among communities of color, compared to Oregon and the U.S. The effects of poverty and under/unemployment are far-reaching. Focus group and interview participants shared that the regional economic environment hinders community members' ability to pay for housing, food, transportation, medications, and child care. Approximately half of survey respondents indicated that cost of living is a primary issue facing them and their community and perceived a lack of support in the community for low-income families and individuals.

Median Household Income, by U.S., State, and County, 2007-2011 and 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

PARENTING AND LIFE SKILLS

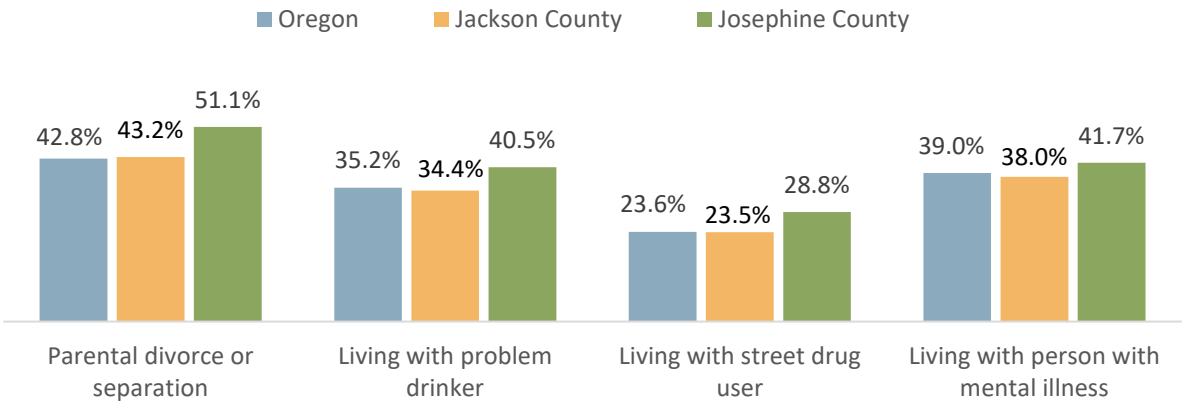
Adverse childhood experiences (ACEs) are instances of child abuse and neglect - physical abuse, sexual abuse, emotional abuse, and living with a household member experiencing substance use, mental illness, and domestic violence that are captured to create a score. The presence of these traumatic experiences not only has immediate impacts, but also increases a child's risk for poor health outcomes

[6] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: What the patterns tell us. American Journal of Public Health. 2010; 100: S186-S196.
[7] Robert Wood Johnson Foundation. How Does Employment – or Unemployment – Affect Health? Health Policy Snapshot Issue Brief. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360 Accessed: October 30, 2018.

as an adult – chronic disease, substance use, depression, suicide, violence and crime.[8] Children raised in safe and nurturing families and communities, free from maltreatment and other adverse childhood experiences, are more likely to have better outcomes as adults.[9]

While child abuse and neglect did not surface extensively in qualitative data for this assessment, quantitative data on a variety of other childhood exposures indicate that the family environment in Jackson and Josephine Counties is not always conducive to good health. When looking across indicators among 11th graders, ACEs in Josephine County appears to be increasing compared to stable or decreasing in Jackson County and Oregon overall.

Percent 11th Grade Students Reported ACEs, by State and County, 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2016

Focus group and interview participants broadly discussed the challenges facing parents as they raise children in Jackson and Josephine Counties, including parents' limited knowledge of and skills for parenting, and stigma associated with asking for help. Assessment participants shared the perception that parents do not have the understanding, skills, and time to devote to parenting given the demands on them to financially provide for their families.

EDUCATION AND WORKFORCE DEVELOPMENT

Education influences health outcomes at many levels – from the individual to population level. As one of the strongest predictors of health, the more education an individual has the more likely they are to live a longer and healthier life.[10] While education beyond high school continues to improve health outcomes, having a credential and skill set that opens the door to benefits, i.e. a job, shows the role education plays in many factors that impact health outcomes. Adults continue to be impacted by their educational attainment, as more education is associated with access to more, and better paying, job

[8] Felitti VJ, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine. 1998; 14(4): 245-258.

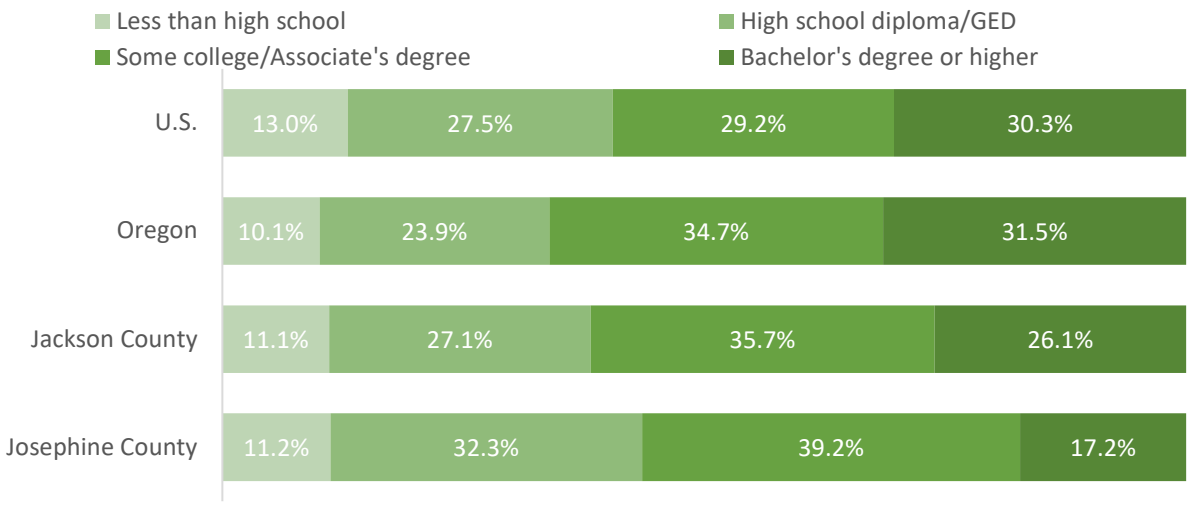
[9] Anda RF, Felitti VJ, Walker J, et al. The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. Eur Arch Psychiatry Clin Neurosci. 2006 Apr;256(3):174–86.

[10] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us. American Journal of Public Health. 2010; 100: S186-S196.

opportunities. This link between education, employment and income drives much of an individual's ability to achieve economic stability and the positive health outcomes that result from access to housing, food and health care.[11]

Educational attainment is the highest level of education that an individual has completed. Based on 2012-2016 data, there was a smaller percentage of individuals 25 years and older who received a bachelor's degree or more in Josephine County (17.2%) and Jackson County (26.1%) compared to Oregon (31.5%). People of color in the two counties are even less likely to have a bachelor's degree or more.

Educational Attainment for Population 25 Years and Over, by U.S., State, and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

The connections between education and employment are strong. Assessment participants explained that low average educational attainment levels among community members in Jackson and Josephine Counties do not meet minimum requirements for many professional workforce needs, and recruitment challenges exist due to limited affordable housing.

NEXT STEPS

The 2018 community health assessment of Jackson and Josephine Counties serves multiple purposes for a variety of audiences. Among these purposes, the assessment enables JRHA and its partners to

- Explore current health status and determinants of health, health priorities, and new and emerging concerns among Jackson and Josephine County community members and service providers
- Hear individual and group voices to provide a deeper understanding of the "why" and "how" of current and emerging health issues
- Understand the shifting patterns of these health issues over time in Jackson and Josephine Counties

[11] Zimmerman EB, Woolf SH, and Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Health care Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html

- Identify assets and resources as well as gaps and needs in services in order to help partners set funding and programming priorities
- Fulfill the community health needs assessment requirements for Asante and Providence Hospitals, regional federally qualified health centers, Jackson and Josephine County Public Health, Community Mental Health Programs, and Coordinated Care Organizations
- Use the data gathered to engage JRHA members, partners and the community in the community health improvement process

This assessment lays the foundation for a regional Community Health Improvement Plan (CHIP) effort to begin in early 2019. The quantitative and qualitative data presented in this report and the six priority key themes identified can guide the development of goals, objectives, strategies and performance measures. While JRHA is the convener for community health improvement planning in Jackson and Josephine Counties, objectives and strategies developed for the CHIP must be owned by a local organization or collaborative for meaningful progress to occur. The priorities identified in this assessment represent complex community issues, and effective action will require infrastructure and community capacity to support collective impact.

INTRODUCTION

Background

Overview of JRHA

Jefferson Regional Health Alliance is a collaboration of regional community leaders from all sectors learning and working together to improve the health and health care resources of Southern Oregonians. The vision of JRHA is a) that the organizations and individuals responsible for the health of the community are interconnected, promoting health and health care transformation together, b) current systems are transformed, reducing economic, cultural and system barriers to health and health care access while reducing the costs of health care services, and c) relationships and resources are leveraged through collaboration to implement best practices and ensure a sustainable health care system.

Purpose and Scope of 2018 Assessment

To create a healthy community for Jackson and Josephine Counties, in 2018 JRHA undertook a collaborative community health assessment (CHA). Many of JRHA's partners have state, federal, or accreditation requirements as stated below:

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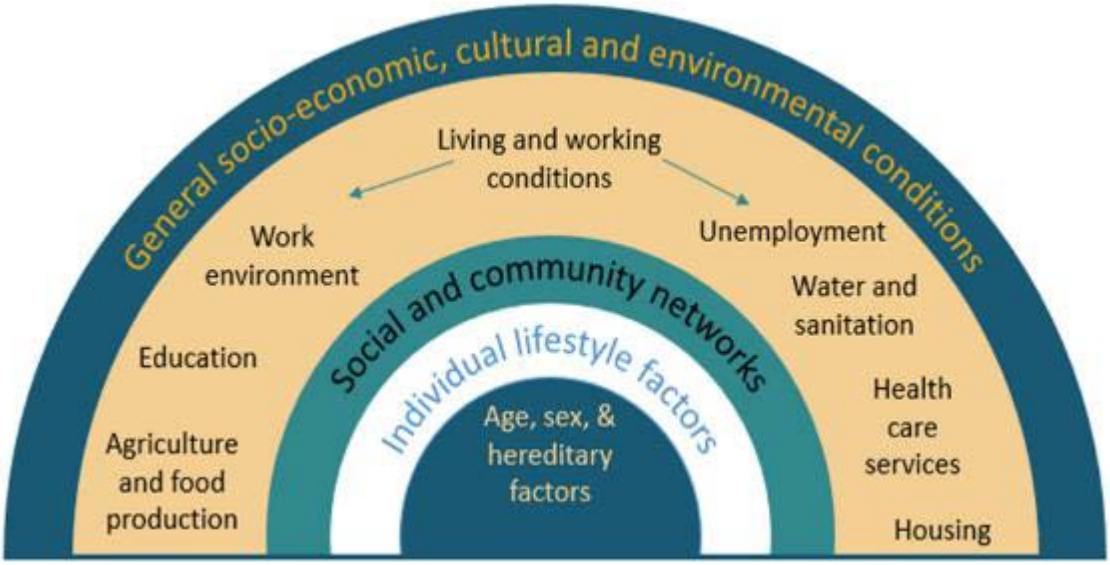
Approach and Methods

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

Social Determinants of Health Framework

It is important to recognize that multiple factors have an impact on health, and that there is a dynamic relationship between community members and their lived environments. The following diagram provides a visual representation of this relationship, demonstrating how individual lifestyle factors are influenced by more upstream factors, such as employment opportunities and housing. The World Health Organization further defines the social determinants of health as "the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources." Social determinants of health can affect individual and community health directly and indirectly, including influence on health promoting behaviors. Policies and other interventions influence the availability of these determinants and how they are distributed among different social groups, including those groups defined by socioeconomic status, race and ethnicity, sex, sexual orientation, disability status, and geographic location. Inequitable distribution of social determinants contributes to health inequities. A stronger understanding of how local societal conditions, health behaviors, and access to health care affect health outcomes in the community can increase awareness and understanding of what is needed to move toward health equity.



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

Health Equity Framework

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

- The color of their skin
- Level of education

- Gender identity
- Sexual orientation
- The job they have
- The neighborhood they live in
- Whether or not they have a disability[12]

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

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

Mobilizing for Action through Partnerships and Planning

JRHA selected the Mobilizing for Action through Planning and Partnerships (MAPP) model as a framework to guide the community health improvement process in Jackson and Josephine Counties. MAPP is a community-based strategic planning process that relies on collaborative partnership and includes four assessment components to inform planning:

a. Community Health Status Assessment
b. Community Themes and Strengths Assessment
c. Forces of Change Assessment
d. Local Public Health System Assessment

SOURCE: https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

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

CHA Oversight

JRHA assembled a CHA Steering Committee in 2016 to explore the development of a single regional community health assessment. The Steering Committee provided strategic oversight of the CHA process and worked closely with HRiA to provide community context and engagement. The Steering Committee is comprised of members representing hospitals and health systems, Coordinated Care Organizations, community health centers, local public health authorities, Community Mental Health Programs, addiction treatment organizations, and other health and human service organizations. The committee provided guidance on each component of the assessment, including the CHA methodology, recommendation of secondary data sources, identification of key informants and focus group segments, dissemination of the community survey, and communication and dissemination throughout the CHA process.

Data Collection and Analysis Methods

In order to better understand the health of Jackson and Josephine Counties, the following data collection methods were used.

Review of secondary data

This assessment incorporated data on social determinants of health as well as health behavior and outcome data from various sources at national, state, regional, county and local levels. These data sources included but were not limited to the U.S. Census, Oregon Health Authority, and both Jackson and Josephine County Public Health. Data included self-report of demographics, health behaviors and outcomes from large, population-based surveys such as the Behavioral Risk Factor Surveillance System (BRFSS). The data work group of the CHA Steering Committee participated in the selection of quantitative data sources and indicators for the assessment. A full list of data indicators and sources can be found in Appendix B – List of data sources and indicators.

Focus groups

In May 2018, HRiA conducted ten focus groups with 95 individuals from across Jackson and Josephine Counties. Focus groups were conducted with representatives of priority populations or sectors, including communities of color, homeless youth, seniors, parents, individuals with disabilities, and rural communities. Focus group discussions explored participants' perceptions of the community, priority health concerns, and suggestions for future programming and services to address these issues. A semi-structured moderator's guide was used across all focus groups to ensure consistency in the topics covered (see Appendix F - Focus Group Discussion Guide). The moderator's guide was translated to Spanish for one focus group. Each focus group was facilitated by a trained moderator, and detailed notes were taken during each discussion. On average, focus groups lasted 90 minutes and included 5-10 participants. As an incentive, focus group participants received a $20 stipend to compensate them for their time.

Interviews

In April through June 2018, HRiA conducted 20 interviews with community stakeholders to gauge their perceptions of the community, health concerns, and what programming, services, or initiatives are most

needed to address these concerns. Interviews were conducted by phone with twenty individuals representing a range of sectors including education, social services, and health care, among others. A semi-structured interview guide was used across all discussions to ensure consistency in the topics covered (see Appendix G - Key informant interview guide). Each interview was facilitated by a trained moderator, and detailed notes were taken during conversations. On average, interviews lasted approximately 45 minutes.

Community forums

On May 7 and 8, 2018 HRiA facilitated two community forums, one in Medford and one in Grants Pass. The purpose of the community forums was to gather additional feedback from community members on priority health concerns, needs and assets. Each forum began with a presentation of the assessment process and preliminary quantitative data. Participants had a chance to reflect and ask questions about the data in small and large group discussions. Detailed notes were taken and incorporated into the qualitative data for this report. A total of 55 community members attended the two community forums.

Community survey

In May through July 2018, a community survey was developed and distributed in both paper and electronic formats across Jackson and Josephine Counties to broadly capture and quantify the perspective of stakeholders. The survey focused on community members' and providers' perceptions of the community, top health concerns, and barriers to accessing health and social services. The survey was developed by HRiA in collaboration with the JRHA CHA Steering Committee, and used both Likert-type scales and closed-ended response categories. Skip patterns were embedded within the electronic survey so that questions could be tailored to the respondent (i.e. provider or community member). English and Spanish versions of the survey were made available to all respondents. In total, 1,116 people completed the survey. The survey instrument can be found in Appendix H - Survey instrument.

Table 1. Community Survey Respondent Characteristics (N=1116), 2018

	N	Percent
County	1116	
Jackson	833	74.6%
Josephine	283	25.4%
Provider	440	39.4%
Community Member	676	60.6%
Gender	983	
Male	276	28.1%
Female	705	71.7%
Other	2	0.2%
Age	**989**	
18-24 years old	36	3.6%
25-34 years old	183	18.5%
35-44 years old	225	22.8%
45-64 years old	429	43.4%

65+ years old	116	11.7%
Race/Ethnicity	**970**	
Hispanic/Latino(a), any race	81	8.4%
African American or Black, non-Hispanic	8	0.8%
American Indian or Alaskan Native, non-Hispanic	14	1.4%
Asian, non-Hispanic	4	0.4%
Native Hawaiian or Other Pacific Islander, non-Hispanic	5	0.5%
White, non-Hispanic	825	85.1%
Other, non-Hispanic	4	0.4%
Multiple races	29	3.0%
Educational Attainment	**980**	
Less than high school	44	4.5%
High school graduate or GED	143	14.6%
Some college	185	18.9%
Associate or technical degree/certification	118	12.0%
College graduate	244	24.9%
Graduate or professional degree	246	25.1%
Household Income	**958**	
Less than $25,000	210	21.9%
$25,000 to $49,999	225	23.5%
$50,000 to 74,999	193	20.1%
$75,000 to $99,999	145	15.1%
$100,000 or more	185	19.3%
Disability (respondents were able to select multiple responses)	**266**	
Hearing	106	39.8%
Vision (blindness, severe vision impairment)	73	27.4%
Mobility (walking, climbing stairs)	87	32.7%
Cognitive functioning (concentrating, remembering, making decisions)	83	31.2%
Independent Living (dressing, bathing)	12	4.5%

Forces of Change Assessment (FOCA)

As part of the assessment, on July 12, 2018, HRiA facilitated a working meeting with 27 stakeholders, comprised of CHA Steering Committee members, Community Advisory Councils (CAC), and a select group of external stakeholders, to determine what factors (e.g. trends, events) are occurring or might occur that affect the health of the community or the public health system. This discussion helped to identify specific threats and opportunities that could be generated by these forces. Forces of change factors identified included issues related to political will, economic factors, trends in legislation, funding shifts, health care, workforce, population changes, health disparities and priorities, and other emerging organizational trends in Jackson and Josephine Counties.

This event explored via small and large group discussions the macro issues that have an impact on health. The discussion focused on generating a list of external factors that were most critical to the region and identifying opportunities and threats for each force. This event served as a brainstorming session for CHA Steering Committee members and other leaders of community-based organizations, health care institutions and hospitals, and health and social service agencies to identify these external

factors, how they might impact—for better or worse—the population's health, and ways to capitalize on opportunities they provide for future initiative planning. On July 30th, the CACs conducted a similar FOCA conversation, the results of which were incorporated into this report. HRiA captured detailed notes from these FOCA discussions, which can be found in Appendix C - Additional findings of Change notes.

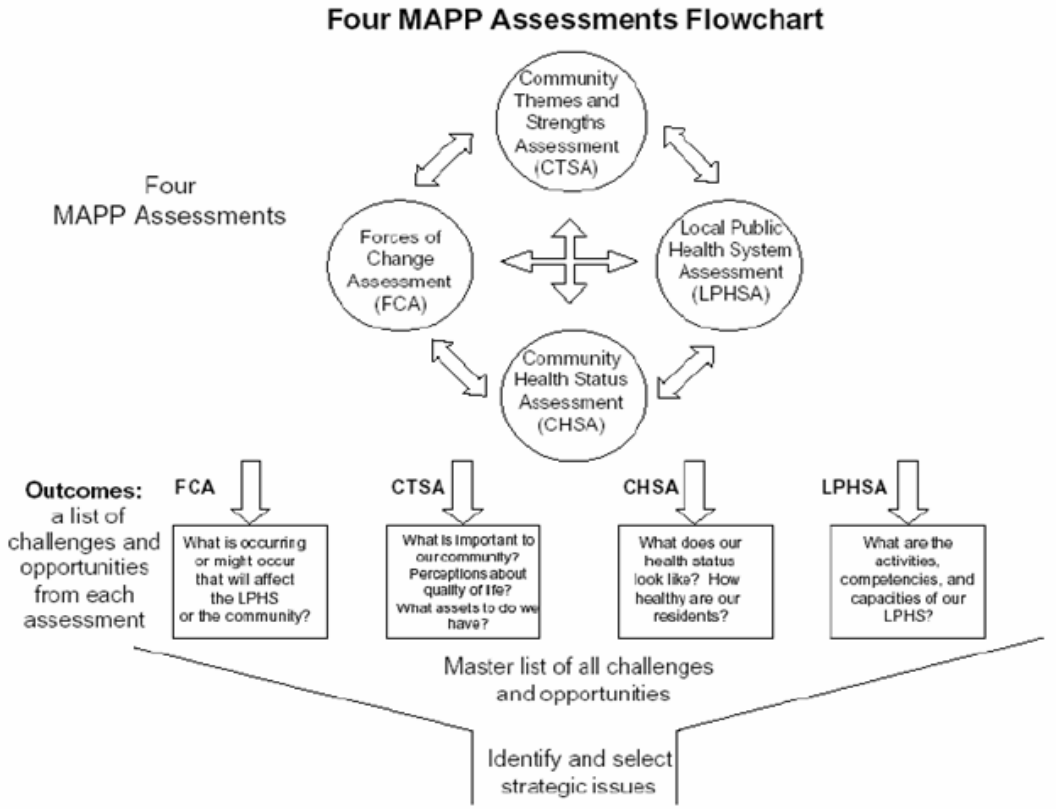
Local Public Health System Assessment (LPHSA)

A group of 35 organizational stakeholders participated in a half-day working meeting on July 12, 2018 to conduct the Local Public Health System Assessment (LPHSA). This process looked at the local public health system activities that are ongoing, identified whether they carry out essential services in the community, and captured this information using the National Public Health Performance Standards Local Public Health System Assessment Instrument which is recommended by the National Association of County and City Health Officials (NACCHO) for use in the LPHSA part of the MAPP process, and is a nationally-recognized gold-standard instrument for the LPHSA. HRiA provided strategic guidance on this effort, facilitated discussion groups and their electronic completion of the LPHSA tool. The results of the LPHSA can be found in Appendix C - Additional findings Public Health Assessment notes.

Data analysis

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

For the survey data, frequencies and cross-tabulations by demographic characteristics were conducted using SPSS statistical software, Version 21. In most instances, response options from the survey were collapsed for ease of interpretation.



SOURCE: https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

Prioritization

Stakeholders convened for a three-hour meeting on October 2, 2018 to review and discuss the preliminary results of the CHA and identify priorities, what the MAPP process calls strategic issues, for the CHIP. Forty-one community members and leaders representing diverse perspectives and multiple sectors from both Jackson and Josephine Counties attended this session.

Participants received an overview of 15 key themes that emerged in the collection of qualitative and quantitative data. While all of the key strategic issues identified through the CHA are important and many have initiatives already underway in many communities, the issues selected for health improvement planning will represent a more focused set of goals, objectives and strategies for collaborative implementation. The prioritization process used a method of rating the key issues against established criteria to then select those health issues that are most appropriate for health improvement planning. The table below represents the criteria presented to the group. Participants rated each key strategic issue based on how well they felt it met each criteria category and then voted on their top highest rated issues.

RELEVANCE How Important Is It?	**APPROPRIATENESS** Should We Do It?	**IMPACT** What Will We Get Out of It?	**FEASIBILITY** Can We Do It?
- Burden (magnitude and severity; economic cost; urgency) of the problem - Community concern - Focus on equity and accessibility	- Ethical and moral issues - Human rights issues - Legal aspects - Political and social acceptability - Public attitudes and values	- Effectiveness - Coverage - Builds on or enhances current work - Can move the needle and demonstrate measurable outcomes - Proven strategies to address multiple wins	- Community capacity - Technical capacity - Economic capacity - Political capacity/will - Socio-cultural aspects - Ethical aspects - Can identify easy short-term wins - FOC alignment

The 15 key themes are presented below, with the top six priorities **bolded**.

- **Affordable housing**
- **Substance use**
- **Poverty and employment**
- **Mental health and wellbeing**
- Transportation
- Health care access
- Fragmentation of services
- **Education and workforce development**
- Aging
- Environmental health
- Community safety
- Oral health
- Food insecurity
- Communicable diseases
- **Parenting and life skills**

Limitations

As with all assessment efforts, there are some information gaps related to the assessment methods that should be acknowledged. First, for quantitative (secondary) data sources, most data could not be provided at geographic levels smaller than county due to the small population size in the region. Similarly, there were limited data available stratified by subgroup (age, race/ethnicity) for the area. It should be noted that while comparisons are made between geographies and demographic groups, these do not reflect tests of statistical significance.

While examining data across multiple time points provides important information about health patterns over time, there were some indicators for which data may not have been available for the same geographic unit across multiple time points. There were also a few indicators that changed slightly since previous assessments. Accordingly, direct comparisons across time points should be interpreted conservatively or with caution. For example, the indicator of poor mental health for adults shifted from 15+ days of poor mental health in the past month to 14+ days of poor mental health.

Data based on self-reports should be interpreted with particular caution. In some instances, respondents may over- or underreport behaviors and illnesses based on fear of social stigma or misunderstanding the question being asked. In addition, respondents may be prone to recall bias—that is, they may attempt to answer accurately but remember incorrectly. In some surveys, reporting and recall bias may differ according to a risk factor or health outcome of interest. Despite these limitations, most of the self-report surveys analyzed in this CHA benefit from large sample sizes and repeated administrations, enabling comparison over time.

Additionally, while the focus groups and interviews conducted for this CHA provide valuable insights, results are not statistically representative of a larger population due to non-random recruiting techniques and a small sample size. Recruitment for focus groups was conducted by community organizations and participants were those individuals who were able to connect to these community organizations. Because of this, it is possible that the responses received only provide one perspective of the issues discussed. Lastly, it is important to note that data were collected at one point in time, so findings, while directional and descriptive, should not be interpreted as definitive.

How This Assessment Can Be Used

The 2018 Community Health Assessment of Jackson and Josephine Counties serves multiple purposes for a variety of audiences. Among these purposes, the assessment enables JRHA and its partners to:

- Explore current health status and determinants of health, health priorities, and new and emerging concerns among Jackson and Josephine County community members and service providers
- Hear individual and group voices to provide a deeper understanding of the "why" and "how" of current and emerging health issues
- Understand the shifting patterns of these health issues over time in Jackson and Josephine Counties
- Identify assets and resources as well as gaps and needs in services in order to help partners set funding and programming priorities
- Fulfill the community health needs assessment requirements for Asante and Providence Hospitals, regional federally qualified health centers, Jackson and Josephine County Public Health Departments, Community Mental Health Programs, and Coordinated Care Organizations
- Use the data gathered to engage JRHA members, partners and the community in the community health improvement process

REGIONAL SNAPSHOT – DEMOGRAPHICS AND HEALTH STATUS

The primary and secondary data collected for this assessment covered a large range of epidemiological, social and economic data. The following section provides a brief quantitative overview of the population demographics and health status of Jackson and Josephine Counties. Additional data related to each of the top six priorities that emerged from the prioritization process can be found in the key themes section and a full range of demographic and health indicators is included in Appendix C - Additional findings.

Demographic Profile

Oregon, Jackson County, and Josephine County all experienced growth in population between 2011 and 2016, with a 4.3% increase in Jackson County and a 1.9% increase in Josephine County (Table 2).

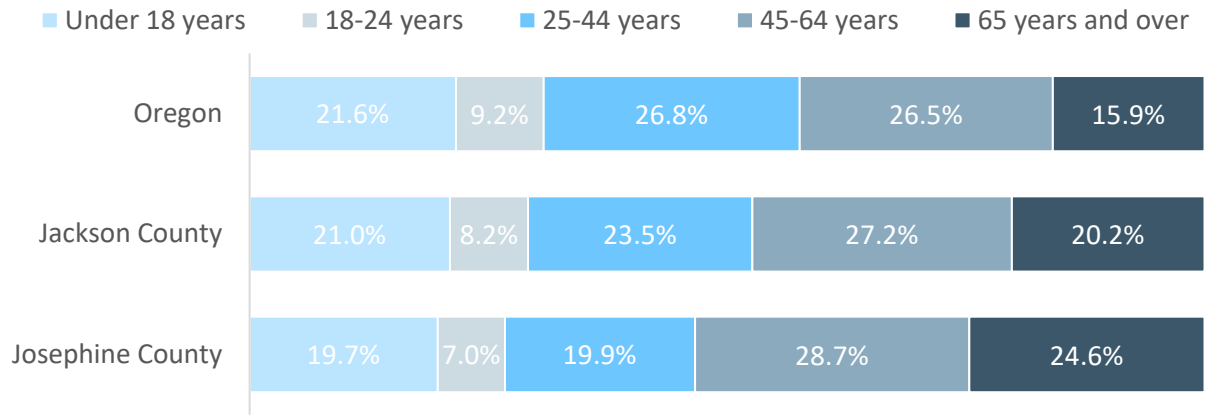
Table 2. Total Population and Percent Change, by State and County, 2007-2011 and 2012-2016

	2011	2016	% change
Oregon	3,801,991	3,982,267	4.7% ⬆
Jackson County	202,178	210,916	4.3% ⬆
Josephine County	82,456	84,063	1.9% ⬆

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Based on 2012-2016 American Community Survey 5-year estimates, Josephine County and Jackson County (24.6% and 20.2%, respectively) had higher proportions of community members aged 65 and over than Oregon as a whole (15.9%) (***Figure 1***). The topic of aging emerged as a theme in qualitative conversations, which highlighted the inadequate resources that exist to support the needs of the disproportionately large number of older community members in the two counties.

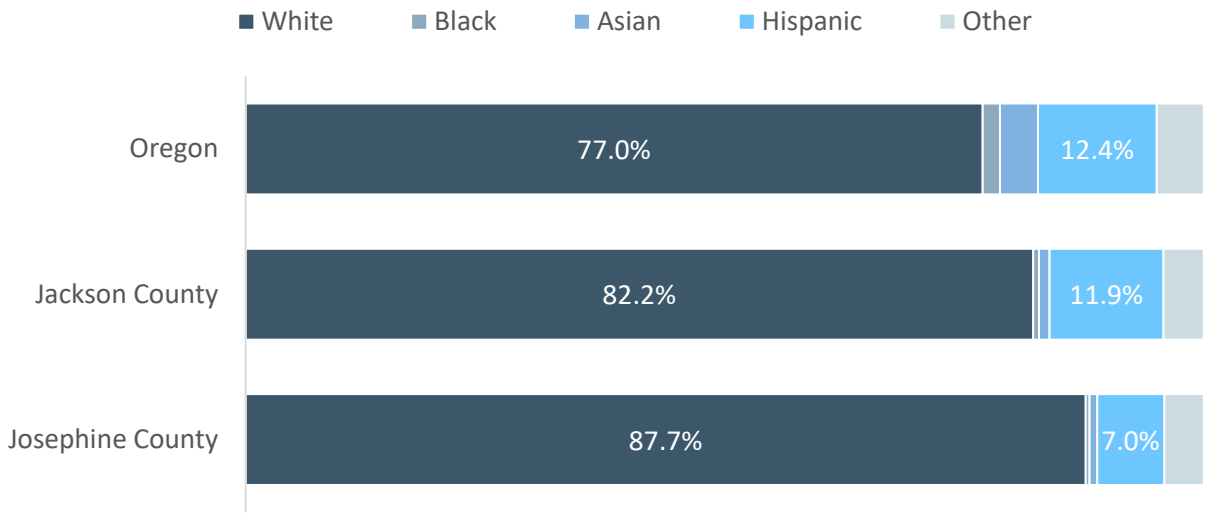
Figure 1. Age Distribution, by State and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

As seen in ***Figure 2***, the majority of community members in the three geographies identified as White, non-Hispanic, with Josephine County having a higher proportion of community members identifying as White, non-Hispanic (87.7%). Jackson and Josephine counties reported to have smaller proportions of community members identifying as non-White compared to the state.

Figure 2. Racial and Ethnic Distribution, by State and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: White, Black, Asian, and Other include only individuals that identify as one race; Hispanic/Latino include individuals of any race; Other includes American Indian and Alaska Native, Native Hawaiian and other Pacific Islander, other race alone, or two or more races

Jackson County saw the largest percent increase in Hispanic or Latino population (18.7%) between 2007-2011 and 2012-2016 compared to Oregon (13.1%) and Josephine County (13.1%) (Table 3). Qualitatively, focus group and interview participants observed growth in the Latino population across both counties and discussed implications for providing culturally-competent services. Participants in several focus groups shared that the community has good intentions to help meet the needs of the growing Latino population regionally. However, interviewees expressed that the community can do a better job both engaging the Latino population and providing leadership opportunities so that "our organizations reflect the diversity of our community members."

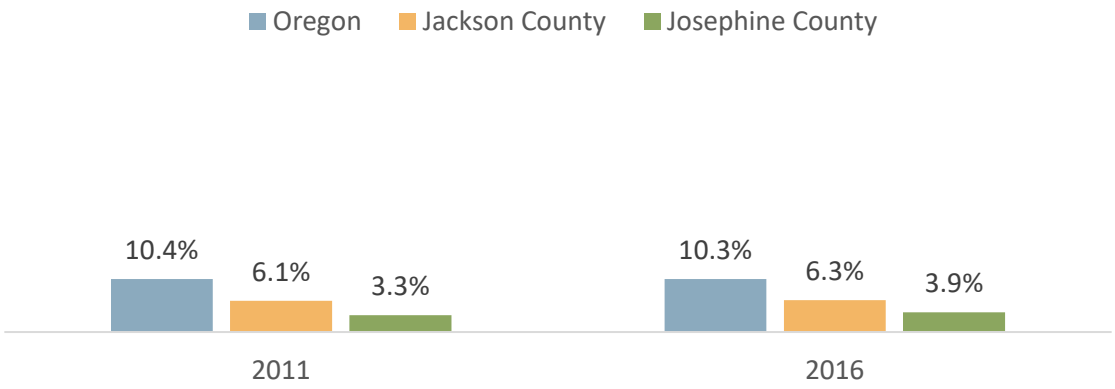
Table 3. Change in Hispanic or Latino Population, by State and County, 2007-2011 and 2012-2016

	2011	2016	% change
Oregon	436,806	494,806	13.3% ⬆
Jackson County	21,109	25,058	18.7% ⬆
Josephine County	5,171	5,850	13.1% ⬆

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Smaller proportions of community members in Jackson and Josephine counties were foreign-born (6.3% and 3.9%, respectively) when compared to Oregon overall (10.3%) (***Figure 3***).

Figure 3. Percent Population 5 Years and Over Foreign-Born, by State and County, 2007-2011 and 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

As depicted in Table 4, across Oregon, Jackson County, and Josephine County, the largest proportions of foreign-born community members were from Central America (41.7%, 57.9%, and 39.8%, respectively).

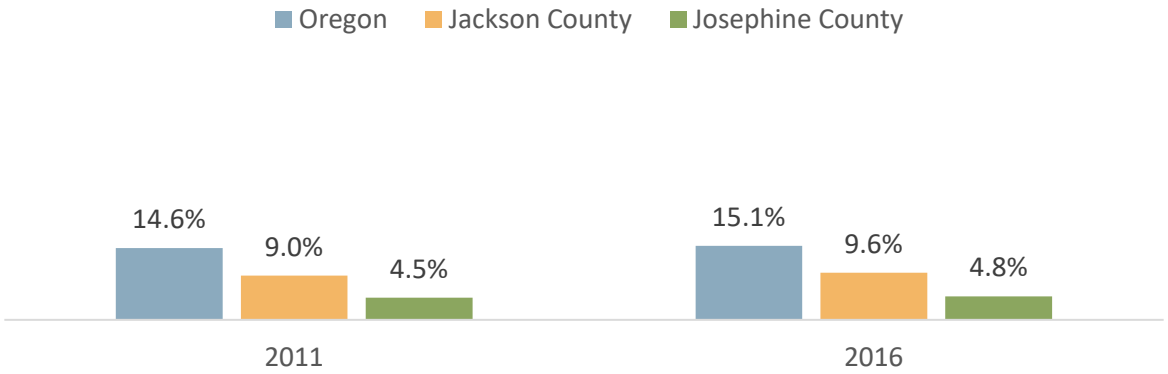
Table 4. Top Five Places of Birth for Foreign-Born Population, by State and County, 2012-2016

	Oregon	Jackson County	Josephine County
1	Central America 41.7%	Central America 57.9%	Central America 39.8%
2	China 6.2%	United Kingdom 5.6%	Germany 10.0%
3	Vietnam 5.2%	Canada 5.3%	United Kingdom 9.4%
4	Canada 3.9%	China 4.4%	Canada 8.3%
5	India 3.6%	Germany 3.4%	Philippines 5.3%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: Central America includes Mexico, Belize, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Panama, and Other Central America; United Kingdom includes England, Scotland, and Crown Dependencies

As shown in ***Figure 4***, approximately one in ten community members in Jackson County (9.6%) and one in twenty community members (4.8%) in Josephine County spoke a language other than English at home, which was lower than the percentage of community members in Oregon (15.1%).

Figure 4. Percent Population 5 Years and Over Speak a Language Other than English at Home, by State and County, 2007-2011 and 2012-2016

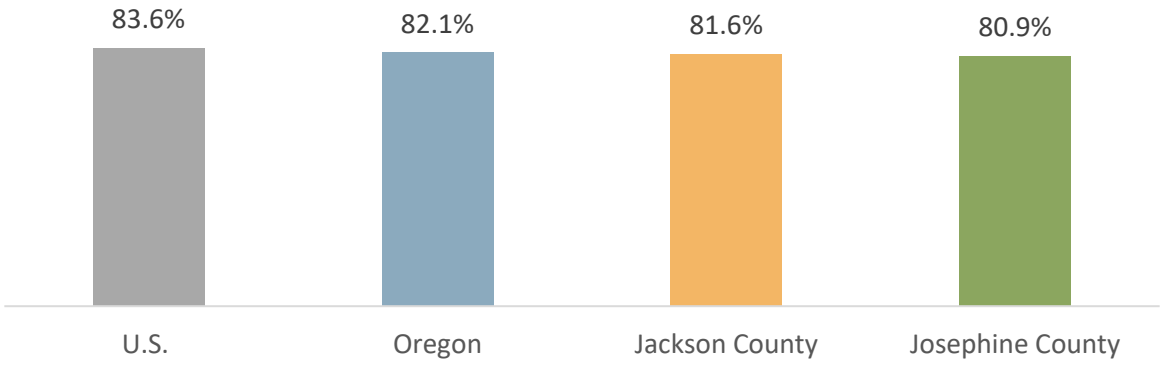


DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

General Health Status and Mortality

According to the BRFSS, a nation-wide survey that asks community members about their health-related risk behaviors, health conditions, and use of preventive services, over 80% of adults reported their general health status to be good, very good, or excellent across all geographies, with adults slightly less likely to report as such in Josephine County (***Figure 5***). While self-reported health status is high, more local data from the community survey indicated that only 46.5% of respondents felt that the general health status of the community within which they live was good, very good or excellent.

