Community Health Assessment

Douglas County

Umpqua Health Alliance

DOUGLAS COUNTY

Acknowledgements

A Special Thanks to the Umpqua Health Alliance Community Advisory Council CHA Committee (CACC)

Paul Morgan
Cindy Shirtcliff
Steve Schenewerk
Dawnelle Marshall
Patti LaFreniere
Bevin Hansell
David Price

Primary Consultant, Technical Writer
Vanessa A Becker, M.P.H., Principal. V Consulting & Associates Inc.
www.vconsults.com

Executive Summary

The purpose of a Community Health Assessment (CHA) is to provide a macro view of community health issues in Douglas County. It completes this task by cataloging and reviewing applicable data related to the health of a community. The process serves to engage community members in identifying trends and opportunities to improve the health of their community. The resulting document assists organizations in planning and prioritizing efforts that ultimately improve health outcomes, the health of individuals and communities and reduces health care costs.

Several community organizations came together in October of 2012 to collaborate on a single, collective community health assessment. Pooling resources, reducing duplication of effort and meeting funding mandates motivated the collaborators to secure a contract with a consultant to lead and facilitate a community health assessment. The Douglas County Community Health Assessment was designed to meet the needs for the Umpqua Health Alliance, Douglas County Public Health Accreditation and the Mental Health Biennial Improvement Plan (BIP).

The Mobilizing for Action through Planning and Partnerships (MAPP) model was the basis of the Community Health Assessment process. The MAPP process is a national best practice and recognized by both the Oregon Health Authority (OHA) and the Public Health Accreditation Standards board as a process for community health assessment. Due to the resources and time required for a thorough MAPP process, the collaborative agreed upon a modified MAPP model with a time line of October 2012-July 2013.

MAPP is a community driven process that results in engagement of new stakeholders and provides a broad understanding of community health issues. Results of the Community Health Assessment include increased community engagement in defining and improving community health, cataloging of community input regarding efficacious health improvement activities and a document that meets the needs of several legislative and policy mandates.

The primary audience of the process and the resulting Community Health Assessment Document is the CCO Community Advisory Council membership. The Community Health Assessment is not meant to stand on its own, but is a process and document designed to complement other community efforts, plans and assessments.

Modified MAPP-Douglas County CHA Process

Timeline: October 2012 — July 2013

Process	*Activities*
Preliminary Data Collection Identify previous community assessments Secondary quantitative data collection	• web based search • key informant interviews
Analysis of Secondary Data for Themes Identify previous community assessments	• review by consultant, CACC
Collection of Primary Data Collect qualitative data	• community focus groups • key informant interviews: • local health system SWOT
Final Inventory and Meta-Analysis Assessment of local health status, community strengths assessment and forces of change assessment	• review by consultant, CACC • list key-health related issues
Write and share Community Health Assessment Document	• summary in presentation and written format
Community Health Improvement Plan (CHIP)	

"We need people to help instill the practice of better lifestyles, helping and bringing people to action and change."

— Focus Group Participant

The CHA document will be added to and changed over the next several years as community health and perceptions of health change. The CHA is not a rigorous research study, nor is it designed to extensively evaluate the efficacy and validity of existing community data. Instead, it is intended to provide a macro view of available community data and help to identify community trends.

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

The following document outlines the process that was completed, notable trends in individual and community health status, community perceptions of health and engagement in improving community health and finally suggestions for priority focus areas for the following Community Health Improvement Plan (CHIP).

Suggested Primary Focus Areas and Indicators

Adults who smoke cigarettes
Adults who are obese
Adults engaging in physical activity
Adults with asthma
Adult fruit and vegetable consumption
Adults with diabetes
Alcohol and Drug Misuse
Follow-up after mental health hospitalization
Prenatal Postpartum Care
Outpatient and Emergency Dept Utilization
Colorectal Cancer Screening
Adolescent Well Child Care Visits
Access to Care
Child Immunization
Oral Health

Contents

Introduction and Purpose

The Douglas County Community Health assessment synthesizes several months of collecting, cataloging and reviewing data related to the health of residents living in Douglas County. The process represents collaboration with several community organizations, including Umpqua Health Alliance, Douglas County Public Health and Douglas County Mental Health. It is the first step in an ongoing process of community health assessment, planning and improvement.

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

Community Health Assessments are required for many organizations in Douglas County. These community organizations came together in October of 2012 and decided to collaborate on a single, collective community health assessment. The Douglas County Community Health Assessment was designed to meet the needs for the Umpqua Health Alliance, Douglas County Public Health Accreditation and the Mental Health Biennial Improvement Plan (BIP).

Plans and Processes requiring Community Health Assessments

CHNA

Community Health Needs Assesment

Required by IRS

Focus is to identify and assess access and needs of community the hospital is serving. Documentation must include written report.

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

Led by hospital

Every 3 years

CCO

Coordinated Care Organization

Required by Oregon Health Authority

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

Led by CCO, with CAC involvement.

Proposed to be every 3 years

Public Health Accreditation

Required by Oregon Health Authority

Collaborative process resulting in a comprehensive community health assesment.

Led by County Public Health with collabrative partners.

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

BIP

Biennial Improvement Plan

Required by Oregon Health Authority

Collaborative process resulting in a comprehensive community health assesment.

Led by County Public Health with collabrative partners.

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

Framework and Process

A desire to pool resources, reduce duplication of effort and meet mandates motivated the collaborative partners to secure a contract with a consultant to lead and facilitate the community health assessment.

The Mobilizing for Action through Planning and Partnerships (MAPP) model was then chosen as the basis of the Community Health Assessment process. The MAPP process is a national best practice and recognized by both the Oregon Health Authority (OHA) and the Public Health Accreditation Standards board as a process for community health assessment. MAPP enables enhanced understanding of the complex influences on community health, through thoughtful and deliberate data collection and analysis. Due to the resources and time required for a thorough MAPP process, the collaborative group agreed upon a modified MAPP model with a time line of October 2012-July 2013.

Modified MAPP-Douglas County CHA Process

Process	Activities
Preliminary Data Collection Identify previous community assessments Secondary quantitative data collection	• web based search • key informant interviews
Analysis of Secondary Data for Themes Identify previous community assessments	• review by consultant, CACC
Collection of Primary Data Collect qualitative data	• community focus groups • key informant interviews: • local health system SWOT
Final Inventory and Meta-Analysis Assessment of local health status, community strengths assessment and forces of change assessment	• review by consultant, CACC • list key-health related issues
Write and share Community Health Assessment Document	• summary in presentation and written format
Community Health Improvement Plan (CHIP)	

Timeline: October 2012 — July 2013

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

> ***"Listening (at focus groups) made me think of health and health issues in a little different way. I learned a lot about my community and my work with the CACC solidified my role as a CAC member." —CACC workgroup member***

The CAC reviewed and edited the full CHA document before recommending the document be accepted by the UHA Board of Directors.

Data Assumptions and Priorities

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

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

All data that was collected was cataloged into a spreadsheet titled the "data sources." The first draft and categorization of the "data sources" document was reviewed by the CACC for organization. The data sources document was and will be continually added to and serve as a community resource of available health status data. PDF versions of all available data sets and assessments were organized in a series of online folders—ensuring accessibility for all leadership team and CAC members.

Types of Data

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

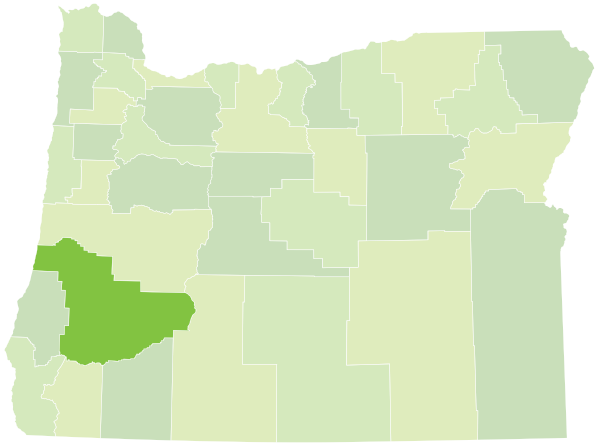
Limitations

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

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

Douglas County: People and Place

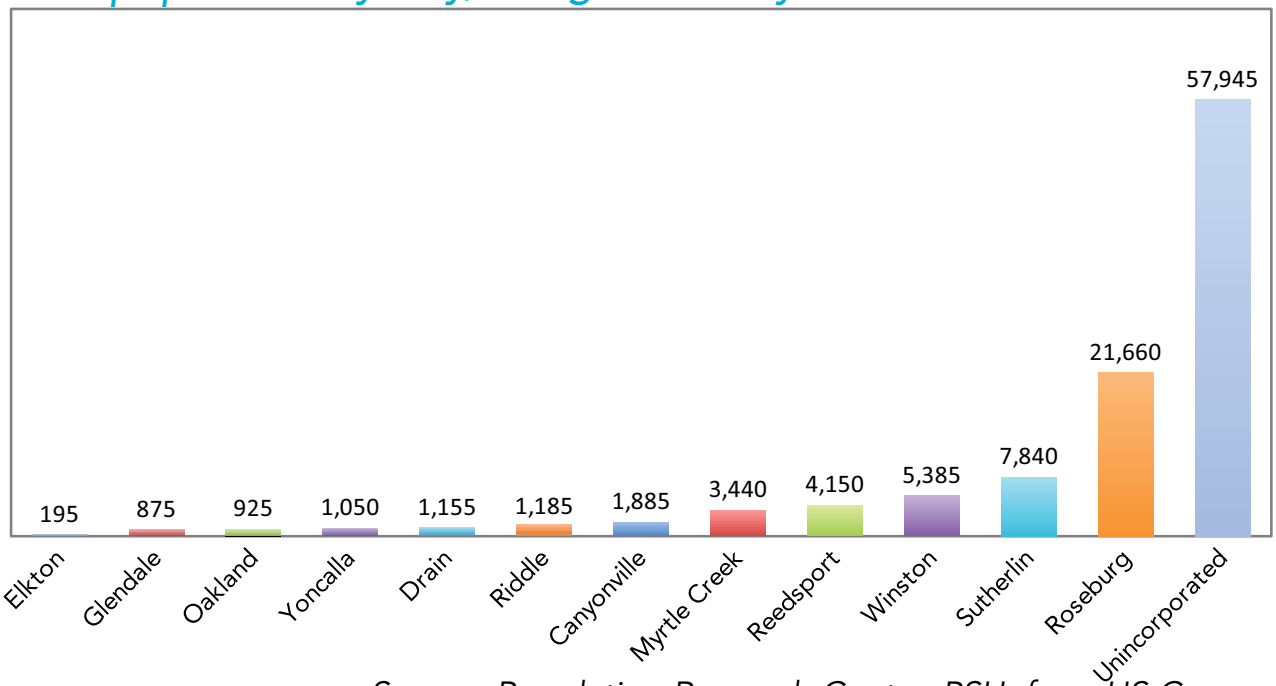
Location and Physical Characteristics



Douglas County is a rural county located in Southwestern Oregon. It is the fifth largest geographical county in the state and ninth in population. Douglas County is 5,071 square miles and stretches from the Pacific Ocean to the Cascade Mountains. There are thirteen incorporated cities and numerous small-rural communities with a total countywide population of 107,690 (2010). Roseburg, the largest city in the county, has a population of 21,660. Interstate 5 (I-5) runs down the center of Douglas County, with Roseburg lying on the I-5 corridor. The terrain and geography is diverse and includes hundreds of hills and valleys, waterways and limited road structures in some areas, creating many small isolated communities. The entire county is designated as a rural county, by the Oregon Office of Rural Health.

The majority of County residents live in unincorporated areas, creating geographic barriers to accessing medical care, services and in some communities access to exercise facilities, grocery stores and fresh foods. Transportation to services continues to be a challenge for many residents in Douglas County, particularly for those living in poverty. Mass transit systems are very limited in most unincorporated areas, or not available at all.

Total population by City, Douglas County 2010



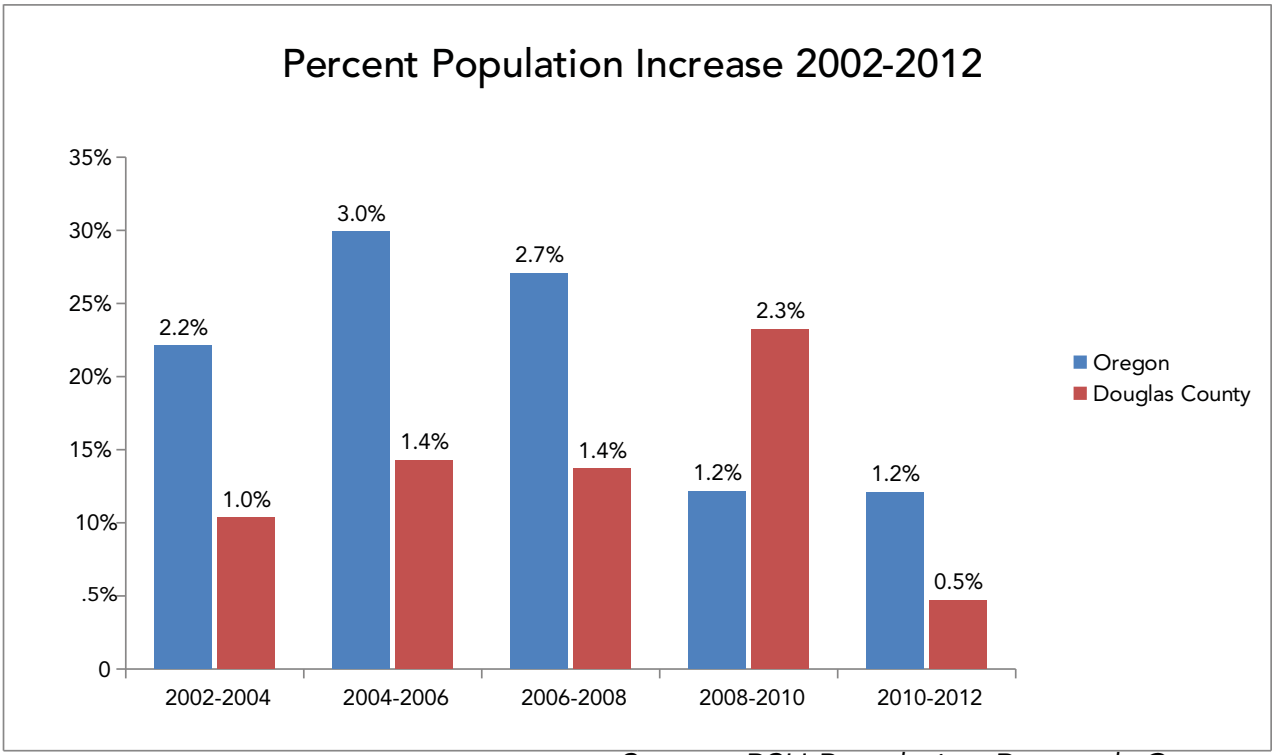
Source: Population Research Center, PSU, from US Census

Health status data and factors that influence health are markedly different in rural counties across Oregon. Douglas County is no exception and ranks high in many risk factors related to healthy communities such as poverty, unemployment, tobacco use, obesity and education.

Demographic Trends

Migration and Growth

Like many rural counties, population growth has been limited although migration has remained slightly positive, with a .4% growth rate in 2011-2012. The migration into Douglas County is still minimal, below the state average and far below most metro/urban counties.