Figure 5. Age-Adjusted Percent Adults Reported General Health Status as Good or Very Good or Excellent, by State and County, 2012-2015

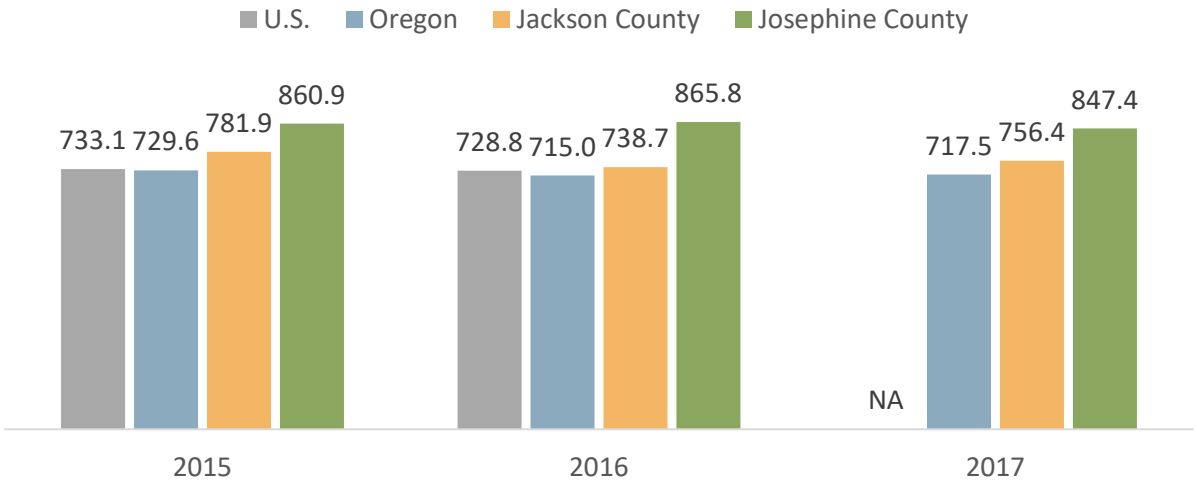


DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Data for U.S. are crude percentages

Mortality statistics help us understand health and how it can be improved. In 2017, the mortality rates for Josephine and Jackson Counties (847.4 deaths per 100,000 population and 756.4 deaths per 100,000 population, respectively) were higher than that for Oregon (717.5 deaths per 100,000 population) (***Figure 6***). Across the

three time points there is some fluctuation in mortality rates but small overall decreases in both counties between 2015 and 2017.

Figure 6. Age-Adjusted Overall Mortality Rate per 100,000 Population, by State and County, 2015-2017



DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, National Center for Health Statistics, Underlying Cause of Death 1999-2015 on CDC WONDER Online Database, 2015-2016; (for state and county data) Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017
NOTE: 2017 data not publicly available for the U.S.

The leading causes of mortality were similar across Oregon and Jackson and Josephine Counties, with the highest mortality rates due to cancer and heart disease (Table 5). The mortality rate due to accidents (unintentional injuries) was higher for Josephine County (72.4 deaths per 100,000) when compared to Oregon (44.7 deaths per 100,000 population) and Jackson County (40.2 deaths per 100,000 population). Both counties experience high mortality rates due to chronic lower respiratory disease compared to the state overall.

Table 5. Top Five Leading Causes of Mortality, Age-Adjusted Rates per 100,000 Population, 2017

Rank	Oregon	Jackson County	Josephine County
1	Cancer 154.2	Cancer 154.8	Cancer 165.8
2	Heart Disease 134.0	Heart Disease 122.0	Heart Disease 146.6
3	Accidents 44.7	Chronic lower respiratory disease 47.8	Accidents 72.4
4	Cerebrovascular disease 39.9	Accidents 40.2	Chronic lower respiratory disease 47.7
5	Chronic lower respiratory disease 39.7	Cerebrovascular disease 37.4	Cerebrovascular disease 43.6

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2017

Years of Potential Life Lost (YPLL) is an estimate of the average years a person would live if they had not died prematurely. A larger number indicates greater loss. For the period of 2012-2016, according to the Oregon Health Authority, the YPLL before age 75 was higher in both Josephine (9,706.2 per 100,000 population) and Jackson Counties (7,486.9 per 100,000 population) compared to the statewide rate (6,432.7 per 100,000 population).

Life expectancy is a summary mortality measure often used to describe the overall health status of a population. Life expectancy is defined as the average number of years a population of a certain age would be expected to live, given a set of age-specific death rates in a given year, in other words how long a person can expect to live. Examining life expectancy at birth across Jackson and Josephine Counties, there are vast differences by census tract, indicating that where people are born and live influences how long they live. Within Jackson County, the range is nearly 20 years (66.2 years to 85.6 years), according to data from the U.S. Small-area Life Expectancy Estimate Project. Overall, the 2014 life expectancy at birth for Jackson County was 79 years, which was the same as Oregon as a whole. Life expectancy at birth was 74 years in Josephine County.

> "Affordable, high-quality health care is essential to our health. But where we live can have an even great impact. Improving health and longevity in communities starts with ensuring access to healthy food, good schools, affordable housing, and jobs that provide us the resources necessary to care for ourselves and our families – in essence, the types of conditions that can help keep us from getting sick in the first place." – Robert Wood Johnson Foundation

KEY THEMES

As detailed in the methods section, this community health assessment covered a broad range of economic, social, and epidemiological quantitative data as well as extensive qualitative data. From these data, and as a result of the prioritization process previously described, several priority key themes emerged. This section of the report provides background on each of the top six priorities, supporting data from the assessment, existing assets and resources in Jackson and Josephine Counties, and future explorations.

Substance Use

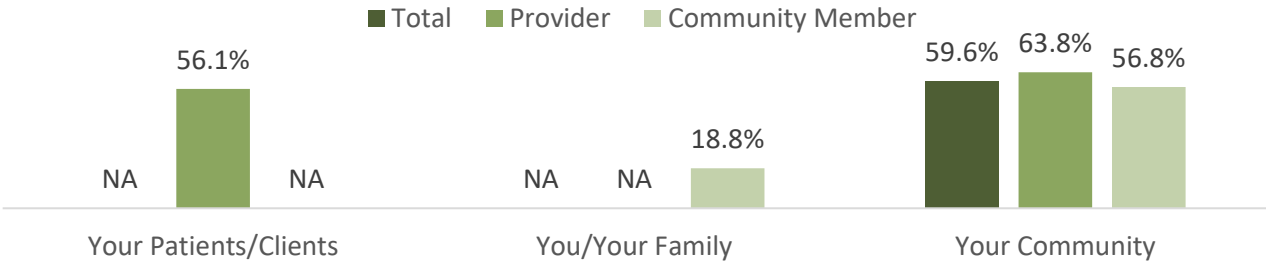
Importance and connection to other health issues

Substance use and abuse is a critical public health issue that affects not only the individual, but also has serious direct and indirect impacts on families, communities and society as whole. The causes of substance use disorders are multi-faceted and include biological, social and environmental factors.[13] Trauma and adverse childhood experiences increase the chances of substance use and addiction.[14] Individuals with substance use disorders can experience negative health and social outcomes including higher rates of infectious disease (HIV, hepatitis), cancer, mental illness, domestic violence, crime, financial hardship, housing instability and homelessness, child-abuse and overdose.[15] Illicit drug use, along with existing and emerging alcohol and marijuana use, strains resources from law enforcement to social and health services.

Key Findings

As seen across all the data sources for this assessment, substance use emerged as a top issue. Looking at the community survey conducted as part of this assessment, substance use was the third most frequently selected health issue having the largest impact on the community (59.6%) and the fourth most frequently selected health issue having the largest impact on themselves/their family/their patients (***Figure 7***). Middle-income households (those making $50,000-$99,999) were more likely to view substance use as a top health issue in the community (65.3%). In general, respondents were more likely to report substance use as a top issue impacting the community compared to as an issue impacting themselves/their family/their patients.

Figure 7. Percent Survey Respondents Reported Substance Use (Alcohol, Marijuana, Heroin, Meth, etc.) as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018.



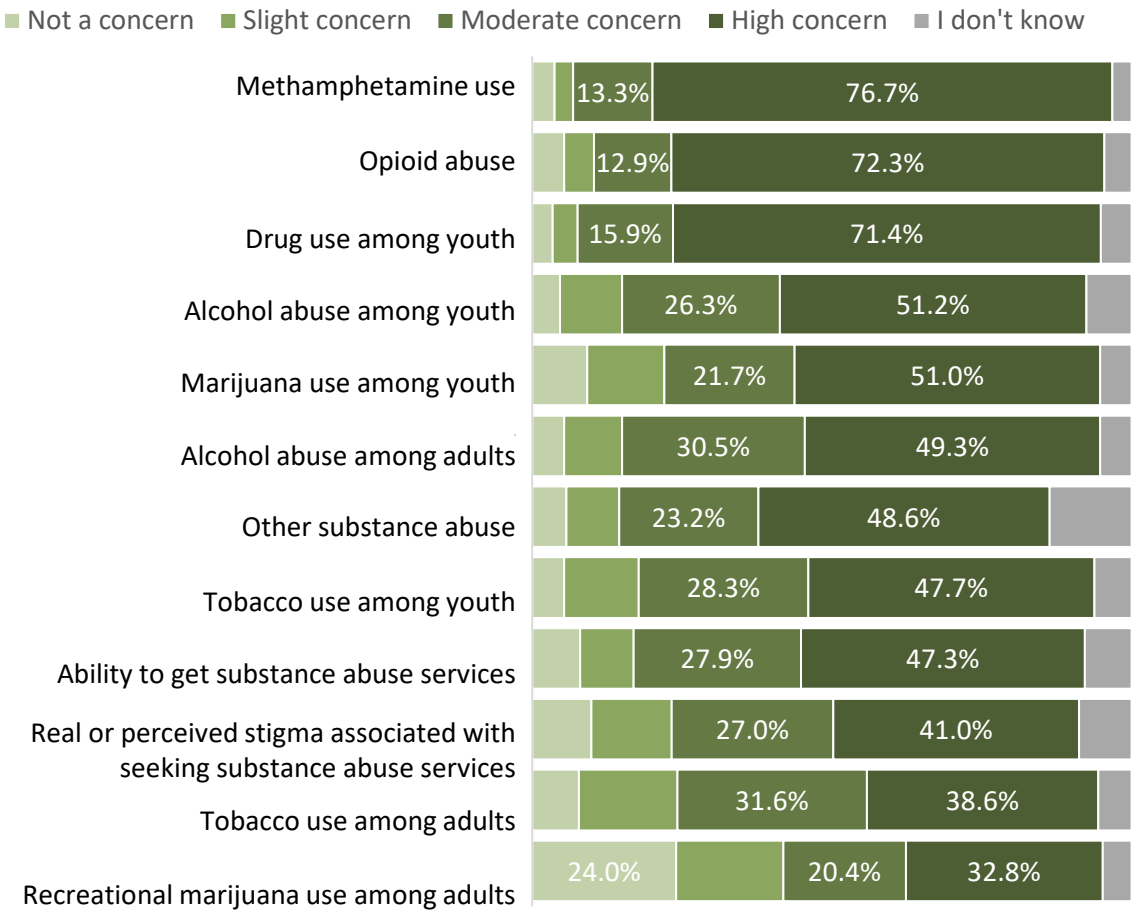
[13] US Department of Health and Human Services, Office of the Surgeon General. Facing Addiction in America The Surgeon General's Report on Alcohol, Drugs, and Health. 2016.
[14] Felitti VJ, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults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

DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

Respondents were asked to rate their level of concern for specific community issues.

Figure 8 lists specific issues related to substance abuse. Over 70% of survey respondents overall reported methamphetamine use (76.7%), opioid use (72.3%), and drug use among youth (71.4%) were of "high concern." Alcohol and marijuana use were also high concerns, particularly among the Hispanic/Latino population.

Figure 8. Survey Respondents Perceived Level of Concern for Issues Related to Substance Abuse, 2018



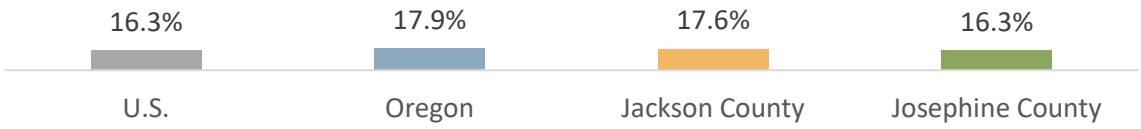
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Data are organized in descending order by "high concern"

These concerns were echoed among focus group and interview participants, who most frequently mentioned substance use as the top community health concern, highlighting opioids, meth, and the co-occurrence of substance use and mental illness.

"There's generational use of meth. We've got 60+ year olds, their kids, and then their teenage grandkids all using."

While harder drugs, such as opioids and meth, were of primary concern to both survey respondents and focus group participants, data are limited as to the prevalence of use among adults. Alcohol use is most commonly and reliably measured among adults. As seen in ***Figure 9***, adults were more likely to report current binge drinking statewide (17.9%) and in Jackson County (17.6%) compared to Josephine County (16.3%) and adults nationwide (16.3%).

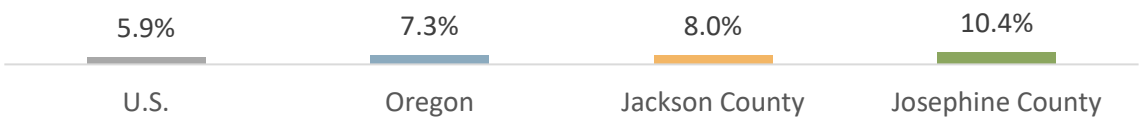
Figure 9. Age-Adjusted Percent Adults Reported Current Binge Drinking, by U.S., State, and County, 2012-2015



DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Data for U.S. are crude percentages; Current binge drinking is defined as consuming five or more (men)/four or more (women) alcoholic beverages on one occasion in past 30 days

A higher percentage of adults in Josephine County reported current heavy drinking (10.4%) compared to Jackson County (8.0%), Oregon (7.3%), and the U.S. (5.9%) (***Figure 10***).

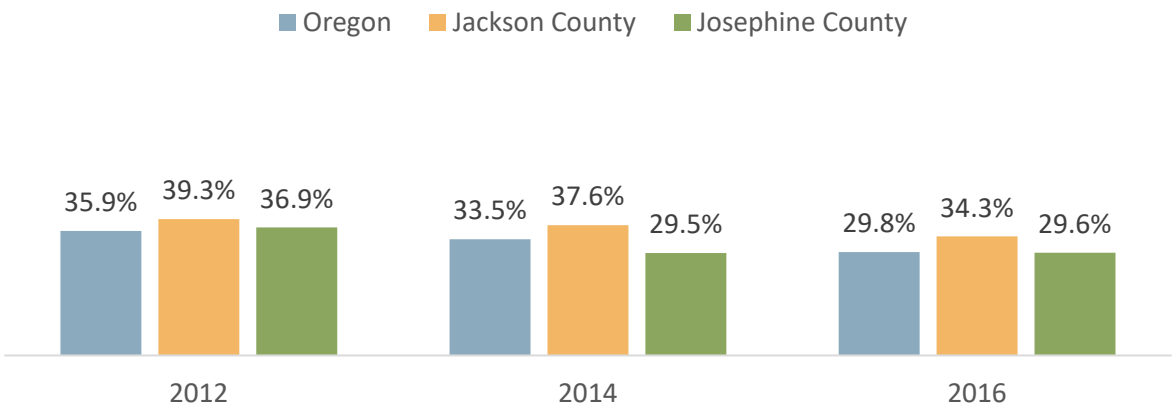
Figure 10. Age-Adjusted Percent Adults Reported Current Heavy Drinking, by U.S., State, and County, 2012-2015



DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Data for U.S. are crude percentages; Current heavy drinking is defined as consuming two or more (men)/one or more (women) alcoholic beverages per day in past 30 days

As noted above, substance use among youth was highlighted as a major concern among survey respondents. Over a third of 11th grade students in Jackson County reported current alcohol consumption (34.3%) in 2016, which was higher than the percentage of 11th graders in Oregon as a whole (29.8%) and Josephine County (29.6%) (**Figure 11**).

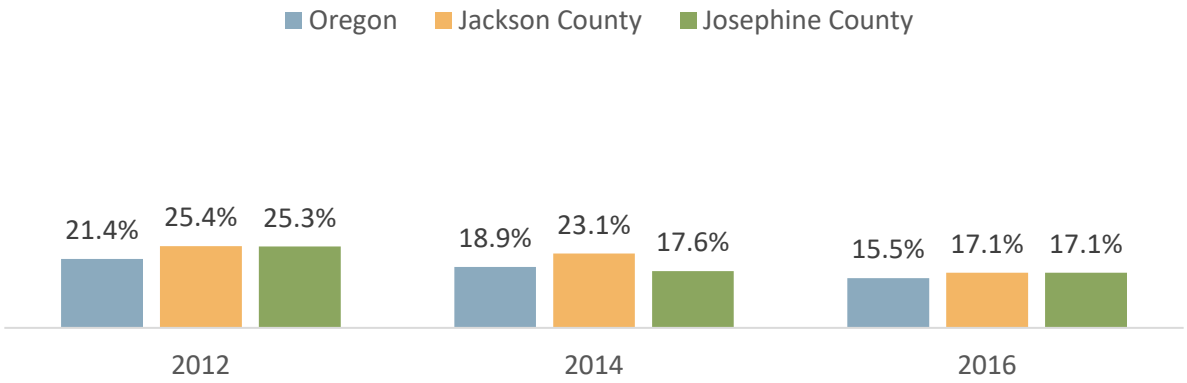
Figure 11. Percent 11th Grade Students Reported Current Alcohol Consumption, by State and County, 2012, 2014, and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current alcohol consumption is defined as "had at least one drink on at least one day in past 30 days"

Compared to 2012, 11th grade students were less likely to report current binge drinking across all geographies in 2016 (***Figure 12***). Slightly higher percentages of 11th grade students reported current binge drinking in Jackson and Josephine counties than in Oregon overall.

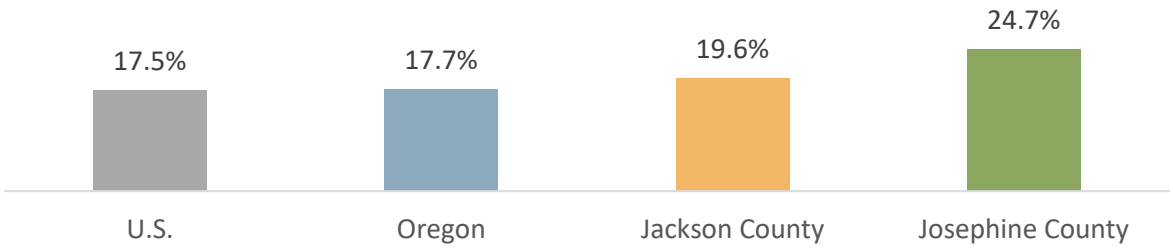
Figure 12. Percent 11th Grade Students Reported Current Binge Drinking, by State and County, 2012, 2014, and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current binge drinking is defined as "had five or more drinks in a row (within a couple of hours) on at least one day in past 30 days"

As shown in ***Figure 13***, in 2015, adults in Josephine County were more likely to report current cigarette smoking (24.7%) than adults in Jackson County (19.6%) and Oregon as a whole (17.7%). It is important to note that Josephine County also experiences higher lung cancer incidence and mortality rates, which can be seen in Appendix C - Additional findings.

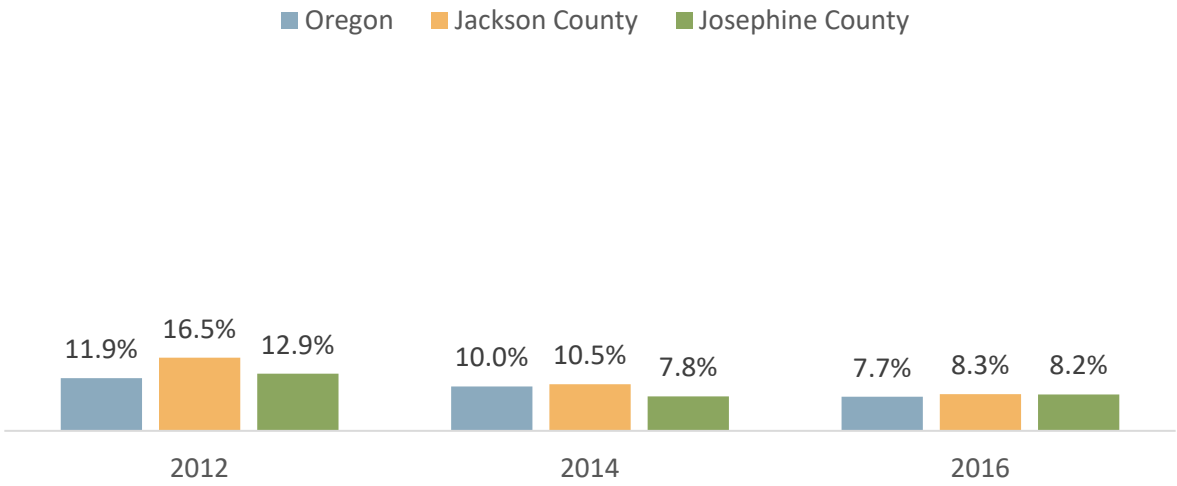
Figure 13. Age-Adjusted Percent Adults Reported Current Cigarette Smoking, by U.S., State, and County, 2012-2015



DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Data for U.S. are crude percentages

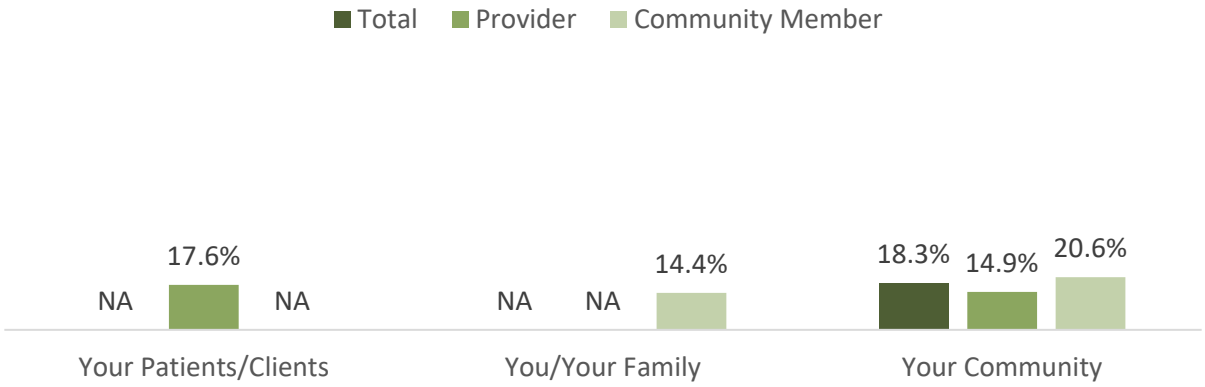
The percentage of 11th grade students reporting current cigarette use decreased between 2012 and 2016 for all geographies (***Figure 14***). In 2016, 11th grade students in Jackson and Josephine counties were slightly more likely to report current cigarette use (8.3% and 8.2%, respectively) than in Oregon overall (7.7%).

Figure 14. Percent 11th Grade Students Reported Current Cigarette Use, by State and County, 2012, 2014, and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current cigarette use is defined as "smoked cigarettes at least one day in past 30 days"

Figure 15. Percent Survey Respondents Reported Smoking as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018

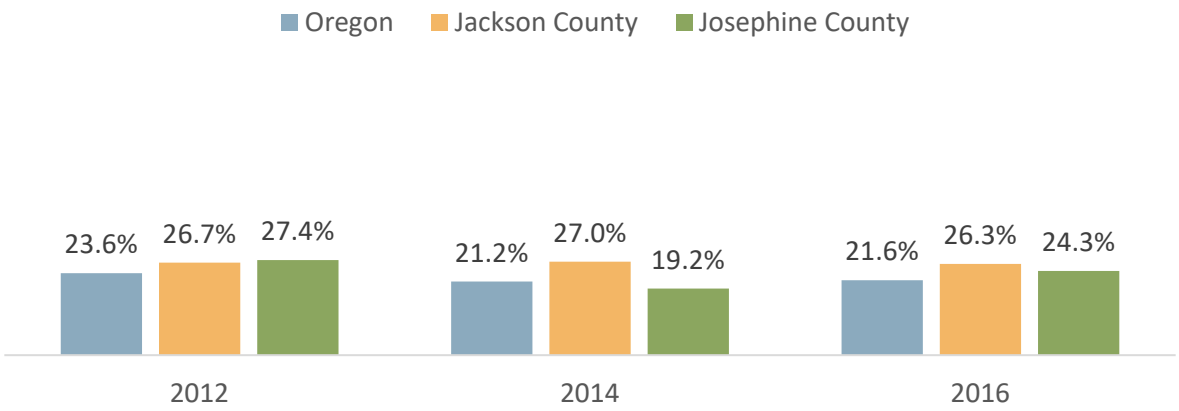


DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

Compared to other substances, few community members viewed tobacco use as a top health concern. Community members who responded to the community survey were slightly more likely to select smoking as a top issue impacting their community (20.6%) compared to providers (14.9%) (***Figure 15***). However, there are disparities by income, with low-income households (those making less than $25,000 per year) more likely to report smoking as a top concern (26.1%).

In 2016, 11th grade students in Jackson and Josephine counties were more likely to report current marijuana use (26.3% and 24.3%, respectively) than in Oregon overall (21.6%) (***Figure 16***).

Figure 16. Percent 11th Grade Students Reported Current Marijuana Use, by State and County, 2012, 2014, and 2016



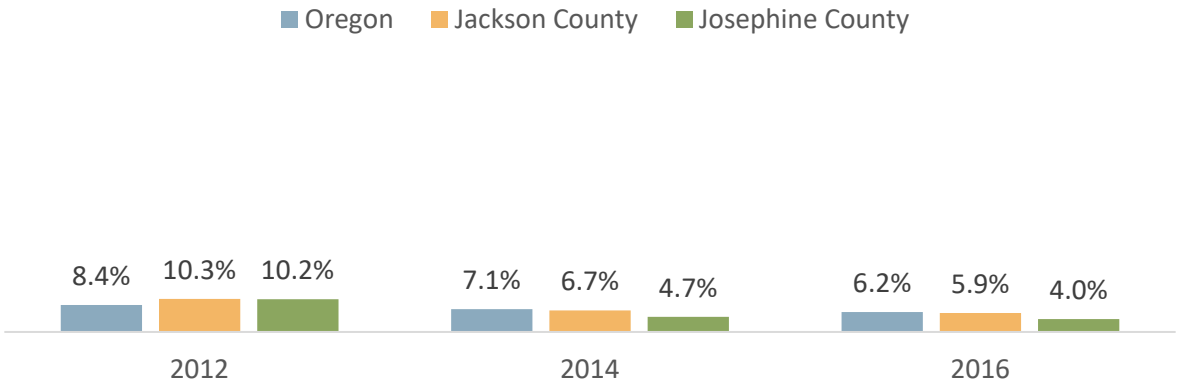
DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current marijuana use is defined as "used marijuana at least one time in past 30 days"

Focus group and interview participants widely discussed the marijuana industry and use of marijuana in the region. Participants spoke positively of the economic growth that the industry has brought to the region; however, the long-term social, environmental, and physical health impacts on the community were raised as concerns.

"Money came in and people came here for the marijuana, but they didn't have an investment in the sense of community."

Survey respondents as well as focus group and interview participants were troubled about the perceived prevalence of prescription drug use among youth. However, the quantitative data are limited to support this perception. The percentage of 11th grade students reporting current prescription drug use without a prescription decreased between 2012 and 2016 (***Figure 17***). In 2016, 11th grade students were less likely to report current prescription drug use in Josephine County (4.0%) compared to Jackson County and Oregon as a whole (5.9% and 6.2%, respectively).

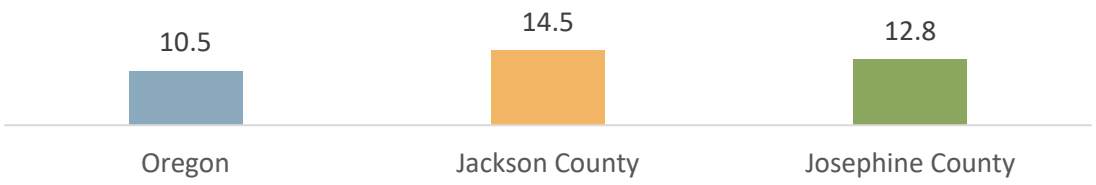
Figure 17. Percent 11th Grade Students Reported Current Prescription Drug Use Without Doctor's Prescription, by State and County, 2012, 2014, and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Current prescription drug use is defined as "used a prescription drug (e.g., OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's orders at least one day in past 30 days"

Figure 8 indicated that opioid use was of particular concern to community survey respondents. As seen in ***Figure 18***, the opioid overdose hospitalization rates were higher for Jackson and Josephine counties (14.5 hospitalizations per 100,000 population and 12.8 hospitalizations per 100,000 population) compared to Oregon overall.

Figure 18. Opioid Overdose Hospitalization Rate per 100,000 Population, by State and County, 2010-2014

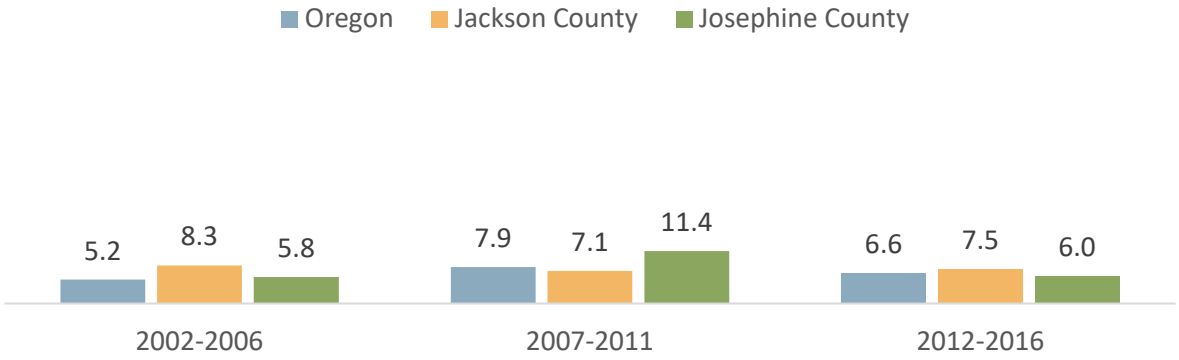


DATA SOURCE: Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Opioid Data Dashboard, 2010-2014

"Opioids are what we're seeing. The amount of heroin that runs through here – it affects so much of the population."

According to 2012-2016 estimates, the mortality rate due to opioid overdose was higher in Jackson County (7.5 deaths per 100,000 population) compared to Josephine County and the state (6.0 deaths per 100,000 population and 6.6 deaths per 100,000 population, respectively) (***Figure 19***).

Figure 19. Age-Adjusted Opioid Overdose Mortality Rate per 100,000 Population, by State and County, 2002-2006, 2007-2011, and 2012-2016



DATA SOURCE: Oregon Health Authority, Center for Health Statistics, Public Health Division, Death Certificates as cited by Opioid Data Dashboard, 2002-2006, 2007-2011, and 2012-2016
NOTE: Includes any opioid

Future Exploration

Future exploration should include developing a better understanding of the risk and protective factors of substance use, and how to best engage in community dialogue about these factors. Additionally, there were many questions raised among interview and focus group participants regarding marijuana production and use in Jackson and Josephine Counties. Assessment participants expressed concerns about the impact of marijuana on land and housing prices, and environmental health concerns related to air and water quality. Further inquiry is needed to understand the impact of legalization and the associated health outcomes.

Existing Assets and Resources

Assessment participants were asked about the assets in their communities related to substance use and shared the following list of resources:

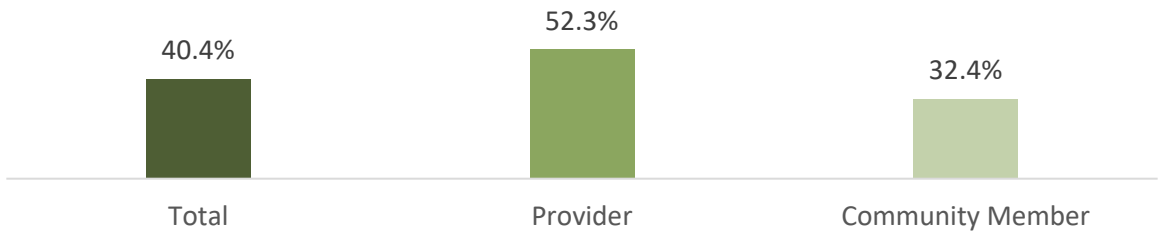
- Adapt
- Addictions Recovery Center
- Allied Health Services
- Choices Counseling Center
- Community Works
- County Alcohol and Drug Prevention and Education Programs (ADPEP)
- County LADPCs (Local Alcohol and Drug Planning Committees)
- County Tobacco Prevention and Education Programs (TPEP)
- Grants Pass Sobering Center

- Grants Pass Treatment Center
- HIV Alliance in Josephine County
- Jackson County Syringe Exchange
- Kolpia Counseling
- La Clinica
- Max's Mission
- OnTrack Rogue Valley
- Options for Southern Oregon
- Oregon Pain Guidance (OPG)
- Oregon Prescription Drug Monitoring Program
- Phoenix Counseling Center
- Rogue Community Health
- Southern Oregon Veterans Rehabilitation Center & Clinics

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

Despite the existence of several local resources to address substance use disorders, as seen in ***Figure 20***, over half of providers selected substance abuse services as a health and social service currently lacking in the community, which was higher than survey respondents overall (40.4%) and community members (32.4%). It should be noted that female survey respondents (44.6%) and those with household incomes of $75,000-$99,999 (51.7%) were more likely to report substance abuse services as lacking in the community.

Figure 20. Percent Survey Respondents Reported Substance Abuse Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Tension between the range of factors affecting substance use disorders can create a challenging environment for open dialogue and may prevent individuals from seeking help from the resources that exist. Nationally, 95% of people with substance use disorders are considered unaware of their issue and many are unaware of the far-reaching effects on children and families.[16] The co-occurrence of substance use disorders and mental illness, and the limited resources to address them, further complicates these issues.

[16] Healthy People 2020

Affordable Housing

Importance and connection to other health issues

Affordability, quality and stability are important characteristics that directly impact an individual's ability to access safe and healthy housing.[17] Unstable housing and homelessness can lead to stress, isolation, chronic disease (e.g., asthma), substance use, mental health issues and violence.[18] For those with housing, the affordability and quality of housing impact health and well-being. Housing is often a household's single greatest expense. The cost of housing directly impacts an individual's ability to afford housing, as well as how much money they can use towards health care, food, childcare and transportation.[19] While housing itself is an important factor in an individual's health, it can also be a cost burden and result in compromises to health in other areas – i.e. foregoing prescription medications – due to cost. High housing-related costs place a disproportionate economic burden on low-income families in particular, as demonstrated by one study which found that low-income people with difficulty paying rent, mortgage or utility bills were less likely to have a usual source of medical care, and were more likely to postpone treatment and use the emergency room for treatment.[20] Additionally, research has shown that children who live in areas with greater housing instability are more likely to have worse health outcomes, more behavioral problems, and lower school performance.[21]

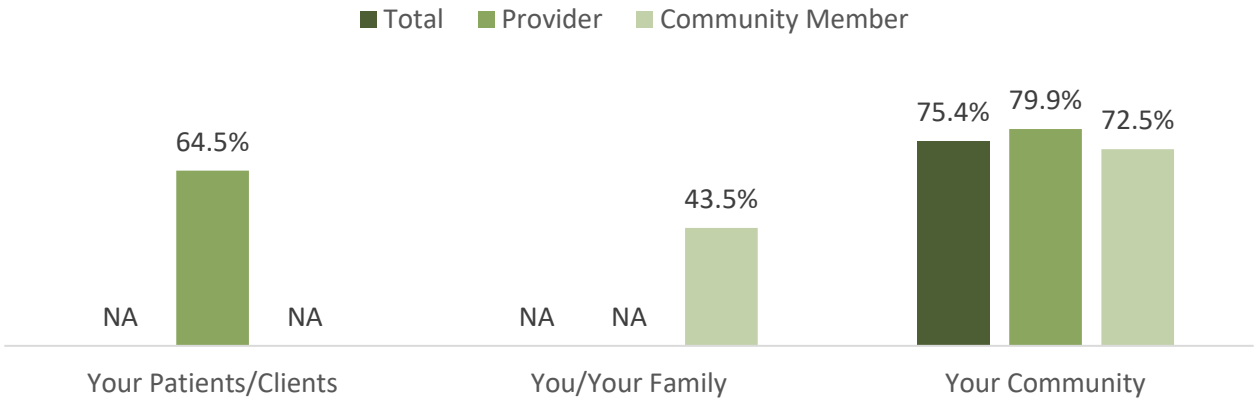
The quality of housing includes everything from the structure of the housing unit itself to the built environment around it. Indoor exposure to lead paint, secondhand smoke and mold are all pollutants that can cause negative health outcomes. The location of housing also has broad health implications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

Key Findings

Affordable housing was the top issue that emerged from focus group and interview discussions. Similarly, among overall survey respondents, affordable housing was the most frequently selected issue having an impact on themselves/their family/their patients (64.5% of providers, 43.5% of community members) and their community (75.4%) (***Figure 21***). Approximately 80% of providers reported affordable housing as a top issue. When looking at these data by race, non-White survey respondents were more likely to select affordable housing as a top health concern for themselves/their family (61.7%) as were respondents who reported household income less than $25,000 (63.1%).

[17] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.
[18] Shaw M. Housing and Public Health. Annual Review of Public Health. 2004; 25: 397-418.
[19] Maqbool N, Viveiros J, and Ault M. The Impacts of Affordable Housing on Health: A Research Summary. Center for Housing Policy. 2015.
[20] Jelleyman T. and Spencer N. Residential Mobility in Childhood and Health Outcomes: A Systemic Review, J Epidemiol Community Health, 62(7): 584-92, 2008.
[21] Jelleyman T. and Spencer N. Residential Mobility in Childhood and Health Outcomes: A Systemic Review, J Epidemiol Community Health, 62(7): 584-92, 2008.

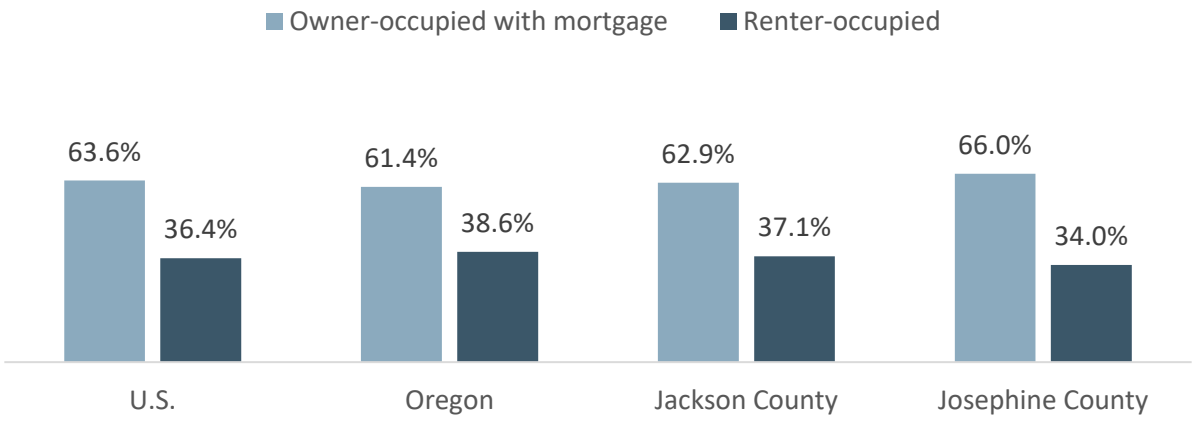
Figure 21. Percent Survey Respondents Reported Affordable Housing as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

It is important to look at how many households are owners compared to renters. Across all geographies, higher proportions of housing units were occupied by owners with mortgages than by renters (***Figure 22***). Josephine County had the highest proportion of owner-occupied housing units (66.0%) compared to the U.S., Oregon, and Jackson County.

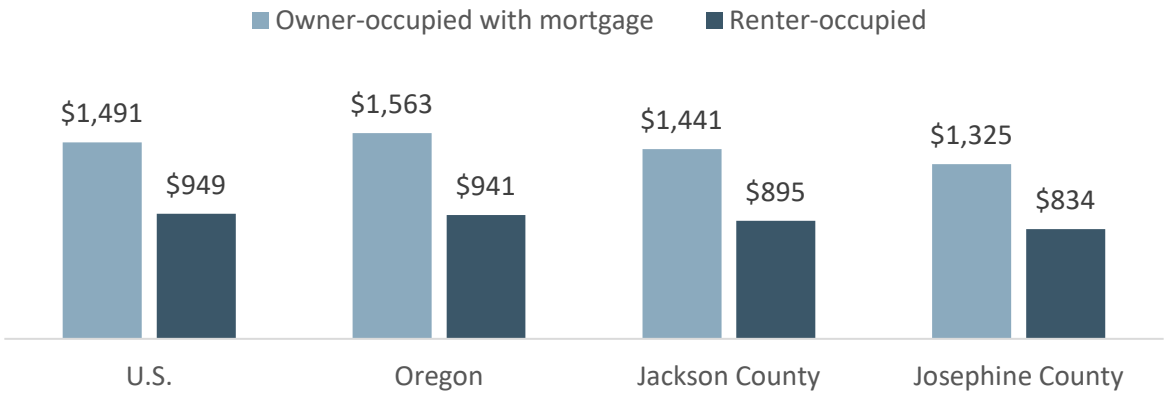
Figure 22. Percent Owner- and Renter-Occupied Housing Units, by U.S., State, and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

As shown in ***Figure 23***, the median monthly housing costs for owners with a mortgage were lower in Jackson County ($1,441/month) and Josephine County ($1,325/month) compared to Oregon ($1,563/month) and the U.S. ($1,491/month). Similar trends were seen for renter-occupied housing units.

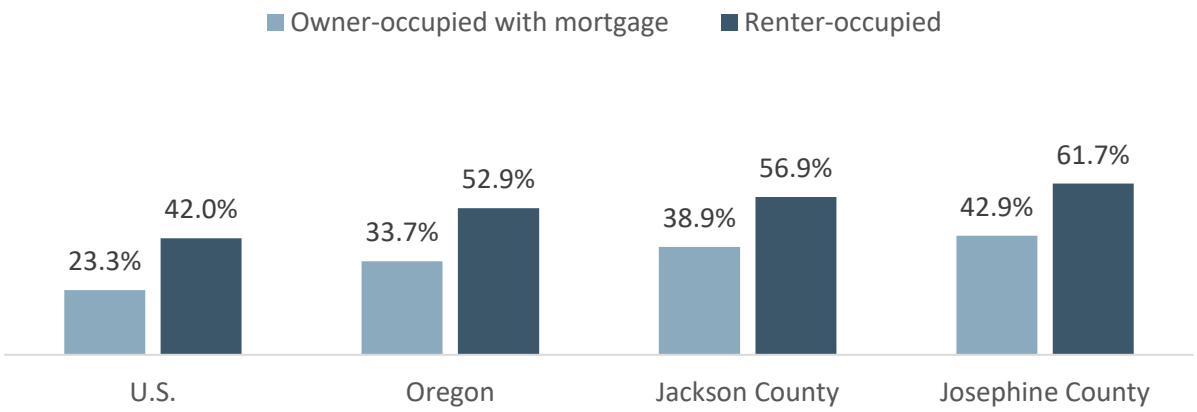
Figure 23. Median Monthly Housing Costs by Owner- and Renter-Occupied Housing Units, by U.S., State, and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Higher percentages of both owner-occupied and renter-occupied households in both counties reported to spend at least 30% of their income on housing costs, compared to Oregon and the U.S. (***Figure 24***). It is important to consider these data in conjunction with income data found in the priority related to poverty and employment. Based on 2012-2016 data, median monthly income is approximately $3,156 in Josephine County and $3,862 in Jackson County. Renters in the region are particularly burdened by the high cost of housing and the high percentage of income spent on housing.

Figure 24. Percent Households where Housing Costs are 30% or More of Income, by U.S., State, and County, 2012-2016



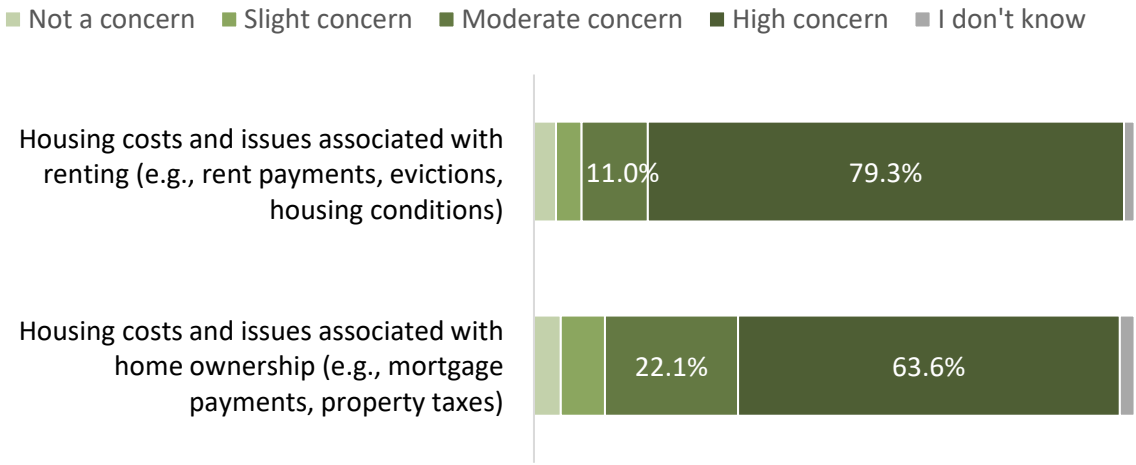
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Housing is a regional issue that is also connected to workforce shortages in some professions, such as health care, which has implications not only for providers but also community members needing care.

"Recruitment of doctors is really hard. Housing is a big part of that. It's hard to bring professionals in for schools and hospitals, since we don't have housing. They essentially have to commute from another city."

Approximately 80% of survey respondents reported housing costs and issues associated with renting to be of high concern and over 60% of survey respondents reported housing costs and issues associated with home ownership to be of high concern (***Figure 25)***.

Figure 25. Survey Respondents Perceived Level of Concern for Issues Related to Housing Costs, 2018

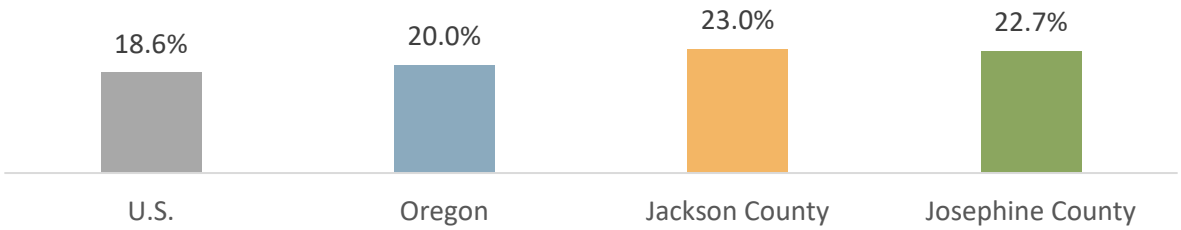


DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Data are organized in descending order by "high concern"

"The rent is astronomical. You can't even ask a landlord to make improvements because someone else is willing to pay double."

Housing safety and quality, particularly in relation to rental properties, was also extensively discussed during focus groups and interviews. As seen in ***Figure 26***, a larger proportion of households were reported to have at least one severe housing problem (incomplete kitchen facilities, incomplete plumbing facilities, more than 1.5 people per room, or cost burden greater than 50%) in Josephine County (22.7%) and Jackson County (23.0%) compared to Oregon (20.0%), and the U.S. (18.6%).

Figure 26. Percent Households with Severe Housing Problems, by U.S., State, and County, 2011-2015



DATA SOURCE: U.S. Department of Housing and Urban Development, Comprehensive Housing Affordability Strategy, using U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2011-2015
NOTE: Severe housing problems is defined as having at least one of four severe housing problems (incomplete kitchen facilities, incomplete plumbing facilities, more than 1.5 persons per room, and cost burden greater than 50%)

Poor health – illness, injury and/or disability – can lead to homelessness when people have insufficient income to afford housing. Further, homelessness can exacerbate existing health issues as well as cause new ones. Chronic diseases, such as hypertension, asthma, diabetes and mental illness, are difficult to manage under the stressful conditions of homelessness.[22]

There was a decrease in the number of homeless individuals in Jackson and Josephine counties between 2015 and 2017, compared to an increase in Oregon (5.9% increase), according to the Oregon point-in-time homeless counts (Table 6). There was a greater decrease seen in Josephine County (26.4% decrease) than in Jackson County (6.8% decrease). It should be noted, however, that 2017 presented a challenge in obtaining an accurate point-in-time count due to extreme winter weather. Because of this challenge, as well as the transience of the population, this "snapshot" of homelessness does not provide the whole picture.

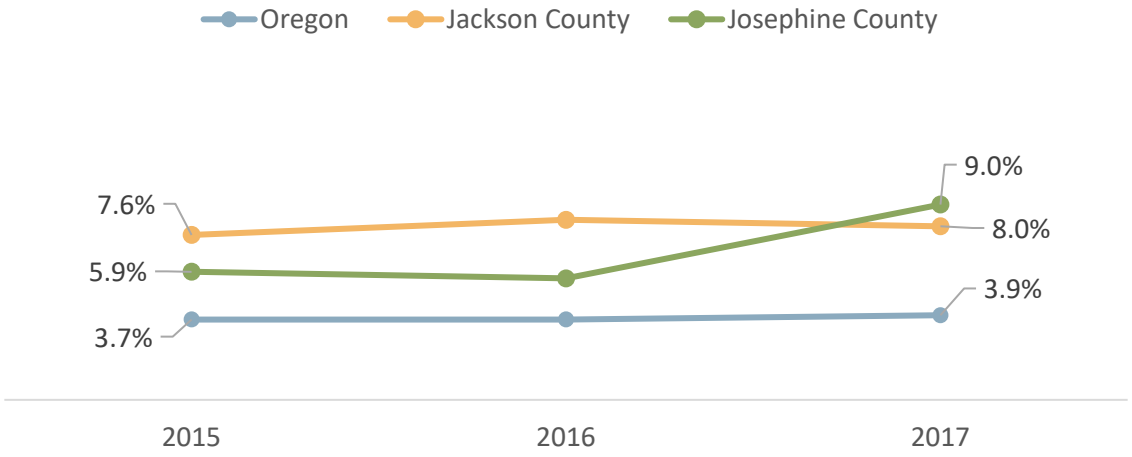
Table 6. Point in Time Homeless Population Count and Percent Change, by State and County, 2015 and 2017

	2015	2017	% change
Oregon	13,176	13,953	5.9% ⬆
Jackson County	679	633	-6.8% ⬇
Josephine County	883	650	-26.4% ⬇

DATA SOURCE: Oregon Housing and Community Services, Oregon Point-in-Time Homeless Counts, 2015 and 2017
Although data to quantify the issue are limited, homelessness among veterans, individuals with mental illness and young people was highlighted among assessment participants. In 2017, higher proportions of students were reported to be homeless in Josephine and Jackson counties (9.0% and 8.0%, respectively) than Oregon as a whole (3.9%) (***Figure 27***). While the percentage of homeless students increased between 2016 and 2017 for all geographies, there was a greater increase in percentages seen in Josephine County.

[22] What is the relationship between health, housing and homelessness? National Health Care for the Homeless Council. Available at: https://www.nhchc.org/faq/relationship-health-housing-homelessness/ Accessed on: November 6, 2018

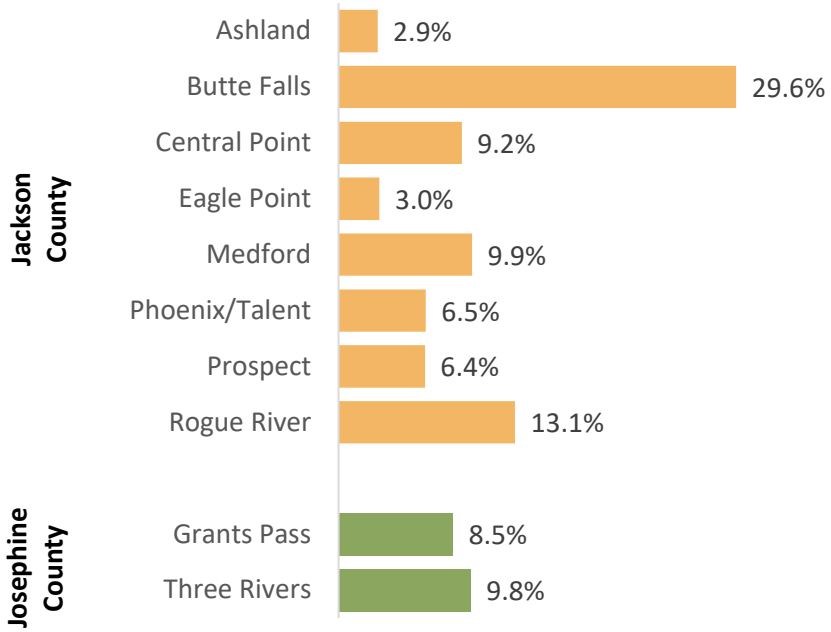
Figure 27. Percent Students (Grades K-12) who are Homeless, by State and County, 2014-2015, 2015-2016, and 2016-2017



DATA SOURCE: Oregon Department of Education, as reported by Children First for Oregon, Oregon County Data Book, 2016 and 2017

Across school districts within Jackson and Josephine counties, Butte Falls and Rogue River school districts had the highest percentages of homeless students (29.6% and 13.1%, respectively) in 2017 (***Figure 28***).

Figure 28. Percent Students (Grades K-12) who are Homeless, by School Districts, 2014-2015, 2015-2016, and 2016-2017



DATA SOURCE: Oregon Department of Education, McKinney-Vento Act, Homeless Student Data, 2014-2015, 2015-2016, and 2016-2017

Future Exploration

While collaborative discussions are occurring in the region related to affordable housing, further inquiry into supply-side barriers and strategies should be explored in both urban and rural contexts of Jackson and Josephine Counties.

Existing Assets and Resources

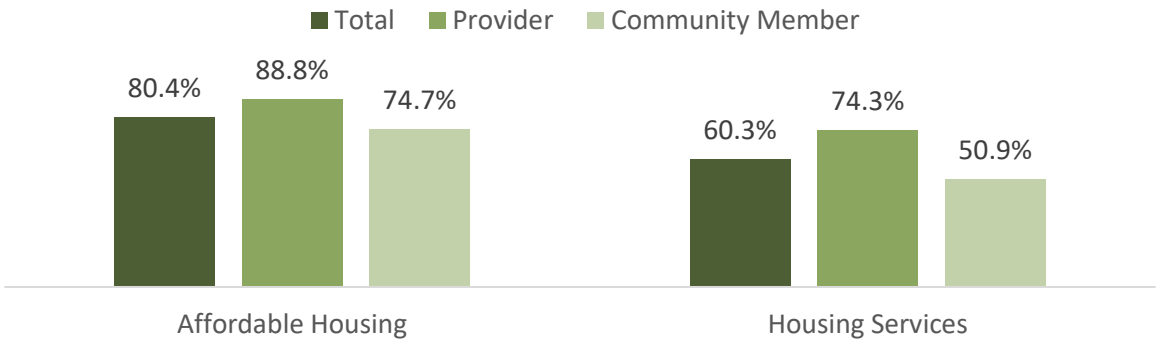
Assessment participants were asked about the assets in their communities related to housing and shared the following list of resources:

- ACCESS
- City of Grants Pass Housing Task Force
- Hearts with a Mission
- Hope Village/Rogue Retreat
- Housing Authority of Jackson County
- Jackson County Continuum of Care
- Jackson County Homeless Task Force
- Josephine County Housing and Community Development Council
- Magdalene Home
- Maslow Project
- United Community Action Network (UCAN)

- NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

When asked to identify services that were lacking in the community, affordable housing (80.4%) was the most common service and housing services (60.3%) was the third most common service identified by survey respondents, indicating that existing services are not adequate to meet community needs (***Figure 29***). Looking at these data by income, middle-income households (making $50,000-$74,999) were most likely to view affordable housing services as lacking (66.8%).

Figure 29. Percent Survey Respondents Reported Affordable Housing and Housing Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Housing Services was worded in the survey as "Housing services (including services for the homeless or housing insecure)

Mental Health and Wellbeing

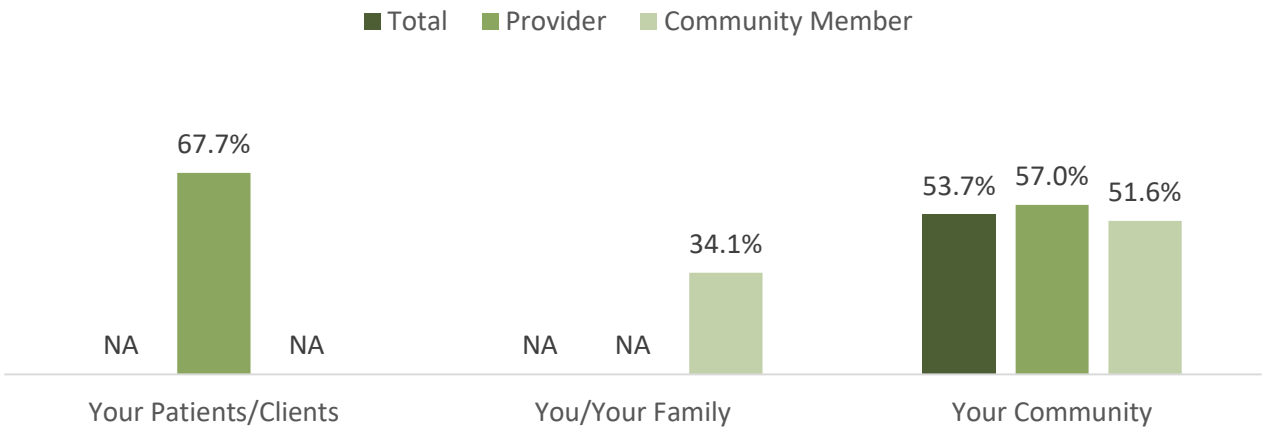
Importance and connection to other health issues

Mental health is essential to overall well-being and is closely connected to physical health. Mental health issues, such as anxiety and depression, can arise from genetic factors and/or from a number of individual and societal factors – incidence of trauma, poor nutrition and poverty. [23] Mental illness affects people's ability participate in health-promoting behaviors, and thus affects their ability to maintain good physical health. Substance use and mental health go hand in hand, as addiction to substances is a form of mental illness. The relationship between mental health and physical health is bidirectional. Issues with physical health, such as chronic diseases, can have serious impacts on mental health and decrease a person's ability to participate in treatment and recovery.[24] Mental illness can also impact other areas of life including attending and focusing at school, obtaining and maintaining a job, finding and keeping housing, and having relationships with friends and family.[25] The complexity of mental health, and its interconnectedness with other priority health issues, necessitates multi-faceted approaches to addressing this issue.

Key Findings

Over half of overall survey respondents selected mental health and stress as a top health issue impacting their community, compared to 67.7% of providers reporting mental health and stress as an issue impacting their patients/clients (***Figure 30***). Women were more likely than men to report mental health and stress as a top health issue.

Figure 30. Percent Survey Respondents Reported Mental Health and Stress as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018



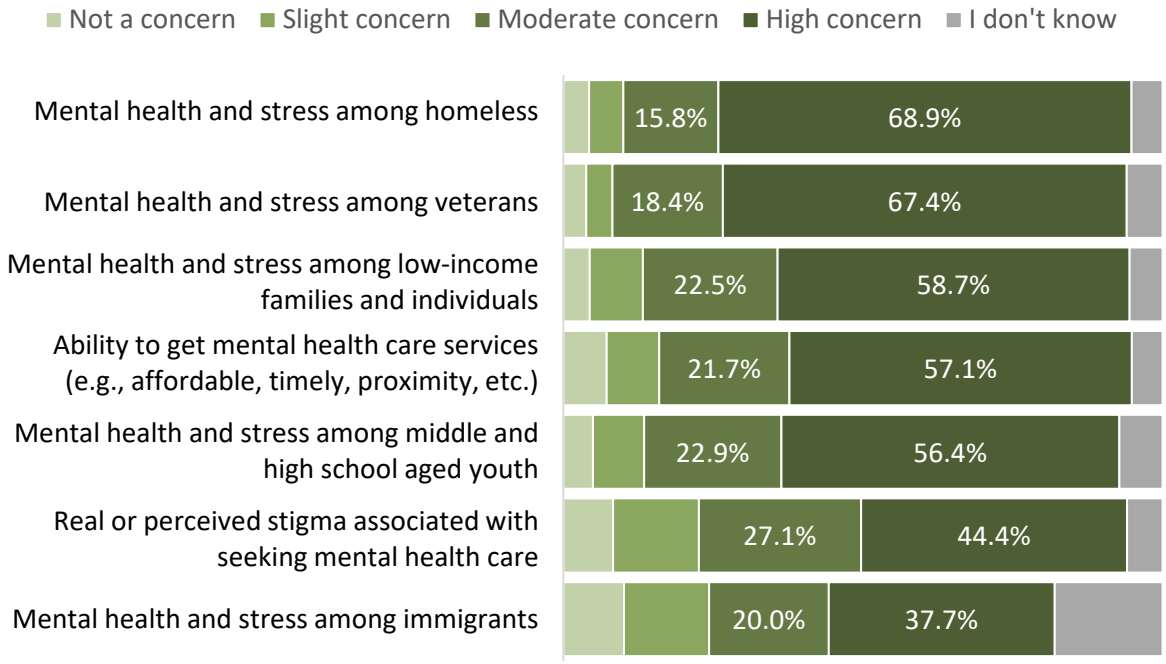
DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

[23] Tulchinsky TH, et al. Editorial: Mental Health as a Public Health Issue. Public Health Reviews. 2012; 34, 2.
[24] Lando J, Marshall Williams S, Sturgis S, et al. A logic model for the integration of mental health into chronic disease prevention and health promotion. Prev Chronic Dis. 2006 April; 3(2):A61.
[25] Mental health and mental disorders. Healthy People 2020. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed on: October 30, 2018

"If you were born here and live here and you want to grow up into something, you can't. There's nothing here. There's no hope."

The community survey also asked respondents about specific mental health issues and populations. Approximately 70% of overall survey respondents reported that mental health and stress among homeless (68.9%) and among veterans (67.4%) were of high concern (***Figure 31***). Further, 51.9% of Hispanic/Latino respondents indicated that mental health and stress among immigrants was a high concern compared to 37.7% of the overall survey sample.

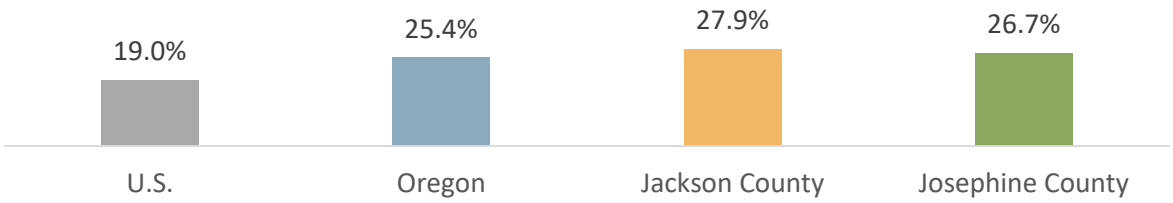
Figure 31. Survey Respondents Perceived Level of Concern for Issues Related to Mental Health and Stress, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Data are organized in descending order by "high concern"

Mental health was one of the two most frequently mentioned health issues among focus group and interview participants. Depression and anxiety were noted as prevalent across the lifespan. For working age adults, mental health was discussed in the context of experiencing stress related to high cost of living and raising a family. Social isolation was the most commonly cited stressor for seniors. Compared to the U.S., adults were more likely to report a depression diagnosis in Jackson County (27.9%), Josephine County (26.7%), and Oregon (25.4%) (**Figure *32***).

Figure 32. Age-Adjusted Percent Adults Reported Depression Diagnosis, by U.S., State, and County, 2012-2015



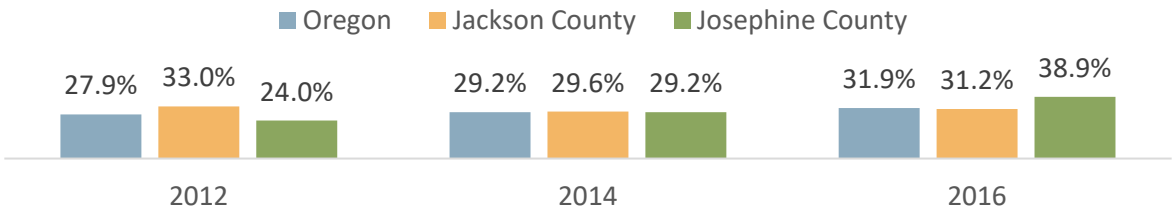
DATA SOURCE: (for U.S. data) Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, Prevalence Data and Analysis Tools, BRFSS Prevalence & Trends Data, 2015; (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Data for U.S. are crude percentages

Mental health of youth was especially concerning to assessment participants, who noted that trauma at home and peer pressure were primary issues facing youth. Female survey respondents in particular viewed mental health and stress among youth to be of high concern.

"Mental health among kids is a real concern. Kids are mean to each other. The amount of cruelty, bullying, violence. I see it consistently."

As seen in ***Figure 33***, in 2016, a higher proportion of 11th grade students in Josephine County reported signs of depression (38.9%) compared to 11th grade students in Oregon as a whole (31.9%) and Jackson County (31.2%). Josephine County 11th grade students experienced a marked increase in signs of depression over time between 2012 and 2016.

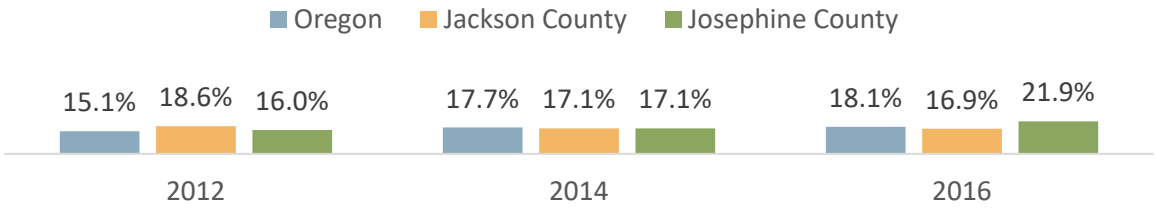
Figure 33. Percent 11th Grade Students Reported Signs of Depression, by State and County, 2012, 2014, and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: Signs of depression is defined as "felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities"

Many mental illnesses can lead to an increased risk of suicide. In 2016, 11th grade students in Josephine County were more likely to report seriously considering attempting suicide (21.9%), compared to 18.1% in Oregon and 16.9% in Jackson County (***Figure 34***).

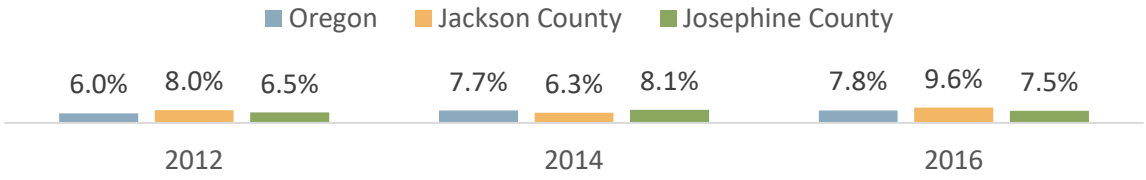
Figure 34. Percent 11th Grade Students Reported Seriously Considering Attempting Suicide, by State and County, 2012, 2014, and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

Approximately one in ten 11th grade students in Jackson County (9.6%) reported to have attempted suicide, which was more than 11th grade students in Oregon (7.8%) and Josephine County (7.5%) (***Figure 35***).

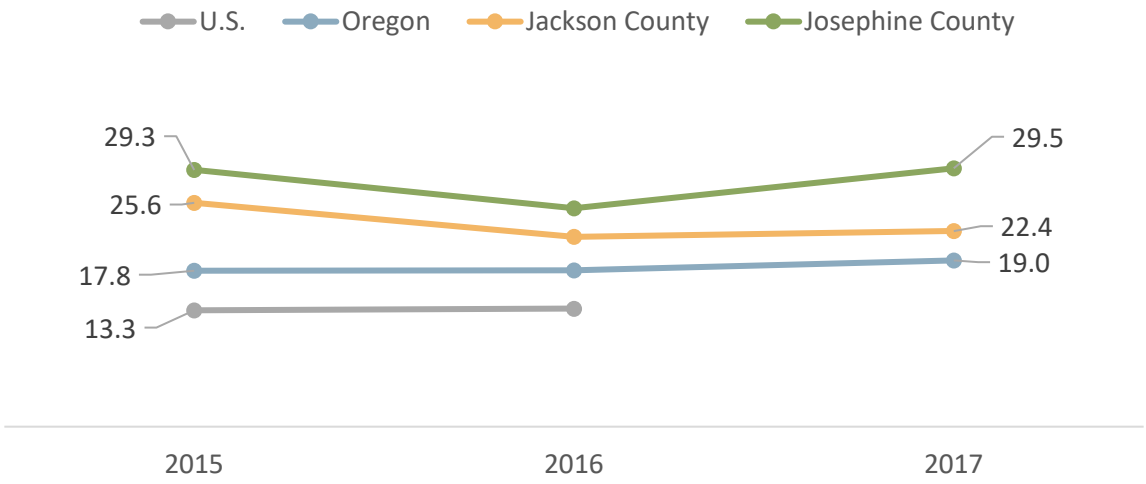
Figure 35. Percent 11th Grade Students Reported Attempting Suicide, by State and County, 2012, 2014, and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

Between 2015 and 2016, the suicide rates in Oregon, Jackson County, and Josephine County were consistently higher than that of the U.S. (***Figure 36***). In 2017, the suicide rate for Josephine County was 29.5 deaths per 100,000 population, which was higher than that for Jackson County (22.4 deaths per 100,000 population) and Oregon (19.0 deaths per 100,000 population).

Figure 36. Age-Adjusted Suicide Rate per 100,000 Population, by U.S, State, and County, 2015-2017



DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017
NOTE: 2017 data not publicly available for the U.S.

Future exploration

Mental health can be difficult to address due to the lack of availability of mental health services, specifically integrated behavioral health services, as well as the stigma attached to mental illness. These issues around access are relevant at both individual and institutional levels. As noted, quantitative data on the prevalence of mental illness is limited. Further inquiry is needed to explore and describe the extent of mental illness among youth and adults in general, as well as specific subpopulations such as LGBTQ. Also, given the other priorities highlighted in this report, additional data correlating mental health with these issues could help focus future strategic action.

Existing assets and resources

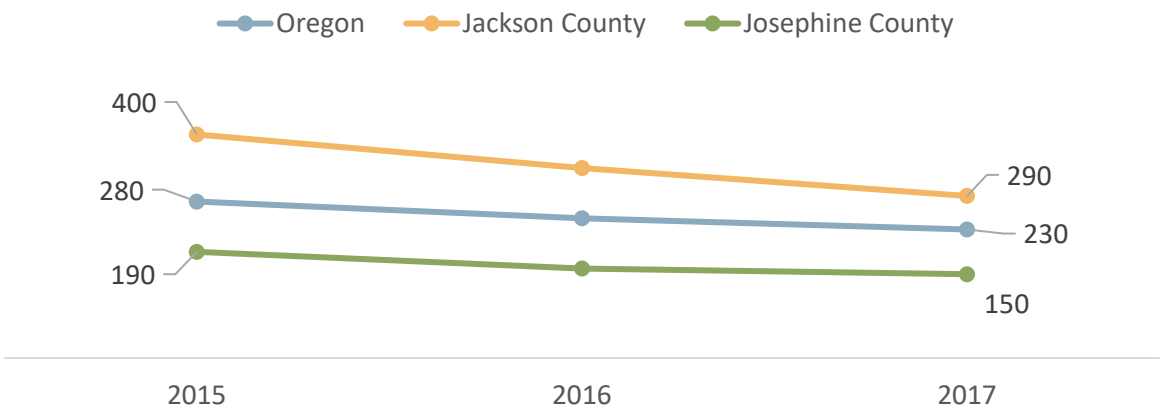
Assessment participants were asked about the assets in their communities related to mental health and shared the following list of resources:

- Adapt
- Addictions Recovery Center
- Asante Rogue Regional Medical Center Behavioral Health Services
- ColumbiaCare Services
- Compass House
- Crisis Resolution Center
- Family Solutions
- Hope Village
- Integrative Health Center at Rogue Community Health
- Jackson County Health & Human Services Crisis Hotline
- Jackson County Mental Health
- Kairos
- La Clinica
- Options for Southern Oregon
- Rogue Community Health
- Rogue Retreat
- Southern Oregon Veterans Rehabilitation Center & Clinics

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

The ratio of the population to one mental health provider decreased between 2015 and 2017 across Oregon and Jackson and Josephine counties (***Figure 37***), indicating an increase in availability of mental health providers. In 2017, the ratio was greatest for Jackson County (signifying higher need), with 290 people to one mental health provider, compared to Oregon and Josephine County.

Figure 37. Ratio of Population to One Mental Health Provider, by State and County, 2015-2017



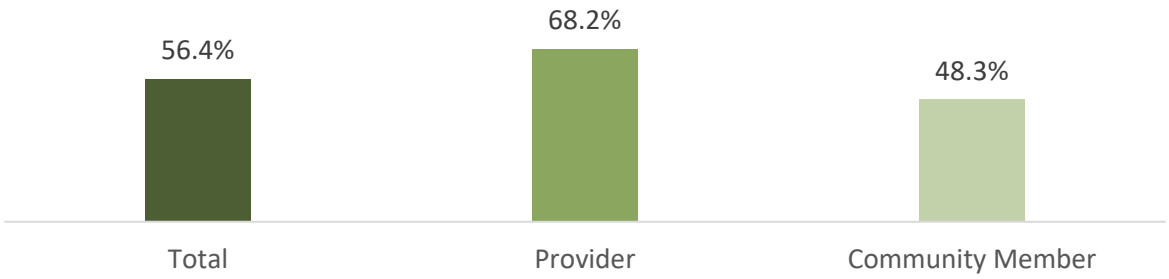
DATA SOURCE: Centers for Medicare and Medicaid Services, National Provider Identification Registry, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2015-2017

However, the limited availability of mental health providers as well as the stigma associated with seeking care were highlighted as barriers to addressing mental health in the region.

"Mental health services are hard to come by. There are huge stigmas around services."

While focus group and interview participants mentioned several resources related to mental health, approximately 56.4% of overall survey respondents selected mental health care services as currently lacking in the community (***Figure 38***), with notable disparities by gender (46.7% of men compared to 59.9% of women) and income (64.7% of households making $50,000-$74,999). Providers were more likely to report mental health care services as currently missing in the community, when compared to overall survey respondents and community members. Assessment participants specifically highlighted the limited services for youth.

Figure 38. Percent Survey Respondents Reported Mental Health Care Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Poverty and Employment

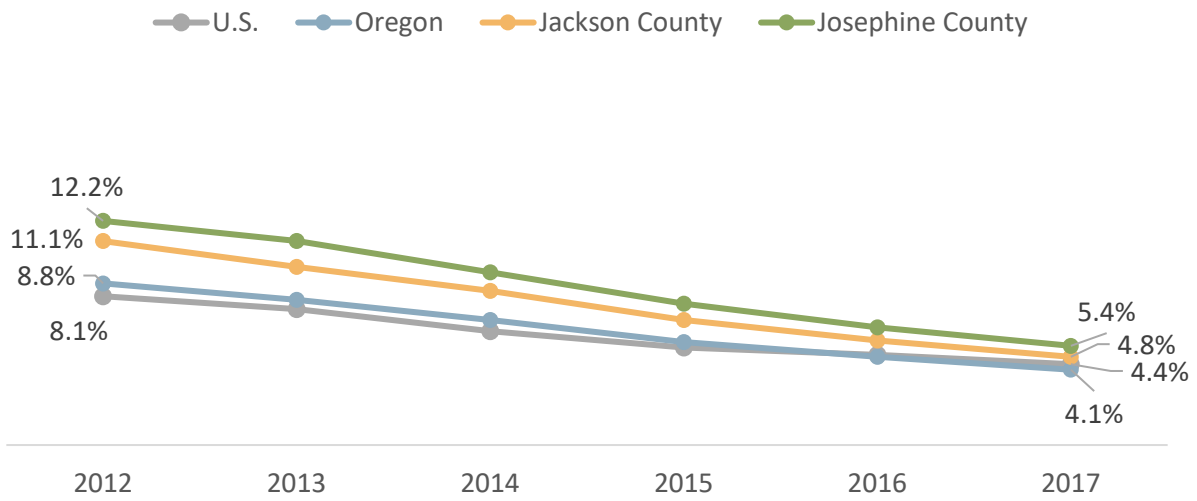
Importance and connection to other health issues

Poverty and unemployment are linked to health[26] – an individual's employment and income level directly impacts their ability to afford access to health care, healthy food, and housing, all of which influence myriad health outcomes. For individuals that are employed, it is more than just having a job that affects health. The number of hours they work, and the wage they earn impacts the level of economic stability that their job affords. This is especially relevant for individuals who find themselves part of the working poor, individuals who meet the definition of being in the labor force but their income level falls below the poverty line.[27] Individuals who are unemployed or underemployed experience higher rates of depression, stress and stress-related conditions, such as stroke, heart attack, heart disease, arthritis.[28]

Key Findings

While the unemployment rate has been steadily decreasing between 2012 and 2017, in 2017 Jackson and Josephine Counties had a slightly higher percentage of the population unemployed (4.8% and 5.4%, respectively) compared to Oregon overall (4.1%) and the U.S. (4.4%) (***Figure 39***).

Figure 39. Trend in Unemployment Rate, by U.S., State, and County, 2012-2017



DATA SOURCE: for U.S. data, U.S. Bureau of Labor Statistics, Current Population Survey, 2012-2017 and for state and county data, U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2017
NOTE: Rates shown are a percentage of the labor force; data refer to place of residence.

According to the American Community Survey, lower percentages of the working age population (16-64 years old) worked full-time in Josephine County (42.6%) and Jackson County (50.3%) compared to Oregon (54.4%) (***Figure 40***). Additionally, over one-third (34.7%) of Josephine County community members aged 16-64 years did not work compared to 25.8% in Jackson County and 23.8% in Oregon.

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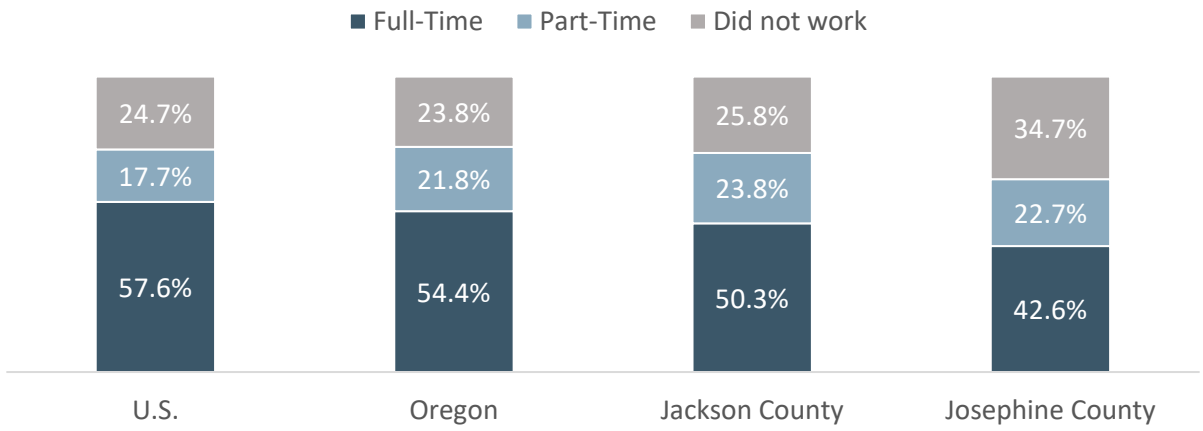
[26] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic disparities in health in the United States: What the patterns tell us. American Journal of Public Health. 2010; 100: S186-S196.
[27] Bureau of Labor Statistics. A profile of the working poor, 2016. BLS Reports. Available at: https://www.bls.gov/opub/reports/working-poor/2016/home.htm Accessed on: October 30, 2018.
[28] Robert Wood Johnson Foundation. How Does Employment – or Unemployment – Affect Health? Health Policy Snapshot Issue Brief. Available at: https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360 Accessed: October 30, 2018.