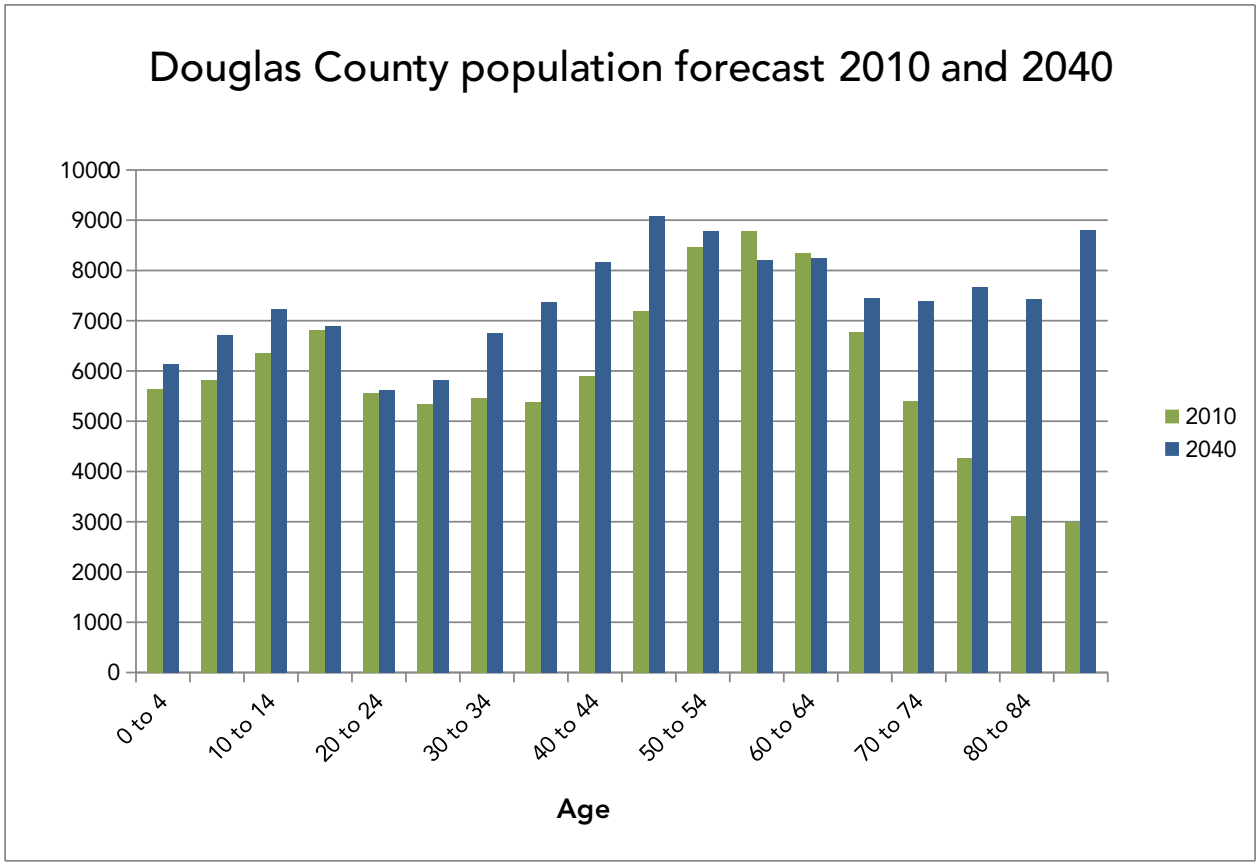


Source: PSU Population Research Center

Douglas County's total population number has remained fairly stagnant for several decades. Even though the total population has stayed steady, shifts between demographics in the community show interesting changes. The economic downturn in 2008 influenced demographics within the county. Local population statistics began showing the trend of younger families and groups leaving rural areas for metropolitan counties to find jobs shortly after the turndown. At the same time, the county has continued to see a steady influx of seniors into the county-largely from out of state. Both the exodus of younger populations and the influx of older demographics into the county, account for the rather steady total number but shifting age groups within the total. The percentage of 60 and over is expected to continue to rise within the county, while percentages of younger age groups diminishes.

Growth in Elderly Population

According to 2010 census data, close to 30% of the county population is over 60 years old. Douglas County has a distinctly higher average age and higher percentage of elderly living in the county than metropolitan counties in the state. Douglas County is grouped in the region of the state with the highest percentage (Southwest Oregon) of 60 and over residents. Many communities within the county have over 40% of their residents 60 and over (communities of Scottsburg and Tiller). Average ages within communities of Douglas County showed great variance, with the very isolated, small rural communities having the highest median ages. Over half of the towns in Douglas County had a median age of 47 or older-with many in the high fifties and one (Scottsburg) with a median age, among all residents, as 61.4.



Source: U.S. Census Bureau, 2008-2010 American Community Survey

Unemployment

High levels of unemployment have been a consistent trend in Douglas County. The county has had a higher unemployment than the national and state averages for several years. The largest industry and employer in the county has historically been timber and wood products, giving Douglas County the title of Timber Capital of the World. Local estimates show that one in four jobs in Douglas County is tied to wood including the harvesting of wood, transporting and making it into products. The economic downturn, subsequent housing and mortgage crisis and reduced building and construction resulted in many

lost timber jobs, having a negative effect on employment and unemployment in the county. Although the industry is beginning to rebound, the effects on unemployment are still evident.

The July 2012 (seasonally adjusted) unemployment rate was 12.3%, still far above the state average of 8.7%

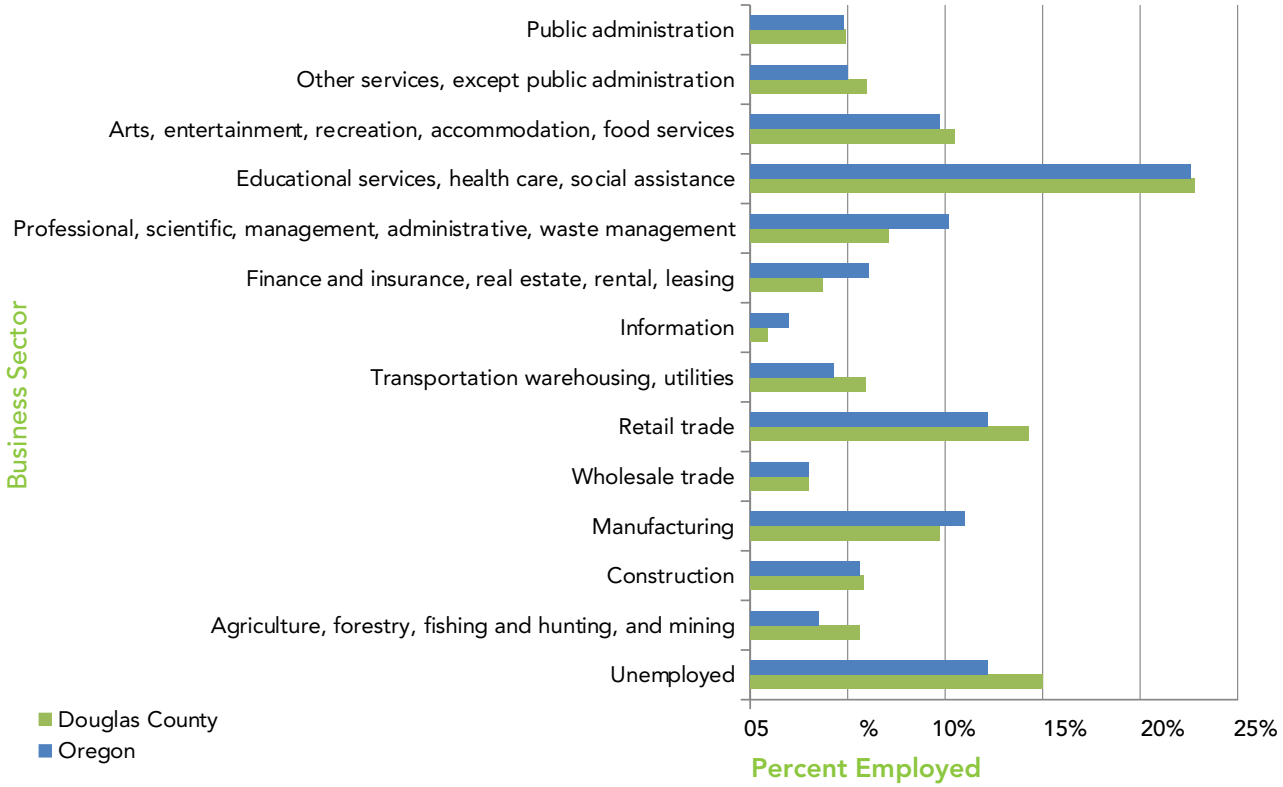
Population Characteristics

Poverty

One in four children in Douglas County live in poverty, creating significant challenges to health and development. Sixteen percent of the total population in Douglas County are living in poverty (2007-2011), this is higher than the 14.8% of the total state. Another indicator of poverty in Douglas County is the percentage of children eligible for free and reduced fee lunch. 80% of children living in Douglas County are eligible—indicating a very high number of households living in poverty.

Percent employed by Business Sector

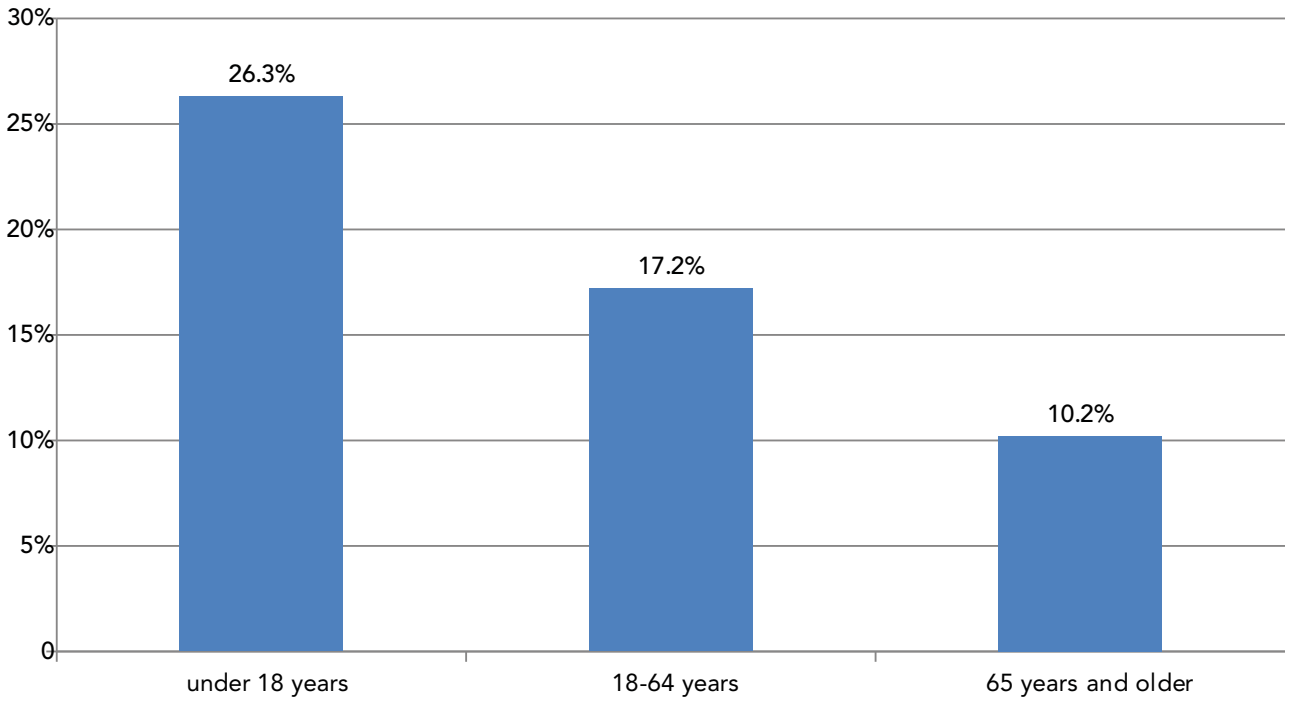
Douglas County and Oregon 2009-2011



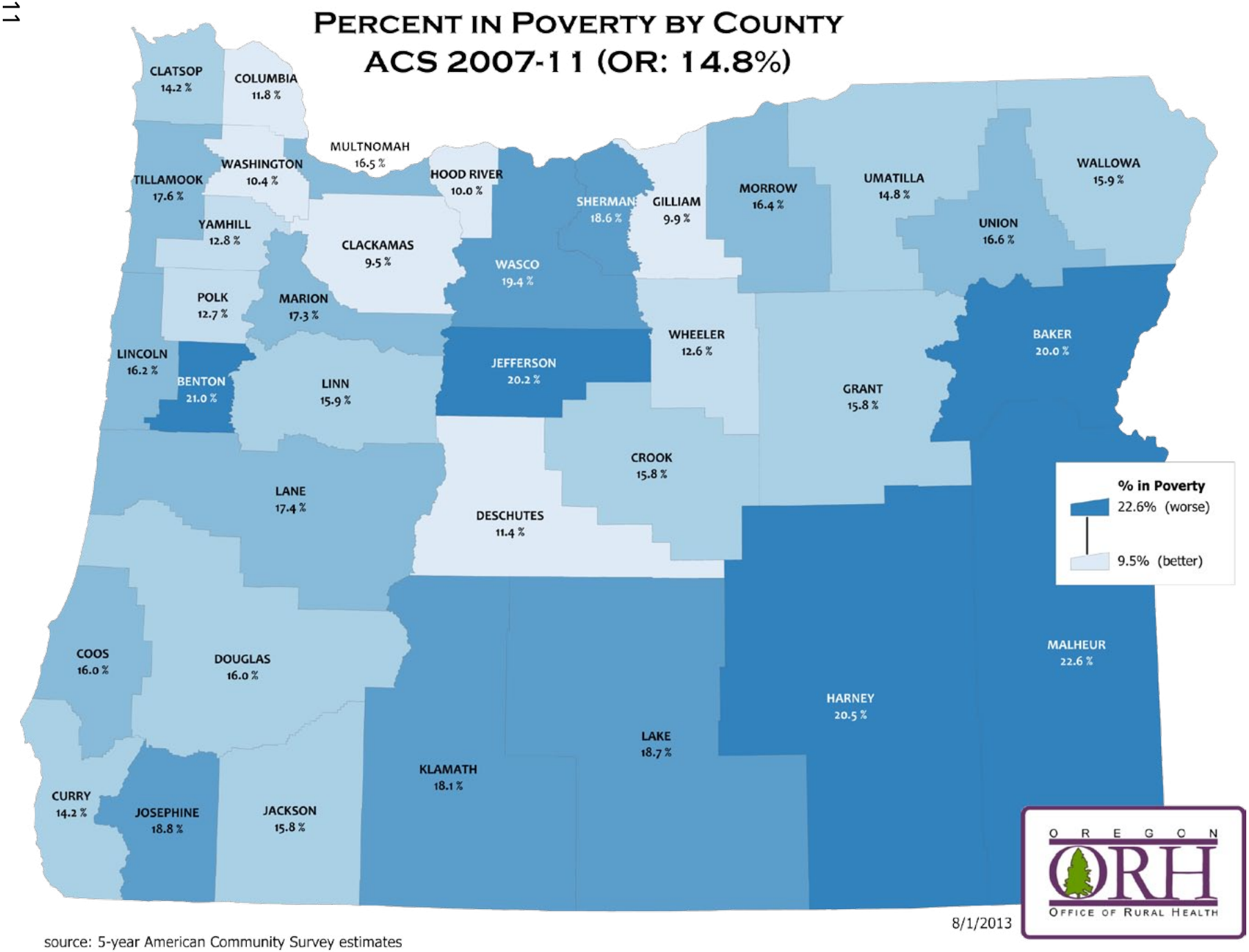
Source, US Census Bureau, Oregon Office of Economic Analysis

Due to significant poverty levels Douglas County has a higher percentage of residents that qualify for Medical Assistance Programs such as the Oregon Health Plan. Many communities outside the I-5 corridor have higher rates of poverty than the county average. Yoncalla is a good example, having nearly twice the percentage of residents living in poverty than the county average.

Percent living below poverty level by age in Douglas County

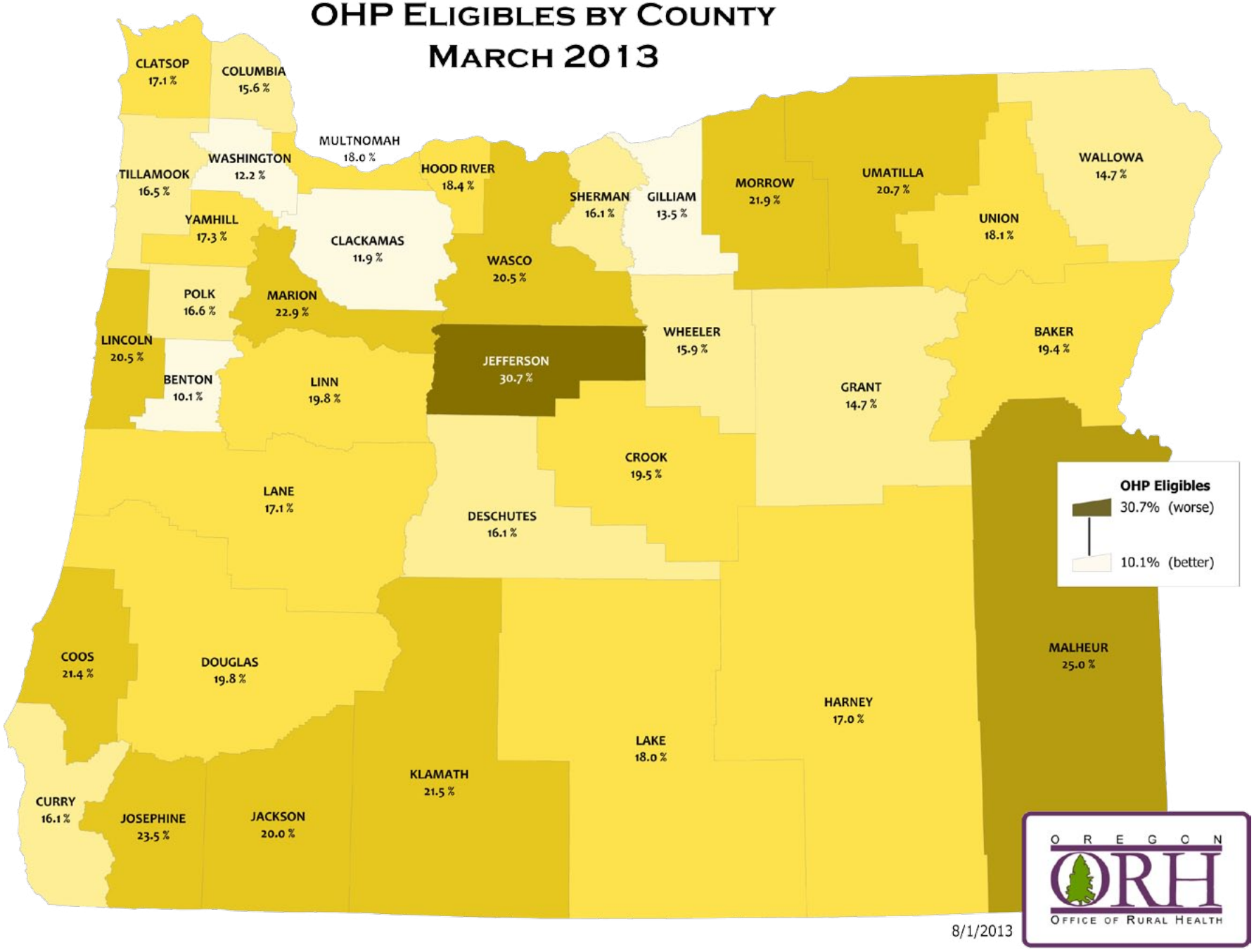


Source: U.S. Census Bureau, 2009-2011 American Community Survey 3-Year Estimates



Source: Oregon Office of Rural Health

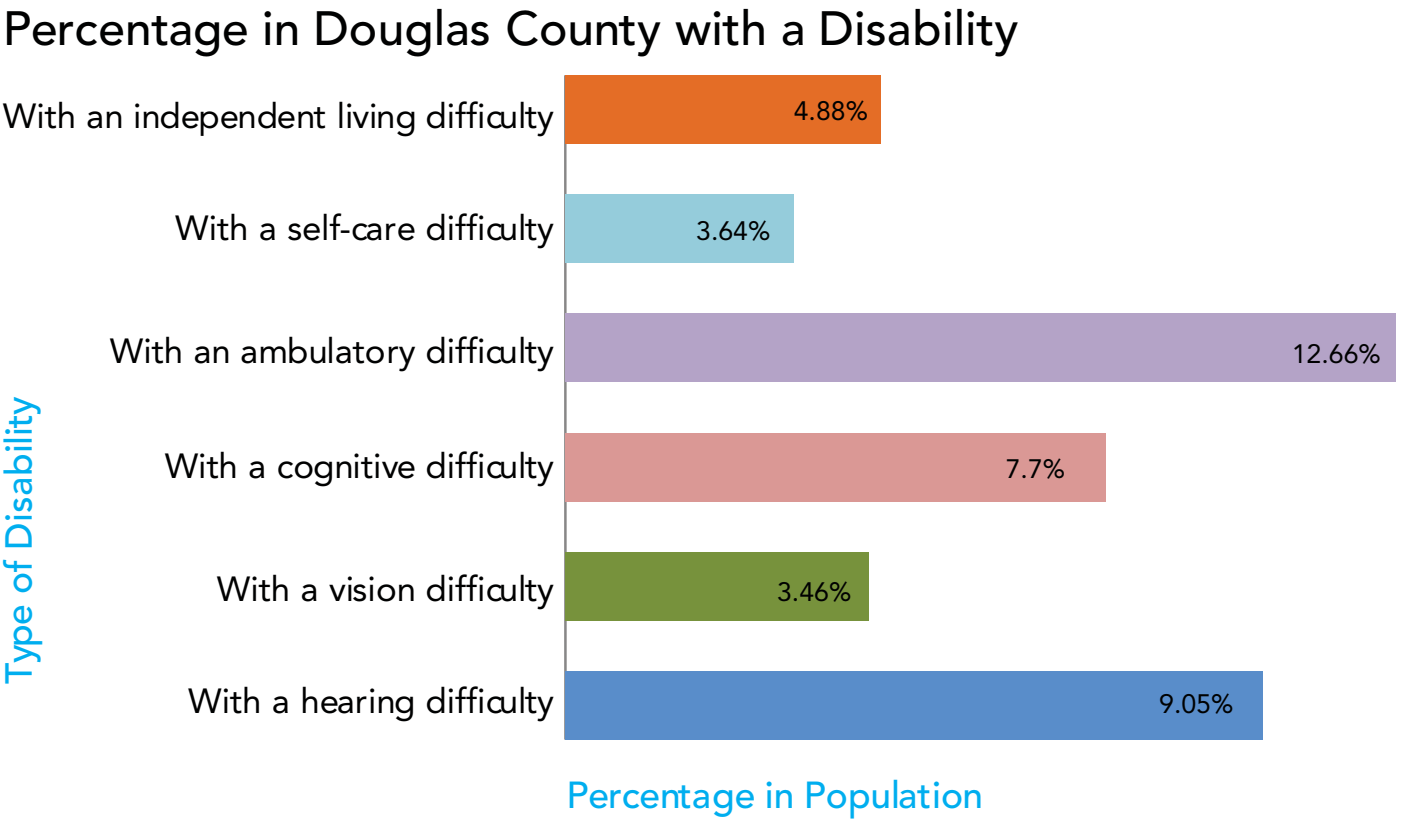
OHP Eligibles by County
March 2013



source: OR Division of Medical Assistance Programs

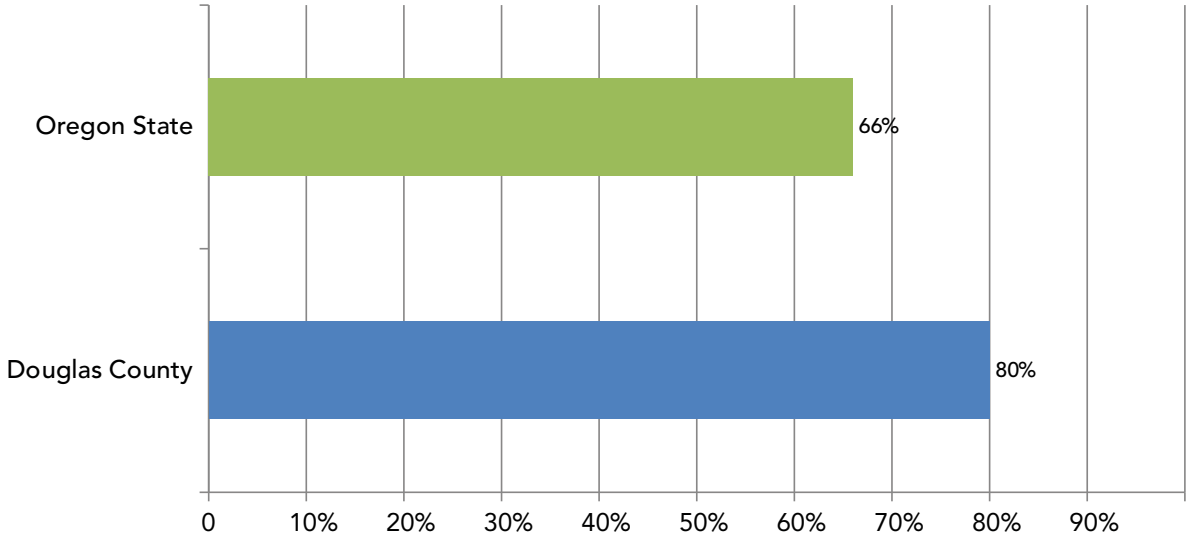
Disabilities

In 2011, approximately 23.1% of Douglas County civilian non-institutionalized residents were living with a disability. The types of disabilities varied, with ambulatory difficulty being the highest at 40% of residents.



Source: U.S. Census Bureau, 2008-2010

Percent K-12 students eligible for free/reduced lunch 2009-2011



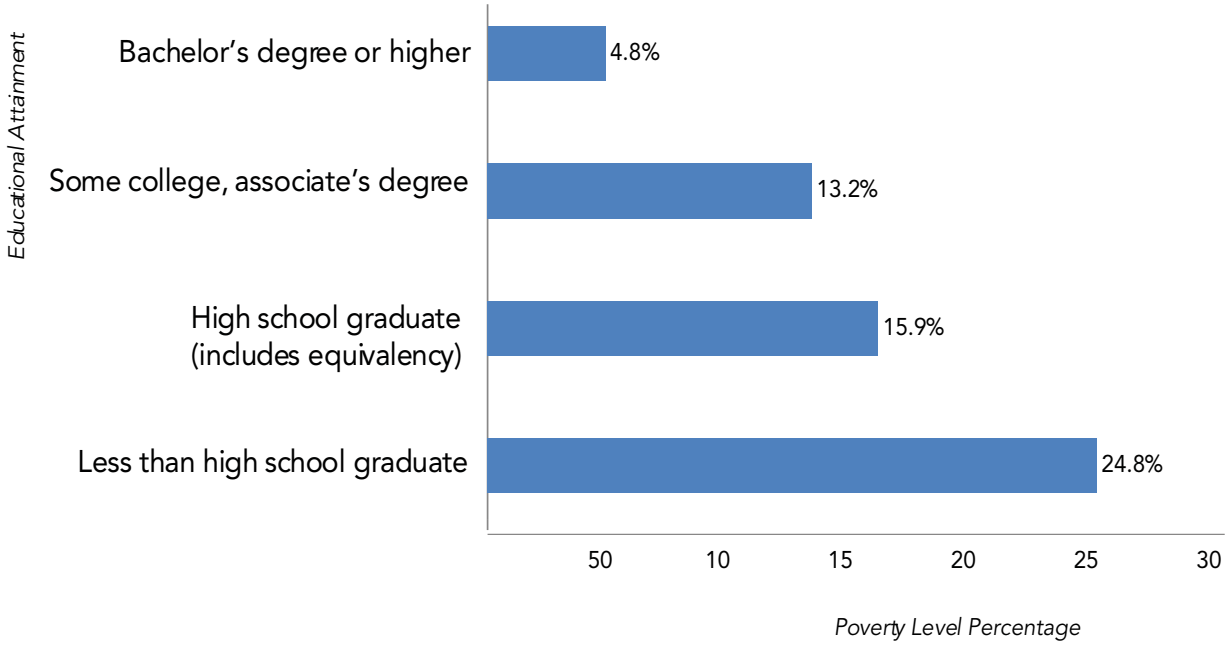
Source: Oregon Department of Education

Education

Douglas County is below state averages in educational attainment. Nationally, poverty is higher in groups with less education attainment and the county is not an exception. 1 in 4 adults (over 25), with less than a high school education in Douglas County, live in poverty, almost twice the percentage of adults 25 and over with some college.

Education attainment numbers are significantly lower in the county than statewide averages. The state average for 25 and older adults having a Bachelor's degree is 18.5%. In Douglas County, only 10.3% of adults 25 and older have a Bachelors Degree.

Douglas County poverty rate for the population 25 years and over by educational attainment, 2009-2011



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

Race and Ethnicity

Douglas County has historically had low percentages of ethnic minorities. The percentages have increased over the last decade, but not significantly. The 2010-2012 census information shows a slight increase to 10.9% of the county population identifying as being an ethnic minority, compared to a state average of 22.2%.

Of the minority populations residing in Douglas County, Hispanic represents the highest portion (40% of total minority population) followed next by American Indian (15% of total minority population).

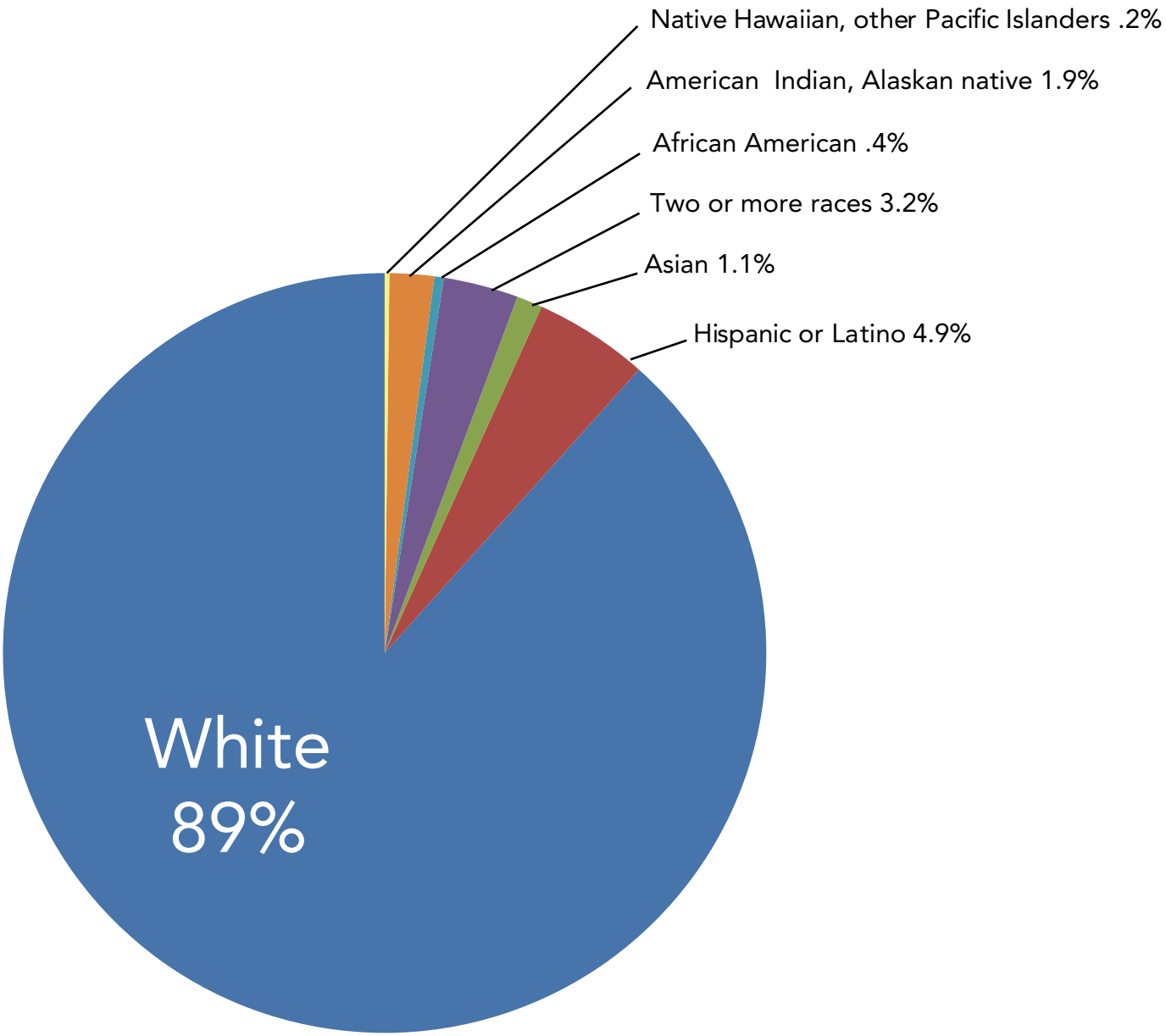
Public school enrollment numbers were also used as comparison data for race/ethnicity. This data illustrates a different picture, showing 21.85% of children as being a race/ethnicity other than white. Significantly higher than the census at 12%. The CACC intentionally spent time evaluating data on race and ethnicity and discussing its limitations. After considerable discussion, the CACC recommended that additional primary data needed to be gathered, specifically from those identifying as being Hispanic.

The CACC facilitated a discussion at a CAC meeting about the differences in the census and elementary enrollment numbers and racial and ethnic disparities. Questions asked included:

1. Who experiences health disparities in Douglas County?
2. How can the CACC collect more primary data on health disparities in Douglas County?