Figure 40. Percent Individuals (16-64 years) by Work Status, by U.S., State, and County, 2012-2016



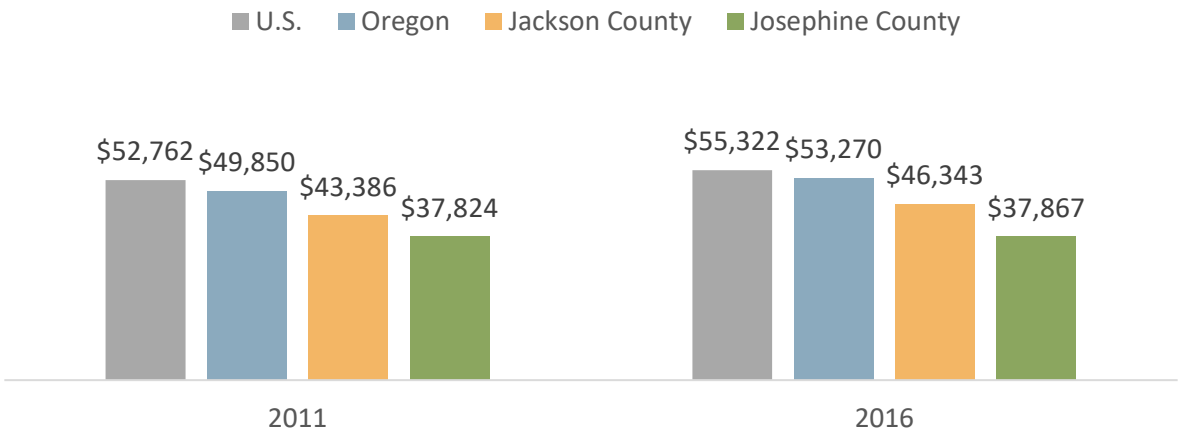
DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTES: The respondent was to report the number of hours worked per week in the majority of the weeks he or she worked in the past 12 months. If the hours worked per week varied considerably during the past 12 months, the respondent was asked to report an approximate average of the hours worked per week. People 16 years old and over who reported that they usually worked 35 or more hours each week during the weeks they worked are classified as "Usually worked full time"; people who reported that they usually worked 1 to 34 hours are classified as "Usually worked part time."

Despite relatively low unemployment, assessment participants indicated that it is a challenge for community members to make a living in the area, given the limited jobs available and the low pay for those opportunities that do exist.

"Young people here who are beginning their work life or family life… they're distressed because there are not enough jobs with sufficient pay."

Household income is an economic measure that is most commonly applied to one household and aggregated across cities, counties or the whole country. It is frequently used to describe a household's economic status. Based on 2012-2016 American Community Survey 5-year estimates, the median household income for Josephine County ($37,867) and Jackson County ($46,343) were lower compared to Oregon ($53,270) (***Figure 41***).

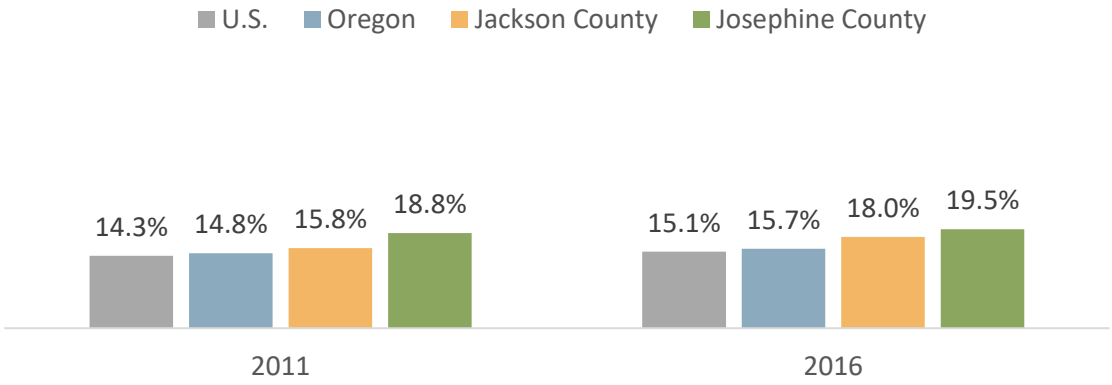
Figure 41. Median Household Income, by U.S., State, and County, 2007-2011 and 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

The most common measure of poverty in the U.S. is the poverty "threshold" set by the U.S. government. This measure uses a set of dollar value thresholds that vary by family size and composition to determine who is in poverty. Based on 2012-2016 American Community Survey 5-year estimates, higher proportions of individuals living below the federal poverty level were reported for Josephine (19.5%) and Jackson (18.0%) counties than Oregon overall (15.7%) (***Figure 42***).

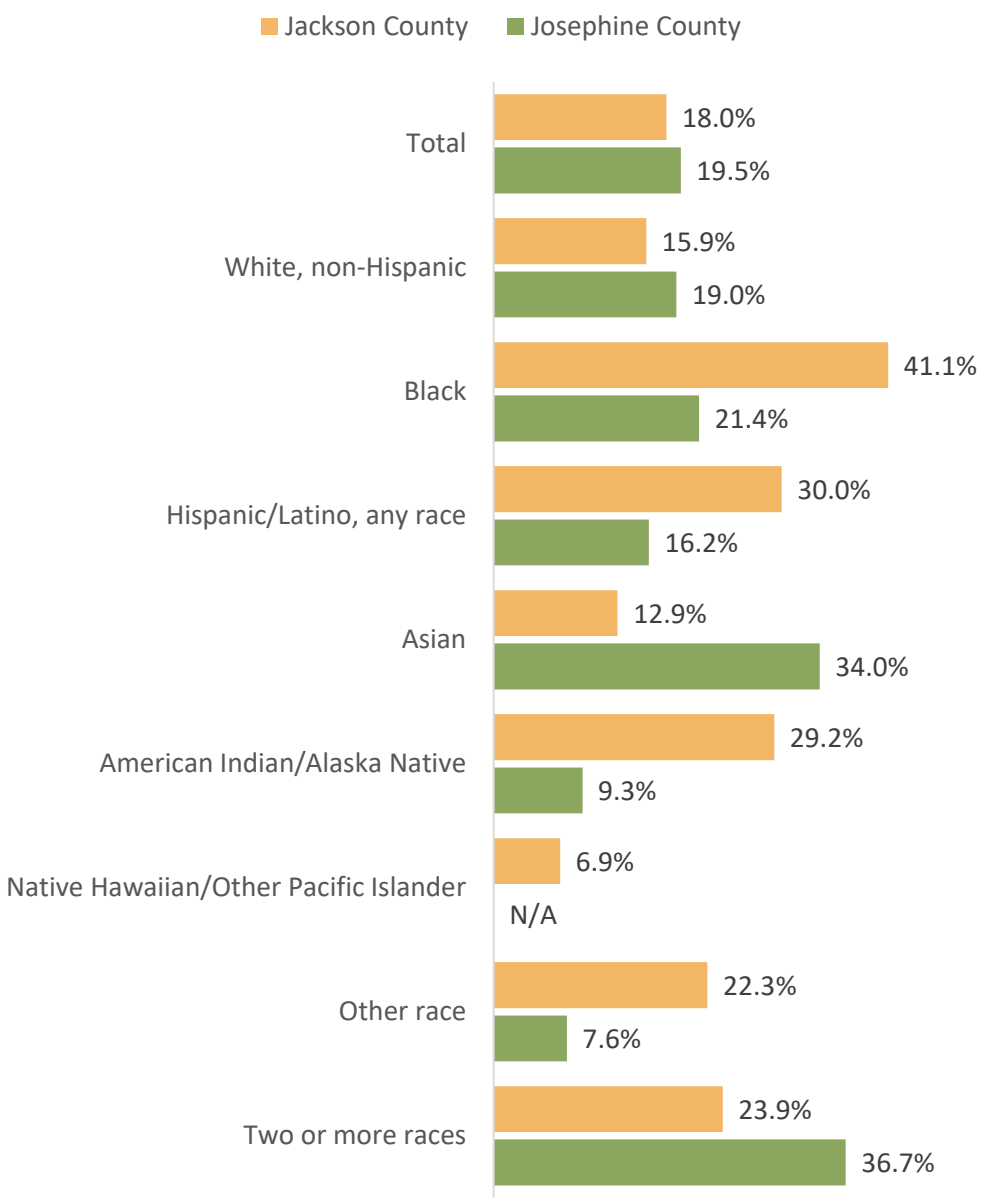
Figure 42. Percent Individuals Living Below Poverty Level, by U.S., State, and County, 2007-2011 and 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Examining poverty data by race/ethnicity, in general people of color experience higher rates of poverty in comparison to people who identify as White, non-Hispanic. In particular, people in Jackson County who identify as Black, Hispanic, or American Indian/Alaskan Native and people in Josephine County who identify as Asian or two or more races are more likely to experience poverty (***Figure 43***).

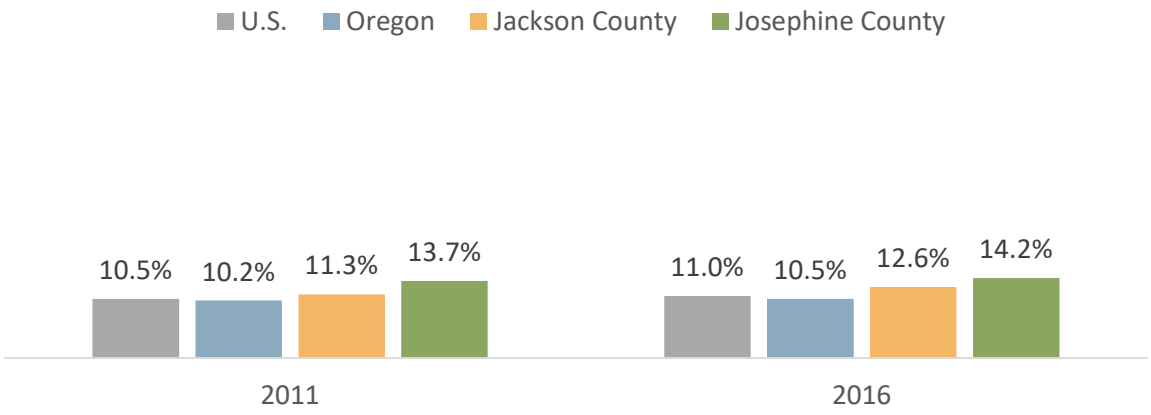
Figure 43. Percent Individuals Living Below Poverty Level, by Race/Ethnicity, by State and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: N/A denotes percentage not calculated due to small numbers

Similarly, higher proportions of families were living below the poverty level in Josephine County (14.2%) in 2016 (***Figure 44***) than in Jackson County or Oregon. The percentages of families living below the poverty level slightly increased across all geographies between 2011 and 2016.

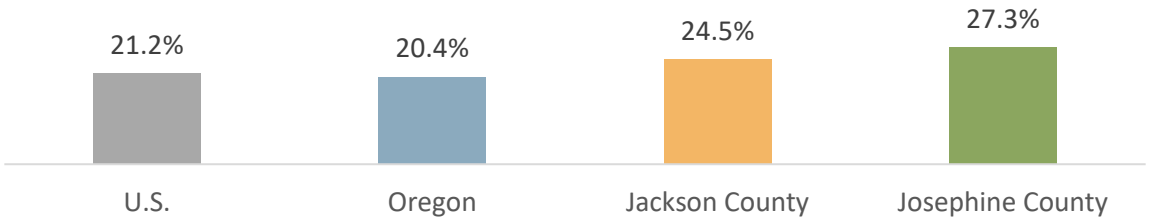
Figure 44. Percent Families Living Below Poverty Level, by U.S., State, and County, 2007-2011 and 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Poverty is particularly detrimental to young people. There were higher proportions of children under 18 years old living below the poverty level in Josephine (27.3%) and Jackson (24.5%) counties than Oregon (20.4%), based on 2012-2016 American Community Survey 5-year estimates (***Figure 45***).

Figure 45. Percent Individuals Under 18 Years Living Below Poverty Level, by U.S., State, and County, 2012-2016

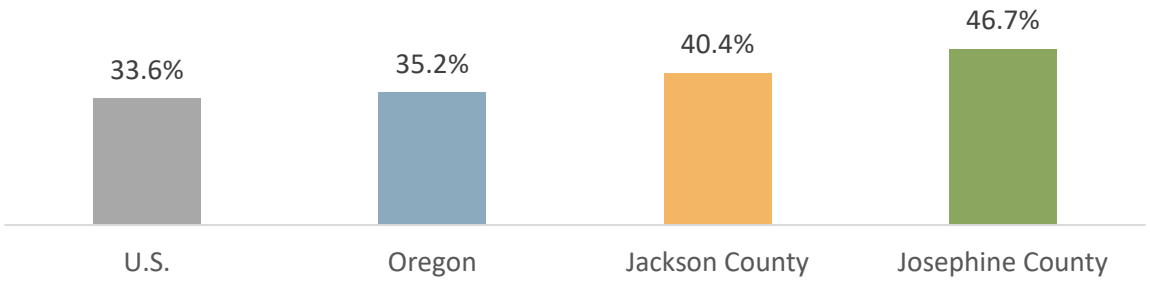


DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Additionally, a slightly higher proportion of individuals aged 65 years and over were living below the poverty level in Josephine County (9.3%), compared to Jackson County (8.1%) and Oregon (8.1%).

Many federal, state, and local programs use the federal poverty guidelines to determine eligibility for services such as Head Start, Supplemental Nutrition Assistance Program (SNAP), the Low-Income Home Energy Assistance Program, and the Children's Health Insurance Program. Greater than 40% of the region's community members – more than 100,000 people – were living below 200% of the poverty level (46.7% in Josephine County; 40.4% in Jackson County), which was greater than in Oregon (35.2%) and the U.S. (33.6%) (***Figure 46***).

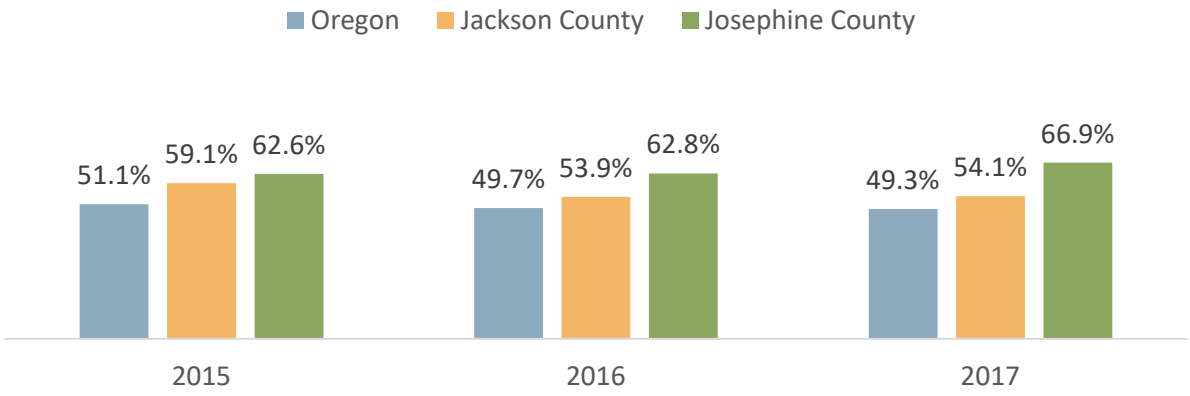
Figure 46. Percent Individuals Living Below 200% of Poverty Level, by U.S., State, and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

The National School Lunch Program is a federally-assisted meal program operating in public and private, nonprofit schools and residential child care; eligibility for this program is also based on the federal poverty guidelines. In 2017, about two-thirds of students in Josephine County were eligible for free and reduced lunch (66.9%), which was higher than the percentage of students eligible in 2015 and 2016 (***Figure 47***). There were lower proportions of students eligible for free and reduced lunch in Jackson County and Oregon overall.

Figure 47. Percent Students Eligible for Free and Reduced Lunch, by State and County, 2014-2015, 2015-2016, and 2016-2017

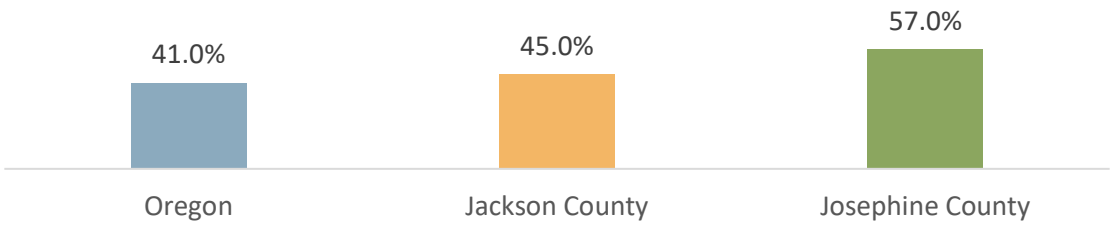


DATA SOURCE: Oregon Department of Education, as reported by Children First for Oregon, Oregon County Data Book, 2016 and 2017

Traditional measures of poverty described above do not fully capture the magnitude of people who are struggling financially. The United Way in a number of states, including Oregon, created the ALICE (Asset Limited, Income Constrained, Employed) Project, which uses standardized measurements to calculate the cost of a basic household budget and to quantify the number of households that cannot afford that budget.[29] According to the United Way report on ALICE, 38% of the population in Josephine County is ALICE compared to 30% in Jackson County. Combined with data on the federal poverty level, over half (57%) of Josephine County community members and 45% of Jackson County community members fall below the ALICE threshold (***Figure 48***).

[29] United Way ALICE Project. Available at: https://www.unitedwayalice.org/home. Accessed on: November 6, 2018

Figure 48. Percent Households Below Asset Limited, Income Constrained, Employed (ALICE) Threshold, by State and County, 2016



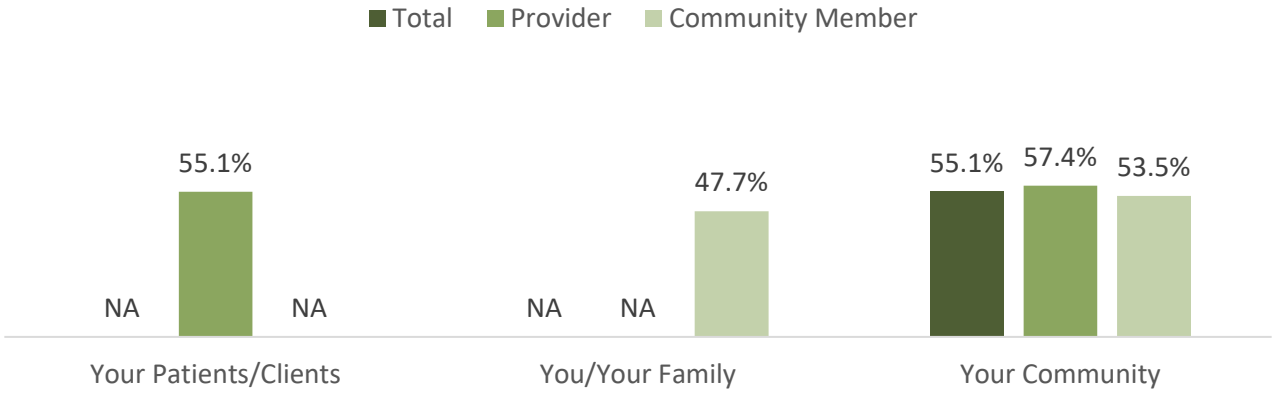
DATA SOURCE: The United Way ALICE Project, Research Center, ALICE: A Study of Financial Hardship in Oregon 2018 Report, County Pages, 2016 (data)

Qualitative data reinforce the statistics above. Assessment participants spoke about the difficulty individuals and families face in breaking out of the cycle of poverty given the low-paying jobs and high cost of living.

"There's intergenerational poverty. There are 80 year olds without running water, and also young families. It's hard to shift because there's no economic base. There is no ability to move up."

Approximately half of survey respondents overall indicated that cost of living is a primary issue facing them (55.1% of providers, 47.7% of community members) and their community (55.1% overall) (***Figure 49***). Communities of color and low-income households are disproportionately impacted by the high cost of living in the region. Among survey respondents who identify as non-White, 69.0% reported cost of living as a primary concern for themselves/their family as did 60.6% of households with income less than $25,000.

Figure 49. Percent Survey Respondents Reported Cost of Living as a Top Health Issue Having the Largest Impact on You/Your Family* and Your Community, by Respondent Type, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTES: Asterisk denotes "You/Your Family" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated or applicable due to the difference in wording in the survey versions

The effects of poverty and under/unemployment are far-reaching. Focus group and interview participants shared that the regional economic environment hinders community members' ability to pay for housing, food, transportation, and medications. Slightly under half of survey respondents overall (46.8%) reported that cost of

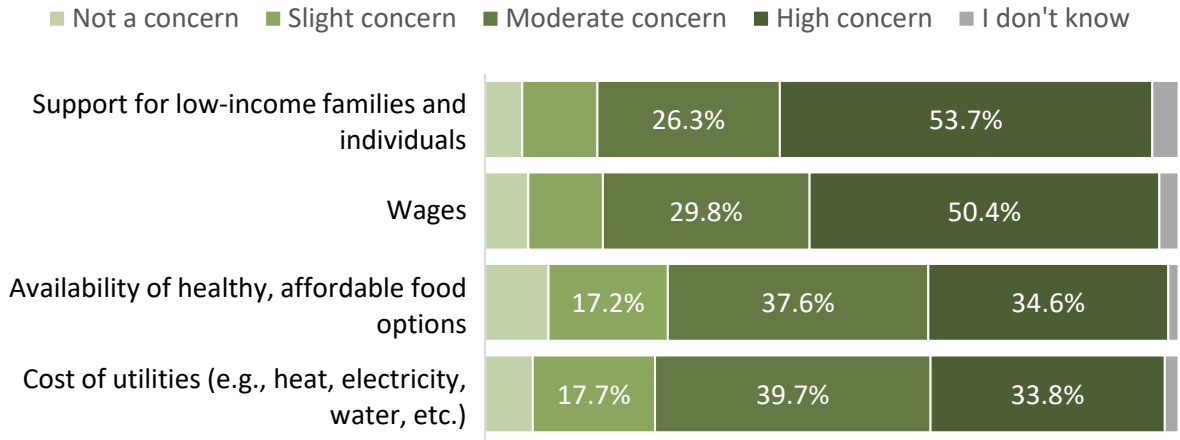
care/co-pays was an issue that made it more difficult for them or their patients to receive health or social services they needed (***Figure 50***). Examining these data by race and ethnicity, survey respondents who identified as Hispanic/Latino were more likely to report that cost of care/co-pays were an issue (63.6%). Women were also more likely to report cost of care/co-pays as a barrier (51.0% of women compared to 37.9% of men) as were households making $25,000-$49,999 (58.5%) compared to those making less than $25,000 (33.3%).

Figure 50. Percent Survey Respondents Reported Cost of Care/Co-Pays as an Issue that Made It More Difficult for You* to Get the Health or Social Services You Needed, by Respondent Type, 2018

DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Asterisk denotes "You" was worded as "Your Patients/Clients" in the survey version for providers; NA denotes the responses were not aggregated due to the difference in wording in the survey versions

Further, survey respondents shared their concerns about the implications of high cost of living on the availability of healthy, affordable foods and the cost of utilities (***Figure 51***).

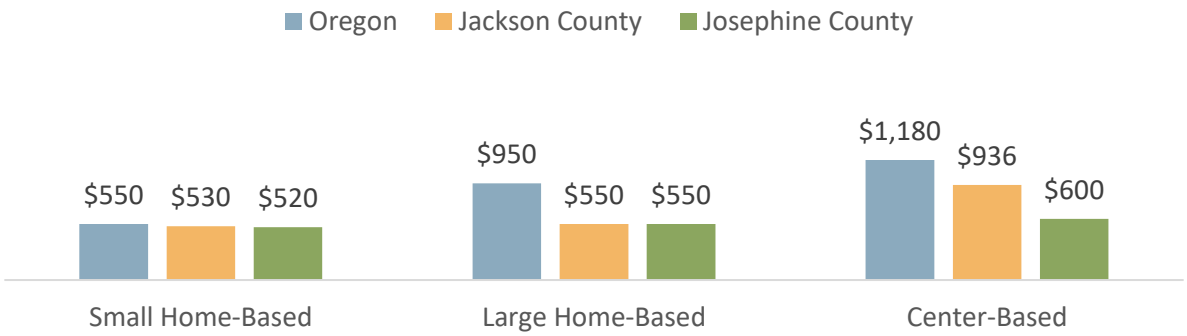
Figure 51. Survey Respondents Perceived Level of Concern for Issues Related to Cost of Living, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018
NOTE: Data are organized in descending order by "high concern"

Additionally, a lack of childcare providers and high cost of existing providers creates stress for parents and families, and places added financial burden on working parents. According to the Oregon Department of Human Services, in 2018 the median monthly cost of small home-based toddler care is $530 in Jackson County compared to $520 in Josephine County (***Figure 52***). The median monthly cost of large home-based toddler care is $550 in each county. The median monthly cost for center-based toddler care is $936 in Jackson County and $600 in Josephine County.

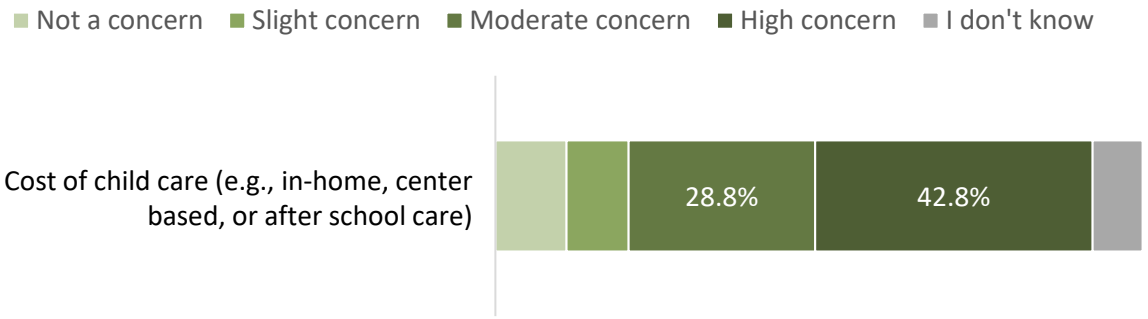
Figure 52. Median Toddler Care Monthly Rate, by Type, by State and County, 2018



DATA SOURCE: Oregon Department of Human Services; Child Care Data, Publications, Reports; Child Care Market Rate Study; 2018

Approximately 42.8% of survey respondents overall reported that cost of child care was a high concern (***Figure 53***), and non-White survey respondents were more likely (50.0%) to report cost of child care as a high concern.

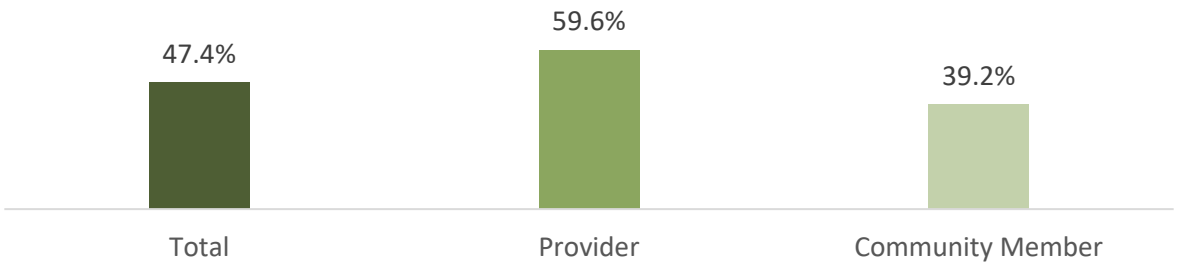
Figure 53. Survey Respondents Perceived Level of Concern for Cost of Child Care, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Slightly under half of survey respondents overall (47.4%) reported affordable child care services to be currently missing in the community, with notable disparities by gender (51.9% of women compared to 38.7% of men) (***Figure 54***).

Figure 54. Percent Survey Respondents Reported Affordable Child Care Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Future exploration

More inquiry is needed into how minimum wage increases since 2016 have affected income of different subgroups (by age, gender, race/ethnicity), as well as the impact of women leaving the workforce to raise children. Additionally, future exploration is needed regarding what specific factors cause high cost of living in an area where median income is low.

Existing assets and resources

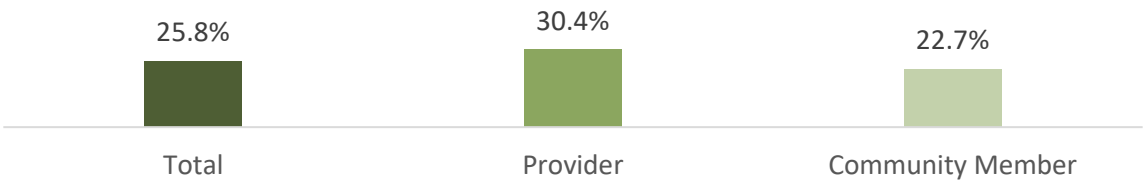
Assessment participants were asked about the assets in their communities related to income and employment and shared the following list of resources:

- ACCESS
- Ashland Resource Center
- Consumer Credit Counseling Services
- Grants Pass Blue Zones Project
- Local Food Banks
- Oregon Department of Human Services
- United Community Action Network (UCAN)
- United Way
- Women Infants and Children (WIC)

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

Although there are several resources available, approximately one quarter of survey respondents overall reported financial assistance services were currently lacking in the community (***Figure 55***). Low-income households making less than $25,000 were more likely to report financial service as lacking (35.9%).

Figure 55. Percent Survey Respondents Reported Financial Assistance Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Parenting and Life Skills

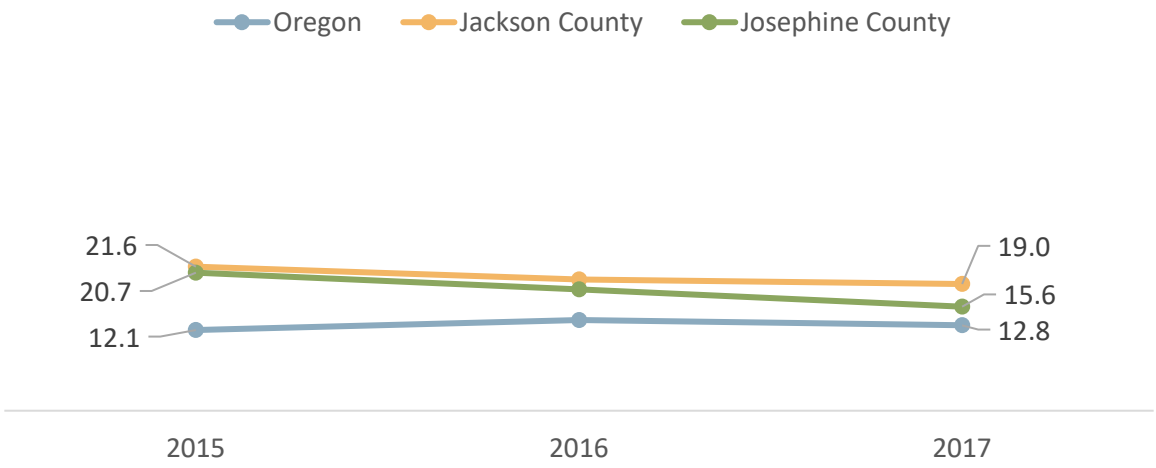
Importance and connection to other health issues

Adverse childhood experiences (ACEs) are instances of child abuse and neglect; physical abuse, sexual abuse, emotional abuse, and living with a household member experiencing substance use, mental illness, and domestic violence that are captured to create a score. The presence of these traumatic experiences has immediate impacts and also increases a child's risk for poor health outcomes as an adult – chronic disease, substance use, depression, suicide, violence and crime.[30] While there is a dose response relationship to the ACE score – the more exposure to adversity the more likely one is to experience negative health outcomes – each of the measures also independently contributes to the increased likelihood of poor health outcomes. [31] Children raised in safe and nurturing families and communities, free from maltreatment and other adverse childhood experiences, are more likely to have better outcomes as adults.[32] Parenting has significant influence on a child's development, impacting their health and well-being. Parenting is not only about preventing abuse, but also being a shield against adversity and building a child's coping and resiliency skills.[33]

Key findings

In 2017, the rate of child abuse/neglect was 19.0 per 1,000 population under 18 years of age in Jackson County, 15.6 per 1,000 population under 18 years of age in Josephine County and 12.8 per 1,000 population under 18 years of age in Oregon overall (***Figure 56)***. Josephine County shows a significant decrease between 2015 and 2017.

Figure 56. Child Abuse/Neglect Victim Rate per 1,000 Population (Under 18), by State and County, FF15-FF17



DATA SOURCE: Oregon Department of Human Services, Child Abuse and Neglect Data, Child Welfare Data Book, 2017

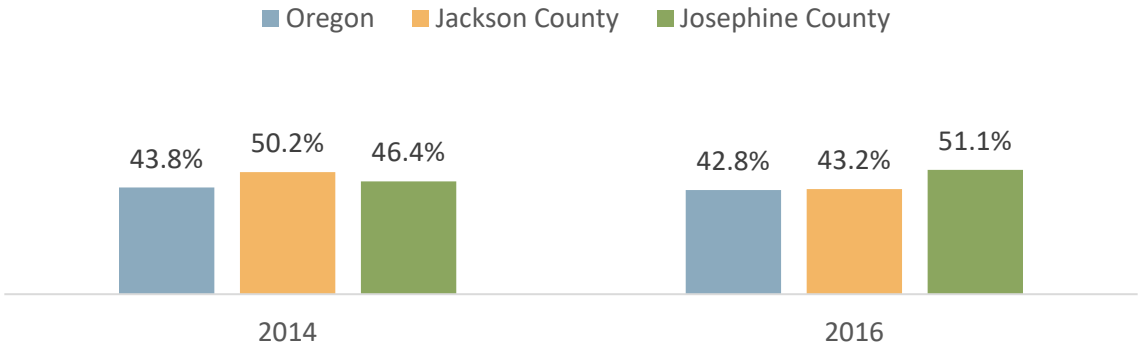
[30] Felitti VJ, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine. 1998; 14(4): 245-258.
[31] Merrick MT, et al. Unpacking the impact of adverse childhood experiences on adult mental health. Child Abuse Neglect. 2017; 69: 10-19.
[32] Anda RF, Felitti VJ, Walker J, et al. The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. Eur Arch Psychiatry Clin Neurosci. 2006 Apr;256(3):174–86.
[33] Hoghughi M. The importance of parenting in child health. British Medical Journal. 1998; 316(7144): 1545-1550.

"We're all so busy making ends meet that it takes time away from family. There are all these pressures to do more, do better, be everything. It leaves this hole in families."

While child abuse and neglect did not surface extensively in qualitative data for this assessment, quantitative data on a variety of other childhood exposures indicate that the family environment in Jackson and Josephine Counties is not always conducive to good health. When looking across indicators among 11th graders, ACEs in Josephine County appears to be increasing compared to stable or decreasing in Jackson County and Oregon overall.

In 2016, 51.1% of 11th grade students in Josephine County reported that they experienced parental divorce or separation during their lifetime, compared to 43.2% of 11th grade students in Jackson County and 42.8% of 11th grade students across Oregon (***Figure 57***).

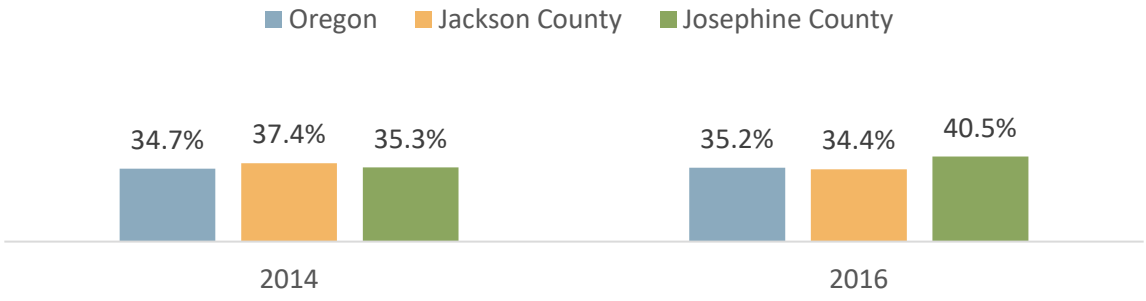
Figure 57. Percent 11th Grade Students Reported Parental Divorce or Separation After They Were Born, by State and County, 2014 and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

As seen in ***Figure 58***, in 2016, 40.5% of 11th grade students in Josephine County reported living with someone who was a problem drinker, compared to 34.4% of 11th grade students in Jackson County and 35.2% of 11th grade students in Oregon overall.

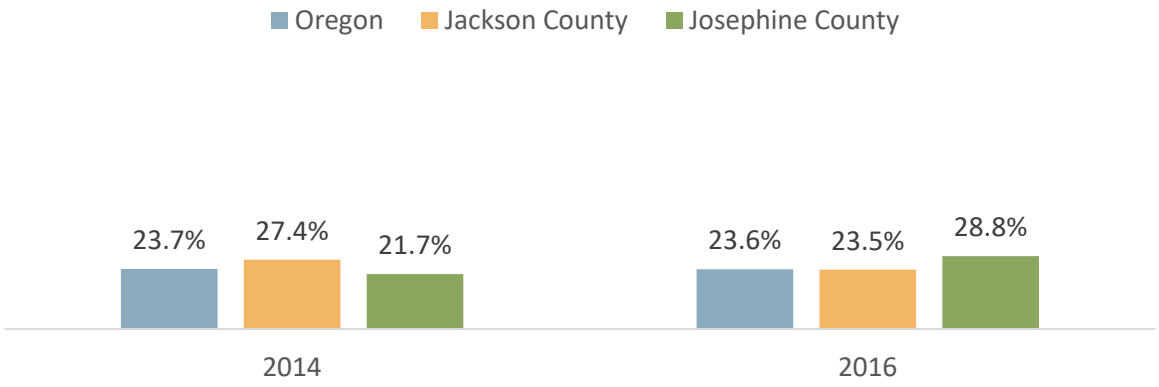
Figure 58. Percent 11th Grade Students Reported Living with Someone Who Is/Was a Problem Drinker or Alcoholic, by State and County, 2014 and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

Approximately 28.8% of Josephine County 11th grade students reported living with someone who used street drugs in 2016, compared to 23.5% of Jackson County 11th grade students and 23.6% of 11th grade students across Oregon (***Figure 59***).

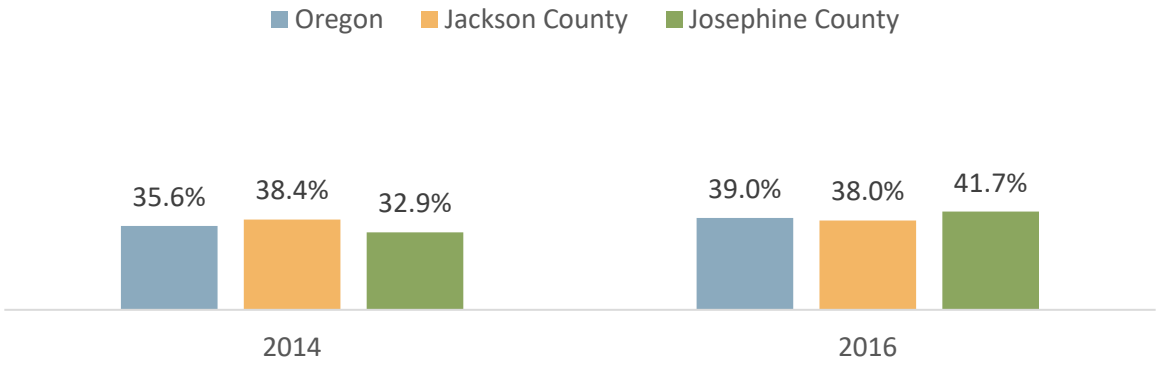
Figure 59. Percent 11th Grade Students Reported Living with Someone Who Uses/Used Street Drugs, by State and County, 2014 and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

In 2016, 41.7% of Josephine County 11th grade students reported living with someone who was depressed or mentally ill, compared to 38.0% of 11th grade students in Jackson County and 39.0% of 11th grade students across Oregon (***Figure 60***).

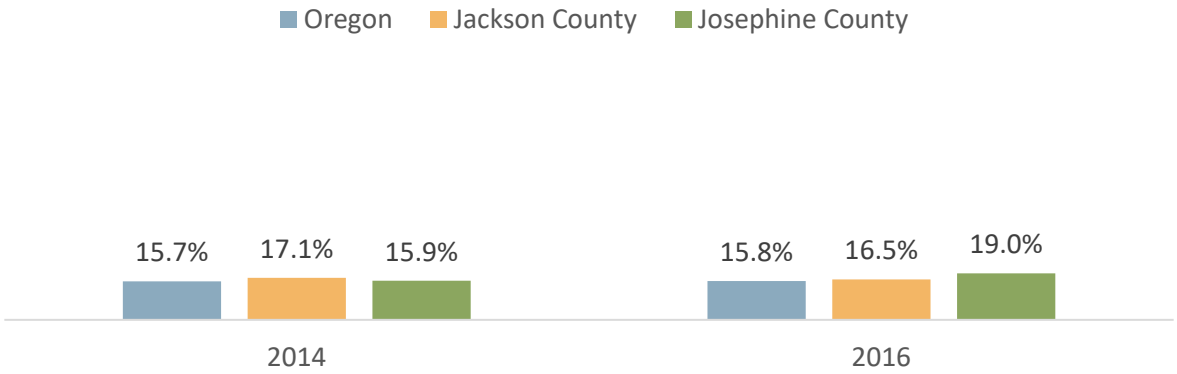
Figure 60. Percent 11th Grade Students Reported Living with a Household Member Who Is/Was Depressed or Mentally Ill, by State and County, 2014 and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

Almost one in five 11th grade students in Josephine County reported they did not have enough to eat (19.0%) in 2016, which was higher than Jackson County (16.5%) and Oregon overall (15.8%) (***Figure 61***).

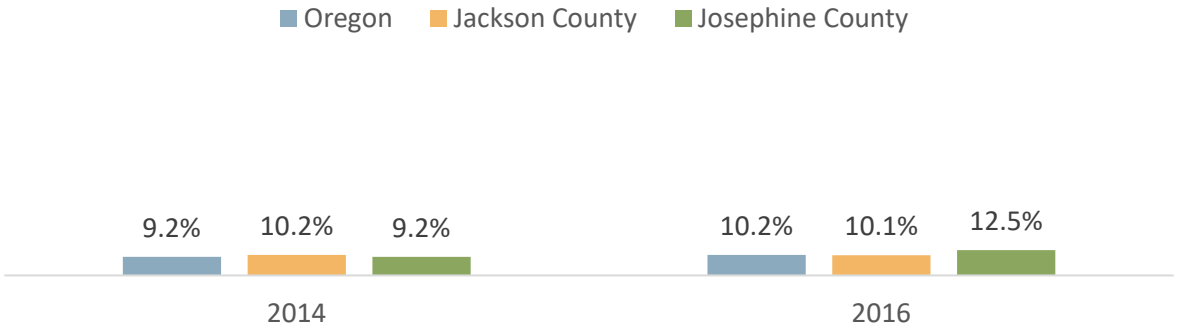
Figure 61. Percent 11th Grade Students Reported Ever Feeling They Did Not Have Enough to Eat, by State and County, 2014 and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

In 2016, 12.5% of Josephine County 11th grade students reported feeling that they had to wear dirty clothes, compared to 10.1% of Jackson County 11th grade students and 10.2% of 11th grade students across Oregon (***Figure 62***).

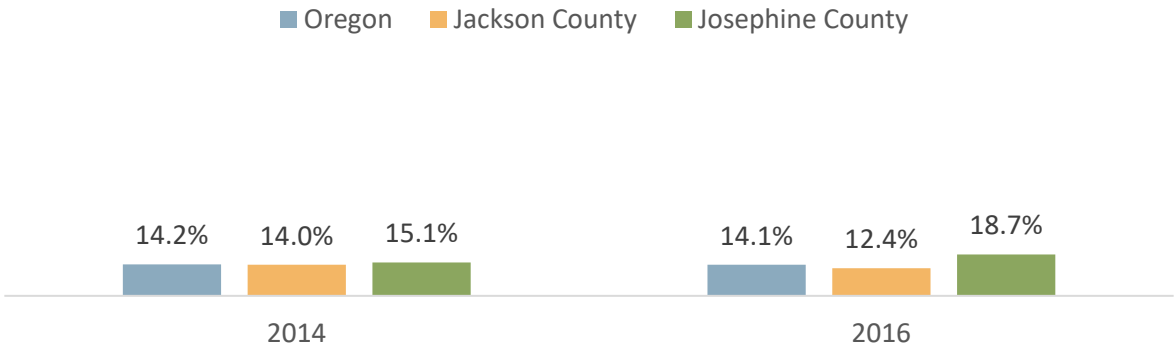
Figure 62. Percent 11th Grade Students Reported Ever Feeling They Had to Wear Dirty Clothes, by State and County, 2014 and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

In 2016, 18.7% of Josephine County 11th grade students reported feeling like they had no one to protect them, compared to 12.4% of Jackson County 11th grade students and 14.1% of 11th grade students across Oregon (***Figure 63***).

Figure 63. Percent 11th Grade Students Reported Ever Feeling They Had No One to Protect Them, by State and County, 2014 and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2014 and 2016
NOTE: Question was not asked in 2012

Focus group and interview participants broadly discussed the challenges facing parents as they raise children in Jackson and Josephine Counties, including parents' limited knowledge of and skills for parenting, and stigma associated with asking for help. Assessment participants shared the perception that parents do not have the understanding, skills, and time to devote to parenting given the demands on them to financially provide for their families. The community can play a role in stepping up to support children and families.

"I really want to give my daughter a loving home, but I don't know what that looks like."

Future exploration

Youth-adult connectedness is a key protective factor for adolescent health and can buffer against a range of risky experiences and behaviors. According to assessment participants, families in the region are not as connected with each other or their communities as would be helpful to support parents and children. Further inquiry is needed into how to best connect and support parents and ensure that children have connections to caring adults. Additionally, while late-middle and high school data are available on risk and protective factors, future explorations should include what age-specific experiences younger youth in the region are facing, and how to best build their coping skills at each age.

Existing assets and resources

Assessment participants were asked about the assets in their communities related to parenting and life skills and shared the following list of resources:

- Babies First!
- Birthright of Medford
- Boys and Girls Club
- CaCoon
- Child and Family Welfare Council
- Child Care Resource Network
- Coalition for Kids
- Early Head Start

- Family Connection
- Family Nurturing Center
- Healthy Families America
- Healthy Families programs
- Healthy Start
- Kids Unlimited
- Magdalene House
- Maternity Case Management
- Nurse Family Partnership
- Oregon Child Development Coalition
- Pregnancy Center
- Project Baby Check
- Resolve
- Rose Circle Mentoring
- Project Baby - Siskiyou Community Health Center
- Southern Oregon Early Learning Services
- Southern Oregon Education Service District
- Southern Oregon Head Start
- Southern Oregon Success
- Teresa McCormick Center
- YMCA

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

Education and Workforce Development

Importance and connection to other health issues

Education influences health outcomes at many levels – from the individual to population level. As one of the strongest predictors of health, the more education an individual has the more likely they are to live a longer and healthier life.[34] During childhood, when a child is engaged in the education system not only are they learning, but they also have access to support systems and resources that can impact health, such as breakfast and lunch programs. Research shows that there are certain levels of education that are defining points, for example increased mortality risk drops at high school graduation.[35] While education beyond high school continues to improve health outcomes, having a credential and skill set that opens the door to benefits, i.e. a job, shows the role education plays in many factors that impact health outcomes. Adults continue to be impacted by their educational attainment, as more education is associated with access to more, and better paying, job opportunities. This link between education, employment and income drives much of an individual's ability to

[34] Braveman PA, Cubbin C, Egerter S, Williams DR, Pamuk E. Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us. American Journal of Public Health. 2010; 100: S186-S196.

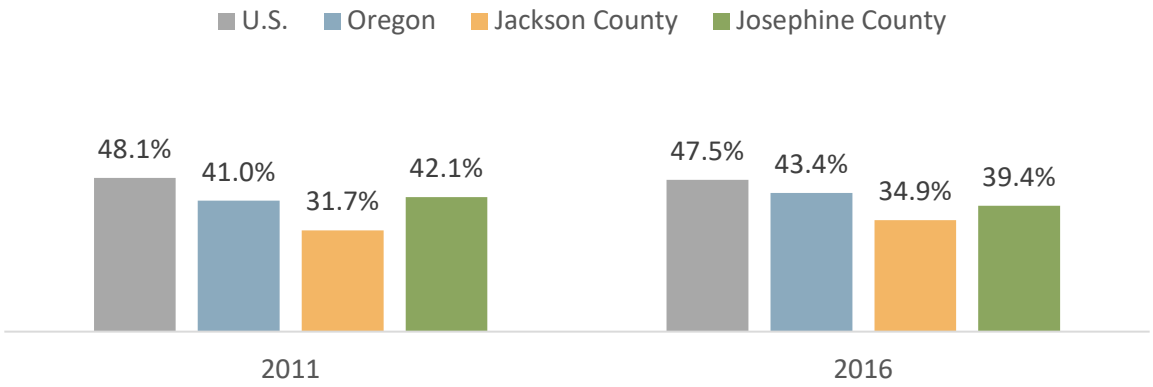
[35] Zimmerman EB, Woolf SH, and Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Health care Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html

achieve economic stability and the positive health outcomes that result from access to housing, food and health care.[36]

Key Findings

Early childhood education has immediate and long-term impacts on child development and adult health.[37] Based on 2012-2016 American Community Survey 5-year estimates, about 34.9% of children aged 3-4 years in Jackson County were enrolled in preschool, compared to 39.4% in Josephine County, 43.4% in Oregon overall, and 47.5% in the U.S. (***Figure 64***).

Figure 64. Percent Population (3 to 4 Years) Enrolled in School, by U.S., State, and County, 2005-2011 and 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2005-2011 and 2012-2016

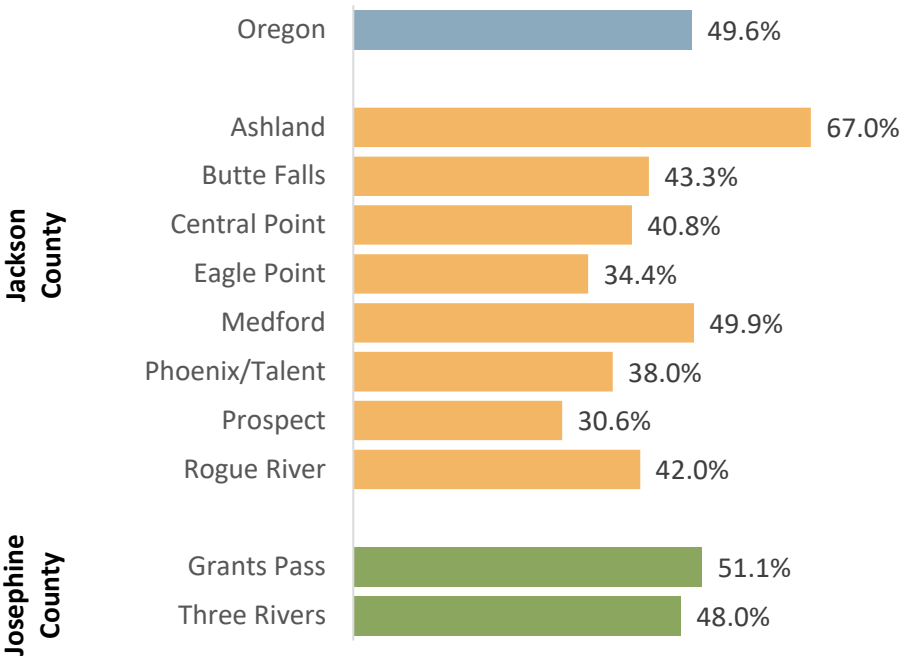
Reading proficiently by 3rd-5th grade is a critical benchmark in a child's educational development. Low achievement has important long-term consequences in terms of individual earning potential, global competitiveness, and general productivity.[38] In 2017, the percentage of students in grades 3-5 meeting English Language Arts (ELA) standards ranged from 30.6% in Prospect school district to 67.0% in Ashland school district (***Figure 65***). In 2017, 42.2% of 3rd grade students were reading at their grade level in Jackson County, compared to 45.3% in Josephine County.

[36] Zimmerman EB, Woolf SH, and Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Content last reviewed September 2015. Agency for Health care Research and Quality, Rockville, MD. http://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html

[37] D'Onise K, McDermott RA, Lynch JW. Does attendance at preschool affect adult health? A systematic review. Public Health. 2010 Sep; 124(9):500-11

[38] Early Warning! Why Reading by the End of 3rd Grade Matters. Annie E. Casey Foundation. 2010

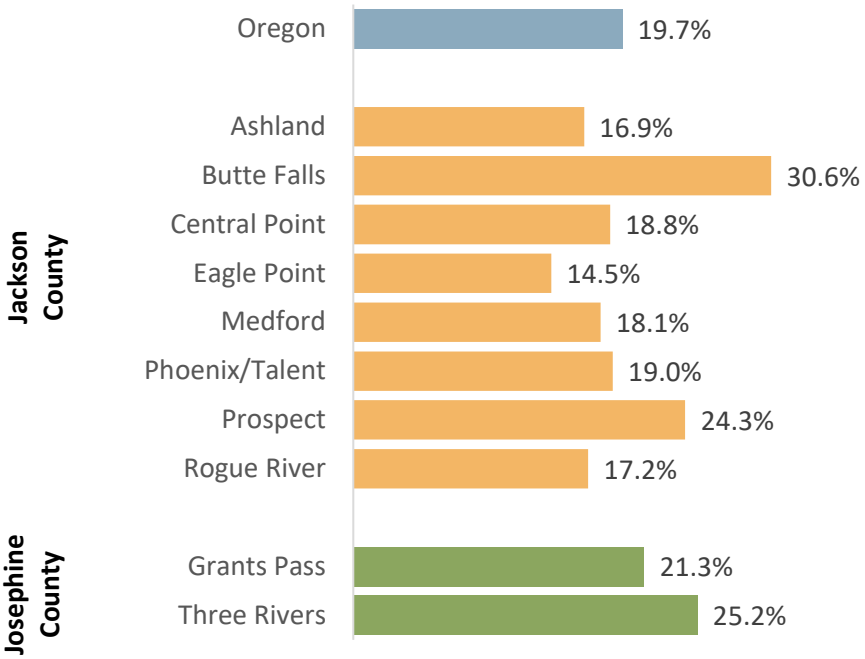
Figure 65. Percent Students (Grades 3-5) Meeting ELA Standards, by State and School District, 2016-2017



DATA SOURCE: Oregon Department of Education, School and District Report Cards, 2016-2017

Chronic absenteeism ranged from 14.5% in Eagle Point to 30.6% in Butte Falls in 2017 (***Figure 66***). These have remained consistent over the past 3 school years.

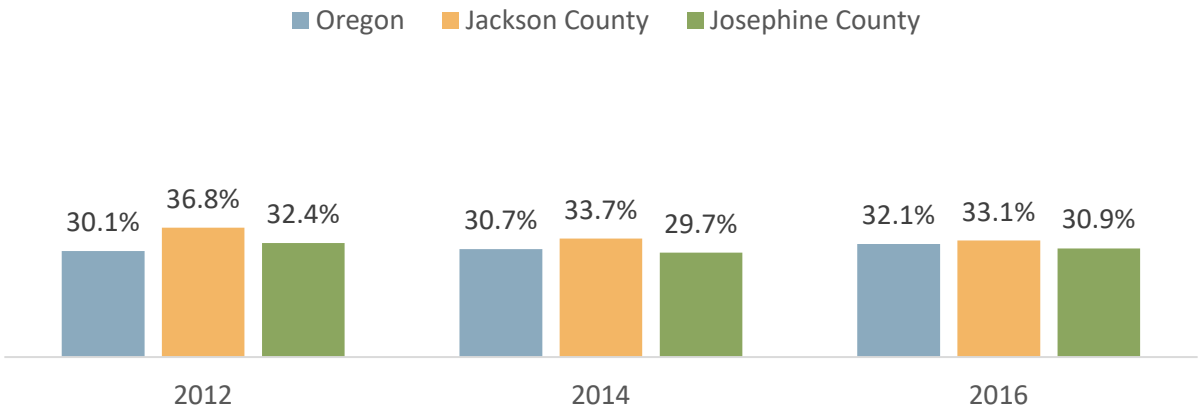
Figure 66. Percent Students Chronically Absent, by State and School District, 2016-2017



DATA SOURCE: Oregon Department of Education, School and District Report Cards, 2016-2017
NOTE: Chronically absent students are defined as students who attended 90% or fewer of their enrolled days between the start of the school year and the first weekday of May in the school year

About one third of 11th grade students in Jackson County (33.1%) reported skipping school in the past four weeks, which was consistent with 11th grade students in Josephine County (30.9%) and in Oregon (32.1%) (***Figure 67***).

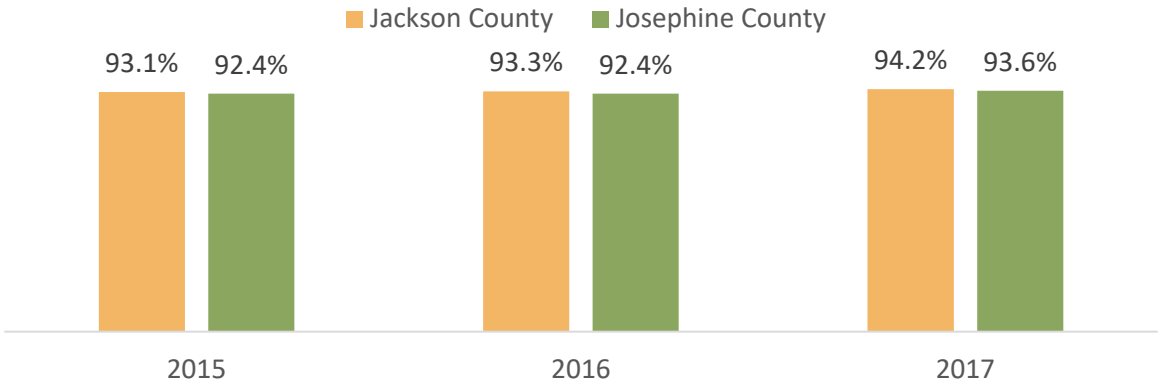
Figure 67. Percent 11th Grade Students Reported Skipping At Least One Day of School in Past Four Weeks, by State and County, 2012, 2014, and 2016



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

In 2017, 9th grade attendance was 94.2% in Jackson County and 93.6% in Josephine County, indicating an approximately 1% increase from 2016 (***Figure 68***).

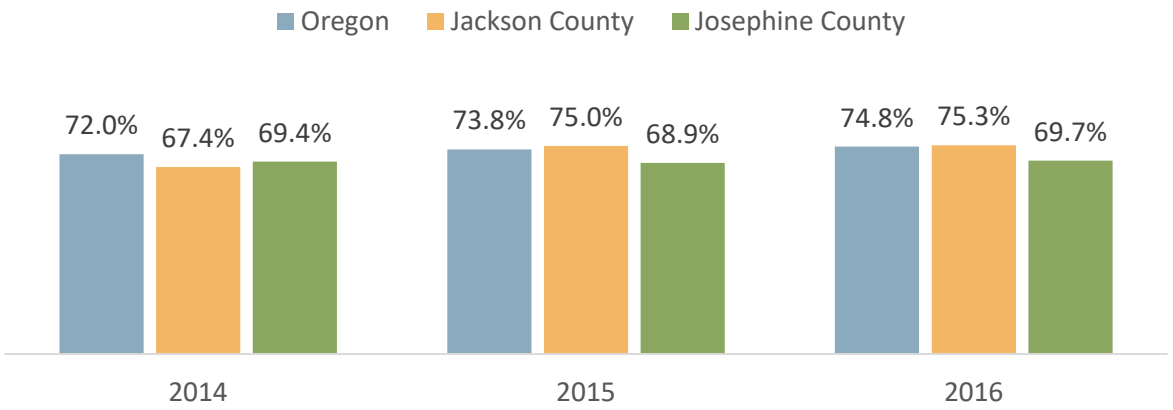
Figure 68. Percent 9th Grade Students in Attendance Each School Day in Year, by County, 2015-2017



DATA SOURCE: Southern Oregon Education Service District, Southern Oregon Success, 2015-2017

Graduation rates increased between 2014 and 2016 in Oregon, Jackson County, and Josephine County, with 74.8% of students graduating in Oregon in 2016, 75.3% in Jackson County, and 69.7% in Josephine County (***Figure 69***). The nationwide high school graduation rate was 84% in 2016.

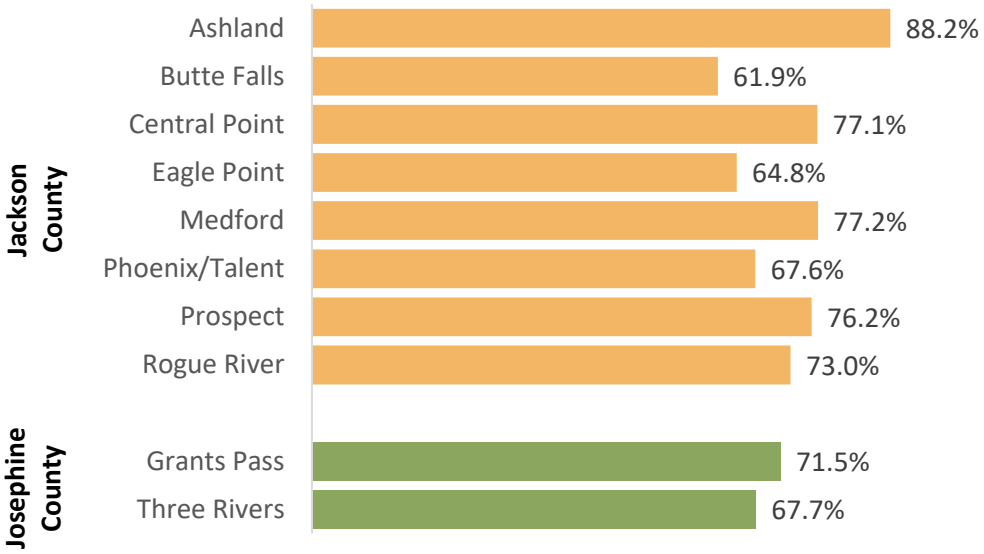
Figure 69. Graduation Rates, by State and County, 2013-2014, 2014-2015, and 2015-2016



DATA SOURCE: Oregon Department of Education, as provided by Children First for Oregon to The Annie E. Casey Foundation, Kids Count Data Center, 2013-2014, 2014-2015, and 2015-2016

High school graduation rates varied across school districts in Jackson and Josephine counties in the 2015-2016 school year. The rate was highest for Ashland school district (88.2%), which is higher than the rate for Oregon overall (74.8%), and lowest for Butte Falls school district (61.9%) (***Figure 70***).

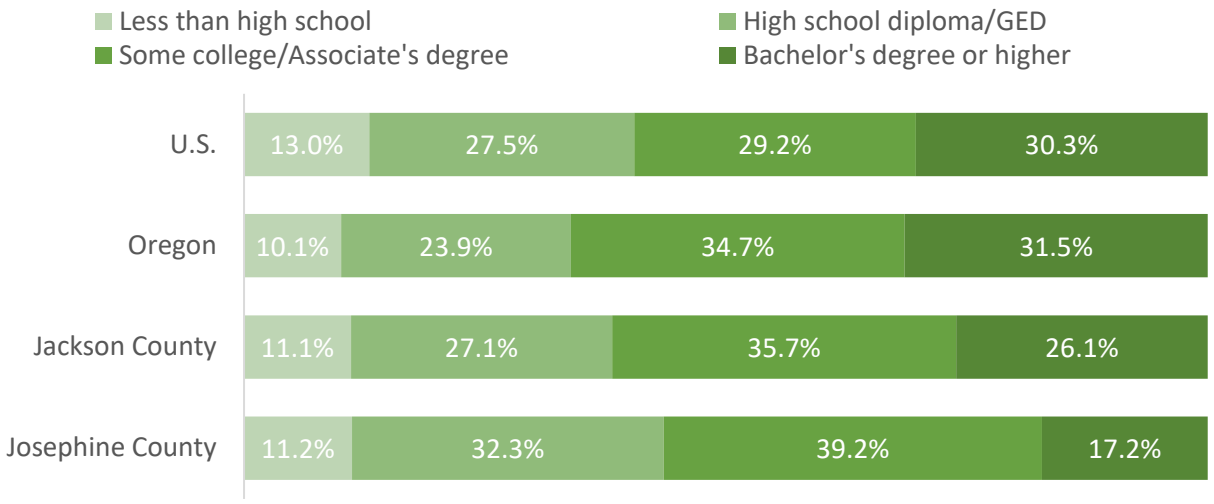
Figure 70. Graduation Rates, by School Districts, 2015-2016



DATA SOURCE: Oregon Department of Education, 2016-2017 School and District Report Cards, 2015-2016

Educational attainment is the highest level of education that an individual has completed. Based on 2012-2016 American Community Survey 5-year estimates, there was a smaller percentage of individuals 25 years old or over who received a bachelor's degree or more in Josephine County (17.2%) compared to Jackson County (26.1%) and Oregon (31.5%) (***Figure 71***).

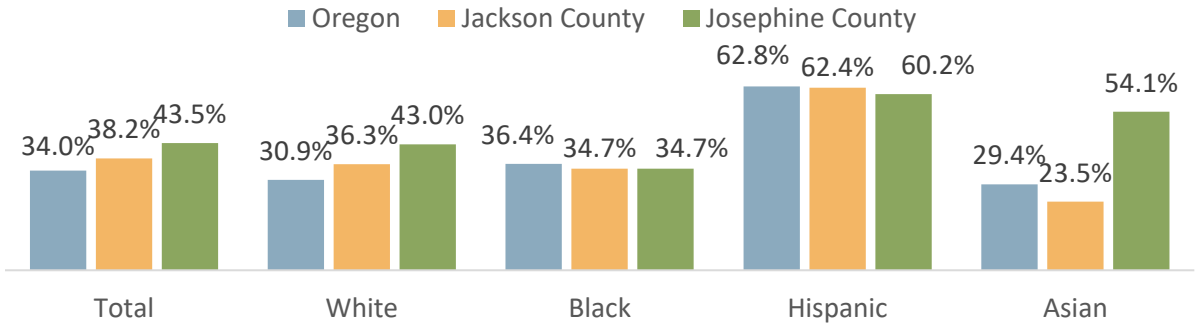
Figure 71. Educational Attainment for Population 25 Years and Over, by U.S., State, and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Examining these data by race and ethnicity, 60.2% of individuals identifying as Hispanic or Latino in Josephine County had a high school degree or less compared to Jackson County (62.4%) and Oregon (62.8%) (***Figure 72***). In Josephine County, individuals identifying as Asian are much more likely (54.1%) to have only a high school degree or less. This is in contrast to the population overall of which 43.5% of Josephine County, 38.2% in Jackson County, and 34.0% in Oregon overall had a high school degree or less. These education data also mirror data on poverty, which showed that individuals identifying as people of color, especially in Jackson County, are more likely to live below the federal poverty level.

Figure 72. Percent Population 25 Years and Over with a High School Diploma or Less, by Race/Ethnicity, by State and County, 2012-2016



DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

The connections between education and employment are strong. The cost of college has increased substantially and many students have difficulty paying for higher education. Further, well-paying jobs for individuals with only a high school degree are limited. Across Jackson and Josephine counties, the leading industries of employment were educational services, health care and social assistance; retail trade; arts, entertainment and recreation, and accommodation and food services; manufacturing; and professional, scientific and management, and administrative and waste management services (Table 7).

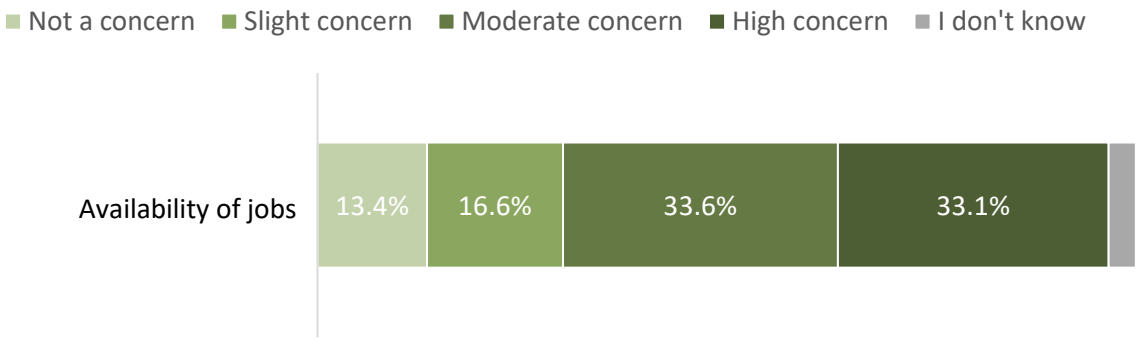
Table 7. Percent Population (16 Years and Over) Employed by Industry, by U.S., State, and County, 2012-2016

	U.S.	Oregon	Jackson County	Josephine County
Agriculture, forestry, fishing and hunting, and mining	1.9%	3.3%	3.4%	2.5%
Arts, entertainment, and recreation, and accommodation and food services	9.7%	10.0%	11.3%	7.7%
Construction	6.3%	5.7%	5.9%	6.3%
Educational services, and health care and social assistance	23.1%	23.0%	24.4%	24.2%
Finance and insurance, and real estate and rental and leasing	6.6%	5.7%	5.0%	5.0%
Information	2.1%	1.9%	1.4%	1.1%
Manufacturing	10.3%	11.4%	9.3%	10.9%
Other services, except public administration	4.9%	4.8%	5.3%	5.9%
Professional, scientific, and management, and administrative and waste management services	11.2%	10.7%	7.9%	10.0%
Public administration	4.7%	4.5%	4.7%	4.4%
Retail trade	11.5%	12.0%	14.2%	14.9%
Transportation and warehousing, and utilities	5.0%	4.2%	4.7%	4.7%
Wholesale trade	2.7%	2.9%	2.4%	2.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

As discussed previously, the region experiences relatively low unemployment; however, jobs are not generally well-paying and median household income is lower than the state and nation. About two-thirds of survey respondents overall reported the availability of jobs was either a moderate concern or high concern (***Figure 73***).

Figure 73. Survey Respondents Perceived Level of Concern for the Availability of Jobs, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

Future exploration

While there is reported misalignment between the educational attainment and skill level of the current population with the existing job base in the region, assessment participants suggested that there are skill sets that can be gained outside of the traditional education system, such as through workforce development training programs, that can help employers train a workforce with the necessary skills and help individuals who are

having difficulty finding employment with their current skill set. This pathway to employment and filling jobs is important to individuals who can benefit from employment, but also to businesses and communities in filling workforce needs from the local population. Further inquiry is needed to better understand the local workforce needs and how they align with the population coming out of regional educational and training institutions.

Existing assets and resources

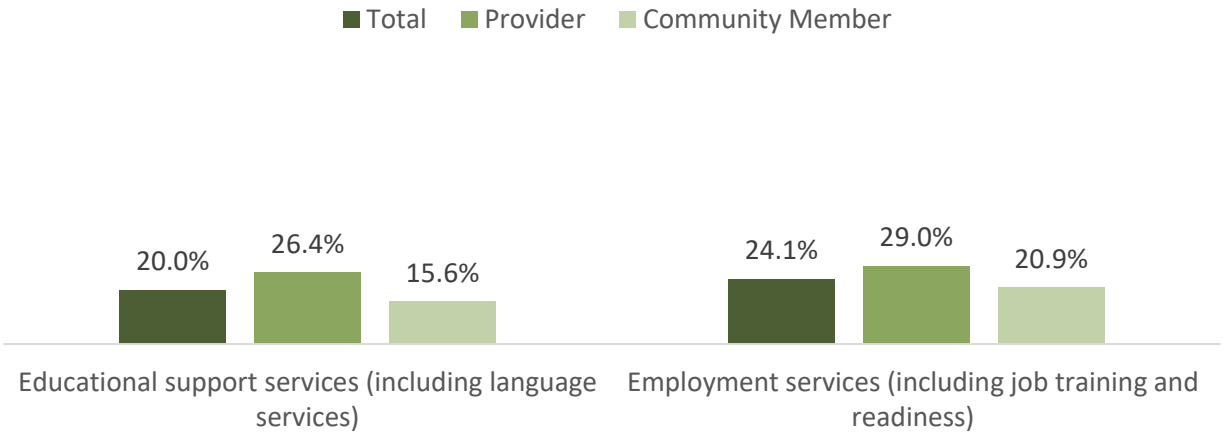
Assessment participants were asked about the assets in their communities related to education and workforce development, and shared the following list of resources:

- Academia Latina
- College and Career for All (CC4A)
- College Dreams
- Kids Unlimited
- Migrant and English Language Learner (ELL) Education programs
- Migrant Parent Action Committee
- Native American and Alaskan Indian Education programs
- Oregon Community Foundation
- Oregon Health Sciences University School of Nursing (Ashland Campus)
- Rogue Community College
- Rogue Workforce Partnership
- Southern Oregon Education Service District
- Southern Oregon Success
- Southern Oregon University
- United Way of Jackson County

NOTE: This list of assets was provided by assessment participants and stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, some resources are available in either Jackson or Josephine county only, and some in both counties.

While there are a number of educational and workforce development resources that assessment participants mentioned, one in five survey respondents reported educational support services were currently missing in the community and almost one in four reported employment services were missing (***Figure 74***). Among Hispanic/Latino survey respondents, nearly one in three (32.9%) indicated that educational support services were lacking. Further, there were notable disparities by gender, with 23.7% of women indicating educational services lacking compared to 12.3% of men.

Figure 74. Percent Survey Respondents Reported Educational Support Services and Employment Services as Health and Social Services Currently Lacking in the Community, by Respondent Type, 2018



DATA SOURCE: Jefferson Regional Health Alliance Community Health Assessment Community Survey, 2018

NEXT STEPS

The 2018 community health assessment of Jackson and Josephine Counties serves multiple purposes for a variety of audiences. Among these purposes, the assessment enables JRHA and its partners to

- Explore current health status and determinants of health, health priorities, and new and emerging concerns among Jackson and Josephine County community members and service providers
- Hear individual and group voices to provide a deeper understanding of the "why" and "how" of current and emerging health issues
- Understand the shifting patterns of these health issues over time in Jackson and Josephine Counties
- Identify assets and resources as well as gaps and needs in services in order to help partners set funding and programming priorities
- Fulfill the community health needs assessment requirements for Asante and Providence Hospitals, regional federally qualified health centers, Jackson and Josephine County Public Health, Community Mental Health Programs, and Coordinated Care Organizations
- Use the data gathered to engage JRHA members, partners and the community in the community health improvement process

This assessment lays the foundation for a regional Community Health Improvement Plan (CHIP) effort to begin in early 2019. The quantitative and qualitative data presented in this report and the six priority key themes identified can guide the development of goals, objectives, strategies and performance measures. While JRHA is the convener for community health improvement planning in Jackson and Josephine Counties, objectives and strategies developed for the CHIP must be owned by a local organization or collaborative for meaningful progress to occur. The priorities identified in this assessment represent complex community issues, and effective action will require infrastructure and community capacity to support collective impact.