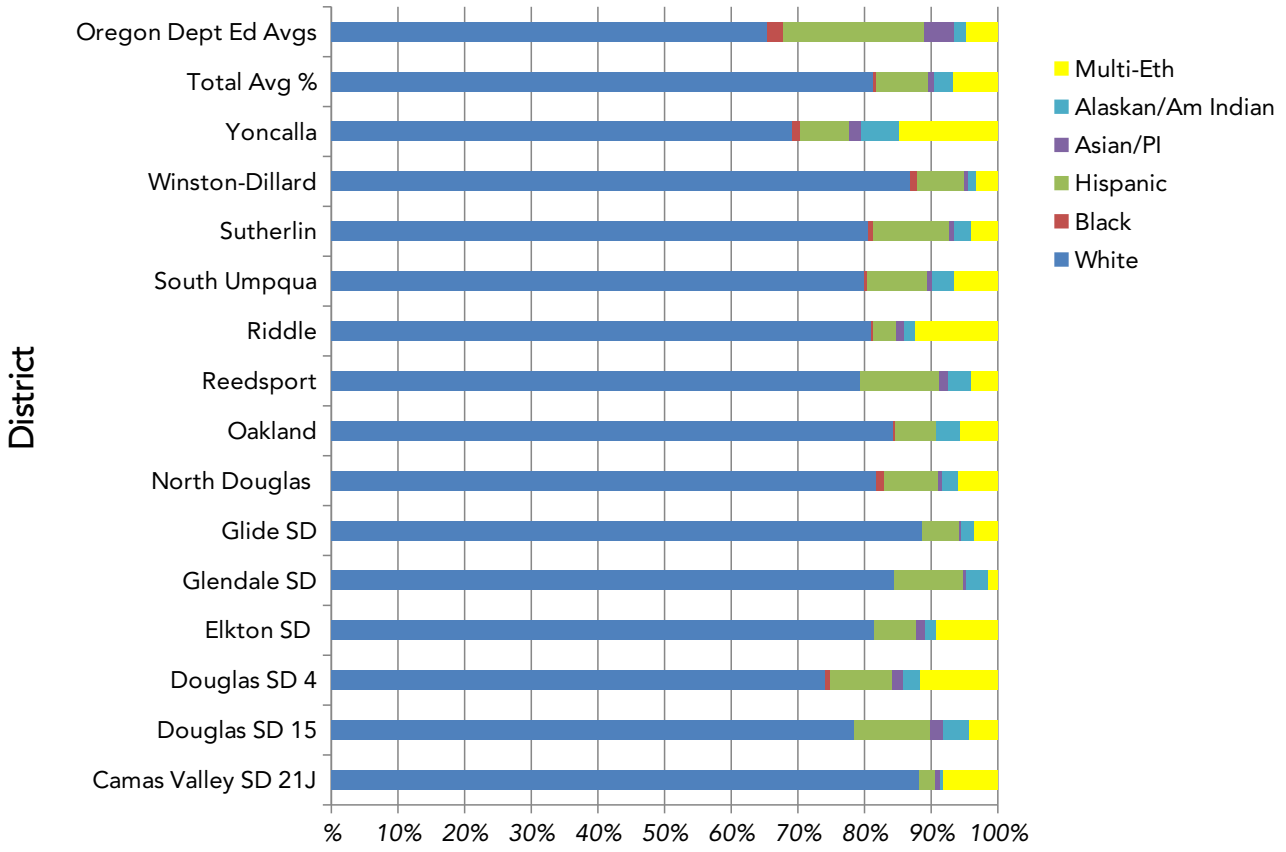
The dialog elicited several themes and trends, in addition to support for a targeted focus group with the Hispanic population. Themes identified included significant barriers and inequities related to poverty and the culture of poverty and the need for more information and data specific to race and ethnic groups.

Population by Race/Ethnicity- Douglas County



Source: U.S. Census, 2012

Public school enrollment by race/ethnicity 2012



Source: Oregon Department of Education

Health Status: Individual and Community Health

County Health Rankings

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

The most recent rankings were released in March 2013 and rankings are available for nearly every county in the United States. The rankings look at a variety of measures that affect health. Although released annually, many data sets used to compute the rankings are older data, presenting limitations when using the rankings exclusively to evaluate county health. However, the rankings do provide the ability to reference health status between counties and an ability to track trends of health status and outcomes.

Douglas County was ranked in the lowest percentile of counties in Oregon in 2013, ranking 30 out of 33 counties in the overall health outcomes ranking category. The county was also ranked 28 out of 33 in the health factors category. Douglas County has been in the lowest percentile of counties since the inception of the rankings model, illustrating significant poor health outcomes and challenging factors related to health of individuals living in Douglas County and overall community health.

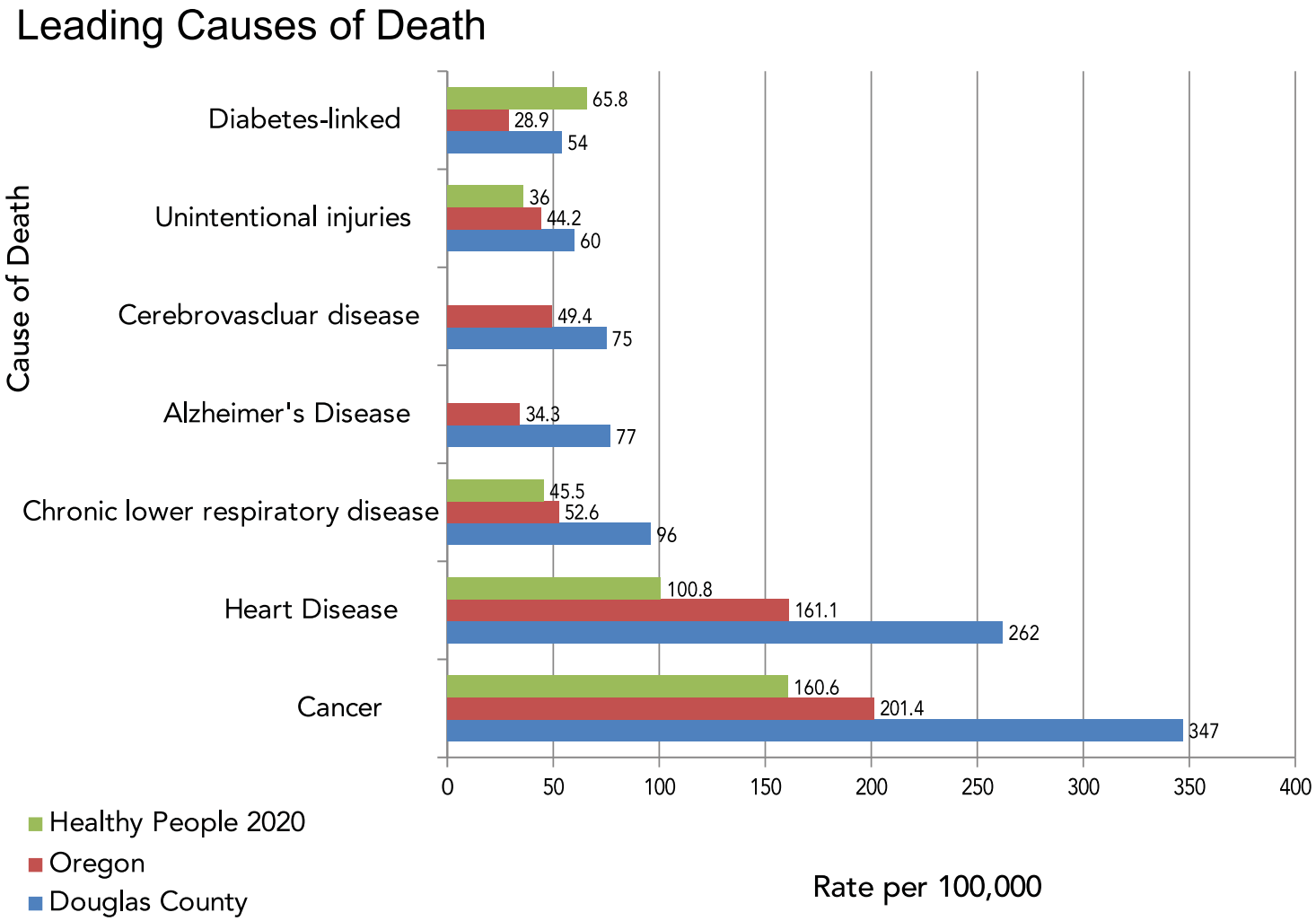
County	Rank
Baker	33
Benton	2
Clackamas	5
Clatsop	12
Columbia	19
Coos	28
Crook	8
Curry	26
Deschutes	7
Douglas	30
Gilliam	NR
Grant	1
Harney	20
Hood River	3
Jackson	13
Jefferson	32
Josephine	29
Klamath	31
Lake	22
Lane	17
Lincoln	24
Linn	23
Malheur	10
Marion	14
Morrow	16
Multnomah	15
Polk	9
Sherman	nr
Tillamook	25
Umatilla	27
Union	21
Wallowa	18
Wasco	11
Washington	4
Wheeler	nr
Yamhill	6

Morbidity and Mortality in Douglas County

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

The cancer death rate is significantly higher in Douglas County than the state or Healthy People 2020 goal. Healthy People 2020 provides national benchmark goals for communities and organizations that create and administer health improvement plans. They are science-based national objectives designed to help communities monitor progress and evaluate success. Douglas County rates are nearly twice the Healthy People benchmark goal in cancer, heart disease and chronic respiratory disease.

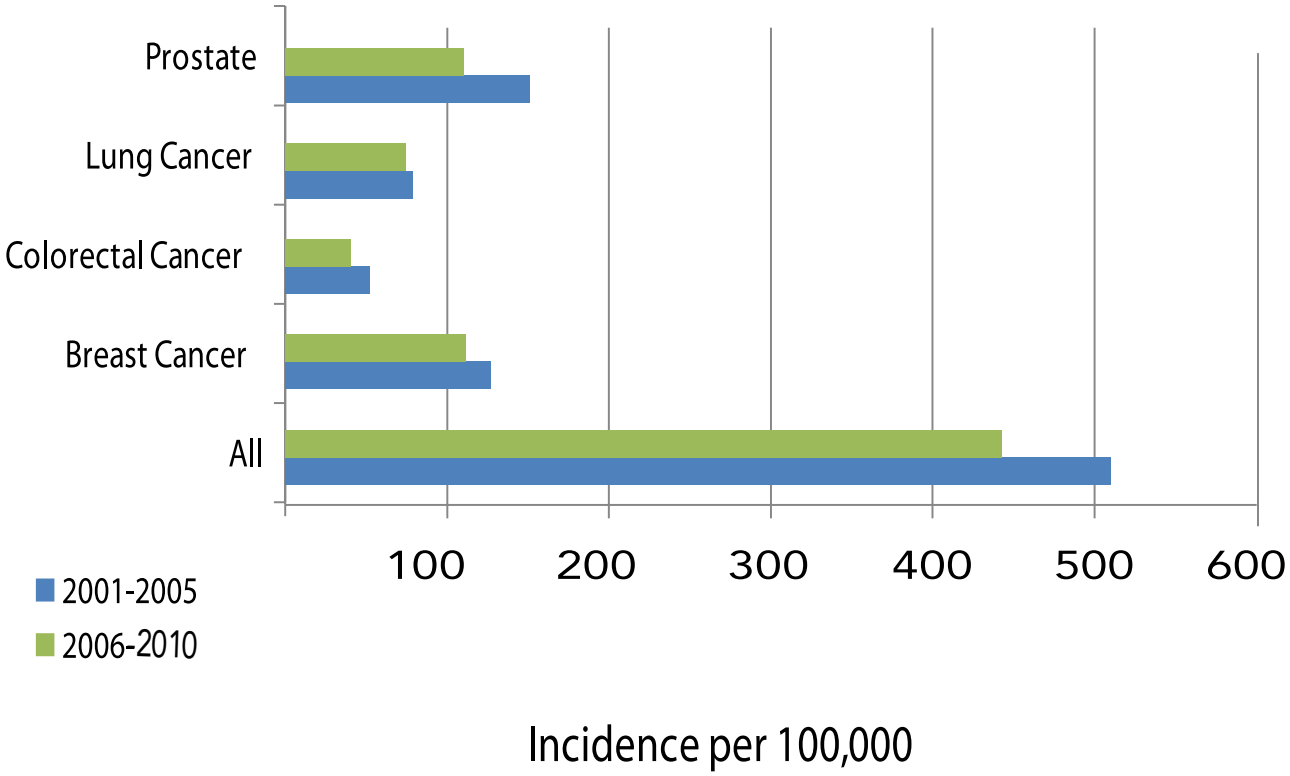
Breast cancer, prostate, lung and colorectal cancers are the leading types of cancer in Douglas County.



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

Leading Types of Cancer Incidence

Douglas County 2001-2010



Oregon Public Health Authority, Cancer in Oregon report, 2010

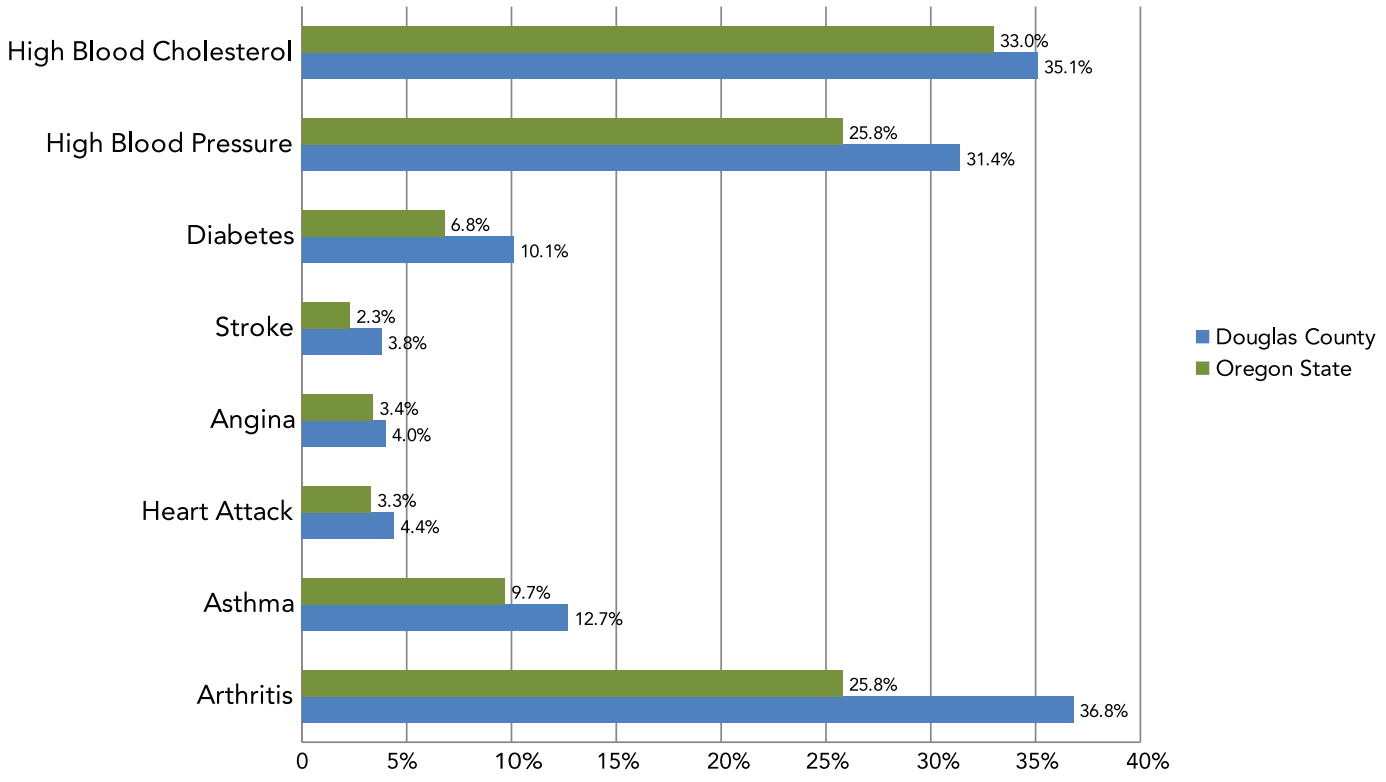
Chronic Disease and Conditions

Prevalence of chronic conditions in Douglas County are higher than state percentages. The county age-adjusted population shows a high burden of arthritis, high-blood pressure, high blood cholesterol, diabetes and asthma.

The burden of chronic conditions in those on Oregon insurance programs, such as the Oregon Health Plan (OHP), show a similar pattern as county population data with a few exceptions. The Division of Medical Assistence Programs, (DMAP) including OHP, shows higher prevalence of asthma and diabetes, however, nearly twice the prevalence when reviewing outpatient diagnosis codes for those on DMAP in Douglas County.