APPENDICES

Appendix A – List of Stakeholders

Cynthia	Ackerman	AllCare Health
Heather	Ackerman	Josephine County Public Health
Anne	Ackles	Jackson County Public Health
Debbie	Ameen	AllCare Health
Hannah	Ancel	Jackson Care Connect
Tina	Anthony	Providence Medford Medical Center
Jean	Atalla	Jackson Care Connect
Charlie	Bauer	Southern Oregon Education Service District
Jackson	Baures	Jackson County Public Health
Jeni	Beck	Rogue Valley YMCA
Vanessa	Becker	AllCare Health
Todd	Bloomquist PhD	Grants Pass School District
Mike	Bond	PrimeCare
Richard	Booth	Siskiyou Community Health Center
Rene	Brandon	Southern Oregon Early Learning Services
Julie	Brown	Rogue Valley Transportation District
Stacy	Brubaker	Jackson County Mental Health
Don	Bruland	AllCare & Jackson Care Connect, Community Advisory Council
Kathy	Bryon	Gordon Elwood Foundation
Peter	Buckley	Southern Oregon Success
Lilia	Caballero	Medford Police Dept
Cara	Carter	Housing Authority of Jackson County
Carolina	Castaneda del Rio	La Clinica
Michael	Cavallaro	Rogue Valley Council of Governments
Kevin	Clark	Grants Pass YMCA
Sheila	Clough	Asante Ashland Community Hospital
Dennie	Conrad	Asante
Spencer	Countiss MD	Grants Pass Clinic
Shannon	Cronin	PrimaryHealth of Josephine County
Terri	Dahl	Medford School District
Beth	DePew	Oregon Health Authority
Karen	Elliott	Rogue Community Health
Jason	Elzy	Housing Authority of Jackson County
Sam	Engel	AllCare Health
DeeAnne	Everson	United Way of Jackson County
Stacy	Ferrell	ColumbiaCare Services
Mary	Ferrell	Maslow Project
Jim	Fong	Rogue Workforce Partnership

Shawn	Furdiga	Southern Oregon Veterans Rehabilitation Center & Clinics
John	Gates	Asante
Cecilia	Giron	LISTO Family Literacy
Michelle	Glass	Rogue Action Center
Lisa	Greif	Jackson County Circuit Court
Brian	Gross MD	Jefferson Regional Health Alliance
Janel	Guretzki	OnTrack Rogue Valley
Bevin	Hansell	Oregon Health Authority
Robin	Hausen	PrimaryHealth of Josephine County
Michelle	Homer-Anderson	Southern Oregon Head Start
Diane	Hoover	Grants Pass Blue Zones
Joseph	Ichter	Providence Health & Services
Brenda	Johnson	La Clinica
Ellen	Johnson	Options for Southern Oregon
Jennifer	Johnstun	PrimaryHealth of Josephine County
Sonya	Kauffman-Smith	Providence Health & Services
Kathy	Keesee	Unete Center for Farm Worker Advocacy
Scott	Kelly	Asante
John	King	Southern Oregon University
Cheryl	Kirk	OSU Extension Services
Jenny	Kowalczyk	Josephine County Public Health
Andrea	Krause	Jackson County Public Health
Kate	Lasky	Josephine County Public Library
Alan	Ledford PhD	OnTrack Rogue Valley
Jennifer	Lind	Jackson Care Connect
Keith	Lundquist	Asante
Harry	Mackin	AllCare Health, Community Advisory Council
Pam	Marsh	Oregon State Representative
Kellyn	Marshall	OnTrack Rogue Valley
Ivonne	Martinez Razo	Jackson County Early Intervention
Christine	Mason	Addictions Recovery Center
Cindy	Mayo	Providence Medford Medical Center
Ruth	McBride	PrimaryHealth of Josephine County
Karla	McCafferty	Options for Southern Oregon
Nancy	McKinnis	Jackson Care Connect
Tony	Mendenhall	PrimaryHealth of Josephine County, Community Advisory Council
Kris	Miller MD	Siskiyou Community Health Center
Michele	Morales	PSU School of Social Work
Emily	Mossberg	Jackson County Public Health
Lee	Murdoch MD	Jefferson Regional Health Alliance
Craig	Newton	Jackson Care Connect, Community Advisory Council

Joanne	Noone	OHSU School of Nursing
Pamela	Norr	Access
William	North	Rogue Community Health
Craig	Norton	Kairos
Laura	O'Bryon	Rogue Valley Council of Governments
Lisa	O'Connor	Family Nurturing Center
Mark	Orndoff	Jackson County Health & Human Services
Lori	Paris	Addictions Recovery Center
Rebecca	Pearson	AllCare Health, Community Advisory Council
Tanya	Phillips	Jackson County Public Health
Bonnie	Pickens	Providence Health & Services
LuAnn	Redding	Josephine County
Sara	Rubrecht	Jackson & Josephine County Emergency Management
Tomi	Ryba	Providence Medford Medical Center
Susan	Sanchez	Providence Medford Medical Center
Dorethy	Schweitzer	AllCare Health, Community Advisory Council
Jim	Shames MD	Jackson County Public Health
Belle	Shepherd	Oregon Health Authority
Becky	Sherman	La Clinica
Amanda	Singh Bans	Health Care Coalition of Southern Oregon
Sarah	Small	Options for Southern Oregon
Ed	Smith-Burns	AllCare Health, Community Advisory Council
Maggie	Sullivan	Health Care Coalition of Southern Oregon
Danni	Swafford	Addictions Recovery Center
Kari	Swoboda	AllCare Health
Brenda	Thomas	PrimaryHealth of Josephine County, Community Advisory Council
Bill	Thorndike Jr	Medford Fabrication
Sue	Thurston	Southern Oregon Veterans Rehabilitation Center & Clinics
Audrey	Tiberio	Josephine County Public Health
Maria	Underwood	La Clinica
Bruce	VanZee MD	Jefferson Regional Health Alliance
Roy	Vinyard	Asante
Heather	Voss	OHSU School of Nursing
Angela	Warren	Jefferson Regional Health Alliance
Michael	Weber	Josephine County Public Health
Kelly	Wessels	United Community Action Network
Caryn	Wheeler	OSU Extension Services
Nicole	Witham	AllCare Health, Community Advisory Council
Thomas K.	Wuest MD	Health Net of Oregon
Jessica	Wynant	Providence Medford Medical Center
Ted	Zuk	Jackson County Development Services

Appendix B – List of data sources and indicators

Topic	Data Indicators	Data Source
Population		
	Population count	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Population change	U.S. Census Bureau, ACS 5-Year Estimates, 2007-2011 v. 2012-2016
	% population in urban v. rural area	U.S. Census Bureau, Decennial Census, as cited by Community Commons, 2010
	% population living with a disability	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Sex		
	Population by sex	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Age		
	Under 18 years; 18-24 years; 25-44 years; 45-64 years; 65-74 years; 75-84 years; 85+ years	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Racial and Ethnic Diversity		
	Racial/ ethnic composition	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Hispanic population change	U.S. Census Bureau, ACS 5-Year Estimates, 2007-2011 v. 2012-2016
	Foreign-born population	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Place of origin (of foreign-born population)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population who speak language other than English at home	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Adverse Childhood Experiences		
	% adult Medicaid members reporting 4+ ACEs (by CCO)	MBRFSS, 2014
	% single parent households	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Total number of child abuse/neglect reports to DHS	Oregon DHS, 2018
	Child abuse/neglect victim rate per 1,000 population (under 18)	Oregon DHS, 2018
	Number of DV and sexual assault calls to Oregon Sexual and Domestic Violence Programs	Oregon DHS, 2018
	Number of individuals sheltered in domestic violence programs	Oregon DHS, 2018
	% students reporting parental divorce or separation after birth	Student Wellness Survey, 2016
	% students reporting ever living with someone who is/was a problem drinker or alcoholic	Student Wellness Survey, 2016
	% students reporting ever living with someone who uses/used street drugs	Student Wellness Survey, 2016
	% students reporting ever living with a household member who is/was depressed or mentally ill	Student Wellness Survey, 2016
	% students reporting ever feeling that they had to wear dirty clothes	Student Wellness Survey, 2016

Topic	Data Indicators	Data Source
Economic		
	% individuals below poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% families below poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% individuals below 200% poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population 65+ living below poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population under 18 living below poverty level	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% student population eligible for free/reduced lunch	Oregon Department of Education, as reported by Children First for Oregon, Oregon County Data Book, 2016 and 2017
	Unemployment rate	Bureau of Labor Statistics, Local Area Unemployment Statistics, 2012-2017
	% individuals 16-64 working FT, PT, not working	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Top industries employing population	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Median household income (and by race)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Median family income	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	GINI index of income inequality	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Median cost of childcare - small home-based care, large home-based care, center-based care	Oregon DHS, 2018
	Per capita income or average wage	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
Education		
	Educational attainment of adults 25 years and older (and by race)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	High school graduation rate	Oregon Department of Education, School and District Report Cards, 2015-2016
	% students continuing education within 16 months of high school graduation (by district)	Oregon Department of Education, School and District Report Cards, 2016-2017
	% 3-4 yo enrolled in preschool	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Kindergarten readiness/early learning (by district)	Oregon Department of Education, Statewide Kindergarten Assessment Results, 2017-2018
	% students in grades 3-5 meeting ELA standards	Oregon Department of Education, School and District Report Cards, 2016-2017
	% students chronically absent	Oregon Department of Education, Regular Attenders Report, 2016-2017
	% students reported skipping at least one day of school in past four weeks	Student Wellness Survey, 2016
Food Insecurity		
	% households receiving food stamps/SNAP	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population food insecure	Map the Meal Gap, Feeding America, 2016
	% population under 18 food insecure	Map the Meal Gap, Feeding America, 2016
	% youth reported eating less because there was not enough money to buy food	Oregon Healthy Teens Survey, 2017

Topic	Data Indicators	Data Source
	% youth reported feeling they did not have enough to eat	Student Wellness Survey, 2016
Housing and Homelessness		
	% households paying 35% or more, 30% or more, 20-29%, and less than 20% of income on housing (by owner occupied and renter occupied)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Median monthly housing costs (by owner occupied and renter occupied)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Housing tenure (owner occupied and renter occupied)	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% of households with severe housing problem	County Health Rankings, 2014
	Homeless count	Oregon Housing and Community Services, Oregon Point-in-Time Homeless Counts, 2017
	% homeless students	Oregon Department of Education, McKinney-Vento Act, Homeless Student Data, 2016-2017
Safety/Crime		
	Property crime rate	State of Oregon, Criminal Justice Commission, Oregon Uniform Crime Report, 2016
	Violent crime rate	State of Oregon, Criminal Justice Commission, Oregon Uniform Crime Report, 2016
	% students reporting did not go to school because they did not feel safe at school or on way to/from school	Student Wellness Survey, 2016
	% students reporting bullied at school during past year	Student Wellness Survey, 2016
	% students reporting physical fight on school property past 30 days	Student Wellness Survey, 2016
Social Support		
	% students reporting feeling they had no one to protect them	Student Wellness Survey, 2016
	% youth reporting having friends and family giving positive energy every day (OR and Grants Pass)	Blue Zones Survey, 2016/2017
	% youth reporting having someone encouraging them to be healthy (OR and Grants Pass)	Blue Zones Survey, 2016/2017
	Average social wellbeing score (OR and Grants Pass)	Blue Zones Survey, 2016/2017
Built Environment		
	Means of transportation to work for workers aged 16+	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% housing units built before 1979	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	Density of liquor stores (or rate of liquor stores per 100,000 population)	Oregon Liquor Control Commission, 2018

Topic	Data Indicators	Data Source
	Density of marijuana dispensaries (or rate of marijuana dispensaries per 100,000 population)	Oregon Liquor Control Commission, 2018
	Number of active recreational marijuana licenses by type	Oregon Liquor Control Commission, 2018
	% tobacco retailers selling to underage youth	Oregon Health Authority, Synar Inspection Results, 2017
	Rate of recreation and fitness facilities per 100,000 population	U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2016
	Rate of fast food restaurants per 100,000 population	U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2016
	Rate of grocery stores per 100,000 population	U.S. Census Bureau, County Business Patterns, as cited by Community Commons, 2016
	Food environment index	County Health Rankings, 2015
	% of population with adequate access to locations for physical activity	County Health Rankings, 2016
Natural Environment		
	% EPA-regulated public water systems with systems score > 11 (meeting standards)	Oregon Public Health Drinking Water Online, 2018
	# confirmed or presumptive cases in children under 18 with elevated childhood blood lead levels	Orpheus, 2017
	Number of extreme heat days	National Oceanic and Atmospheric Administration, 2017
	Annual particulate matter concentration	U.S. Environmental Protection Agency, Outdoor Air Quality Data, Air Quality Statistics Report, 2017
	% days that had good air quality	U.S. Environmental Protection Agency, Outdoor Air Quality Data, Air Quality Statistics Report, 2017
Overall Health		
	% adults reporting at least one day of activity limitations in past month	BRFSS, 2012-2015
	% adults reporting poor physical or mental health limiting daily activities and/or health problems requiring use of special equipment in past month	BRFSS, 2012-2015
	% adults reporting general health status as good, very good, or excellent	BRFSS, 2012-2015
Mortality		
	Overall mortality rate	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Premature mortality (or years of potential life lost)	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Leading causes of death	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016

Topic	Data Indicators	Data Source
	Age-adjusted heart disease mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted cancer mortality rate per 100,000 population (and by cancer type)	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted accidents (unintentional injuries) mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted chronic lower respiratory disease mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted diabetes mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted cerebrovascular disease mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Fall injuries mortality rate per 100,000 population (65+ population)	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted motor vehicle related mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	Age-adjusted opioid overdose mortality rate per 100,000 population	Oregon Health Authority, Center for Health Statistics, Public Health Division, Death Certificates as cited by Opioid Data Dashboard, 2012-2016
	Age-adjusted alcohol related mortality rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
Diet and Physical Activity		
	% adults reporting meeting fruits and vegetables consumption recommendations	BRFSS, 2012-2015
	% students reporting consumption of 5+ servings of fruits or vegetables per day	Oregon Healthy Teens Survey, 2017
	% adults reporting meeting aerobic and strengthening physical activity recommendations	BRFSS, 2012-2015
	% students reporting physical activity (for 60+ minutes) per day in past week	Oregon Healthy Teens Survey, 2017
	% adults reporting consumption of 7+ soda beverages per week	BRFSS, 2012-2015
	% students reporting consumption of soda at least one time in past week	Oregon Healthy Teens Survey, 2017
Chronic Diseases		
	Cancer incidence rate per 100,000 population (and by cancer type)	OSCaR, 2014

Topic	Data Indicators	Data Source
	% adults reporting current asthma	BRFSS, 2012-2015
	% adults reporting diabetes diagnosis	BRFSS, 2012-2015
	% adults reporting heart attack	BRFSS, 2012-2015
	% adults reporting stroke	BRFSS, 2012-2015
	% adults reporting high blood cholesterol	BRFSS, 2012-2015
	% adults reporting high blood pressure	BRFSS, 2012-2015
	% female adults reporting pap test in past 3 years	BRFSS, 2012-2015
	% female adults reporting mammogram in past 2 years	BRFSS, 2012-2015
	% adults reporting meeting colorectal cancer screening recommendations	BRFSS, 2012-2015
	% adults reporting overweight or obesity	BRFSS, 2012-2015
	% students reporting overweight or obese	Student Wellness Survey, 2016
Alcohol, Tobacco, and Drugs		
	% students reporting current alcohol consumption	Student Wellness Survey, 2016
	% adults reporting binge drinking	BRFSS, 2012-2015
	% students reporting binge drinking	Student Wellness Survey, 2016
	% adults reporting heavy drinking	BRFSS, 2012-2015
	% adults reporting current marijuana use (data not available by counties)	BRFSS, 2012-2015
	% students reporting current marijuana use	Student Wellness Survey, 2016
	% adults reporting current cigarette smoking	BRFSS, 2012-2015
	% students reporting current cigarette smoking	Student Wellness Survey, 2016
	% students reporting current prescription drug use without prescription	Student Wellness Survey, 2016
	Opioid overdose hospitalization rate per 100,000 population	Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Opioid Data Dashboard, 2010-2014
	Heroin overdose hospitalization rate per 100,000 population	Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Opioid Data Dashboard, 2010-2014
	Substance related hospitalization rate per 100,000 population (e.g., alcohol, marijuana, opioids, etc.)	Agency for Health care Research and Quality, HCUPnet, 2014
Mental Health		
	Age-adjusted suicide rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2016
	% adults reporting depression diagnosis	BRFSS, 2012-2015
	% students reporting frequent mental distress	Student Wellness Survey, 2016

Topic	Data Indicators	Data Source
	% students reporting seriously considered suicide in past year	Student Wellness Survey, 2016
	% students reporting attempted suicide in past year	Student Wellness Survey, 2016
Oral Health		
	% adults reporting dental visit in past year	BRFSS, 2012-2015
	% students reporting dental visit in past year	Oregon Healthy Teens Survey, 2017
	% population served with water fluoridation	SDWIS, Oregon Public Health Drinking Water Data, 2018
	% adults reporting all permanent teeth removed due to tooth decay or gum disease (or one or more)	BRFSS, 2012-2015
Maternal, Child, and Infant Health		
	% mothers reporting currently breastfeeding	Oregon Health Authority, Oregon Pregnancy Risk Assessment Monitoring System, 2015
	Infant mortality rate per 1,000 live births	Linked infant births/Death certificates
	% low birth weight births	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
	% premature births	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
	% births with prenatal care in first trimester	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
	% births with no prenatal care	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
	Teen (15-17) birth rate per 1,000 population (and by race)	Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2016
Hepatitis		
	Hepatitis C (chronic) incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
	Hepatitis A (viral hepatitis) incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
HIV/AIDS		
	HIV infection incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program, 2016
STI		

Topic	Data Indicators	Data Source
	Syphilis incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
	Gonorrhea incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
	Chlamydia incidence rate per 100,000 population	Oregon Public Health Assessment Tool, Oregon Health Authority, HIV/STD/TB Prevention Program and Oregon Health Authority, Oregon Public Health Epidemiologists' User System (Orpheus), 2017
Immunizations		
	% adults had flu shot in past year	BRFSS, 2012-2015
	% adults 65+ had flu shot in past year	BRFSS, 2012-2015
	% two-year olds up-to-date on vaccines (4:3:1:3:3:1:4)	Oregon Health Authority, Oregon Immunization Program, 2017
	% adolescents 13 to17 years old with Meningococcal vaccination	Oregon Health Authority, Oregon Immunization Program, 2017
	% adolescents 13 to 17 years old with HPV (1+) vaccination	Oregon Health Authority, Oregon Immunization Program, 2017
	% adolescents 13 to 17 years old with up to date HPV vaccination	Oregon Health Authority, Oregon Immunization Program, 2017
	% children K-12 with non-medical exemption for any vaccine	Oregon Health Authority, Oregon Immunization Program, 2018
	% children in Kindergarten with non-medical exemption for any vaccine	Oregon Health Authority, Oregon Immunization Program, 2018
Access		
	% population without insurance	U.S. Census Bureau, ACS 5-Year Estimates, 2012-2016
	% population under 65 years uninsured	U.S. Census Bureau, Small Area Health Insurance Estimates: Health Insurance Interactive Data Tool, 2016
	% population under 19 uninsured	U.S. Census Bureau, Small Area Health Insurance Estimates: Health Insurance Interactive Data Tool, 2016
	Medical health care providers per capita - primary care physicians	County Health Rankings, 2015
	Nurse midwives, nurse practitioners, physician assistants per capita	County Health Rankings, 2017
	Behavioral health care providers per capita	County Health Rankings, 2017
	Dentists per capita	County Health Rankings, 2016
	% adults who have a personal doctor or health care provider	BRFSS, 2012-2015
	% adults reporting not seeing health care provider due to cost in past year	BRFSS, 2012-2015
	% students reporting routine checkup in past year	Oregon Healthy Teens, 2017

Topic	Data Indicators	Data Source
	% female adults at risk for unintended pregnancy reporting effective contraceptive use (data not available by counties)	BRFSS, 2012-2015

Appendix C - Additional findings

Community Demographics

Appendix Table 1. Percent Population Living in Urban and Rural Areas, by State and County, 2010

	Urban	Rural
Oregon	81.0%	19.0%
Jackson County	80.0%	20.1%
Josephine County	55.0%	45.0%

DATA SOURCE: U.S. Census Bureau, Decennial Census, as cited by Community Commons, 2010

Appendix Table 2. Percent Population Living with a Disability, by State and County, 2012-2016

	Percent
Oregon	14.7%
Jackson County	17.2%
Josephine County	19.4%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 3. Percent Population Male and Female, by State and County, 2007-2011 and 2012-2016

	2011		2016	
	Male	Female	Male	Female
Oregon	49.5%	50.5%	49.5%	50.5%
Jackson County	48.8%	51.2%	48.7%	51.3%
Josephine County	48.5%	51.5%	48.9%	51.1%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Social Determinants of Health

Adverse childhood experiences

Appendix Table 4. Percent Adult Medicaid Members Reported 4+ ACEs, by State and CCO, 2014

	Percent
Oregon	34.7%
AllCare Health Plan	37.6%
Jackson Care Connect	37.6%
Primary Health of Josephine County	35.9%

DATA SOURCE: Oregon Health Authority, Office of Health Analytics, Medicaid Behavioral Risk Factor Surveillance System (MBRFSS) Survey, Report of Results, 2014

Appendix Table 5. Percent Single Parent Households, by U.S., State, and County, 2005-2011 and 2012-2016

	2011	2016
U.S.	26.0%	26.8%
Oregon	22.5%	23.6%
Jackson County	23.5%	24.9%
Josephine County	21.0%	24.9%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Appendix Table 6. Total Number of Child Abuse/Neglect Reports to DHS, by State and County, FF17

	Number
Oregon	80,683
Jackson County	5,489
Josephine County	2,005

DATA SOURCE: Oregon Department of Human Services, Child Abuse and Neglect Data, Child Welfare Data Book, 2017

Appendix Table 7. Number of Domestic Violence and Sexual Assault Calls to Oregon Sexual and Domestic Violence Programs, by State and County, 2016

	Domestic Violence	Sexual Assault
Oregon	93,799	11,483
Jackson County	1,308	59
Josephine County	3,746	410

DATA SOURCE: Oregon Department of Human Services, Domestic Violence Data and Publications, Domestic and Sexual Violence Service Providers Annual Reports, Striving to Meet the Need: Summary of Services Provided by Sexual and Domestic Violence Programs in Oregon, 2016

Appendix Table 8. Number of Individuals Sheltered in Domestic Violence Programs, by State and County, 2016

	Number
Oregon	4,296
Jackson County	303
Josephine County	292

DATA SOURCE: Oregon Department of Human Services, Domestic Violence Data and Publications, Domestic and Sexual Violence Service Providers Annual Reports, Striving to Meet the Need: Summary of Services Provided by Sexual and Domestic Violence Programs in Oregon, 2016

Appendix Table 9. Number of Individuals (Under 18) Sheltered in Domestic Violence Programs, by State and County, 2016

	Number
Oregon	1,926
Jackson County	122
Josephine County	140

DATA SOURCE: Oregon Department of Human Services, Domestic Violence Data and Publications, Domestic and Sexual Violence Service Providers Annual Reports, Striving to Meet the Need: Summary of Services Provided by Sexual and Domestic Violence Programs in Oregon, 2016

Economic factors

Appendix Table 10. Median Household Income by Race/Ethnicity, by State and County, 2012-2016

	Oregon	Jackson County	Josephine County
Total	$53,270	$46,343	$37,867
White, non-Hispanic	$55,125	$48,062	$37,988
Black	$32,062	$30,862	$44,732
Hispanic/Latino, any race	$42,311	$35,148	$42,125
Asian	$68,694	$68,950	--
American Indian/Alaska Native	$36,781	$25,833	--
Native Hawaiian/Other Pacific Islander	$40,333	--	--

Other race	$42,017	$40,843	$43,958
Two or more races	$46,226	$39,979	$18,101

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: Dashes represent where median income was not calculated due to small numbers

Appendix Table 11. Average Household Income, by U.S., State, and County, 2007-2011 and 2012-2016

	2011	2016
U.S.	$72,555	$77,866
Oregon	$65,589	$72,013
Jackson County	$57,751	$62,014
Josephine County	$50,137	$54,628

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Appendix Table 12. Median Family Income, by U.S., State, and County, 2007-2011 and 2012-2016

	2011	2016
U.S.	$64,293	$67,871
Oregon	$61,302	$65,479
Jackson County	$53,751	$56,174
Josephine County	$47,420	$47,788

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Appendix Table 13. GINI Index of Income Inequality, by U.S., State, and County, 2007-2011 and 2012-2016

	2011	2016
U.S.	0.470	0.480
Oregon	0.449	0.461
Jackson County	0.446	0.459
Josephine County	0.451	0.479

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016
NOTE: The GINI index is a measure that represents the income or wealth distribution, i.e. inequality, of a geographic area. A GINI index of 0 represents perfect equality and 1 represents maximal inequality.

Education

Appendix Table 14. Percent Students Continuing Education within 16 Months of High School Graduation, by State and School District, 2014-2015, 2015-2016, and 2016-2017

	2015	2016	2017
Oregon	60.5%	59.4%	57.4%
Ashland	55.3%	60.6%	54.2%
Butte Falls	46.2%	33.3%	30.0%
Central Point	53.2%	50.2%	55.9%
Eagle Point	42.9%	37.9%	31.0%
Medford	55.0%	49.5%	44.6%
Phoenix/Talent	41.8%	45.3%	47.3%
Prospect	52.6%	50.0%	53.8%
Rogue River	46.8%	55.8%	50.0%
Grants Pass	51.6%	51.7%	52.0%
Three Rivers	59.1%	50.6%	51.4%

DATA SOURCE: Oregon Department of Education, School and District Report Cards, 2014-2015, 2015-2016, and 2016-2017

Housing and homelessness

Appendix Table 15. Percent Households by Percent of Income Spent on Housing Costs, by U.S., State, and County, 2012-2016

	Less than 20% of income	20% to 29% of income	30% or more of income
U.S.	42.1%	21.8%	32.9%
Oregon	37.9%	23.3%	36.0%
Jackson County	35.3%	22.5%	39.3%
Josephine County	37.2%	19.9%	39.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 16. Percent Households where Housing Costs are More than 35% of Income, by U.S., State, and County, 2012-2016

	2011		2016	
	Owner-occupied with mortgage	Renter-occupied	Owner-occupied with mortgage	Renter-occupied
U.S.	31.3%	43.5%	23.3%	42.0%
Oregon	37.5%	49.5%	25.2%	44.0%
Jackson County	39.2%	51.3%	30.0%	49.3%
Josephine County	31.3%	43.5%	34.2%	52.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2007-2011 and 2012-2016

Social support

Appendix Table 17. Percent Youth Reported Having Friends/Family Giving Positive Energy Every Day and Having Someone Encouraging Them to be Healthy, by State and City, 2016/2017

	Positive Energy from Friends/Family	Encouragement to be Healthy
Oregon	65.7%	67.3%
Grants Pass (Josephine County)	59.8%	62.1%

DATA SOURCE: Blue Zones Project by Healthways, brought to Oregon by Cambia Health Foundation, Survey Results, 2016 (for Grants Pass: 2017)

Appendix Table 18. Average Social Wellbeing Score, by State and City, 2016/2017

	Score
Oregon	67.9
Grants Pass (Josephine County)	65.9

DATA SOURCE: Blue Zones Project by Healthways, brought to Oregon by Cambia Health Foundation, Survey Results, 2016 (for Grants Pass: 2017)

Transportation

Appendix Table 19. Means of Transportation to Work for Workers 16 Years and Over, by U.S., State, and County, 2012-2016

	Car, truck, or van - alone	Car, truck, or van - carpool	Public transportation	Other
U.S.	76.4%	9.3%	5.1%	9.2%
Oregon	71.4%	10.3%	4.4%	13.8%

Jackson County	76.0%	9.4%	1.0%	13.5%
Josephine County	81.5%	7.8%	0.5%	10.2%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016
NOTE: Other includes walking, working from home, and other means of transportation

Food insecurity

Appendix Table 20. Percent Households Receiving Food Stamps/SNAP Benefits, by State and County, 2012-2016

	Percent
Oregon	18.8%
Jackson County	21.6%
Josephine County	23.5%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 21. Percent Population Food Insecure, by State and County, 2014-2016

	2014	2015	2016
Oregon	15.2%	14.2%	12.9%
Jackson County	16.0%	15.3%	14.2%
Josephine County	17.3%	16.5%	15.6%

DATA SOURCE: Feeding America, Map the Meal Gap, 2014-2016

Appendix Table 22. Percent Population Under 18 Years Food Insecure, by State and County, 2014-2016

	2014	2015	2016
Oregon	24.5%	22.5%	20.0%
Jackson County	26.8%	25.1%	22.8%
Josephine County	29.4%	27.7%	25.0%

DATA SOURCE: Feeding America, Map the Meal Gap, 2014-2016

Appendix Table 23. Food Environment Index, by State and County, 2015

	Index
Oregon	7.6
Jackson County	7.3
Josephine County	7.0

DATA SOURCE: USDA Food Environment Atlas, Map the Meal Gap, as cited by County Health Rankings, 2015
NOTE: The Food Environment Index ranges from 0 (worst) to 10 (best) and equally weights two indicators of the food environment: limited access to healthy foods (the percentage of the population that is low income and does not live close to a grocery store) and food insecurity (the percentage of adults who did not have access to a reliable source of food during the past year).

Appendix Table 24. Percent 11th Grade Students Reported Eating Less than They Felt They Should Because There Was Not Enough Money to Buy Food in Past Year, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	19.3%	18.5%	17.8%
Jackson County	22.5%	19.8%	21.6%
Josephine County	23.0%	NA	14.2%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017

NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Built environment

Appendix Table 25. Percent Housing Units Built Before 1980, by U.S., State, and County, 2012-2016

	Percent
U.S.	55.3%
Oregon	54.7%
Jackson County	48.7%
Josephine County	52.0%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 26. Density of Liquor Stores, by State and County, 2018

	Number of Liquor Stores	Rate per 100,000 Population
Oregon	267	6.5
Jackson County	13	6.0
Josephine County	3	3.5

DATA SOURCE: Oregon Liquor Control Commission, last updated 6-20-18, 2018

Appendix Table 27. Density of Marijuana Dispensaries, by State and County, 2018

	Number of Dispensaries	Rate per 100,000 Population
Oregon	570	13.9
Jackson County	37	17.1
Josephine County	9	10.5

DATA SOURCE: Oregon Liquor Control Commission, last updated 6-8-18, 2018

Appendix Table 28. Number of Active Recreational Marijuana Licenses by Type, by State and County, 2018

	Recreational Producer	Recreational Retailer	Recreational Wholesaler	Recreational Processor	Laboratory
Oregon	1013	559	122	171	22
Jackson County	201	35	15	15	2
Josephine County	137	9	5	5	0

DATA SOURCE: Oregon Liquor Control Commission, Recreational Marijuana Licensing, Approved Marijuana Licenses as of 7/27/2018, 2018

Appendix Table 29. Percent Tobacco Retailers Selling to Underage Youth, by State and County, 2016-2017

	2016	2017
Oregon	4.4%	9.9%
Jackson County	12.9%	5.6%
Josephine County	0.0%	22.2%

DATA SOURCE: Oregon Health Authority, Health Promotion and Chronic Disease Prevention, Synar Inspection Results, 2017

Appendix Table 30. Rate of Recreational and Fitness Facilities per 100,000 Population, by State and County, 2016

	Rate

Oregon	12.4
Jackson County	13.3
Josephine County	8.5

DATA SOURCE: U.S. Census Bureau, County Business Patterns, additional data analysis by CARES, as cited by Community Commons, 2016

Appendix Table 31. Rate of Fast Food Restaurants per 100,000 Population, by State and County, 2016

	Rate
Oregon	76.5
Jackson County	76.3
Josephine County	62.9

DATA SOURCE: U.S. Census Bureau, County Business Patterns, additional data analysis by CARES, as cited by Community Commons, 2016

Appendix Table 32. Rate of Grocery Stores per 100,000 Population, by State and County, 2016

	Rate
Oregon	19.3
Jackson County	17.2
Josephine County	19.3

DATA SOURCE: U.S. Census Bureau, County Business Patterns, additional data analysis by CARES, as cited by Community Commons, 2016

Appendix Table 33. Percent Population with Adequate Access to Locations for Physical Activity, by State and County, 2016

	Percent
Oregon	77.0%
Jackson County	37.0%
Josephine County	67.0%

DATA SOURCE: Business Analyst, Delorme map data, ESRI, & US Census Tigerline Files, as cited by County Health Rankings, 2016

Appendix Table 34. Percent EPA-Regulated Public Water Systems Meeting Standards (Systems Score ≥ 11), by Water Systems, by County, 2018

	Community	Transient Non-Community	Non-Transient Non-Community	Non-EPA
Jackson County	98%	99%	100%	100%
Josephine County	100%	98%	100%	NA

DATA SOURCE: Oregon Health Authority, SDWIS, Oregon Public Health Drinking Water Online, https://yourwater.oregon.gov/, 2018

NOTE: Classifications of public water systems can be found at https://www.epa.gov/dwreginfo/information-about-public-water-systems

Appendix Table 35. Number of Confirmed or Presumptive Cases of Elevated Childhood Blood Lead Levels in Children Under 18 Years, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	144	143	170	207

Jackson County	2	0	14	7
Josephine County	1	6	1	1

DATA SOURCE: Oregon Health Authority, Orpheus, 2014-2017
NOTE: Oregon changed their Investigative Guidelines, adopting a new lower case definition value of ≥ 5 in May 2016

Appendix Table 36. Number of Extreme Heat Days, by Southern Oregon Region, 2015-2017

	2015	2016	2017
HeatRisk Magenta Days	1	0	0
HeatRisk Red Days	14	7	7
HeatRisk Orange Days	35	31	38
HeatRisk Yellow Days	135	134	115

DATA SOURCE: National Oceanic and Atmospheric Administration (NOAA), 2015-2017
NOTE: Heat risk assigned based on Medford Rogue Valley International Airport temperatures. Definitions can be found at https://www.wrh.noaa.gov/wrh/heatrisk/

Appendix Table 37. Annual Particulate Matter Concentration (PM2.5 Weighted Annual Mean), by County, 2015-2017

	2015	2016	2017
Jackson County	12.1	7.2	15.5
Josephine County	8.3	5.8	15.8

DATA SOURCE: U.S. Environmental Protection Agency (EPA), Outdoor Air Quality Data, Air Quality Statistics Report, 2015-2017
NOTE: EPA air quality standards for PM2.5 annual is 12 µg/m3; The data presented INCLUDES exceptional events data

Appendix Table 38. Particulate Matter Concentration (PM2.5 98th Percentile), by County, 2015-2017

	2015	2016	2017
Jackson County	46	21	111
Josephine County	18	15	115

DATA SOURCE: U.S. Environmental Protection Agency (EPA), Outdoor Air Quality Data, Air Quality Statistics Report, 2015-2017
NOTE: 98th percentile of the daily average measurements in the year; EPA air quality standard for PM2.5 24-hour is 35 µg/m3; The data presented INCLUDES exceptional events data

Appendix Table 39. Percent Days that Had Good Air Quality, by County, 2015-2017

	2015	2016	2017
Jackson County	64.1%	83.6%	64.4%
Josephine County	75.9%	86.9%	68.2%

DATA SOURCE: U.S. Environmental Protection Agency (EPA), Outdoor Air Quality Data, Air Quality Statistics Report, 2015-2017
NOTE: "Good" air quality is having an Air Quality Index (AQI) value of 0 through 50

Health care access

Appendix Table 40. Percent Population Uninsured, by State and County, 2012-2016

	Percent
Oregon	10.4%
Jackson County	11.5%

Josephine County	10.9%

DATA SOURCE: U.S. Census Bureau, American Community Survey, 5-Year Estimates, 2012-2016

Appendix Table 41. Percent Population Under 65 Years Uninsured, by State and County, 2014-2016

	2014	2015	2016
Oregon	11.6%	8.4%	7.4%
Jackson County	12.9%	8.9%	8.0%
Josephine County	12.0%	8.9%	7.9%

DATA SOURCE: U.S. Census Bureau, Small Area Health Insurance Estimates: Health Insurance Interactive Data Tool, 2014-2016

Appendix Table 42. Percent Population Under 19 Years Uninsured, by State and County, 2014-2016

	2014	2015	2016
Oregon	5.1%	4.1%	3.5%
Jackson County	5.7%	4.0%	3.9%
Josephine County	5.5%	3.9%	3.8%

DATA SOURCE: U.S. Census Bureau, Small Area Health Insurance Estimates: Health Insurance Interactive Data Tool, 2014-2016

Appendix Table 43. Ratio of Population to One Primary Care Provider, by State and County, 2013-2015

	2013	2014	2015	2016
Oregon	1,070	1,070	1,070	1,070
Jackson County	1,110	1,100	1,090	1,090
Josephine County	1,190	1,160	1,280	1,280

DATA SOURCE: Area Health Resource File, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2013-2015

Appendix Table 44. Ratio of Population to One Other Primary Care Physician*, by State and County, 2015

Oregon	1,341
Jackson County	993
Josephine County	1,177

DATA SOURCE: Centers for Medicare and Medicaid Services, Area Health Resource File/National Provider Identification File, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2015

NOTE: Other primary care physicians include nurse practitioners (NP), physician assistants (PA), and clinical nurse specialists

Appendix Table 45. Ratio of Population to One Mental Health Provider, by State and County, 2015-2017

	2015	2016	2017
Oregon	280	250	230
Jackson County	400	340	290
Josephine County	190	160	150

DATA SOURCE: Centers for Medicare and Medicaid Services, National Provider Identification Registry, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2015-2017

Appendix Table 46. Ratio of Population to One Dentist, by State and County, 2016

Oregon	1,270
Jackson County	1,250
Josephine County	1,280

DATA SOURCE: Centers for Medicare and Medicaid Services, Area Health Resource File/National Provider Identification File, as cited by Robert Wood Johnson Foundation, University of Wisconsin Population Health Institute, County Health Rankings, 2016

Appendix Table 47. Age-Adjusted Percent Adults Reported Routine Check-Up in Past Year, by State and County, 2012-2015

	Percent
Oregon	60.3%
Jackson County	56.4%
Josephine County	55.9%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 48. Percent 11th Grade Students Reported a Routine Check-Up or Physical Exam in Past Year, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	59.1%	61.5%	62.2%
Jackson County	50.5%	55.6%	55.2%
Josephine County	56.6%	N/A	61.6%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017
NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 49. Age-Adjusted Percent Adults Reported Not Seeing Health Care Provider Due to Cost in Past Year, by State and County, 2012-2015

	Percent
Oregon	12.7%
Jackson County	20.4%
Josephine County	20.2%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 50. Age-Adjusted Percent Female Adults at Risk for Unintended Pregnancy Reported Effective Contraceptive Use, by State and County, 2012-2015

	Percent
Oregon	68.7%
Jackson County	NA
Josephine County	NA

DATA SOURCE: Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015
NOTE: Data not available for counties

Overall health and mortality

Appendix Table 51. Age-Adjusted Percent Adults Reported At Least One Day of Activity Limitations in Past Month, by State and County, 2012-2015

	Percent
Oregon	27.2%
Jackson County	28.8%
Josephine County	27.1%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 52. Age-Adjusted Percent Adults Reported Poor Physical or Mental Health Limits Daily Activities and/or Health Problems Requiring Use of Special Equipment in Past Month, by State and County, 2012-2015

	Percent
Oregon	25.9%
Jackson County	27.4%
Josephine County	32.7%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 53. Years of Potential Life Lost Before Age 75 per 100,000 Population, by State and County, 2014-2016

	2014	2015	2016
Oregon	6,524.2	6,521.2	6,480.6
Jackson County	7,472.6	7,899.6	7,632.8
Josephine County	9,194.1	10,473.3	9,955.6

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2014-2016

Appendix Table 54. Age-Adjusted Heart Disease Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	137.6	137.1	134.0
Jackson County	138.6	129.2	122.0
Josephine County	136.1	119.8	146.6

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 55. Age-Adjusted Cancer Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2014	2015	2016
Oregon	160.3	160.2	155.8
Jackson County	160.4	169.3	156.9
Josephine County	173.2	180.9	192.4

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 56. Age-Adjusted Female Breast Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	20.0
Jackson County	20.4
Josephine County	32.1

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 57. Age-Adjusted Colorectal Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	13.7
Jackson County	13.4
Josephine County	15.9

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 58. Age-Adjusted Lung Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	41.7
Jackson County	42.6
Josephine County	52.8

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 59. Age-Adjusted Cervical Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	2.0
Jackson County	1.9
Josephine County	--

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015
NOTE: Rate not calculated for Josephine County due to small numbers

Appendix Table 60. Age-Adjusted Prostate Cancer Mortality Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	20.8
Jackson County	23.1
Josephine County	26.9

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 61. Age-Adjusted Accidents (Unintentional Injuries) Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017

Oregon	44.4	46.4	44.7
Jackson County	44.4	47.4	40.2
Josephine County	66.2	62.8	72.4

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 62. Age-Adjusted Chronic Lower Respiratory Disease Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	42.8	40.9	39.7
Jackson County	51.0	46.3	47.8
Josephine County	61.2	56.1	47.7

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 63. Age-Adjusted Diabetes Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	23.2	24.3	23.9
Jackson County	24.3	22.5	17.1
Josephine County	24.2	20.3	25.1

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 64. Age-Adjusted Cerebrovascular Disease Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	37.9	38.4	39.9
Jackson County	39.0	34.7	37.4
Josephine County	33.8	35.1	43.6

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 65. Falls Mortality Rate (65+) per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	98.8	96.3	96.8
Jackson County	80.2	75.5	70.5
Josephine County	61.6	97.2	82.0

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 66. Age-Adjusted Motor Vehicle Related Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	11.8	12.2	11.7
Jackson County	13.9	16.7	13.5

Josephine County	36.5	29.3	27.3

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Appendix Table 67. Age-Adjusted Alcohol Induced Mortality Rate per 100,000 Population, by State and County, 2015-2017

	2015	2016	2017
Oregon	18.7	16.9	17.4
Jackson County	22.0	19.0	18.5
Josephine County	30.8	27.4	28.2

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Death Certificates, 2015-2017

Chronic diseases and related risk factors

Healthy eating and physical activity

Appendix Table 68. Age-Adjusted Percent Adults Reported Meeting Recommendations for Fruits and Vegetables Consumption, by State and County, 2012-2015

	Percent
Oregon	19.9%
Jackson County	25.0%
Josephine County	24.5%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Meeting Recommendations is defined as consumed five or more servings of fruits and vegetables per day

Appendix Table 69. Percent 11th Grade Students Reported Consuming Five or More Servings of Fruits or Vegetables Per Day, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	22.2%	19.5%	18.8%
Jackson County	22.6%	20.5%	18.3%
Josephine County	19.9%	N/A	18.8%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017
NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 70. Age-Adjusted Percent Adults Reported Meeting Recommendations for Aerobic and Strengthening Physical Activity, by State and County, 2012-2015

	Percent
Oregon	22.9%
Jackson County	29.6%
Josephine County	32.0%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 71. Percent 11th Grade Students Reported Being Physical Activity (for 60+ Minutes Per Day) Each Day in Past Seven Days, by State and County, 2013, 2015, and 2017