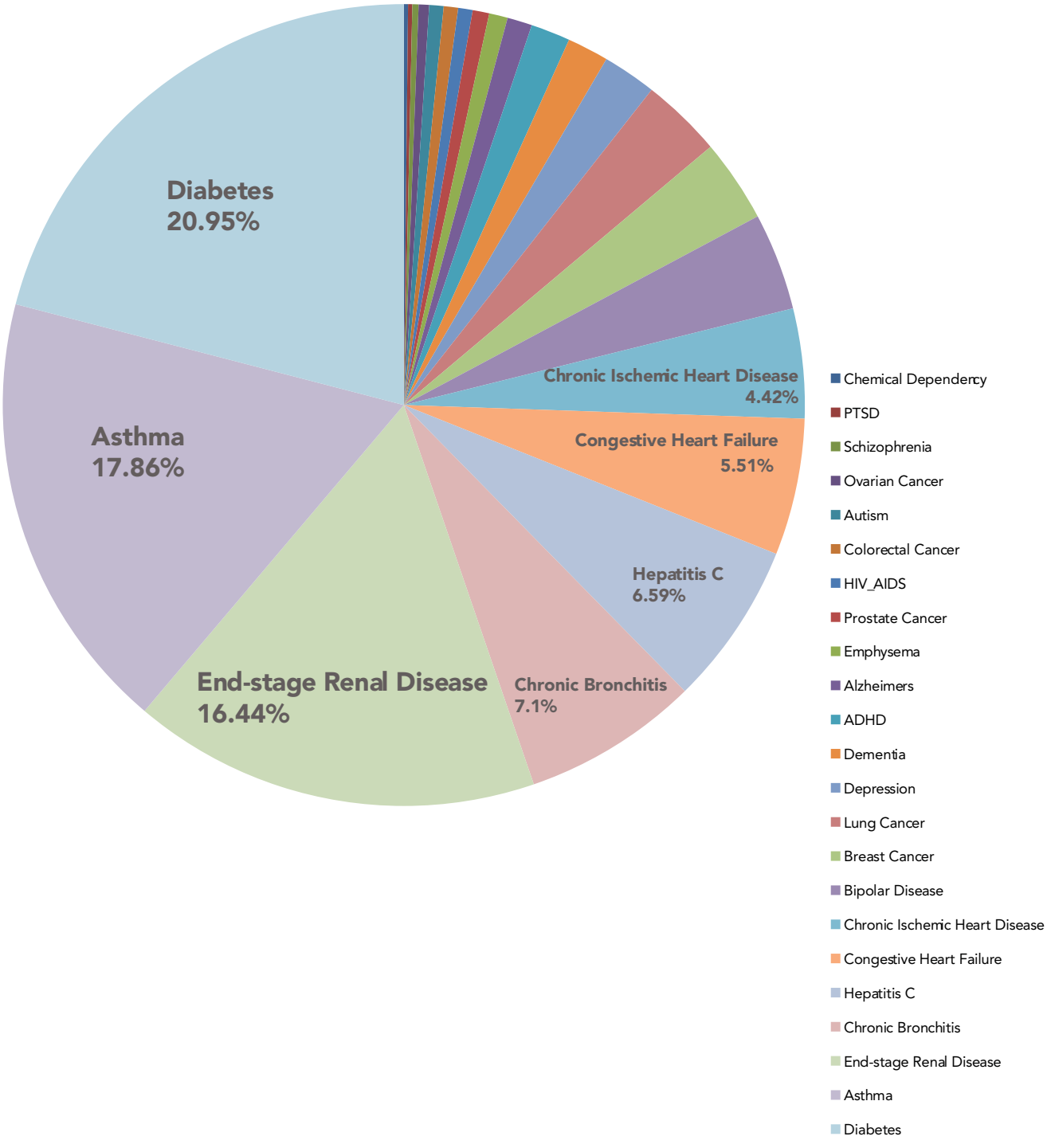
The higher prevalence of asthma and diabetes in the DMAP population in Douglas County has been trending up, showing increases when comparing data from 2008, 2009 and 2010. Diabetes in the total county population has also been trending up, and continues to be higher than the state average. Concern about diabetes, its effects and how to manage it effectively was a common theme in primary data collection focus groups.

Prevalence of Chronic Conditions, Douglas and State. Age adjusted 2006-2009



Source: Oregon BRFSS County Combined Dataset 2006-2009

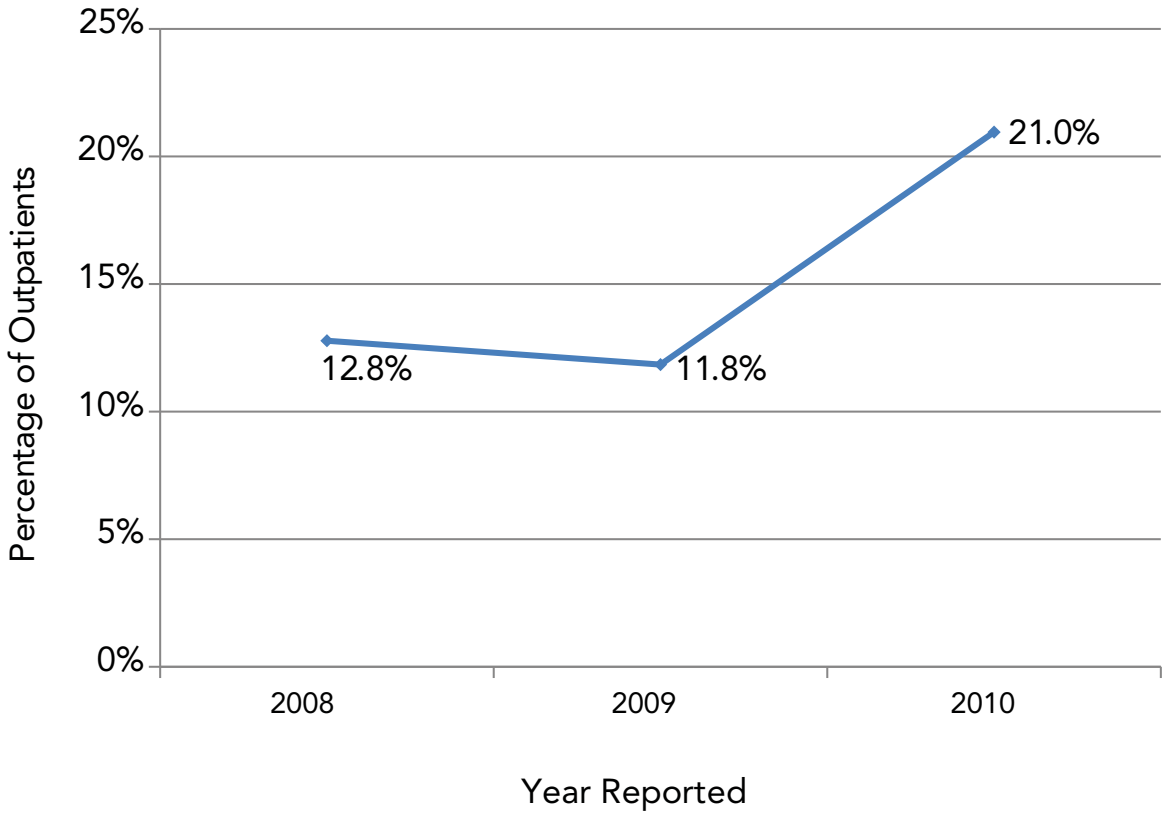
Chronic Conditions, 2010 Outpatient DMAP Population Douglas County *



Source: Douglas County DMAP Data, 2010

**data set does not count multiple/co-occurring chronic conditions.*

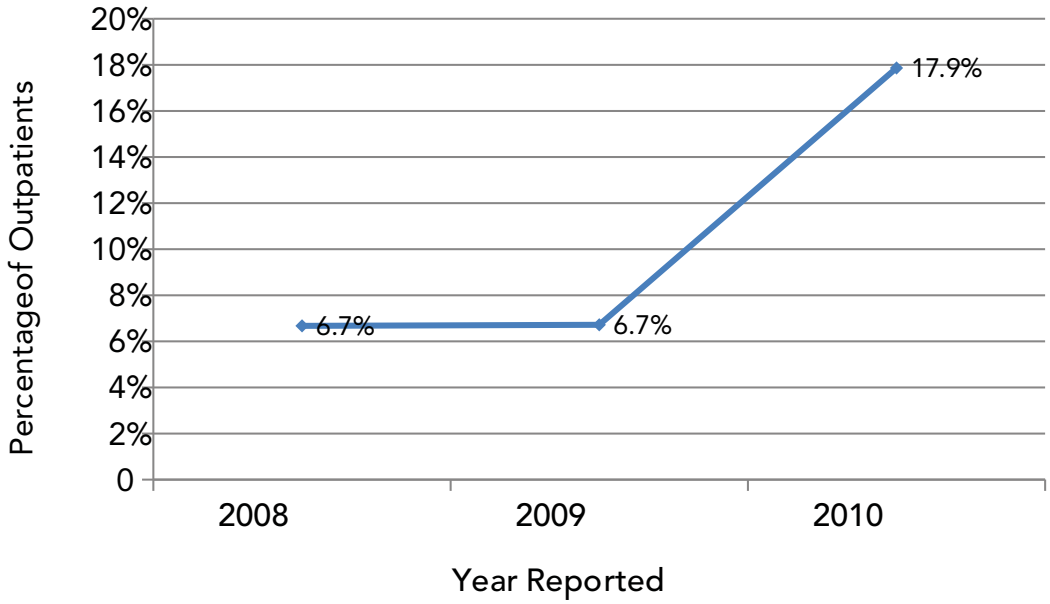
Douglas County DMAP: Percentage of Outpatients with Diabetes, 2008-2010



"My mom is diabetic and she has trouble understanding what she is told about her diet—it is too complicated to retain." — Focus Group Participant

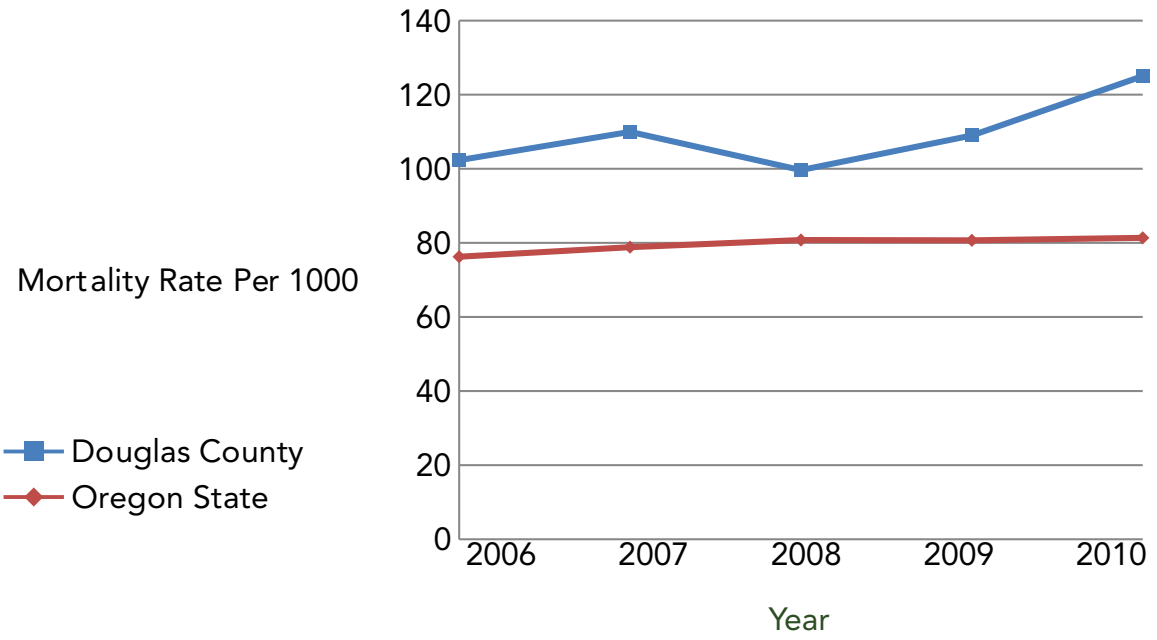
Asthma in the total adult county population is consistently higher than the state average.

Douglas County DMAP: Percentage of Outpatients with Asthma, 2008-2010



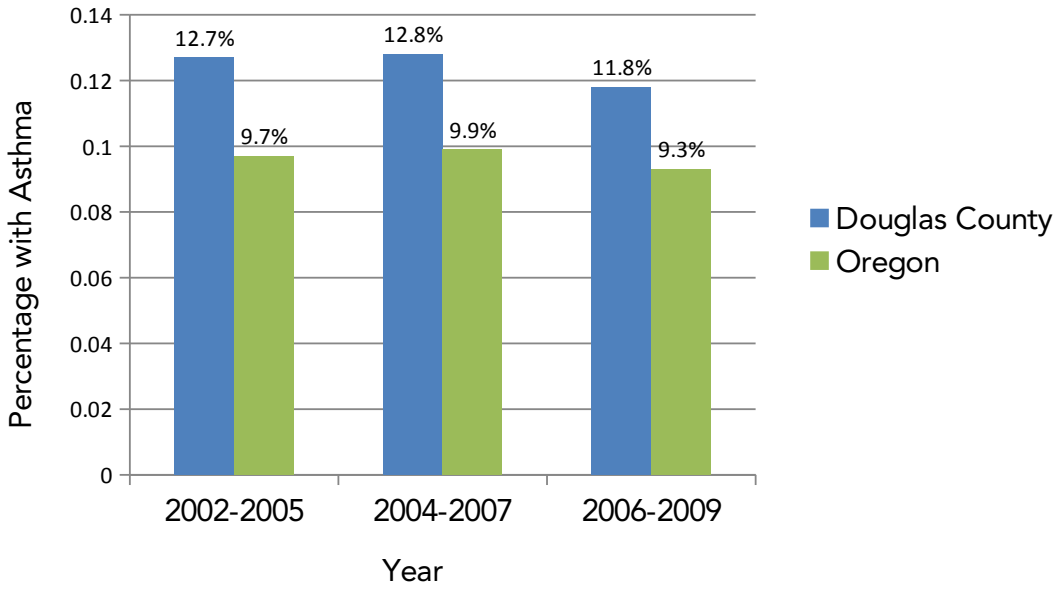
Source: Douglas County DMAP Data, 2010

Diabetes Related Mortality Rate per 1000, 2006-2010



Source: Oregon Vital Statistics Annual Reports

Adults with Asthma, Douglas County

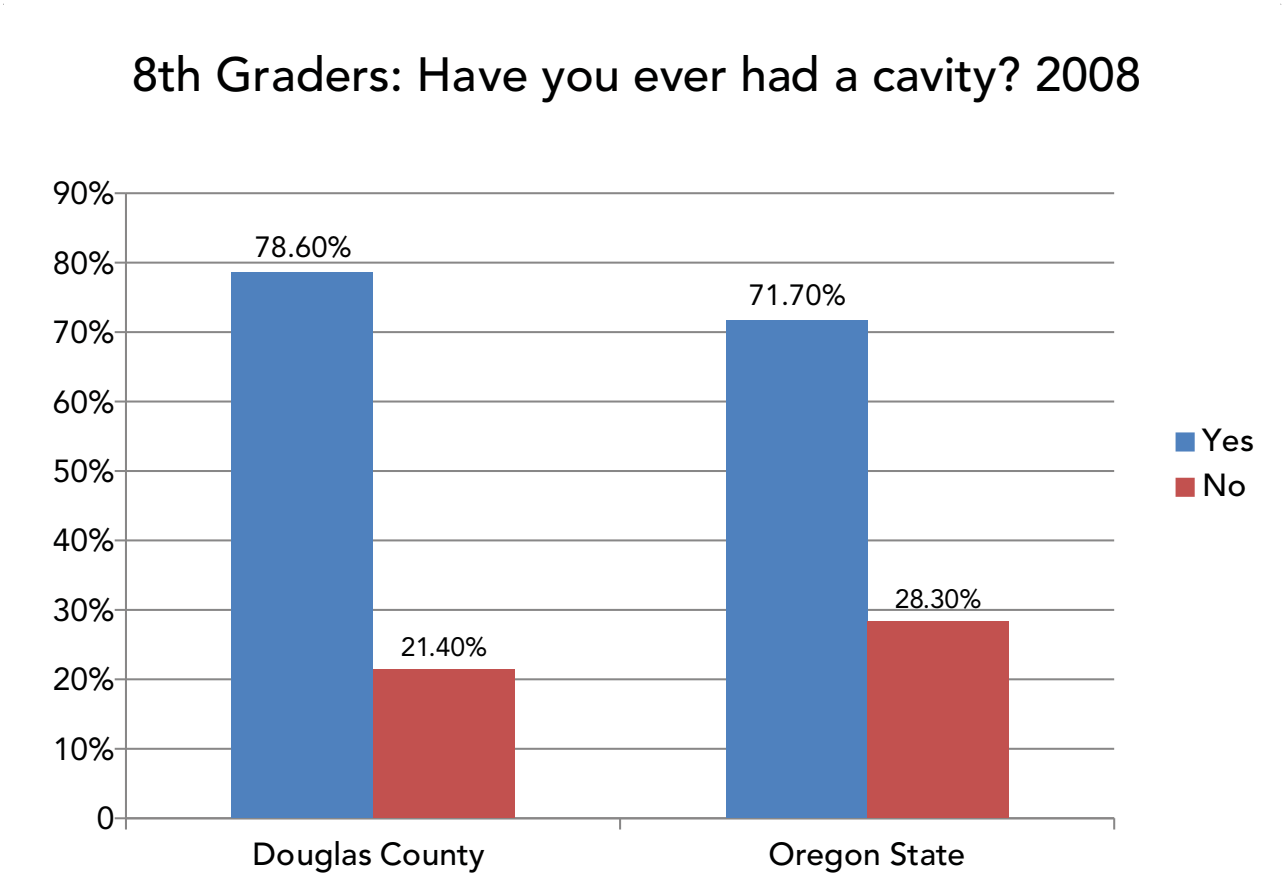


Source: Oregon BRFSS County Combined Dataset 2006-2009

Oral and Dental Health

Oral health indicators and county level data are very limited. National and Oregon data show that Oregon has five times the number of children suffering from tooth decay than asthma, putting dental health as a priority concern for Oregonians. In Oregon, oral disease is on the rise and is not limited by socio-economic status, race, ethnicity or age according to a recent needs assessment commissioned by the Oregon Community Foundation.

The Oregon Healthy Teens survey found that Douglas County 8th graders reported having had more cavities than the state average. Close to 80% of 8th graders reporting having had cavities in 2008.

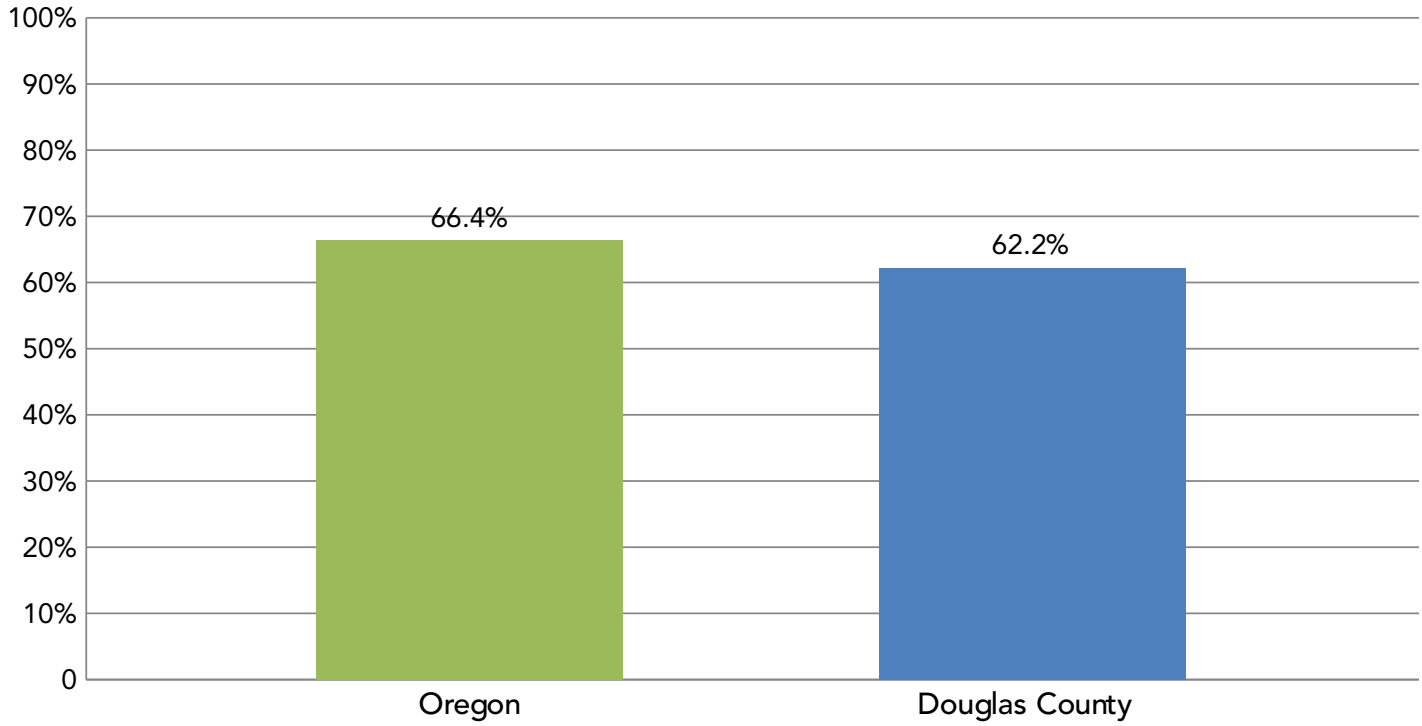


Source: Oregon Healthy Teens 2008, Douglas County (not all districts participated)

Mental Health

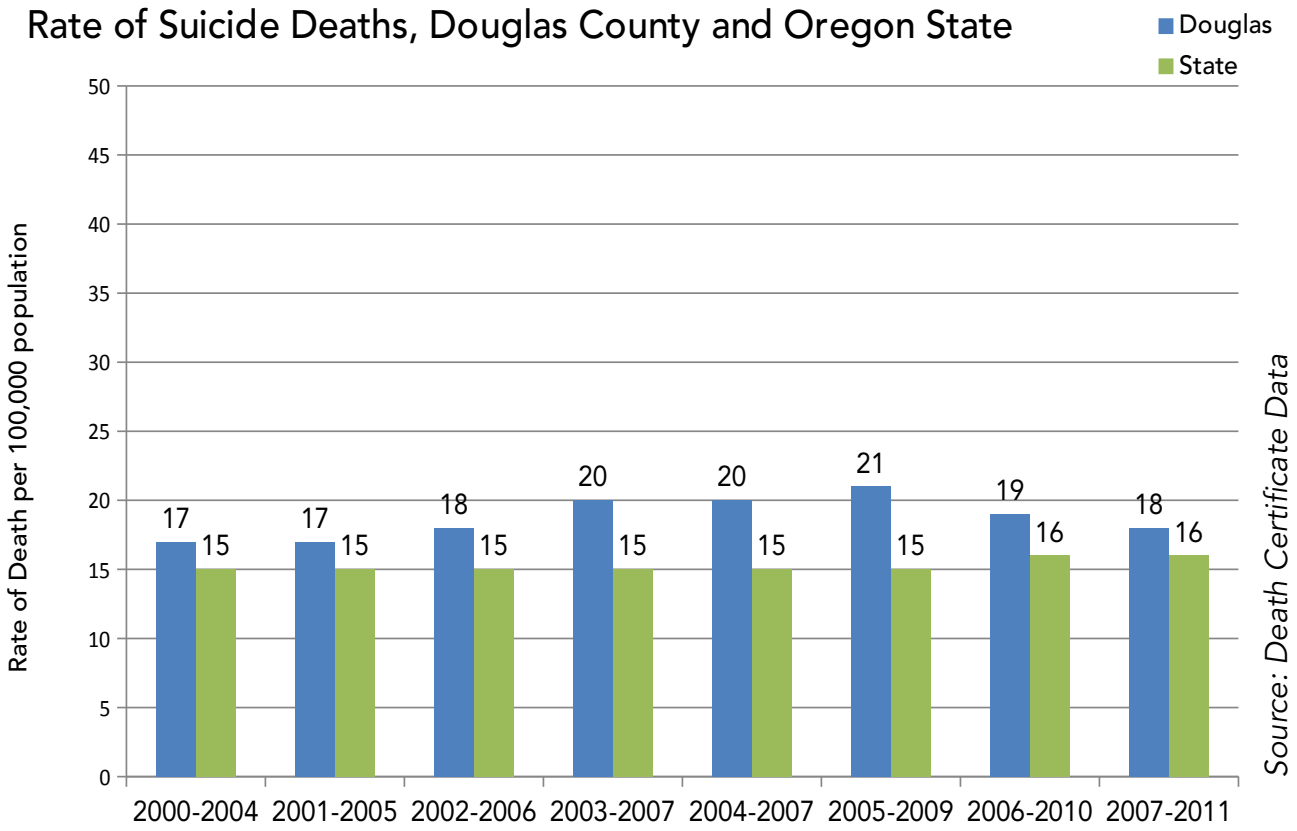
Those living in Douglas County have higher rates of mental and emotional health challenges including depression and suicide. Overall health is linked to mental well-being. When people don't feel as though their mental health is good, health-related quality of life is reduced. Close to 40% of respondents in Douglas County said they did not have good mental health in surveys taken from 2006-2009.

Oregon Adults in Good Mental Health, Douglas County and Oregon, 2006-2009



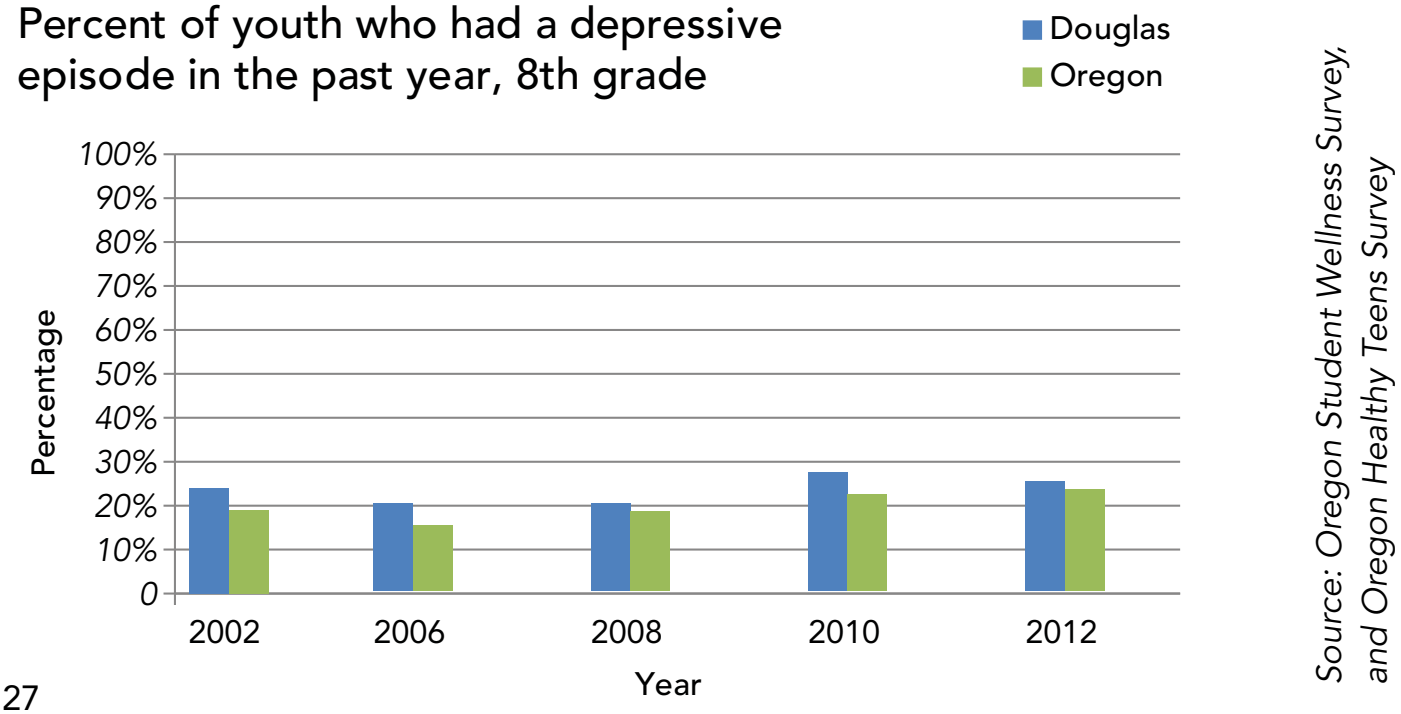
Source: Oregon Behavioral Risk Factor Surveillance System

"My depression is severe. I work full time and have a son with special needs. I'm not making enough to provide for me and my son, he gets OHP but I make $3 too much to get it and can't get meds for my depression. Sometimes I don't eat so he can. The fight has gone out of me."
— Focus Group Participant



Rates of suicide deaths have been consistently higher than the state rate and fairly stable over the last decade 17-20 per 100,000. Suicide is highly correlated with depression, intimate partner violence and several mental health disorders.

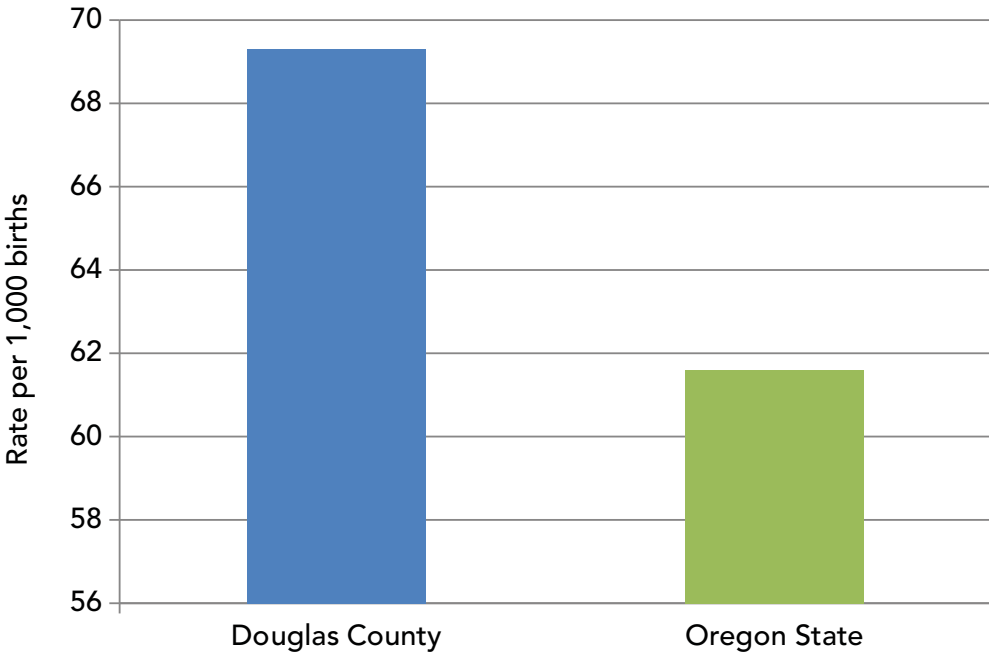
Depression in Douglas County youth is also high, with one in four 8th graders reporting a depressive episode in the past year.



Maternal and Child Health

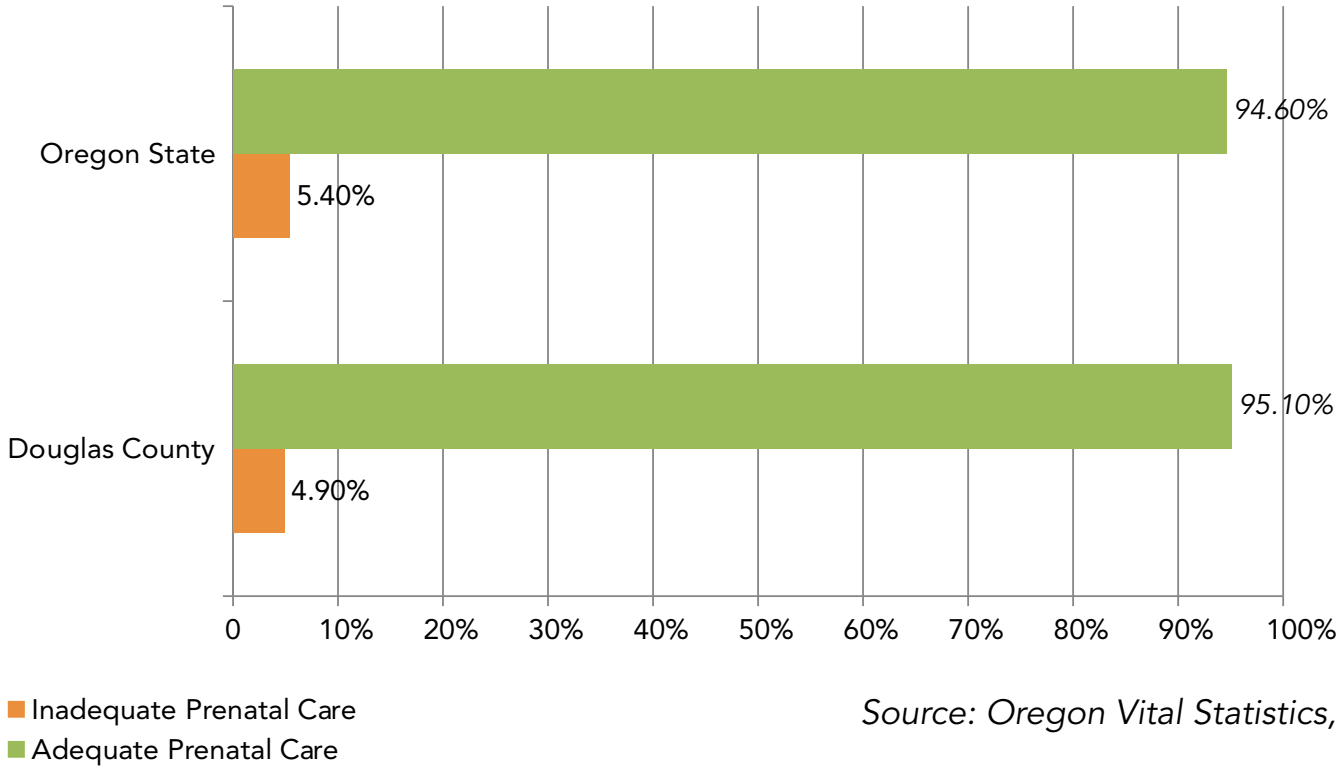
Causes of low birth weight include tobacco use, alcohol and other drug use, socioeconomic factors such as education level and poverty as well as maternal and fetal medical conditions. Babies born with low birth weight (considered 1500-2499 grams at birth) typically have more long-term disabilities and developmental issues, including cerebral palsy, learning disabilities, impairment of sight, hearing and/or lung functioning.