	2013	2015	2017

Oregon	25.8%	23.7%	22.5%
Jackson County	26.9%	23.5%	21.3%
Josephine County	36.7%	N/A	32.8%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017
NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 72. Age-Adjusted Percent Adults Reported Consumption of Seven or More Soda Beverages (Non-Diet) Per Week, by State and County, 2012-2015

	Percent
Oregon	12.2%
Jackson County	14.3%
Josephine County	13.4%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 73. Percent 11th Grade Students Reported Consuming Soda At Least One Time in Past Seven Days, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	68.1%	50.8%	67.0%
Jackson County	70.5%	46.8%	64.2%
Josephine County	64.5%	N/A	64.8%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017
NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 74. Age-Adjusted Percent Adults Reported Obesity or Overweight, by State and County, 2012-2015

	Percent
Oregon	63.3%
Jackson County	58.8%
Josephine County	62.0%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 75. Percent 11th Grade Students Reported to Be Overweight or Obese, by State and County, 2012, 2014, and 2016

	2013	2015	2017
Oregon	11.6%	13.5%	14.4%
Jackson County	11.5%	12.5%	9.6%
Josephine County	13.4%	13.5%	15.7%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016
NOTE: BMI calculation based on self-reported height and weight

Asthma

Appendix Table 76. Age-Adjusted Percent Adults Reported Current Asthma, by State and County, 2012-2015

	Percent
Oregon	11.1%

Jackson County	11.1%
Josephine County	10.6%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Diabetes

Appendix Table 77. Age-Adjusted Percent Adults Reported Diabetes Diagnosis, by State and County, 2012-2015

	Percent
Oregon	9.1%
Jackson County	7.7%
Josephine County	7.2%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Heart disease

Appendix Table 78. Age-Adjusted Percent Adults Reported Ever Had a Heart Attack, by State and County, 2012-2015

	Percent
Oregon	3.2%
Jackson County	3.1%
Josephine County	3.3%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Cerebrovascular disease

Appendix Table 79. Age-Adjusted Percent Adults Reported Ever Had a Stroke, by State and County, 2012-2015

	Percent
Oregon	2.7%
Jackson County	2.7%
Josephine County	4.6%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Risk factors

Appendix Table 80. Age-Adjusted Percent Adults Reported High Blood Cholesterol, by State and County, 2012-2015

	Percent
Oregon	31.3%
Jackson County	30.3%
Josephine County	31.8%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 81. Age-Adjusted Percent Adults Reported High Blood Pressure Diagnosis, by State and County, 2010-2013

	Percent
Oregon	29.3%
Jackson County	27.4%
Josephine County	25.9%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Cancer

Appendix Table 82. Age-Adjusted Percent Female Adults (21-65 Years) Reported Pap Smear in Past Three Years, by State and County, 2012-2015

	Percent
Oregon	80.6%
Jackson County	82.6%
Josephine County	63.0%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015
NOTE: Out of those who did not have a hysterectomy

Appendix Table 83. Age-Adjusted Percent Female Adults (50-74 Years) Reported Mammogram in Past Two Years, by State and County, 2012-2015

	Percent
Oregon	77.1%
Jackson County	67.7%
Josephine County	72.3%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 84. Age-Adjusted Percent Adults (50-75 Years) Reported Meeting Colorectal Cancer Screening Recommendations, by State and County, 2012-2015

	Percent
Oregon	69.4%
Jackson County	61.4%
Josephine County	56.3%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 85. Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	434.0
Jackson County	427.1
Josephine County	462.4

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 86. Female Breast Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate

Oregon	125.0
Jackson County	134.6
Josephine County	146.0

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 87. Colorectal Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	34.9
Jackson County	36.4
Josephine County	43.1

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 88. Lung Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	56.3
Jackson County	60.0
Josephine County	71.4

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 89. Cervical Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	6.8
Jackson County	6.8
Josephine County	7.7

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Appendix Table 90. Prostate Cancer Incidence Rate per 100,000 Population, by State and County, 2011-2015

	Rate
Oregon	95.3
Jackson County	81.8
Josephine County	83.9

DATA SOURCE: Oregon Health Authority, Oregon State Cancer Registry, 2011-2015

Substance Use

Appendix Table 91. Heroin Overdose Hospitalization Rate per 100,000 Population, by State and County, 2010-2014

	Rate
Oregon	1.5
Jackson County	1.8
Josephine County	--

DATA SOURCE: Oregon Health Authority, Center for Health Statistics, Public Health Division, Oregon Hospital Discharge Data as cited by Opioid Data Dashboard, 2010-2014
NOTE: Rate not calculated for Josephine County due to small numbers

Appendix Table 92. Rate of Discharges for Hospital Stays Related to Substance Use per 100,000 Population), by State and County, 2014

	Alcohol	Cannabis	Drug-induced mental disorders	Hallucin-ogens	Opioids	Stimulants	Other
Oregon	577.6	198.4	73.8	7.7	280.7	204.7	63.7
Jackson County	694.3	250.1	87.9	18.9	406.4	236.9	78.2
Josephine County	756.6	256.1	86.9	17.6	225.6	256.1	79.9

DATA SOURCE: Agency for Health care Research and Quality, HCUPnet, 2014
NOTE: Other includes sedatives, hypnotics, anxiolytics, tranquilizers, barbiturates; note: all stay-type and substance-type rates are crude rates per 100,000 population

Communicable diseases and related risk factors

Hepatitis

Appendix Table 93. Crude Chronic Hepatitis C Rate per 100,000 Population, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	140.3	147.3	143.6	146.5
Jackson County	145.0	200.2	175.5	180.1
Josephine County	208.1	197.1	215.4	238.6

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016; Orpheus, 2017
NOTE: Rates represent newly diagnosed cases per year; 2017 rates are preliminary and were calculated using 2016 population estimates via OPHAT

Appendix Table 94. Crude Viral Hepatitis (Hepatitis A) Rate per 100,000 Population, by State and County, 2014-2016

	2014	2015	2016
Oregon	0.4	0.6	0.4
Jackson County	0.0	0.0	0.0
Josephine County	0.0	0.0	0.0

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016

HIV

Appendix Table 95. HIV Infection Rate per 100,000 Population, by State and County, 2014-2016

	2014	2015	2016
Oregon	6.1	5.6	5.5
Jackson County	8.1	6.1	6.0
Josephine County	NA	NA	NA

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016
NOTE: NA denotes rate not calculated due to small counts

Sexually transmitted infections

Appendix Table 96. Crude Early Syphilis (Primary, Secondary & Early Latent) Incidence Rate per 100,000 Population, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	10.7	14.3	14.5	14.1

Jackson County	4.3	6.6	8.4	13.8
Josephine County	8.4	N/A	N/A	12.7

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016

Appendix Table 97. Crude Gonorrhea Incidence Rate per 100,000 Population, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	57.8	80.6	106.3	122.7
Jackson County	68.5	44.9	81.7	100.2
Josephine County	88.5	93.2	97.8	98.9

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016; Orpheus, 2017

Appendix Table 98. Crude Chlamydia Incidence Rate per 100,000 Population, by State and County, 2014-2017

	2014	2015	2016	2017
Oregon	386.7	406.3	425.5	455.2
Jackson County	304.5	325.9	348.7	432.3
Josephine County	264.3	299.7	366.7	385.3

DATA SOURCE: Oregon Public Health Assessment Tool, 2014-2016; Orpheus, 2017

Influenza/pneumonia

Appendix Table 99. Age-Adjusted Percent Adults Reported Had Flu Shot in Past Year, by State and County, 2012-2015

	Percent
Oregon	37.7%
Jackson County	29.7%
Josephine County	27.7%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 100. Age-Adjusted Percent Adults (65+ Years) Reported Had Flu Shot in Past Year, by State and County, 2012-2015

	Percent
Oregon	57.1%
Jackson County	47.9%
Josephine County	48.0%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Vaccinations

Appendix Table 101. Percent Children Aged Two Years Up-To-Date on Vaccines (4:3:1:3:3:1:4), by State and County, 2015-2017

	2015	2016	2017
Oregon	64%	66%	68%
Jackson County	60%	62%	63%
Josephine County	63%	60%	64%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2015-2017

Appendix Table 102. Percent Adolescents Aged 13 to 17 Years with Meningococcal Vaccination, by State and County, 2015-2017

	2015	2016	2017
Oregon	70.3%	74.0%	75.2%
Jackson County	52.7%	55.8%	59.6%
Josephine County	52.8%	55.8%	58.3%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2015-2017

Appendix Table 103. Percent Adolescents Aged 13 to 17 Years with HPV (1+) Vaccination, by State and County, 2015-2017

	2015	2016	2017
Oregon	55.9%	60.9%	64.7%
Jackson County	42.6%	47.1%	51.4%
Josephine County	36.4%	39.0%	42.6%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2015-2017

Appendix Table 104. Percent Adolescents Aged 13 to 17 Years with Up-To-Date HPV Vaccination, by State and County, 2017

	Percent
Oregon	44.3%
Jackson County	31.9%
Josephine County	27.5%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2017

Appendix Table 105. Percent Children in Kindergarten with Non-Medical Exemption for Any Vaccine, by State and County, 2016-2018

	2016	2017	2018
Oregon	6.2%	6.5%	7.5%
Jackson County	8.0%	8.9%	10.9%
Josephine County	11.8%	11.2%	13.5%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2016-2018

Appendix Table 106. Percent Youth (K-12) with Non-Medical Exemption for Any Vaccine, by State and County, 2016-2018

	2016	2017	2018
Oregon	4.1%	4.7%	5.2%
Jackson County	6.5%	7.1%	8.2%
Josephine County	8.2%	9.4%	10.1%

DATA SOURCE: Oregon Health Authority, Immunization Program, 2016-2018

Maternal and child health

Appendix Table 107. Percent Low Birth Weight Births, by State and County, 2014-2016

	2014	2015	2016
Oregon	6.3%	6.4%	6.5%

Jackson County	6.9%	6.5%	6.6%
Josephine County	6.7%	8.1%	6.0%

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016
NOTE: Low birth weight is defined as under 2,500 grams

Appendix Table 108. Percent Preterm Births, by State and County, 2014-2016

	2014	2015	2016
Oregon	7.7%	7.6%	7.9%
Jackson County	8.2%	8.1%	8.5%
Josephine County	10.0%	9.1%	8.1%

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016
NOTE: Preterm is defined as gestation less than 37 weeks

Appendix Table 109. Percent Births with Prenatal Care in First Trimester, by State and County, 2014-2016

	2014	2015	2016
Oregon	77.5%	79.0%	79.7%
Jackson County	78.0%	80.4%	78.2%
Josephine County	77.5%	80.4%	76.7%

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016
NOTE: Prenatal care began in first trimester

Appendix Table 110. Percent Births with No Prenatal Care, by State and County, 2014-2016

	2014	2015	2016
Oregon	0.7%	0.7%	0.8%
Jackson County	0.8%	0.9%	0.8%
Josephine County	0.8%	0.9%	1.8%

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016

Appendix Table 111. Teen Birth Rate (Mothers Aged 15-17), by State and County per 1,000 Females, 2014-2016

	2014	2015	2016
Oregon	8.5	8.0	6.6
Jackson County	9.7	9.2	8.1
Josephine County	10.2	11.7	7.0

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2014-2016

Appendix Table 112. Teen birth rates (White, Non-Hispanic Mothers Aged 15-17) per 1,000 Females, by State and County, 2008-2010, 2011-2013, and 2014-2016

	2010	2013	2016
Oregon	9.7	7.2	5.2
Jackson County	10.8	11.2	7.5

Josephine County	13.1	11.1	9.1

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2008-2010, 2011-2013, and 2014-2016

Appendix Table 113. Teen birth rates (Hispanic Mothers Aged 15-17), by State and County per 1,000 Females, 2008-2010, 2011-2013, and 2014-2016

	2010	2013	2016
Oregon	42.9	25.7	16.2
Jackson County	39.5	21.4	16.5
Josephine County	17.0	12.6	14.2

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Birth Certificates, 2008-2010, 2011-2013, and 2014-2016

Appendix Table 114. Percent Mothers Currently Breastfeeding or Feeding Pumped Milk to Infant, by State and County, 2013-2015

	2013	2014	2015
Oregon	70.8%	73.2%	74.7%
Jackson County	76.2%	65.3%	74.6%
Josephine County	--	--	--

DATA SOURCE: Oregon Health Authority, Oregon Pregnancy Risk Assessment Monitoring System, 2013-2015
NOTE: Data not available for Josephine County due to small numbers

Appendix Table 115. Infant Mortality Rate per 1,000 Live Births, by State and County, 2014-2016

	2014	2015	2016
Oregon	5.1	5.1	4.6
Jackson County	5.2	4.6	5.2
Josephine County	5.8	8.1	5.7

DATA SOURCE: Oregon Public Health Assessment Tool, Oregon Health Authority, Center for Health Statistics: Oregon Linked Birth & Death Certificates, 2014-2016
NOTE: Includes neonatal and post-neonatal mortality

Oral health

Appendix Table 116. Age-Adjusted Percent Adults Reported Dental Visit in Past Year, by State and County, 2012-2015

	Percent
Oregon	66.8%
Jackson County	62.8%
Josephine County	62.3%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 117. Percent 11th Grade Students Reported a Dental Visit in Past Year, by State and County, 2013, 2015, and 2017

	2013	2015	2017
Oregon	74.5%	74.9%	73.8%
Jackson County	72.9%	72.2%	73.4%

Josephine County	69.6%	N/A	68.5%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2013, 2015, and 2017
NOTE: No school districts in Josephine County participated in 2015; therefore, data are not available for 2015; Data includes students who went to a dentist or dental hygienist for a check-up, exam, teeth cleaning, or other dental work in past 12 months

Appendix Table 118. Age-Adjusted Percent Adults Reported One or More Permanent Teeth Removed Due to Tooth Decay or Gum Disease, by State and County, 2012-2015

	Percent
Oregon	37.8%
Jackson County	40.8%
Josephine County	52.5%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 119. Age-Adjusted Percent Adults Reported All Permanent Teeth Removed Due to Tooth Decay or Gum Disease, by State and County, 2012-2015

	Percent
Oregon	5.6%
Jackson County	4.6%
Josephine County	5.6%

DATA SOURCE: (for Oregon data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2015; (for county data) Oregon Public Health Assessment Tool, Behavioral Risk Factor Surveillance System, 2012-2015

Appendix Table 120. Percent Population Served with Water Fluoridation, by State and County, 2018

	Number of Systems	Percent of Population Served
Oregon	43	20.7%
Jackson County	0	0%
Josephine County	0	0%

DATA SOURCE: Oregon Health Authority, SDWIS, Oregon Public Health Drinking Water Online, https://yourwater.oregon.gov/fluoride.php?sort=cs, 2018

Safety and injuries

Appendix Table 121. Violent and Property Crime Rate per 100,000 Population, by State and County, 2016

	Person Crime	Property Crime
Oregon	1,055	4,748
Jackson County	1,625	7,050
Josephine County	1,215	5,094

DATA SOURCE: State of Oregon, Criminal Justice Commission, Oregon Uniform Crime Report, 2016
NOTES: Person crimes include criminal offenses where a victim is present and the act is violent, threatening, or potentially physically harmful, such as homicide, rape, sex crimes, kidnapping, and assault; Property crimes include arson, bribery, burglary, counterfeiting/forgery, embezzlement, extortion/blackmail, larceny, motor vehicle theft, robbery, stolen property, and vandalism; Classification of crimes by Oregon UCR differ from those by the National UCR

Appendix Table 122. Percent 11th Grade Students Reported Missing School Because They Felt Unsafe at School or on Their Way to/From School, by State and County, 2012, 2014, and 2016

	2014	2015	2016
Oregon	4.1%	5.7%	7.7%
Jackson County	5.1%	3.9%	6.8%
Josephine County	6.4%	6.9%	9.1%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

Appendix Table 123. Percent 11th Grade Students Reported Being Bullied at School (or on the Way To/From School) For Any Reason, by State and County, 2015 and 2017

	2015	2017
Oregon	19.9%	20.6%
Jackson County	19.0%	20.0%
Josephine County	NA	25.5%

DATA SOURCE: Oregon Health Authority, Oregon Healthy Teens Survey, 2015 and 2017
NOTES: Question was asked differently in 2013; No school districts in Josephine County participated in 2015; therefore, data are not available for 2015

Appendix Table 124. Percent 11th Grade Students Reported Being in a Physical Fight on School Property in Past Year, by State and County, 2012, 2014, and 2016

	2014	2015	2016
Oregon	6.6%	5.9%	5.8%
Jackson County	9.7%	5.3%	7.1%
Josephine County	7.1%	5.3%	4.4%

DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2012, 2014, and 2016

Appendix D – Forces of Change Assessment notes

Forces of Change Assessment

Summary of Key Forces of Change *(listed in no particular order within each grouping)*	**# Groups**
Housing	4 out of 4 groups
Workforce	4 out of 4 groups
Income, Poverty, and Unemployment	4 out of 4 groups
Population Changes and Diversity	4 out of 4 groups
Legalization of Marijuana	4 out of 4 groups
Coordinated Care Organizations (CCO)	4 out of 4 groups
Technology	3 out of 4 groups
Opioid Use/Addiction	3 out of 4 groups
Mental Health System	3 out of 4 groups
Legislative/Political Climate and Processes	3 out of 4 groups
Oral Health	3 out of 4 groups
Mental Health Issues	2 out of 4 groups
Climate Change	2 out of 4 groups
Strong Regional Identity/Pride	2 out of 4 groups
Community Collaboration Efforts	2 out of 4 groups
Food Insecurity	2 out of 4 groups
Health Care Coverage Rates	2 out of 4 groups
Emergency Management System (EMS)	2 out of 4 groups
Communication Systems	2 out of 4 groups
Transportation System, Mobility	2 out of 4 groups
Child Care Costs & Access	2 out of 4 groups

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
1. Housing	x	x	x	x	**Cost** • Availability in different price ranges - people being pushed into housing they cannot afford • High concentrations of wealth driving up housing costs • High cost • Seniors - cost burden in housing market **Quality** • People stuck in substandard housing • Habitability – in a highly competitive housing stock there is a high risk of units not being maintained **Impact on Workforce** • Workforce impact - Not being able to recruit professionals into the area • Lack of housing for service economy workforce **Homelessness** • Chronic and growing homelessness • Only dealing with homelessness through punitive measures **Stock** • Lack of housing - Need more stock **Combination of Threats** • Supply of affordable, accessible housing in the right locations **Other** • Instability in housing market due to rent increases and no cause evictions • Mobility - seniors who want to get out of a larger house into a smaller house. • Veterans impacted • Businesses impacted	**Impact on Workforce** • Trades are becoming proactive in training/expanding the workforce • Opportunity to bring businesses into working for the solutions to housing **Stock** • Increasing stock • If we are increasing stock - have opportunities to look at where we put that stock - accessibility, location, housing type **Combination of Opportunities** • Hope Village Model – people are responding well, and Medford Council just doubled units • Opportunity to extend our planning horizons for all community services. Housing stock will take many years to replenish - what else do we need to address today? **Legislative** • New community leadership looking for more comprehensive solutions to housing and homelessness • Potential legislative measures (next year) • Potential state legislative options **Other** • Need emphasis on accessible lifelong housing General recognition by all sections of housing as an issue • Medford urban growth boundary • Regionwide planning effort to address housing issues in all communities - looking at regional strategies • Relatively low density • Relative low density in local urban cores – could densify and then increase transit services

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
2. Workforce	x	x	x	x	**Housing** • Lack of housing for staff and professionals **Availability** • Lack of staff available at all professional levels • Lack of/reduced numbers of psychiatrists **Funding** • Decreased funding for case managers, navigators, community health workers, home visiting nurses • Reimbursement for case managers, navigators, community health workers, home visiting nurses **Other** • Age of providers - New providers want more of a work/life balance, potentially increasing cost of care • Workforce diversity and income diversity • Brain drain - training people up and out of the community, promotability - need to leave to get promoted	• Opportunity to grow electronic services in healthcare and consumer credit counseling - job creation • Support “without borders” • Long term handholding from case managers, navigators, community health workers, home visiting nurses

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
3. Income, Poverty, and Unemployment	x	x	x	x	**Income/Wages** • Cost living relative to income • Stagnant wage and deregulation of worker safety • Increased minimum wage – risks of expenses to businesses **Poverty** • Intergenerational poverty and associated criminality and need for addiction providers • Masked issue of poverty based on how we measure it **Other** • Low unemployment rate (less jobs, less opportunities) • Increased debt load, especially for young people (student loans) – can't afford housing, children, cars • Lack of economic diversity and vitality - Not a lot of big employers that create economic stability • Workforce diversity and income diversity	• Federal money for addiction providers • Increased minimum wage providing increased wages and benefits • Low unemployment rate means more people are employed

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created

4. Population Changes and Diversity	x	x	x	x	**Specific Populations**
					• Increase in LGBTQ populations
					  - Lack of educational support
					  - Increased needs for mental health support
					• POC folks feeling unwelcome, experiencing hostility
					• Bullying up in schools around race/ethnicity
					• Gentrification of communities - pushes diverse populations into specific, poorer neighborhoods
					• Aging population in our region - Trend (65+ is the fastest growing demographic group)
					  - Coming crisis in caregivers – we don't have the workforce, we don't have the wages we need to sustain this workforce
					  - Impact of aging populations on schools, development of health care areas, etc.
					  - Memory care needs are different
					• Uniqueness of millennials
					  - Disease risks
					  - Possible changes in utilization
					  - Change from untraditional PCP model
					Resources
					• Population growth - competition with bigger communities for funding, lack of adequate resources
					Other
					• Increasing diversity of the community – not recognized, lack of support
					• People are leaving our community or staying home and not accessing services, children are being held home from school
					• Local and national climate of fear
					• IP 22
						• Increased diversity of the community
						• Aging population in our region - Trend (65+ is the fastest growing demographic group)
						  - Build on community health worker model to elevate caregivers at the state level
						  - Plan how to engage people later
						• Generational change is looking like it may help with racial equity issues
						• Need to focus more resources on identifying solutions for racial equity issues that have remained largely unacknowledged and unaddressed by the wider community
						• Increased focus on equity - reach more populations (disparity)
						• Diversity conference/attract people to the field
						• Uniqueness of millennials: education

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
5. Legalization of Marijuana • Pull back on THC • More people are growing hemp now	x	x	x	x	**Money** • Economics not seen (where's $?) • Making money usable (via banks) • Lack of dollars coming back into the system **Land/Water** • Driving land prices up • Impacting food production (taking away agricultural land) • Changing the value of agricultural land • Impacts on water - environmental **Workforce** • Employment • High risk for employees **Other** • Lack of research, understanding (don't know) • Long term impact on health not known (unintended consequences for younger population who will have access that other generations have not) • Increased access for teens • Area reputation • Community security in rural areas • Pull of creation of parallel businesses can pull contractors from building housing • Disruptive	**Workforce** • Employment (jobs) • New jobs paying more than min wage • Creation of entrepreneurs **Economy** • Number of parallel business that have started (labs, garden centers, lighting, security) • Boost the economy • Tax revenue **Investments in Health** • More money for SDOH, healthcare, education • Opportunity for industry to become a good citizen and fund vital needs like SBHC **Other** • Area reputation • Limiting entry into criminal justice system • Expanded research opportunities • Some health impacts of medicinal

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created
6. Coordinated Care Organizations (CCO) • The delivery system • Evolution and transition of CCO's	x	x	x	x	• Instability among private market insurance providers under the ACA • Decreased funding - will impact investment in other long-term issues, eg., SDOH • 2019 • Multiple CCOs • Competitive? • Instability with ACA providers in private market • CCO 2.0 • Funding to support goals • Changes in system of care • Unknowns make it hard to plan • Different issues for those who are insured, those who are on state insurance, and those who have no coverage. • State investments specific to Medicaid population - no one is talking about Medicare • Access issues for privately covered people • Parity issues • Lack of global budget for CCO's (things are still siloed) • Medicare population • Oregon tax system and revenue generation - all of these things we need to fund, you've got to have revenue **Increase push for coordination of care and communication** • Is it working for patients/consumers? • Are we using efficiently? Increased burden on small agency staff for paperwork and admin	• Opportunities to use CCO's in Oregon in response to threat "a" • 2019 • Innovative efforts • Create global budgets • Opportunity to use CCOs as providers under ACA to preserve coverage • Created political opportunity to have shared conversations and mobilize around how we use Medicaid dollars • CCO 2.0 • More focus on SDOH **Increase push for coordination of care and communication** • VA system successful model that is working • We have a community that knows each other • People care about this community and want to make it stronger • We have many of the core orgs that are necessary

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
7. Technology	x		x	x	**Telemedicine** • Telehealth issues • No funding for tele-med systems • Fear of the quality of services • Jobs may not stay here (tele-med can come from somewhere else in the country) • Privacy issue around tele-med, increase risk in large amounts of data being leaked (intentional or not) • Telemedicine can be outsourced **Broadband** • Low access to broadband • No existing rural platform • No money for system • Incongruity of care with people who don't have access • Rely on tech for communications, but rural areas don't have access • Access to apps and tools • Digital inequity **Other** • Whether the increase EMR was creating a burden on small agencies, and whether we are using it efficiently • Overuse of technology in things like parenting • K-12 no self-regulation because of abundant use of screens of kids entering the system	**Telemedicine** • Tele-med may make people living here more able to serve people in other areas. • Potential for work/life balance through tele-med • Increasing Health literacy - increasing • Self-care: helping people manage their disease. • Opportunity for telehealth with hard-to-recruit specialty care. Addressing needs in rural communities. **Broadband** • Leverage federal and state resources for broadband in rural areas to give services to people in poverty and leverage resources like tele-med **Other** • How to reach millennials • Explosion of apps & tools that could change health care delivery dramatically. • The tech in health care makes it easier to measure outcomes, quality (beyond tele-med) • Better integration of healthcare • Already have a great HIE here • Assessing of threats in education due to lack of self-regulation of kids entering the system

8. Opioid Use	x	x		x	**Health** • Increase of HepC, HIV associated with injection drug use, • Increase in STI's • Spike in deaths **Other Drugs** • As people reduce opioids, the may change to using other drugs (fentanyl, heroin) • Synthetic drugs on the market – dangerous products flooding market and people don't always know what's in the drug due to cutting **Impact on Families** • Drug affected infants • Social impact - isolation, degradation, family instability • Children who don't have hope - continues the cycle • Intergenerational drug use/ opioid use and addiction **Impact on Social Systems** • Impact on law enforcement, social services. • Secondary trauma for all service agencies • Burden on the foster system and capacity to address the needs of children and house them **Addiction System Changes** • Capacity • There is still stigma around addiction • Access to services • Oregon Administrative Rules (OAR) and training requirements are different **Other** • A lot of dangerous opioid products flooding our community because of I-5 (highway) • Transitioning veterans off of opioid pills to lifestyle very difficult and disruptive for veterans • Cannibalizes our workforce - younger people who would be otherwise contributing are lost.	**Treatment** • Opportunities to expand alternatives to opioids – need more reliable and effective alternatives • Alignment around MAT development • Expand alternatives and alternative treatments **Addiction System Changes** • Develop capacity that is needed • ARC has grown • Access - make it easier • Stigma • CCO/OHA RFI to develop residential care • Better quality of care **Funding** • Looking at federal and state grant opportunities around high intensity drug trafficking areas (HIDTAs) **Approaches/Recommendations** • Increased peer support • Exploring innovative models from other areas • Safe use injection sites • Max's Mission/Naloxone • Oregon Pain Guidance (OPG) • Support groups for families who are affected • Continuation and expansion of the Stay Safe Oregon campaign • Use the public attention to rebuild the addiction system • ROC Court - drug court • Prescription Drug Monitoring Program • To be able to educate people about taking, becoming more educated and questioning in regards to their own health care. Pharmacy led and doctor led. Questioning how much medication they need - more personal responsibility. • Challenge direct consumer marketing for medication • Transitioning veterans off of opioid pills to lifestyle
9. Mental Health System	x	x		x	**Youth**	**Youth**

• Change and Evolution					• Increase in need for MH services among young people (anxiety, depression, suicide - high schoolers, LGBTQ, people of color) • Trend emerging around decreasing/declining mental health among young people • We need the schools, but they are so strapped! **Navigation** • Confused clients - not knowing where to go, how to get help. **Providers** • Lack of providers to provide services to diverse communities **Stigma** • Stigma with specific population groups, stigma across all population groups **Other** • A lot of people are seeking mental health care in EDs. Number isn't changing based on data, but perception is that more people are seeking care in EDs	• Identifying kids who might be more likely to be headed for trouble - multiple ACES, or actual behaviors. • SORS leadership to help with CHA for schools in key priorities **Schools** • Use the schools, but how? • Need to seize opportunity between the school leadership and CHA process to put a bit more "how" to the plan. • Help schools do more – parenting **Stigma** • Perception that some people are not feeling as much stigma as much as struggling with access (general population). **Legislative** • Bipartisan support for investing in behavioral health • Have state and feds investing in the Medicaid arena, or indigent arena • State investments specific to Medicaid population - Need legislation for Oregon waivers for Medicare and expanding the workforce that serves that population **Other** • Looking at new and different ways to approach mental health needs (CHW, more flexibility in mental health system) • Potential for increased resources and access • Think about preventive and activities that promote positive mental health, vs. just treatment of disease. • Asking and receiving and utilizing care • Expand the health care integration across the safety net structure in the private HC structure • Defining what integrated behavioral health is - including focus on case management • We have more suicide prevention programs

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created
10. Legislative/Political Climate and Processes	x	x		x	**Process** • Local and state legislative/government processes lack transparency/communication **Funding** • Opposition to taxes, local bonds and levies • Need outcome-based budgeting • $800 million gap for 2019 Oregon Legislative Session - Could collapse coverage levels - Community funding could go away - CCOs transformation funds, medical system stability overall - Jobs (less for FQHCs than other clinics) **Other** • Lacks community • National Election – from liberal to conservative poses risk to health care and changes to the labor system • Nationwide legislative anxiety • Government (all levels) viewed as inefficient and ineffective **Specific Legislation** • IP 1 – outlaw public (not federal) funding for abortion • IP22 – repeal sanctuary state law • IP37 – Ban on taxing groceries – attempt to pre-empt sugary drinks taxes • Measure 101 passing - political will for healthcare overage/equity of coverage	**Process** • Need to do analysis of how process communicated, how (if) effective **Funding** • Opportunity for bipartisan support to aggressively fund mental health **Other** • More people getting engaged in local politics – attending meetings, running for office **Specific Legislation** • Measure 101 – Passed with a 2/3 majority - Oregonians have spoken about how important healthcare access and transformation is • Measure 98 - Increased schools funding could increase grades
11. Oral Health		x	x	x		

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
12. Mental Health Issues	x			x	• Social isolation – loneliness, suicide, risk of mental health • Increase in suicides **Youth** • Long-term education impact and impact on school staff of children with behavioral issues • Trauma informed care practices (ACES) - Doesn't help align with traditional practices. 3 kids murdered parents this year - drain to all systems • Widespread and growing sense of lack of hope - even in very young children • Increases in disruptive behavior in young children • Kids coming into Kindergarten not ready to learn – barriers to early learning and high cost of childcare • FORCE: early learning gaps • High rates of anxiety/depression and suicide among middle/high schoolers	• Social isolation Ability to approach community from a view of community not individuals • Trauma informed care practices (ACES) - Increased awareness of TIC, needs, issues • Increase mental health • Strengthen safety nets including social determinants of health
13. Climate Change	x			x	• Water resource management issues • Air quality issues • Impacts on most vulnerable i.e. farmworkers and homeless • Fire and smoke season and its impact on health, tourism/livelihoods, and risks to homes	• People are mobilizing/responding
14. Strong Regional Identity - State of Jefferson, Regional pride	x			x	• Distrust/skepticism of Salem/Portland/National sources, leaders, recommendations • Skepticism of evidence-based health approaches – and increase in alternative medicine • Sense that decisions are made elsewhere that impact people here and that we have little/no agency over those decisions	• Community resilience • High level of collaboration • Can do a lot with a little sometimes

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created
15. Community Collaboration Efforts	x		x		• Does funding support collaboration?	• SORS, SOELS, suicide issues • CHA/CHIP • Move beyond competition
16. Food Insecurity	x			x	• Farm bill cutting SNAP benefits and access to farmers markets • Prices for agricultural land is very high • Impacts from newly legal cannabis industry on agriculture as a whole – large factor in driving prices up • Long-term impacts to health and well-being	• Increasing consciousness about food quality • Local orgs working to help people access safe, healthy, nutritious • Local movement for local food - RV Food systems Network
17. Health Care Coverage Rates	x			x	• M101 • ACA repeal effort • IP 1 - • High deductibles, makes unaffordable	• counter movement to expand coverage • RHEA • Single payer movement • 95% covered
18. Emergency Management System (EMS)	x	x				• Effective in events
19. Communication Systems	x	x			• Lack of info • Ongoing changes • Community perception without knowledge • 211	• Increases access to resources • 211
20. Transportation System, Mobility	x			x	• Threats to funding for public transit • Local bond sunsetting in 2021 • Need more infrastructure and systems • Recent survey indicated that transportation is the #1 barrier for women and #2 barrier for men for access to addiction services	• Push for walkable/active lifestyle • Planned neighborhoods and city planning – opportunity in S.O. • More accessible housing – saves money over time on repairs and retrofits and increases livability • After hours support (CCOs, hospitals, United Way) • State legislation without increase funding • Better opportunities for those in poverty
21. Child Care Costs & Access	x			x	• Increased costs • Lack of access, safety, quality • #2 barrier for women	• Improvements with early learning work

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created
22. Focus on wellness in the health system	x				• Decreasing hospital sizes • Need for more PCPs	• Healthier community
23. Social mobility of families	x				• Educational attainment	• More opportunities to track families, kids, education, etc.
24. Work requirements for SNAP recipients	x					
25. Justice systems	x				• Jail space • Funding for one program vs. others	• Other opportunities vs. jail
26. Vaccination rates	x				• Increased outbreaks • Increased disease rate	
27. Lack of metrics and data for quality improvement	x				• Inability to agree on approach to improve community-based issues • Need more metrics/data • Qualitative approaches	• Long term improvements to systems
28. Resources / Access	x				• With 3 new urgent cares for Asante, they are seeing 67,000 visits a year. ED visits have stayed the same • Understanding of how to access • Push back to access • Stigma • Constant barriers to accessing services = overwhelming process to continue to move forward	• Resources exist
29. Funding sources - how we address problems			x		• Who is going to pay for what we decide? Behavioral Health… • Feels like a nearly impossible problem	

Forces (Trends, Events, Factors)	Group 1	2	3	4	Threats Posed	Opportunities Created
30. Strong head start programs	x					• Supports families • Serve meals
31. Grants Pass rural designation change			x			
32. Medford's urban growth boundary expansion			x			• How do we seize this opportunity to really address the population projections? •
33. FQHC evolution and medical homes		x			• Pharmacy costs!! Dollars are key • Mental Health drugs more locally done? • We look at data differently • People don't understand the system and the positive changes we've had	• Keep track of data to show that preventive care works • Educate public about ways to be a frugal healthcare consumer/good patient/civic engagement • Shift where to spend healthcare dollars
34. Safety Net Clinics	x				• Competitive? • Federal health $	• Helped support overall health system transformation
35. Accountable Health Communities program	x				• Length of time to collect info	• Screening OHP members on SDOH • Tracks outcomes/needs
36. Downsizing of Josephine County Public Health		x				

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
37. Social Determinants of Health (SDOH)		x				• Involving commercial HC plans in community health and SDoH • Can we encourage the workforce we need (like through STEM) • LPC vs LCSW - addiction co-training • Parity for LPCs
38. Chronic Disease Epidemic - especially in aging population and low economic status.			x		• Expensive to treat comorbidities • Getting it on both sides with the aging population and then the low SES	
39. Restructuring of how we receive payments for services; how organizational structure went from OHP to CCOs					• Federal changes, uncertainty in how ACA is funded	

Forces (Trends, Events, Factors)	Group				Threats Posed	Opportunities Created
	1	2	3	4		
40. Local Health System Trends				x	• Chaos in our addictions and mental health systems and barriers to access • Increase of STIs	• Build on successes of Blue Zone Projects – such as working with employers • Increased emphasis on social determinants of health and upstream work – threat is sustainable funding for CCOs and the future of OHP • New community wide emphasis on ACES (adverse childhood experiences) • Successful models • Telemedicine • Electronic medical records • Recent expansion in our region of medical interpreters in S.O. for deaf and Spanish speaking • We're doing more work getting the people actually impacted by policies into the process – increase this
41. Response to instability				x	• People feel increasingly pitted against each other	• Opportunities to emphasize the common interests – public health • Have a combined health assessment • Next step would be to take action based on collectively identified gaps

Appendix E – Local Public Health System Assessment notes

Local Public Health System Assessment

Performance Score Legend

LPHSA Performance Scores				
0% or absolutely no activity.	Greater than zero but no more than 25% of the activity described within the question is met.	Greater than 25% but no more than 50% of the activity described within the question is met.	Greater than 50% but no more than 75% of the activity described within the question is met.	Greater than 75% of the activity described within the question is met.
No Activity (0%)	**Minimal Activity** (1–25%)	**Moderate Activity** (26–50%)	**Significant Activity** (51–75%)	**Optimal Activity** (76–100%)

Average Performance Scores for Essential Services

Essential Services	**Average LPHSA Performance Scores**	**Average Health Equity Performance Scores**
Essential Service 1: Monitor Health Status to Identify Community Health Problems	37.5	25.0
Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards	80.8	16.7
Essential Service 3: Inform, Educate, and Empower People about Health Issues	55.6	43.8
Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems	53.6	25.0
Essential Service 5: Develop Policies and Plans That Support Individual and Community Health Efforts	45.8	50.0
Essential Service 6: Enforce Laws and Regulations That Protect Health and Ensure Safety	64.6	50.0
Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable	56.3	58.3
Essential Service 8: Assure a Competent Public Health and Personal Healthcare Workforce	58.3	30.0
Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	65.4	50.0
Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems	40.9	37.5

Model Standards Average Performance Scores & Discussion Notes

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 1: Monitor Health Status to Identify Community Health Problems				**37.5**
Model Standard 1.1: Population-Based Community Health Assessment				**25.0**
1.1.1 Conduct regular CHAs?				50
1.1.2 Update the CHA with current information continuously?				0
1.1.3 Promote the use of the CHA among community members and partners?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• CHA's are done often by varying organizations/ communities	• While CHA's are done, they are not consistent, they are segmented, they are not all inclusive of entire system partners • Information becomes outdated quickly, measurable goals not followed up on. Information not updated with current information	• New partnership with current CHA in progress with plan for sustainability	• See ratings above.	
Model Standard 1.2: Current Technology to Manage and Communicate Population Health Data				**33.3**
1.2.1 Use the best available technology and methods to display data on the public's health?				50
1.2.2 Analyze health data, including geographic information, to see where health problems exist?				25
1.2.3 Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Our community has placed high value on the importance of data and outcomes for system improvement in recent years. • CCOs providing data.	• Systems remain disjointed and access to all systems is limited. No community dashboard or agreed upon metrics. • Difficult to get data at the specific community level which makes change difficult	• A database of all databases, who has access, with data dictionary.	• Investment into the PHS so organizations have the resources needed to both contribute and use data	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 1.3: Maintaining Population Health Registries				**62.5**
1.3.1 Collect timely data consistent with current standards on specific health concerns in order to provide the data to population health registries?				75
1.3.2 Use information from population health registries in CHAs or other analyses?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Registries are established and integrated. They function well, and they are accessible. • Efforts to place more emphasis on chronic conditions in addition to the traditional acute issues.	• It's very funding-focused. • Not everyone knows which registries exists • Treating public health data as if it's proprietary (what are the barriers to releasing data?)	• Community, including CCOs, can come to agreement on health outcomes to prioritize as well as the sharing of data.	•	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards				**80.8**
Model Standard 2.1: Identifying and Monitoring Health Threats				**75.0**
2.1.1 Participate in a comprehensive surveillance system with national, state, and local partners to identify, monitor, and share information and understand emerging health problems and threats?				75
2.1.2 Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies, and emerging threats (natural and manmade)?				75
2.1.3 Ensure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Strong surveillance system in place for acute and communicable disease. We do a good job in emergency preparedness and using the information for response.	• Tracking and responding to chronic, persistent disease with emphasis on mental health and addition. • Surveillance systems for dental issues. • Emerging issues related to legal state changes such as marijuana use and abuse. What is the impact of legalization? • Waiting on labs for results to report suspected diagnoses and other variations in timely reporting expectations		• Ongoing education on what should be reported to providers and individual staff members due to variation in understanding of reporting practices. • Better systems to report secondary and tertiary diagnoses.	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 2.2: Investigating and Responding to Public Health Threats and Emergencies				**83.3**
2.2.1 Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?				100
2.2.2 Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?				75
2.2.3 Designate a jurisdictional Emergency Response Coordinator?				100
2.2.4 Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?				75
2.2.5 Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?				75
2.2.6 Evaluate incidents for effectiveness and opportunities for improvement (such as After Action Reports, Improvement Plans, etc.)?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• We have a lot structure in policy and written procedure. • Depending on the emergency, and once the community is aware, the response is rapid and robust	• Need expanded use of exercises and drills. • Not all Emergency Response Coordinators are dedicated full-time to that role.		• Education and training on detection of various threats and how and when to notify associated response team	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 2.3: Laboratory Support for Investigating Health Threats				**81.3**
2.3.1 Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?				75
2.3.2 Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?				75
2.3.3 Use only licensed or credentialed laboratories?				100
2.3.4 Maintain a written list of rules related to laboratories, for handling samples (including collecting, labeling, storing, transporting, and delivering), determining who is in charge of the samples at what point, and reporting the results?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Strong laboratory network and access, very good at responding to emerging diseases as well. Most are open 24/7	• State lab consistency and enforcement around training by lab of specimen handling, collection, transportation. • Provider reporting suspect cases while in transport to lab. • Rules are constantly changing.			