Low Birthweight Rate 2012



Source: Oregon Vital Statistics, 2012

Prenatal Care



Source: Oregon Vital Statistics, 2012

Single Year New Births: Douglas County

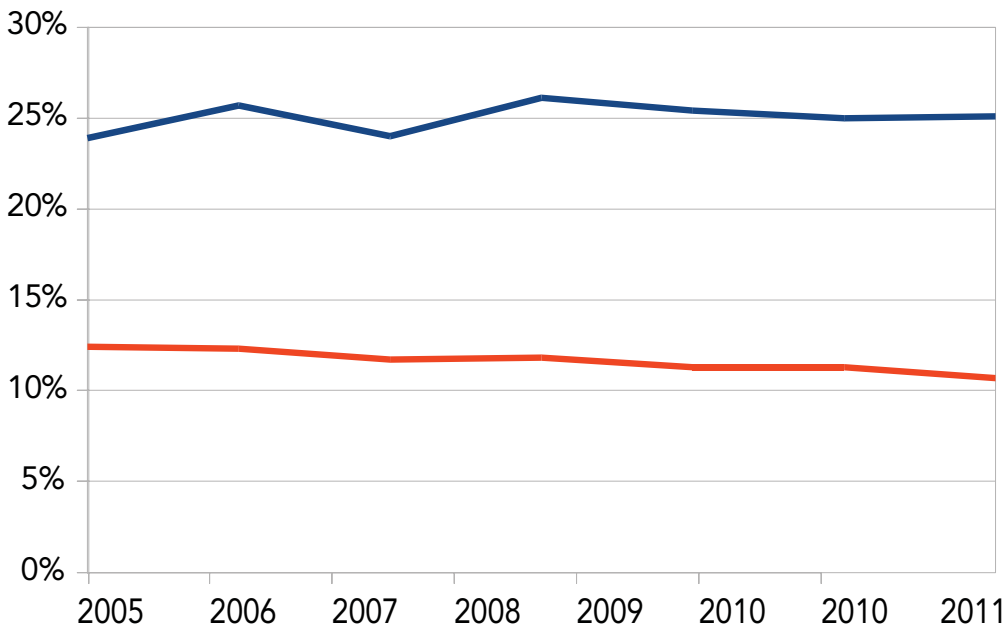
Group	Actual LBW Rates	Total Cost	with prenatal clinic rate	Total Costs (includes birth and program costs)	Cost Avoided
U. S	*8.1*	*$19,762,971,148*	*2.7%*	*$10,414,145,686*	*$9,348,825,462*
Oregon	*6*	*$172,718,088*	*2.7%*	*$123,792,776*	*$ 48,925,312*
Douglas County	*6.5*	*$4,397,100*	*2.7%*	*$2,893,354*	*$1,503,746*

Source: Douglas County Prenatal Clinic Study 2012

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

Although pregnancy risk factors are high (such as maternal tobacco use) in Douglas County, utilization of prenatal care is strong, with over 90% of mothers in the county receiving prenatal care. Those women receiving prenatal care in Douglas County, have a marked reduced rate of low birth weight babies compared to those without prenatal care.

A primary risk factor for low birth weights and child outcomes is maternal smoking. Maternal smoking is currently much higher than the state average and has been for several years. Nearly 1 in 4 women smoke during pregnancy in Douglas County.



Source: Oregon BRFSS County Combined Dataset 2006-2009

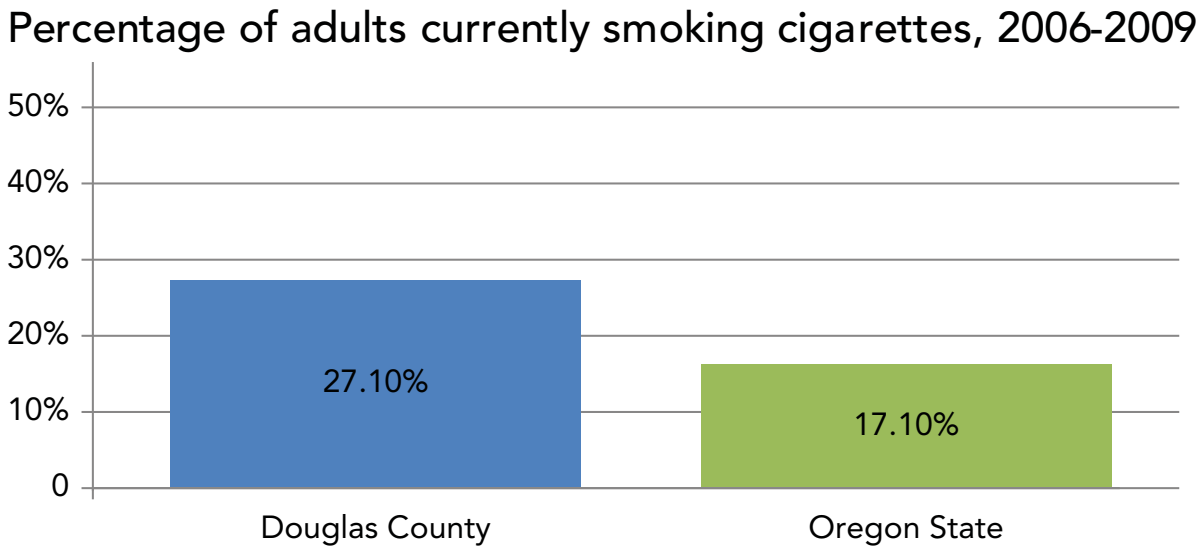
Health Behavior and Lifestyle Factors

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

Tobacco

Tobacco usage has remained high in Douglas County for many years. More than 1 in 4 adults in the county smoke cigarettes, considerably higher than the state average of 17%.

> *"Tobacco—if we could just reduce it by even half we would have tremendous impact." —Focus Group Participant*

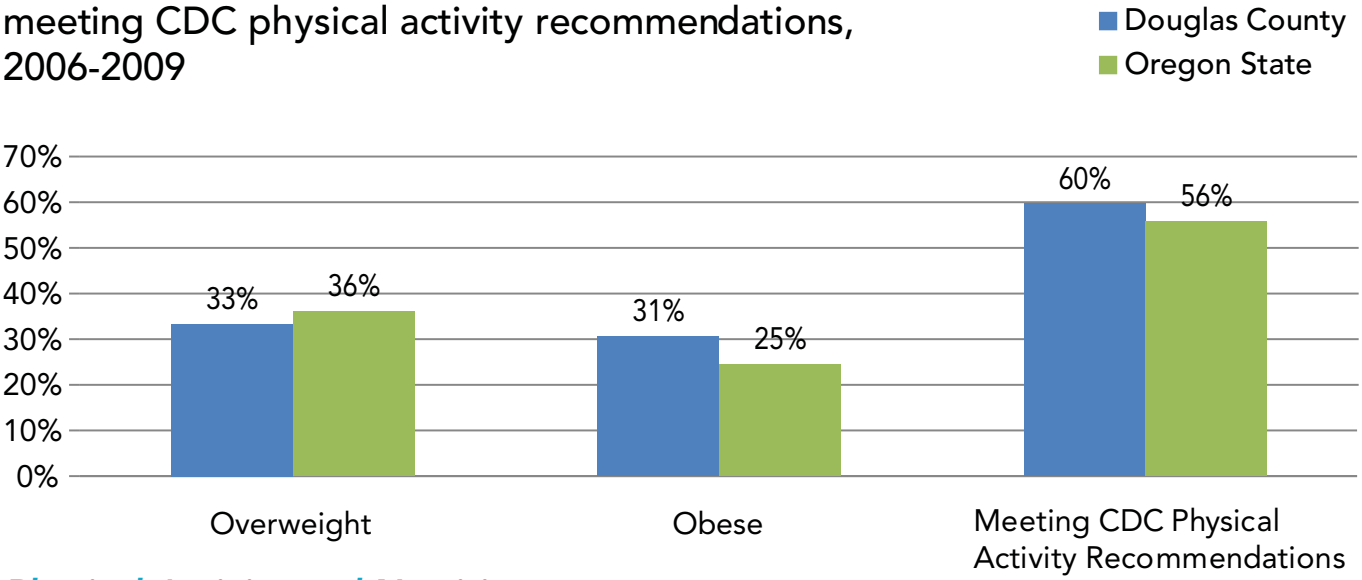


Source: Oregon BRFSS County Combined Dataset 2006-2009

Obesity

Obesity is a modifiable risk factor for several chronic conditions. Overweight is defined as a body mass index of 25-30, obesity is defined as a BMI of 30 or higher. BMI is calculated by using both height and weight. Research has shown that overweight and obesity are associated with increased risk of coronary heart disease, type 2 diabetes, cancer, high blood pressure, stroke, liver and gallbladder disease. One-third of adults in Douglas County are overweight, an additional 31% of residents are obese. Douglas County exceeds the national goal and the state average for obesity and being overweight.

Percentage population overweight, obese and those meeting CDC physical activity recommendations, 2006-2009



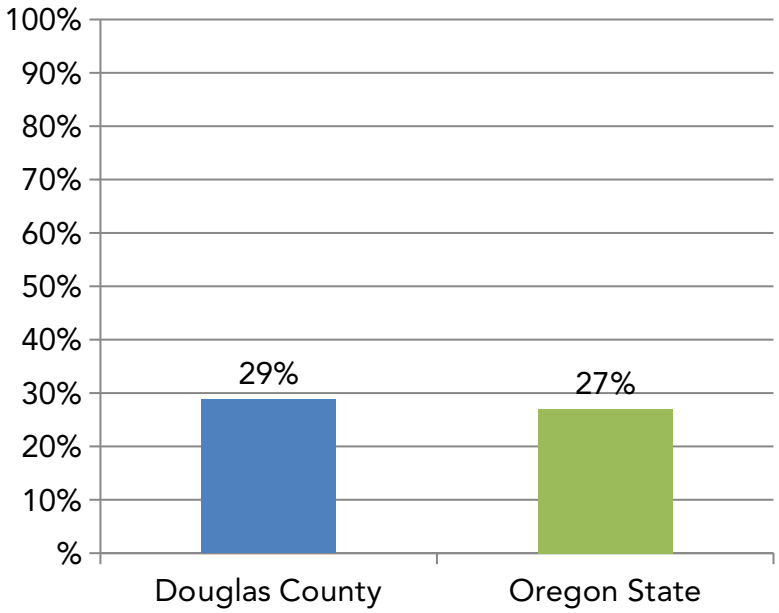
Physical Activity and Nutrition

Regular physical activity and a healthy diet reduce the risk for chronic disease and obesity. Approximately 22% of Douglas County residents are defined as being physically inactive. Physical inactivity is defined for adults as 20 and over reporting no leisure time physical activity.

The percentage of adults consuming at least five servings of fruits and vegetables a day in Douglas County from 2006-2009 was 28.8%, slightly exceeding the state average. The proportion of restaurants in the county that are fast food establishments are close to half, at 44%, almost twice the national benchmark.

"We have a lot of poor lifestyles, nobody is out there walking on sunny days. I go to the park on sunny days and nobody is there except in Myrtle Creek where they have Tai Chi in the park."
—Focus Group Participant

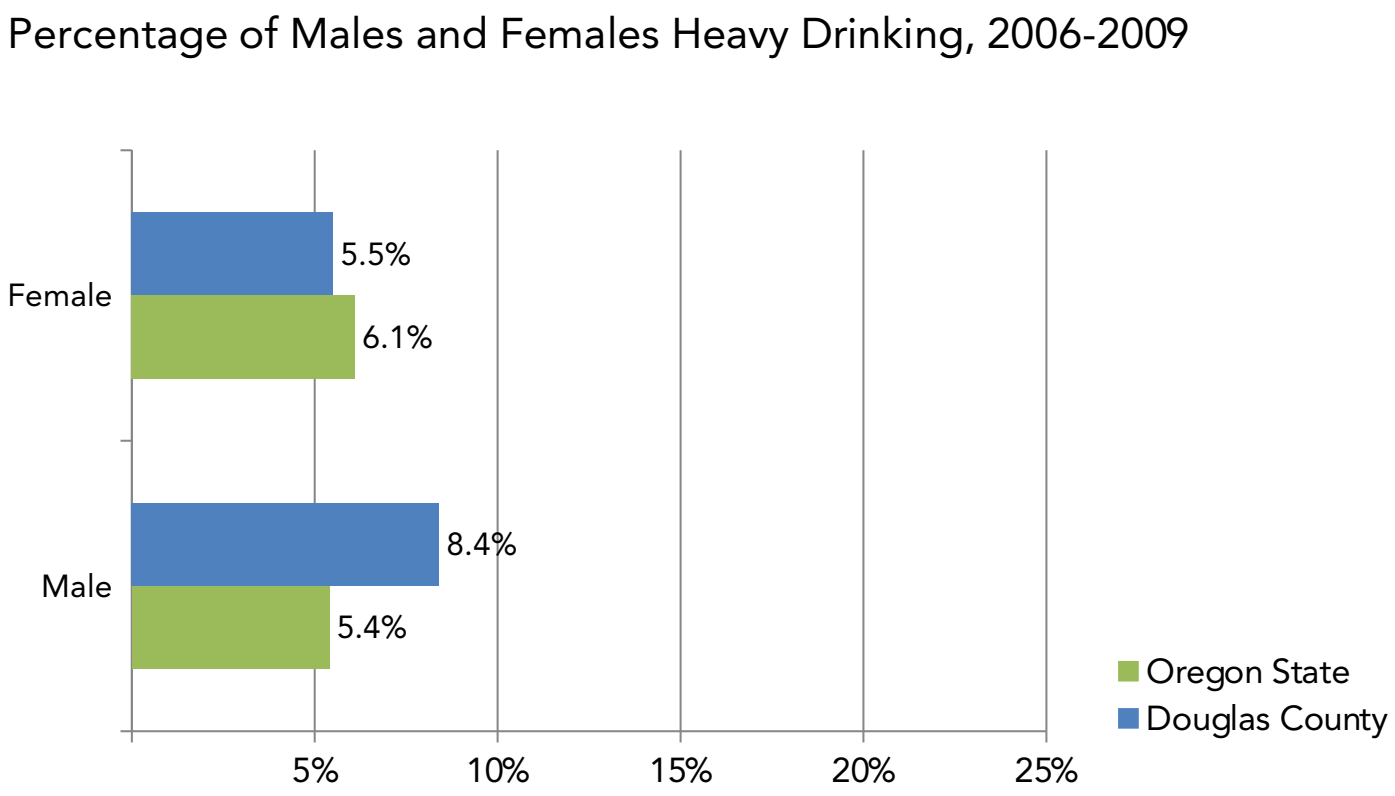
Percentage of adults who consumed at least 5 servings of fruits and vegetables a day 2006-2009



ISource: Oregon BRFSS County Combined Dataset 2006-2009

Alcohol

Excessive heavy alcohol consumption can contribute to chronic health issues, including heart disease, liver cirrhosis, high blood pressure, stroke, coma and death. 15% of Douglas County adults drink excessively, men having a higher rate. Heavy or excessive drinking is defined as adults consuming more than 1 (for females) or 2 (for males) beverages per day on average.