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 3: Inform, Educate, and Empower People about Health Issues				**55.6**
Model Standard 3.1: Health Education and Promotion				**58.3**
3.1.1 Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?				75
3.1.2 Coordinate health promotion and health education activities at the individual, interpersonal, community, and societal levels?				50
3.1.3 Engage the community throughout the process of setting priorities, developing plans, and implementing health education and health promotion activities?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• SOS getting a lot of information out around ACEs • developing non-media social, so tabling, community. • Jenny direct care public information more so than policymakers and stakeholders; sharing information through collaborative efforts with other professional organizations. Folks are hearing • messaging reinforcement may be strong, but not cohesive beyond jurisdictions • a lot of community collaboration around	• a lot of red tape, slow getting priorities to the forefront • LPH caution about bringing forth political issues • strong collaborations that maybe struggle to partner with new groups/voices. • for consumers it is still challenging to find health promotion opportunities; hard to get messages out and get access to resources • calling 2-1-1 is weird and tough to navigate; funding is not stabilized so a challenge of bringing awareness to something that may not be updated	• systems of care groups in both counties (Options and Jackson County MH/JCC/Options/AC) both groups working on a common referral process; • coordinated referral system • Reliance was JHIE; has to be people who are in the system and there are e-referrals • Authentic engagement of those who are most deeply impacted; a lot of expecting people to come to us • When decisions are made without community and then the fall out of that. So how do we begin with community and get to a decision. • Gathering where people are; schools.	• normalizing asking for help; google ads for 211?	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 3.2: Health Communication				**50.0**
3.2.1 Develop health communication plans for media and public relations and for sharing information among LPHS organizations?				25
3.2.2 Use relationships with different media providers (e.g., print, radio, television, the Internet) to share health information, matching the message with the target audience?				50
3.2.3 Identify and train spokespersons on public health issues?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Seems like a lot of communications are coming out with multiple agency logos attached • Southern Oregon Meth Project; television station donated time for this. • Good at communicating urgent and emergent public health issues (e.g., fires, flu, etc.) • Getting better at matching messaging to the audience	• With shared messaging the question is always who is carrying the work? • Communication happening ad hoc among LPHS but not formally. • Need a more diverse group of spokespersons	• Messaging around syphilis • Ashland Chamber of Commerce working with ACH to develop a job satisfaction survey	• CHIP Report, monthly report out to partners	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 3.3: Risk Communication				**58.3**
3.3.1 Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?				75
3.3.2 Make sure resources are available for a rapid emergency communication response?				75
3.3.3 Provide risk communication training for employees and volunteers?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Accreditation with Jackson County PH really ramped this area up. • Partners respect local government as point of contact for all emergency communications around emergencies. • Strong relationships with local media make communication with public easier. Local media sees themselves as an integral. • Internal plans are in place for risk communications, but only for those who are actually involved in communicating.	• Question: do we have communications for different language audiences? • Diversity of messengers • What does it look like if/when cell systems go down? Partners curious to know how public will be alerted. • We suspect that PIOs from the other organizations are talking to one another, but none of us here know.	• Communication to partners about how this process works	•	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems				**53.6**
Model Standard 4.1: Constituency Development				**50.0**
4.1.1 Maintain a complete and current directory of community organizations?				25
4.1.2 Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?				50
4.1.3 Encourage constituents to participate in activities to improve community health?				75
4.1.4 Create forums for communication of public health issues?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• SOS has a big resource list of community organizations: health care, mental health care, education, early learning, public agencies, etc. Peter Buckley is the coordinator for that page. Need to promote it more broadly. • Last few years there has been new partners coming to the table as they consider how they are part of improving health. • Project Community Connect. • There are a lot of encouragements for getting constituents to improve community health; difference between encouragement and actual arrival. • People showing up for forums around marijuana, housing... • Good at engaging professionals	• We are consistently bringing community around issues we as professionals identify, as opposed to having the communities bring forth their issues. • Being flexible enough to meet the community where they are at (e.g., smoking cessation v stress reduction strategies). • Not so good at consistently engaging community around public health issues; when they do show up next steps are unclear, momentum lost	•	• Bringing together CHA/CHIP partners around a sustained CHIP implementation project (2-3) issues	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 4.2: Community Partnerships				**58.3**
4.2.1 Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?				50
4.2.2 Establish a broad-based community health improvement committee?				75
4.2.3 Assess how well community partnerships and strategic alliances are working to improve community health?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Great at gathering, struggle with actually developing a cohesive approach developed. • ACEs trainings really came out of the CCOs and education and law enforcement. • 3 CCOs are continually hitting their incentive metrics, quality improvement metrics. • Doing a better job of assessing outcomes of the partnership, not necessarily how well the community partnerships and strategic alliances are working.	• Energy for gathering together around an issue, sometimes struggle with work being too broad and it is hard to specify forward thrust from there • Struggle to develop collaborative, systems-wide metrics that will help us measure community health. • Can only assess based on partners that show up.	• Accountable Health Communities will help us get data to support 4.2.3	• Accountable Health Communities will help us get data to support 4.2.3	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 5: Develop Policies and Plans That Support Individual and Community Health Efforts				**45.8**
Model Standard 5.1: Governmental Presence at the Local Level				**66.7**
5.1.1 Support the work of the local health department (or other governmental local public health entity) to make sure the 10 Essential Public Health Services are provided?				75
5.1.2 See that the local health department is accredited through the PHAB's voluntary, national public health department accreditation program?				50
5.1.3 Ensure that the local health department has enough resources to do its part in providing essential public health services?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Jackson County Public Health is accredited. • CCOs provide a lot of support in Jo Co. • Both counties work with CCOs. • CCOs support syringe exchange in Jackson County	• CCOs don't support syringe exchange in JoCo. • JoCo had recently put out an RFP for many public health services.	• JoCo will be pursuing accreditation.	• JoCo will be pursuing accreditation.	
Model Standard 5.2: Public Health Policy Development				**25.0**
5.2.1 Contribute to public health policies by engaging in activities that inform the policy development process?				25
5.2.2 Alert policymakers and the community of the possible public health effects (both intended and unintended) from current and/or proposed policies?				25
5.2.3 Review existing policies at least every three to five years?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Guidance from the Oregon Health Authority to local public health authorities. • OHA involves LPHAs when crafting new administrative rules. • Jackson County has a prevention coalition that makes recommendations for PH ordinances/policies	• Political climate can be challenging to pass local PH policies. • Some local county policy makers don't have in depth knowledge of public health.	• Finding local champions for policies.	•	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 5.3: Community Health Improvement Process and Strategic Planning				**41.7**
5.3.1 Establish a CHIP, with broad-based diverse participation, that uses information from the CHA, including the perceptions of community members?				75
5.3.2 Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?				25
5.3.3 Connect organizational strategic plans with the CHIP?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Current JRHA process will greatly improve CHA/CHIP collaboration.	• Current CHIP doesn't have common metrics or way to evaluate	• Having all partners participate in the CHIP.	• Identifying common metrics • Have a broader CHIP, and broader CHIP organizational involvement/engagement	
Model Standard 5.4: Planning for Public Health Emergencies				**50.0**
5.4.1 Support a workgroup to develop and maintain emergency preparedness and response plans?				75
5.4.2 Develop an emergency preparedness and response plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?				50
5.4.3 Test the plan through regular drills and revise the plan as needed, at least every two years?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Have Emergency Management workgroups in both counties. This included Public Health and hospitals. • Actual emergencies frequently test the plans, especially wildfires.	• Plans are revised every 5 years. • Not enough drills/exercises.			

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 6: Enforce Laws and Regulations That Protect Health and Ensure Safety				**64.6**
Model Standard 6.1: Reviewing and Evaluating Laws, Regulations, and Ordinances				**62.5**
6.1.1 Identify public health issues that can be addressed through laws, regulations, or ordinances?				75
6.1.2 Stay up-to-date with current laws, regulations, and ordinances that prevent health problems or that promote or protect public health on the federal, state, and local levels?				75
6.1.3 Review existing public health laws, regulations, and ordinances at least once every three to five years?				25
6.1.4 Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Both counties have a wood burning stove/open burning ordinance. • Both counties have legal counsel.	• No formal policy to review existing laws. • Public opinion of local laws/ordinances.	• Put a mechanism in place to alert organizations to upcoming or proposed policy/law changes. • Put a mechanism in place to formally review existing laws.	• Put a mechanism in place to alert organizations to upcoming or proposed policy/law changes. • Put a mechanism in place to formally review existing laws	
Model Standard 6.2: Involvement in Improving Laws, Regulations, and Ordinances				**41.7**
6.2.1 Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?				25
6.2.2 Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote public health?				50
6.2.3 Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• We have a lot of existing laws and local ordinances in place. • JoCo is good at creating proactive laws ordinances.	• Not having a clearly identified role or staff to review public health issues that are inadequately addressed.	• Having a person to address and review laws/ordinances	• Participation in changing existing laws and ordinances.	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 6.3: Enforcing Laws, Regulations, and Ordinances				**80.0**
6.3.1 Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?				75
6.3.2 Ensure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?				75
6.3.3 Ensure that all enforcement activities related to public health codes are done within the law?				100
6.3.4 Educate individuals and organizations about relevant laws, regulations, and ordinances?				75
6.3.5 Evaluate how well local organizations comply with public health laws?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• LPHS understand the organizations and roles to enforce public health laws.	• No formal evaluation for complying with laws.	• Establish formal evaluation for complying with laws.		

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 7: Link People to Needed Personal Health Services and Assure the Provision of Healthcare When Otherwise Unavailable				**56.3**
Model Standard 7.1: Identifying Personal Health Service Needs of Populations				**56.3**
7.1.1 Identify groups of people in the community who have trouble accessing or connecting to personal health services?				75
7.1.2 Identify all personal health service needs and unmet needs throughout the community?				50
7.1.3 Defines partner roles and responsibilities to respond to the unmet needs of the community?				50
7.1.4 Understand the reasons that people do not get the care they need?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• PH identifies veterans, developmental disabilities, pregnancy • Population-focused organizations look at particular communities such as senior & disabilities. • Inter-institutional partnerships. • Health Equity Coalition looks at specific community groups that we may have trouble accessing. • Work around pregnant women and babies in Josephine County. • Good advance in some pockets of complex problems. • Efforts towards oral health. • Integrated Behavioral Health services in other systems such as corrections, schools, etc.	• Mostly unknown about Josephine County. • Example of opiate crisis, a lot of community conversation, but limited definition of roles and responsibilities. • Although we understand, we have difficulty finding right strategies to change. Difficulties with funding and human resources. • Systems trauma.	• Need for more open-access, trauma-informed services, walk-in centers. • Improve integration, more permeability in organizational walls.	• Need to educate the community.	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 7.2: Ensuring People Are Linked to Personal Health Services				**56.3**
7.2.1 Connect or link people to organizations that can provide the personal health services they may need?				50
7.2.2 Help people access personal health services in a way that takes into account the unique needs of different populations?				75
7.2.3 Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?				75
7.2.4 Coordinate the delivery of personal health and social services so that everyone in the community has access to the care they need?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Good knowledge of each other (organizations) we link people with them, but ---> • Most organizations have staff who focuses on addressing unique needs (case managers, chws, advocates, etc.) • OHP sign ups is everywhere. • We do well with subpopulations.	• There are care coordination complications that burden the ability to link and connect people with services. • A lot of people don't qualify for OHP. • Difficulty with resources for Medicare and underinsured. • Difficulty addressing complexity, given the limitations of our scopes.			

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 8: Assure a Competent Public Health and Personal Healthcare Workforce				**58.3**
Model Standard 8.1: Workforce Assessment, Planning, and Development				**41.7**
8.1.1 Complete a workforce assessment, a process to track the numbers and types of LPHS jobs—both public and private sector—and the associated knowledge, skills, and abilities required of the jobs?				50
8.1.2 Review the information from the workforce assessment and use it to identify and address gaps in the LPHS workforce?				50
8.1.3 Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• quarterly review of talent and gaps at Rogue Health Care workforce committee locally • 20-30 stakeholders in the room: SOU, RCC, high schools, trade schools, Asante, RV Manor • high strengths for Asante and focus on traditional healthcare • some focus on Community Health Worker model	• doesn't cover all health needs, like mental health and addictions • large complicated issues, many different perspectives • needs to be more inclusive of ancillary health workforce needs	• expand review of system to mental health, oral health, public health nursing, etc. • find a tool that can be utilized and is more comprehensive • need to assure right people are in the room	• address long term issues like housing	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 8.2: Public Health Workforce Standards				**66.7**
8.2.1 Ensure that all members of the local public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and comply with legal requirements?				100
8.2.2 Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the 10 Essential Public Health Services?				50
8.2.3 Base the hiring and performance review of members of the public health workforce in public health competencies?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• MH services have moved the bar on this work at a local level in the last 5 years based on lack of support for licensure • Public Health has always been consistent • Traditional medical roles are strongly enforced, but nontraditional are less than	• Community Health Workers, including peers, have lots of hoops to get final certification • barriers for certification are really difficult • better state enforcement • for 8.2.2 and 8.2.3 moderate where appropriate: many jobs would not cover all areas of the 10 essential services and therefore would not be reflected in the job descriptions or in the performance reviews and hiring processes	• simplify processes for licensure and certification needs	• Assure all agencies are competent in getting this done • build into HR policies to assure that this is happening across the board, maintain standards through HR	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 8.3: Life-Long Learning through Continuing Education, Training, and Mentoring				**70.0**
8.3.1 Identify education and training needs and encourage the public health workforce to participate in available education and training?				100
8.3.2 Provide ways for public health workers to develop core skills related to the 10 Essential Public Health Services?				75
8.3.3 Develop incentives for workforce training, such as tuition reimbursement, time off for attending class, and pay increases?				75
8.3.4 Create and support collaborations between organizations within the LPHS for training and education?				75
8.3.5 Continually train the public health workforce to deliver services in a culturally competent manner and understand the social determinants of health?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• increased training activity with local partners for things like equity, ACEs, Trauma, etc. Many funded by CCOs • collaboration with health care institutions • social services collaborate with other social services • Asante's Smullin Center is key area used by the community for community education • Student training at schools is focused on equity and SDOH	• Lack of pay increases, some potential tuition reimbursement (not all) • more collaboration across multi-disciplinary organizations like health and social services	• get more info about a variety of other organizations like LTC, FQHCs, etc. • CNA 1's? is there more opportunity for support? • Addictions support • extended collaboration can improve economy of scale across disciplines and counties, i.e. ACES training model	• more money into addictions system to assure there is sustainability of staff as their training increases • need more management level focus on equity and poverty to extend training to agencies	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 8.4: Public Health Leadership Development				**50.0**
8.4.1 Provide access to formal and informal leadership development opportunities for employees at all organizational levels?				50
8.4.2 Create a shared vision of community health and the LPHS, welcoming all leaders and community members to work together?				75
8.4.3 Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?				50
8.4.4 Provide opportunities for the development of leaders who represent the diversity of the community?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Asante is a leader in this work for all pieces of the organization • smaller agencies encourage working at multiple levels • 8.4.2 strength of collaboration across the region and across systems with leadership	• Union structures discourage working outside of job descriptions • 8.4.3: we know that some opportunities exist within orgs and outside of orgs, but unsure of how to define questions • Diversity of opportunities is low	• encourage CNA 1 level (entry level) to remove barriers (time and cost) to moving up on the ladder	• 8.4.2 Encouragement at community level • Increase opportunities for diverse workforce.	

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Essential Service 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services				**65.4**
Model Standard 9.1: Evaluating Population-Based Health Services				**56.3**
9.1.1 Evaluate how well population-based health services are working, including whether the goals that were set for programs and services were achieved?				75
9.1.2 Assess whether community members, including vulnerable populations, are satisfied with the approaches taken toward promoting health and preventing disease, illness, and injury?				25
9.1.3 Identify gaps in the provision of population-based health services?				75
9.1.4 Use evaluation findings to improve plans, processes, and services?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
Model Standard 9.2: Evaluating Personal Health Services				**65.0**
9.2.1 Evaluate the accessibility, quality, and effectiveness of personal health services?				50
9.2.2 Compare the quality of personal health services to established guidelines?				75
9.2.3 Measure user satisfaction with personal health services?				75
9.2.4 Use technology, like the Internet or electronic health records, to improve quality of care?				75
9.2.5 Use evaluation findings to improve services and program delivery?				50
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
	• PH does not have electronic medical records.			

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 9.3: Evaluating the Local Public Health System				**75.0**
9.3.1 Identify all public, private, and voluntary organizations that contribute to the delivery of the 10 Essential Public Health Services?				75
9.3.2 Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to the delivery of the 10 Essential Public Health Services?				75
9.3.3 Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?				75
9.3.4 Use results from the evaluation process to improve the LPHS?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Community approach despite organizational differences.		• More dissemination of CHIP and CHA		

Model Standards by Essential Services *At what level does the LPHS…*	**Average LPHSA Performance Scores**
Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems	**40.9**
Model Standard 10.1: Fostering Innovation	**43.8**
10.1.1 Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?	25
10.1.2 Suggest ideas about what currently needs to be studied in public health to organizations that conduct research?	25
10.1.3 Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?	75
10.1.4 Encourage community participation in research, including deciding what will be studied, conducting research, and sharing results?	50

Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*
• traditional academic studies are based on the researcher's ideas - now flipped to listen to community organizations identifying areas to focus on and study so research is more focused towards community needs • 10.1.1: have more opportunities with higher ed students and nurses, but time is still limited and programs is still limited • 10.1.2: strength is connection to social services, CCOs, FQHCS vs to hospitals or LTC facilities • Promising practices (vs. evidence-based practices) have increased • 10.1.3: partnerships and work with CCOs and on metrics has improved sharing best practices throughout the region, this has improved dramatically over the last 5 years	• 10.1.2 and 10.1.4: Research is more qualitative than IRB based	• increase opportunities to build further connection with academia and students • provide more opportunities for higher ed students to learn real life practices for on the ground work	• find ways to pilot projects that expand current interventions • focus more on promising practices -improve structures for 10.1.4

Model Standards by Essential Services *At what level does the LPHS…*				**Average LPHSA Performance Scores**
Model Standard 10.2: Linking with Institutions of Higher Learning and/or Research				**58.3**
10.2.1 Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?				75
10.2.2 Partner with colleges, universities, or other research organizations to conduct public health research, including community-based participatory research?				25
10.2.3 Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?				75
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• Academic organizations include: SOU, RCC, OHSU, PSU, OSU, OIT - multiple organizations to work with on multiple projects/processes, etc. Partnerships exist from both sides of Healthcare and academia. I-CAn project as an example of also providing direct care. • Data walks with community members shared with nursing students	• 10.2.2: barriers to providing data and working together on it. Also, barriers to costs for research at the academic level • can't share HIPPA related data	• more CBPR • more access to systems resources • more collaborative work on both ends • more data provision • engage more community participants in the process of research	• reduce regulatory data if possible	
Model Standard 10.3: Capacity to Initiate or Participate in Research				**25.0**
10.3.1 Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?				25
10.3.2 Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?				25
10.3.3 Share findings with public health colleagues and the community broadly, through journals, Web sites, community meetings, etc.?				25
10.3.4 Evaluate public health systems research efforts throughout all stages of work from planning to effect on local public health practice?				25
Strengths	*Weaknesses*	*Short-Term Improvement Opportunities*	*Long-Term Improvement Opportunities*	
• current CHA work is leading towards this type of collaboration	• less formal research • who are researchers in the valley that we should work with • what subjects make sense to rise to this level	• identify opportunities to improve on research ideas and resources as they exist		

Health Equity Performance Scores

	Health Equity Performance Scores					
At what level does the LPHS…	**No Activity (0%)**	**Minimal Activity (1–25%)**	**Moderate Activity (26–50%)**	**Significant Activity (51–75%)**	**Optimal Activity (76–100%)**	**Average Performance Scores**
Essential Service 1: Monitor Health Status to Identify Community Health Problems						**25.0**
Conduct a community health assessment that includes indicators intended to monitor differences in health and wellness across populations, according to race, ethnicity, age, income, immigration status, sexual identify, education, gender, and neighborhood?		25				
Monitor social and economic conditions that affect health in the community, as well as institutional practices and policies that generate those conditions?		25				
Essential Service 2: Diagnose and Investigate Health Problems and Health Hazards						**16.7**
Operate or participate in surveillance systems designed to monitor health inequities and identify the social determinants of health inequities specific to the jurisdiction and across several of its communities?		25				
Collect reportable disease information from community health professionals about health inequities?	0					
Have the necessary resources to collect information about specific health inequities and investigate the social determinants of health inequities?		25				

	Health Equity Performance Scores					
At what level does the LPHS…	**No Activity (0%)**	**Minimal Activity (1–25%)**	**Moderate Activity (26–50%)**	**Significant Activity (51–75%)**	**Optimal Activity (76–100%)**	**Average Performance Scores**
Essential Service 3: Inform, Educate, and Empower People about Health Issues						**43.8**
Provide the general public, policymakers, and public and private stakeholders with information about health inequities and the impact of government and private sector decision-making on historically marginalized communities?			50			
Provide information about community health status (e.g., heart disease rates, cancer rates, and environmental risks) and community health needs in the context of health equity and social justice?			50			
Plan and conduct health promotion and education campaigns that are appropriate to culture, age, language, gender, socioeconomic status, race/ethnicity, and sexual orientation?		25				
Plan campaigns that identify the structural determinants of health inequities and the social determinants of health inequities (rather than focusing solely on individuals' health behaviors and decision-making)?			50			
Essential Service 4: Mobilize Community Partnerships to Identify and Solve Health Problems						**25.0**
Have a process for identifying and engaging key constituents and participants that recognizes and supports differences among groups?		25				
Provide institutional means for community-based organizations and individual community members to participate fully in decision-making?		25				
Provide community members with access to community health data?		25				

	Health Equity Performance Scores					
At what level does the LPHS…	**No Activity (0%)**	**Minimal Activity (1–25%)**	**Moderate Activity (26–50%)**	**Significant Activity (51–75%)**	**Optimal Activity (76–100%)**	**Average Performance Scores**
Essential Service 5: Developing Policies and Plans that Support Individual Community Health Efforts						**50.0**
Ensure that community-based organizations and individual community members have a substantive role in deciding what policies, procedures, rules, and practices govern community heath efforts?			50			
Essential Service 6: Enforce Laws and Regulations that Protect Health and Ensure Safety						**50.0**
Identify local public health issues that have a disproportionate impact on historically marginalized communities (that are not adequately addressed through existing laws, regulations, and ordinances)?			50			
Essential Service 7: Link People to Needed Personal Health Services						**58.3**
Identify any populations that may experience barriers to personal health services based on factors such as on age, education level, income, language barriers, race or ethnicity, disability, mental illness, access to insurance, sexual orientation and gender identity, and additional identities outlined in Model Standard 7.1?				75		
Identify the means through which historical social injustices specific to the jurisdiction (e.g., the inequitable distribution health services and transportation resources) may influence access to personal health services?		25				
Work to influence laws, policies, and practices that maintain inequitable distributions of resources that may influence access to personal health services?				75		

	Health Equity Performance Scores					
At what level does the LPHS…	**No Activity (0%)**	**Minimal Activity (1–25%)**	**Moderate Activity (26–50%)**	**Significant Activity (51–75%)**	**Optimal Activity (76–100%)**	**Average Performance Scores**
Essential Service 8: Assure a Competent and Personal Health Care Workforce						**30.0**
Conduct assessments related to developing staff capacity and improving organizational functioning to support health equity initiatives?			50			
Identify staff perspectives on the facilitators and barriers to addressing health equity initiatives?		25				
Include staff members that are often excluded from planning and organizational decision-making processes in workforce assessments?		25				
Recruit and train staff members from multidisciplinary backgrounds that are committed to achieving health equity?		25				
Recruit and train staff members that reflect the communities they serve?		25				
Essential Service 9: Evaluate the Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services						**50.0**
Identify community organizations or entities that contribute to the delivery of the Essential Public Health Services to historically marginalized				75		
Monitor the delivery of the Essential Public Health Services to ensure that they are equitably distributed?		25				

	Health Equity Performance Scores					
At what level does the LPHS…	**No Activity (0%)**	**Minimal Activity (1–25%)**	**Moderate Activity (26–50%)**	**Significant Activity (51–75%)**	**Optimal Activity (76–100%)**	**Average Performance Scores**
Essential Service 10: Research for New Insights and Innovative Solutions to Health Problems						**37.5**
Encourage staff, research organizations, and community members to explore the root causes of health inequity, including solutions based on research identifying the health impact of structural racism, gender and class inequity, social exclusion, and power differentials?			50			
Share information and strategize with other organizations invested in eliminating health inequity?			50			
Use Health Equity Impact Assessments to analyze the potential impact of local policies, practices, and policy changes on historically marginalized communities?		25				
Facilitate substantive community participation in the development and implementation of research about the relationships between structural social injustices and health status?		25				

Appendix F - Focus Group Discussion Guide

Goals of the focus groups:

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

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

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

I. BACKGROUND (5-10 MINUTES)

- Welcome everyone. My name is _____, and I work for Health Resources in Action, a non-profit public health organization in Boston.

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

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

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

- [NOTE AUDIOTAPING IF APPLICABLE] Just in case we miss something in our note-taking, we are also audio-taping the groups tonight. We are conducting several of these discussion groups around the area, and we want to make sure we capture everyone's opinions. After all of the groups are done,

we will be writing a summary report of the general opinions that have come up. In that report, I might provide some general information on what we discussed tonight, but I will not include any names or identifying information. Your responses will be strictly confidential. In our report, nothing you say here will be connected to your name.

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

- Lastly, please turn off your cell phones or at least put them on silent or vibrate mode. The group will last only about 80-90 minutes. If you need to go to the restroom during the discussion, please feel free to leave, but we'd appreciate it if you would go one at a time.

- Any questions before we begin our introductions and discussion?

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

1. Now, first let's spend a little time getting to know one another. Let's go around the table and introduce ourselves. Please tell me: 1) Your first name; 2) what community you live in; and 3) something about yourself – such as how many children you have or what activities you like to do in your spare time. [AFTER ALL PARTICIPANTS INTRODUCE THEMSELVES, MODERATOR TO ANSWER INTRO QUESTIONS]

III. COMMUNITY AND HEALTH PERCEPTIONS (20-30 MINUTES)

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

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

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

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

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

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

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

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

        i. What supports your health and wellness?

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

IV. PERCEPTIONS OF PUBLIC HEALTH/PREVENTION SERVICES AND HEALTH CARE (20-30 minutes)

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

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

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

7. What do you think are some things a community could do to make it easier for people to be healthy? [PROBE ON SPECIFICS IF NEEDED: What would these programs/services include? Where should they be offered? During what hours?]

8. [IF NOT ALREADY MENTIONED] I'd like to ask specifically about health care in your community. Have you or someone close to you ever experienced any challenges in trying to get health care? What specifically? [PROBE FOR BARRIERS: INSURANCE ISSUES, LANGUAGE BARRIERS, LACK OF TRANSPORTION, CHILD CARE, ETC.]

    a. [NAME BARRIER] was mentioned as something that made it difficult to get health care. What do you think would help so that people don't experience the same type of problem that you did in

getting health care? What would be needed so that this doesn't happen again? [REPEAT FOR OTHER BARRIERS]

V. VISION OF COMMUNITY AND PROGRAM/SERVICE ENVIRONMENT (5 minutes)

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

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

VI. CLOSING (5 MINUTES)

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

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

As I mentioned before, we are conducting these groups around Jackson and Josephine Counties, and we're also talking to people who work at organizations. After all this is over, we're going to be writing up a report. Jefferson Regional Health Alliance will post this report on their website.

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

Appendix G - Key informant interview guide

Goals of the Key Informant Interview

- To gather perceptions of the health strengths and needs of Jackson and Josephine Counties
- To identify health-related gaps, challenges, and assets
- To explore opportunities for addressing community health needs more effectively

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

BACKGROUND (5 minutes)

- Hi, my name is _____ and I am with Health Resources in Action, a non-profit public health organization in Boston. Thank you for taking the time to speak with me today.

- As you may know, the Jefferson Regional Health Alliance is conducting a community health assessment to gain a greater understanding of the health issues of Jackson and Josephine County community members, how those needs are being addressed, and whether there might be opportunities to address these issues more effectively.

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

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

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

THEIR AGENCY / ORGANIZATION (5 minutes)

[SKIP THIS SECTION FOR ELECTED OFFICIALS]

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

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

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

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

COMMUNITY ISSUES (10 minutes)

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

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

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

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

HEALTH ISSUES (10 minutes)

3. What do you think are the most pressing <u>health</u> concerns in the community? Why? [PROBE ON SPECIFICS]

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

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

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

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

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

PROGRAM / SERVICE ENVIRONMENT (10 minutes)

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

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

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

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

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

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

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

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

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

VISION OF THE FUTURE (10 minutes)

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

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

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

        ii. Who should be involved in this effort?

CLOSING (2 minutes)

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

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

Thank you again. Have a good afternoon.

Appendix H - Survey instrument

Jefferson Regional Health Alliance is conducting a community health assessment to better understand the health of Jackson and Josephine County community members. The assessment will inform future regional activities to improve the community's health.

We are asking community members to give us your thoughts and suggestions about health-related concerns and services in Jackson and Josephine Counties by completing this survey by July 3rd. All responses are completely anonymous. There are no right or wrong answers; it's your opinion that matters!

You can complete this survey online at: https://www.surveymonkey.com/r/JRHACHA2018

Or return it by mail to: JRHA, 670 Superior Ct., Ste 208, Medford, OR 97504

Your input is valuable and we appreciate your participation!

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1. What county do you live in?

☐ Jackson
☐ Josephine
☐ Other [If other, skip to the end/not eligible]

2. Are you a health or social service provider in Jackson or Josephine County?

☐ Yes
☐ No

3. In general, how would you describe the health of the community in which you live?

☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

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

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

	YOU AND/OR YOUR FAMILY	YOUR COMMUNITY
Affordable housing	☐	☐
Aging health concerns (Alzheimer's, arthritis, dementia, falls, etc.)	☐	☐
Air quality	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Cost of living (e.g., housing, child care, groceries, etc.)	☐	☐
Dental/oral health	☐	☐
Diabetes	☐	☐
Disabilities (including lack of services for individuals with disabilities)	☐	☐
Getting health care (transportation, health insurance, cost, etc.)	☐	☐
Heart disease/ heart attacks	☐	☐
High blood pressure/hypertension	☐	☐
Homelessness	☐	☐
Infectious/contagious diseases (tuberculosis, pneumonia, flu, etc.)	☐	☐
Mental health and stress	☐	☐
Obesity/ overweight	☐	☐
Physical activity opportunities	☐	☐
Public safety	☐	☐
Sexually transmitted infections (STIs) (Chlamydia, Gonorrhea, etc.)	☐	☐
Smoking	☐	☐
Substance Use (alcohol, marijuana, heroin, meth, etc.)	☐	☐
Teenage pregnancy	☐	☐
Transportation (e.g. schedules, cost, accessibility)	☐	☐
Other (please specify): _____	☐	☐

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

- ☐ Lack of transportation
- ☐ Have no regular doctor/source of health care
- ☐ Cost of care/co-pays
- ☐ Lack of evening and weekend services/lack of convenient times and locations
- ☐ Insurance problems/lack of coverage/not enough coverage
- ☐ Language problems/could not communicate with provider or office staff
- ☐ Discrimination/unfriendliness of provider or office staff
- ☐ Providers won't accept me as a patient
- ☐ Afraid to have health check-up
- ☐ Afraid due to my immigration status
- ☐ Don't know what type of services are available
- ☐ No available providers near me
- ☐ Long waits for appointments
- ☐ Health care information is not kept confidential
- ☐ I have never experienced any difficulties getting care
- ☐ Other (please specify): _____

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

- ☐ Services for older adults
- ☐ Services for people with disabilities
- ☐ Services for veterans
- ☐ Services for new immigrants

- ☐ Services for youth
- ☐ Educational support services (including language services)
- ☐ Transportation services
- ☐ Affordable housing
- ☐ Affordable child care services
- ☐ Substance abuse services
- ☐ Mental health care services
- ☐ Health care services (including primary care, specialty care, hospital services)
- ☐ Exercise and physical activity opportunities
- ☐ Employment services (including job training and readiness)
- ☐ Financial assistance services
- ☐ Housing services (including services for the homeless or housing insecure)
- ☐ Food services (including food stamps, food pantries, nutrition education and support)
- ☐ I don't know
- ☐ Other (please specify):
  _____

7. The following questions ask you to rate your concern for specific community issues. Please indicate how high of a concern each of the following topics are to you as a community member in Jackson or Josephine County.

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

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

Disabilities	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Availability of services for physical disabilities	☐	☐	☐	☐	☐
Availability of services for developmental disabilities	☐	☐	☐	☐	☐
Accessibility of public buildings and housing for community members with disabilities (i.e. compliance with the Americans with Disabilities Act)	☐	☐	☐	☐	☐

Accessibility of public transportation for community members with disabilities	☐	☐	☐	☐	☐

Older Adults and Aging	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Affordable housing for older adults	☐	☐	☐	☐	☐
Mental health and social isolation for older adults	☐	☐	☐	☐	☐
Support for independent living	☐	☐	☐	☐	☐
Memory care services (e.g., services for dementia and Alzheimer's)	☐	☐	☐	☐	☐
Support services for low-income older adults	☐	☐	☐	☐	☐
Issues related to healthy living for older adults (e.g., nutrition services, physical activity, medical care, etc.)	☐	☐	☐	☐	☐
Access to medical specialists	☐	☐	☐	☐	☐

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

Substance Abuse	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Ability to get substance abuse services (e.g., affordable, timely, proximity, etc.)	☐	☐	☐	☐	☐
Real or perceived stigma associated with seeking substance abuse services	☐	☐	☐	☐	☐
Opioid abuse (e.g., prescription pain killers, heroin, etc.)	☐	☐	☐	☐	☐
Alcohol abuse among youth	☐	☐	☐	☐	☐
Alcohol abuse among adults	☐	☐	☐	☐	☐
Tobacco use among youth (including vaping and e-cigarettes)	☐	☐	☐	☐	☐
Tobacco use among adults	☐	☐	☐	☐	☐
Methamphetamine use	☐	☐	☐	☐	☐
Drug use among youth (including misuse of prescriptions, use of other illicit drugs)	☐	☐	☐	☐	☐
Marijuana use among youth	☐	☐	☐	☐	☐
Recreational marijuana use among adults	☐	☐	☐	☐	☐
Other substance abuse	☐	☐	☐	☐	☐

Public Safety	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Violent crime	☐	☐	☐	☐	☐
Property crime	☐	☐	☐	☐	☐
Neighborhood safety	☐	☐	☐	☐	☐
Adequate law enforcement system, including jail, parole, and probation	☐	☐	☐	☐	☐

Community and Civic Engagement	Not a Concern	Slight Concern	Moderate Concern	High Concern	I don't know
Opportunities for physical activity (e.g., affordable gyms, public walking paths, etc.)	☐	☐	☐	☐	☐
Availability of health care services (e.g., primary care services, specialty care, urgent care, etc.)	☐	☐	☐	☐	☐
Availability of social services (e.g., food pantries, employment services, education services, etc.)	☐	☐	☐	☐	☐
Availability of community-wide activities (e.g., classes or programs for youth or families, library programming, community concerts, etc.)	☐	☐	☐	☐	☐
Inclusion of new community members into the community	☐	☐	☐	☐	☐
Participation in civic activities (e.g., voting in local elections, opportunities to participate in community meetings or forums)	☐	☐	☐	☐	☐

8. Are there any other issues of concern – not listed previously – that are of high concern to you as Jackson or Josephine County community member?
   - ☐ No
   - ☐ Yes, please specify: _____

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

9. What's your zip code? _____

10. How old are you?
    - ☐ Under 18 years old
    - ☐ 18-24 years old
    - ☐ 25-34 years old
    - ☐ 35-44 years old
    - ☐ 45-64 years old
    - ☐ 65+ years old

11. What is your gender?
    - ☐ Male
    - ☐ Female
    - ☐ Other (please specify) _____

12. How would you describe your ethnic/racial background? (Please check all that apply.)
    - ☐ African American or Black
    - ☐ American Indian or Alaskan Native
    - ☐ Asian
    - ☐ Hispanic/Latino(a)
    - ☐ Native Hawaiian or Other Pacific Islander
    - ☐ White
    - ☐ Other (please specify) _____

13. What language do you speak most often at home? (Please choose one.)
    - ☐ English
    - ☐ Spanish
    - ☐ Other (please specify) _____

14. What is the highest level of education that you have completed?
    - ☐ Less than high school
    - ☐ High school graduate or GED
    - ☐ Some college
    - ☐ Associate or technical degree/certification
    - ☐ College graduate
    - ☐ Graduate or professional degree

15. What is your household income?
    - ☐ Less than $25,000
    - ☐ $25,000 to $49,999
    - ☐ $50,000 to $74,999
    - ☐ $75,000 to $99,999
    - ☐ $100,000 or more

16. Have you or someone in your family experienced housing insecurity or homelessness in the last 12 months?
    - ☐ Yes
    - ☐ No

17. How long have you lived in Jackson or Josephine County?
    - ☐ Less than one year
    - ☐ At least 1 year but less than 5 years
    - ☐ At least 5 years but less than 10 years
    - ☐ At least 10 years but less than 15 years
    - ☐ At least 15 years but less than 20 years
    - ☐ 20 years or more

18. Do you have difficulty with any of the following? (Please check all that apply.)
    - ☐ Hearing (deafness or severe hearing impairment)
    - ☐ Vision (blindness or severe vision impairment)
    - ☐ Mobility (walking, climbing stairs)
    - ☐ Cognitive Functioning (concentrating, remembering, making decisions)
    - ☐ Independent Living (dressing, bathing)
    - ☐ Other (please write): _____

Jefferson Regional Health Alliance

www.jeffersonregionalhealthalliance.org

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