Source: Oregon BRFSS County Combined Dataset 2006-2009

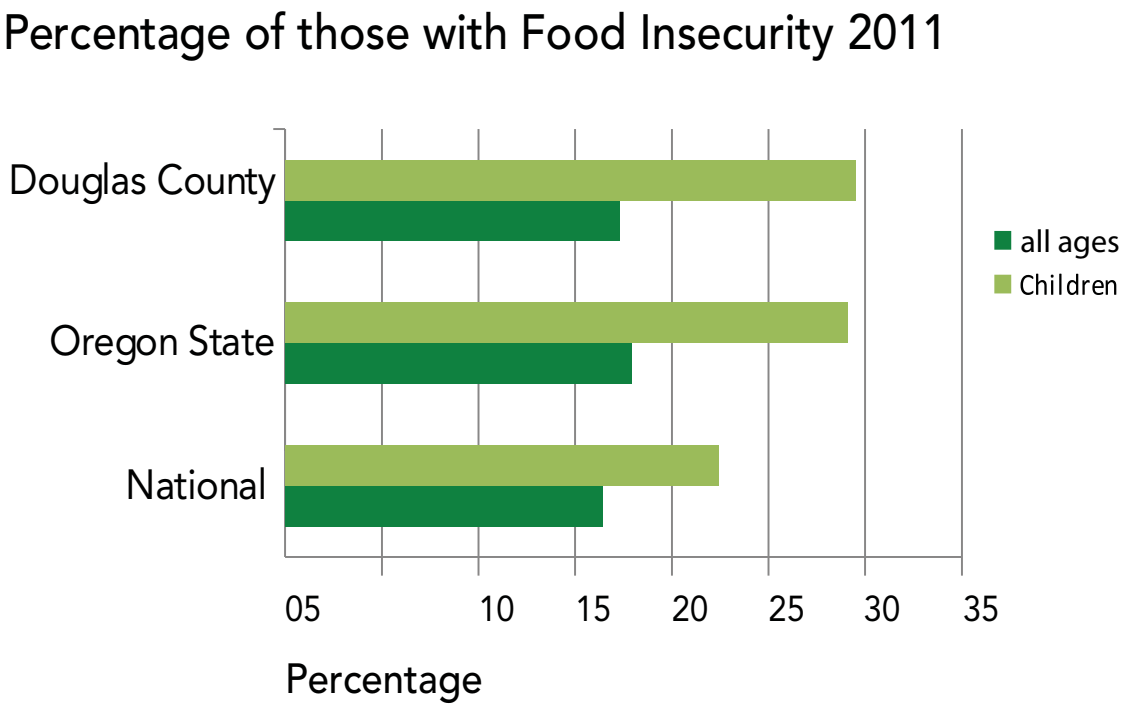
"As long as I stay sober I can stay out of trouble and be healthy." —Focus Group Participant

Additional Social Determinants of Health

Food Insecurity

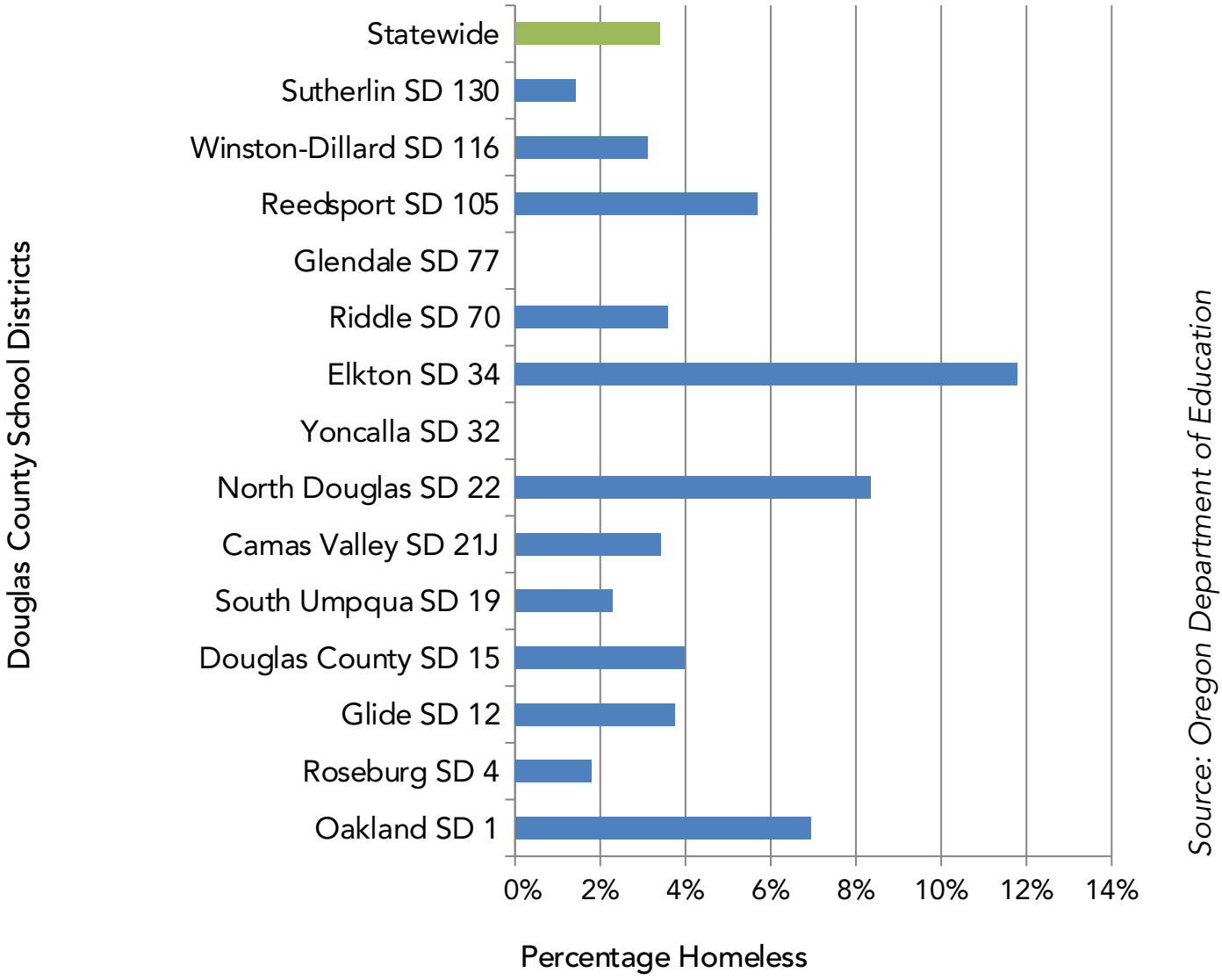
Food insecurity refers to USDA's measure of lack of access to enough food for an active, healthy life for all members in a household, limited or uncertain availability of nutritionally adequate foods. 17.3% of Douglas County households are food insecure. 79% of households that are food insecure have income low enough to qualify for Supplemental Nutrition Assistance Program (SNAP) and other nutrition programs. Close to 30% of children in Douglas County households experienced food insecurity in 2011. It is estimated that an additional 7.5 million dollars would have been needed to meet food needs of those living with food insecurity in Douglas County in 2011.

> *"Our economics affects our health. Affording good food is expensive so if you are on a tight budget you buy cheaper starches and pastas instead of fresh vegetables and fruits."*
> *—Focus Group Participant*



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

Homeless students grades K-12, Douglas County 2009-2010



Housing/Homelessness

Homelessness continues to be a challenge in Douglas County. Children under 18 that are homeless are more likely to be at risk for violent crime, lower educational outcomes and higher rates of substance abuse. Nearly all districts in the county have homeless K-12 students.

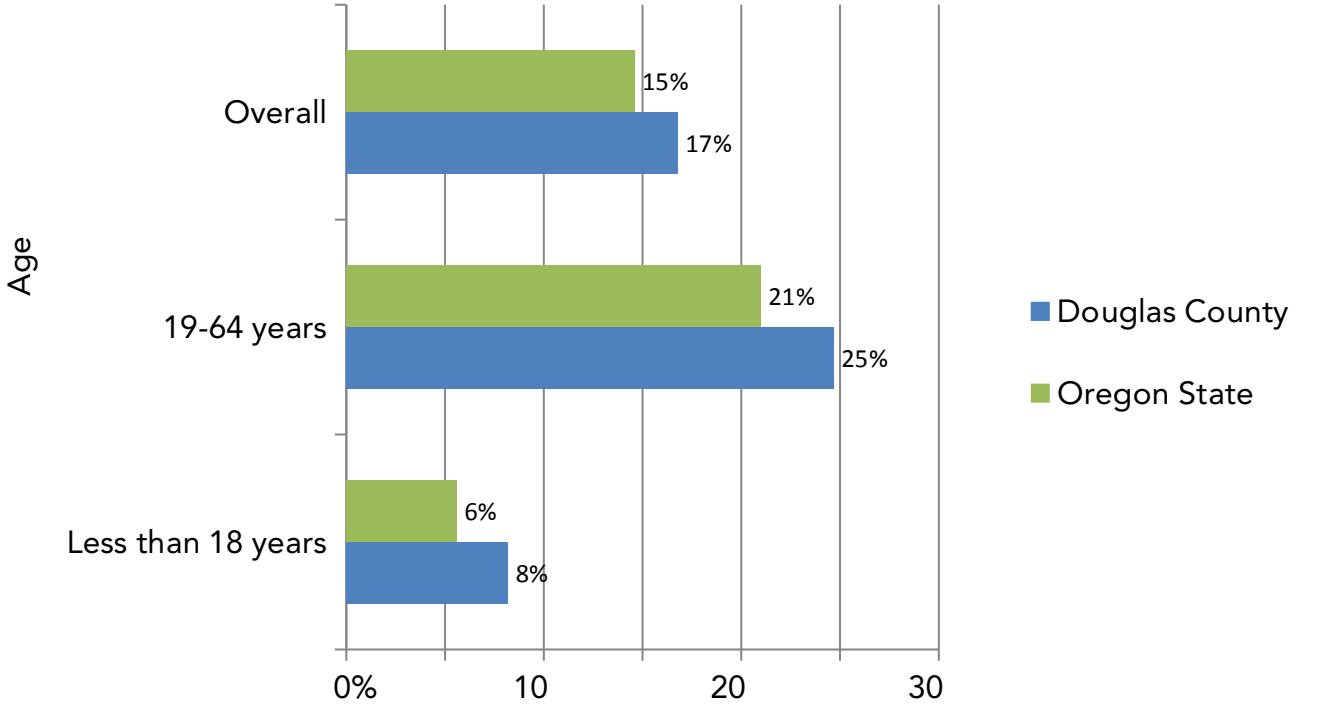
"I see homeless people in need everywhere, There are homeless women living in their car at the park."
—Focus Group Participant

Health System

Access to Medical Care

Lack of health insurance coverage continues to be a significant barrier to accessing needed health and medical care. Uninsured people are likely to experience more adverse physical, mental and financial outcomes than those with insurance. Douglas County far exceeds the national benchmark of 11%. 24.7% of adults age 19-64 in Douglas County were uninsured in 2011.

Percent Population Uninsured, 2011



Source: 2011 Oregon Health Insurance Survey

"We (uninsured) are not very healthy-people procrastinate when they don't have insurance." —Focus Group Participant

Those that don't speak English or have English as a second language have additional barriers to accessing health and medical care. Health information in Spanish is limited in Douglas County.

"There is a lack of information in Spanish about Diabetes and nutrition."—Focus Group Participant

"A lot of doctors don't listen or talk to us (Spanish speakers), they just tell us to take Tylenol or Ibuprofen."
—Focus Group Participant

Community Perceptions of Health

Community Health Assessment
and Discussions with people living in Douglas County

Focus Group Report

Prepared for:
Umpqua Health Alliance
Douglas County Public Health
Douglas County Mental Health

July 2013

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

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

Eight focus groups were completed through Douglas County, in the spring of 2013. Seventy seven community members participated in the groups, representing several target populations. A subcommittee of the CAC, titled the CACC, began by prioritizing populations and locations for focus groups. The CACC also discussed and guided the selection of data and questions to gather at the focus groups.

Several themes emerged from the focus groups. Focus group participant responses are presented in six sections.

1. Health behavior and lifestyle
2. Social Determinants of health
3. The Community's health
4. Access to health and medical services
5. Health literacy
6. Individual health, including mental health

Findings from the focus groups serve to add community perceptions about issues related to health while the process of the focus groups provided opportunity for increased community engagement in improving individual and community health.

Process

The focus groups are part of a larger community health assessment process. Several community partners met in 2012 to discuss collaborating on a collective community health assessment. Pooling resources, reducing duplication of effort and meeting funding mandates motivated several collaborative partners to

secure a contract with a consultant to lead and facilitate a community health assessment (CHA). The results of the collaboration would include a community health assessment that would meet the needs for the Umpqua Health Alliance, Douglas County Public Health Accreditation and the Mental Health Biennial Improvement Plan (BIP).

The entire CHA process follows a modified Mobilizing for Action through Planning and Partnerships (MAPP) model. The focus groups were part of the data collection and analysis of the entire CHA process. The focus groups are part of the Primary Data Collection Process.

Modified MAPP-Douglas County CHA Process

Process	*Activities*
Preliminary Data Collection Identify previous community assessments Secondary quantitative data collection	• web based search • key informant interviews
Analysis of Secondary Data for Themes Identify previous community assessments	• review by consultant, CACC
Collection of Primary Data Collect qualitative data	• community focus groups • key informant interviews: • local health system SWOT
Final Inventory and Meta-Analysis Assessment of local health status, community strengths assessment and forces of change assessment	• review by consultant, CACC • list key-health related issues
Write and share Community Health Assessment Document	• summary in presentation and written format

Community Health Improvement Plan (CHIP)

Timeline: October 2012 — July 2013

Eight focus groups were completed through Douglas County in the spring of 2013. A subcommittee of the CAC, titled the CACC, began by prioritizing populations and locations for focus groups.

CACC Priorities
Seniors
South county
North county
WIC participants
Mental health population
Teens and young adults
Developmentally disabled
Homeless population
Spanish speaking population
Coast - Reedsport
CAC members

The CACC also discussed and guided the selection of data and questions to gather at the focus groups. The focus group guide, including questions, is attached in the Appendices. Participants were recruited via outreach and flyers of specific populations. Data was gathered during the groups via open-ended questions and instant feedback polling questions. The instant feedback polling questions utilized Turning Technology "clickers," capturing instant demographic data and polling on health priorities and perceptions. The use of multiple feedback collection methodologies ensured 100% participation of focus group attendees.

The focus groups were all facilitated by a local consultant and assisted by Community Advisory Council (CAC) members and Coordinated Care Organization (CCO) staff. Light refreshments and $10 gift cards were provided to focus group participants as incentives. The focus groups were completed within two hours and averaged 9 participants per group.

Group	Date	Location
Seniors	March 21	Riddle: senior dining site
WIC	March 14	Drain: public health WIC site
CAC Members	March 21	Community Cancer Center
Homeless Teens	April 16	Casa de Belen
Spanish Speakers	March 17	St Joseph's Spanish Mass - Roseburg
Chronic Mental Heath	April 24	Douglas County - Roseburg
Reedsport	April 24	Solution Center - Roseburg
Developmentally Disabled	June 24	Douglas County DD - Roseburg

Demographics of Participants

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

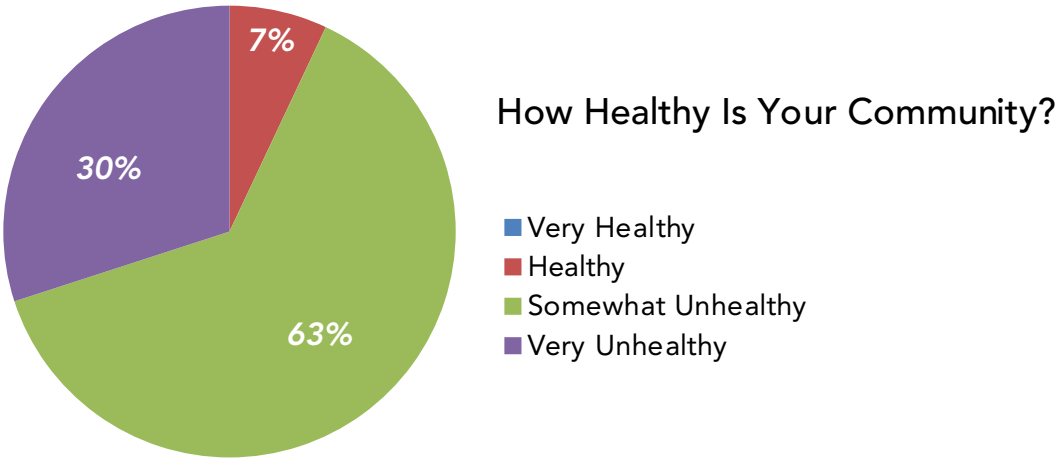
Characteristic	Response (number)	Response (%)
Age		
25 or under	9	12.5%
26-39	5	12.5%
40-54	23	36%
55-64	13	21%
65 or over	12	18%
Sex		
Female	46	73%
Male	15	27%
Ethnicity		
African American/Black	0	0%
Pacific Islander	0	1%
Hispanic/Latino	15	21%
Native American	3	4%
White/Caucasian	44	73%
Other	0	1%
Marital status		
Married or co-habitating	31	51%
Not married, single, divorced, widowed	31	49%
Highest level of education		
Less than HS Diploma	12	19%
HS diploma or GED	18	33%
College Degree or higher	28	46%
Other	2	2%
Household income		
Less than $20,000	27	46%
$20,000-29,999	10	15%
$30,000-49,000	5	8%
Over $50,000	20	31%

Demographics of Participants

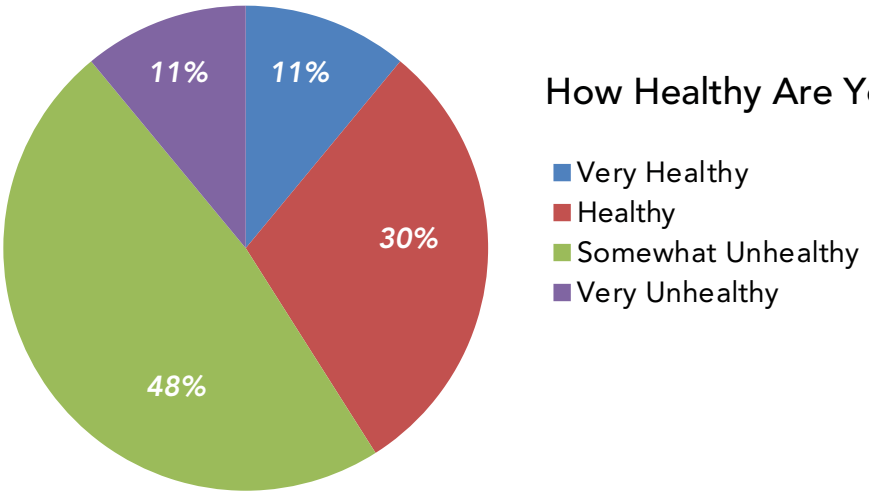
Community Perceptions

Focus group participants also answered questions about their personal health, the community health and ranked their top health problems, risk factors and conditions that influenced a healthy community. The following data were collected with the Turning Technologies clicker system. Commentary from discussion questions are summarized in the section titled ***Participant Commentary***.

One polling question that all participants took was to rate the general health of their community and themselves. It is notable that zero participants rated their community as being very healthy.



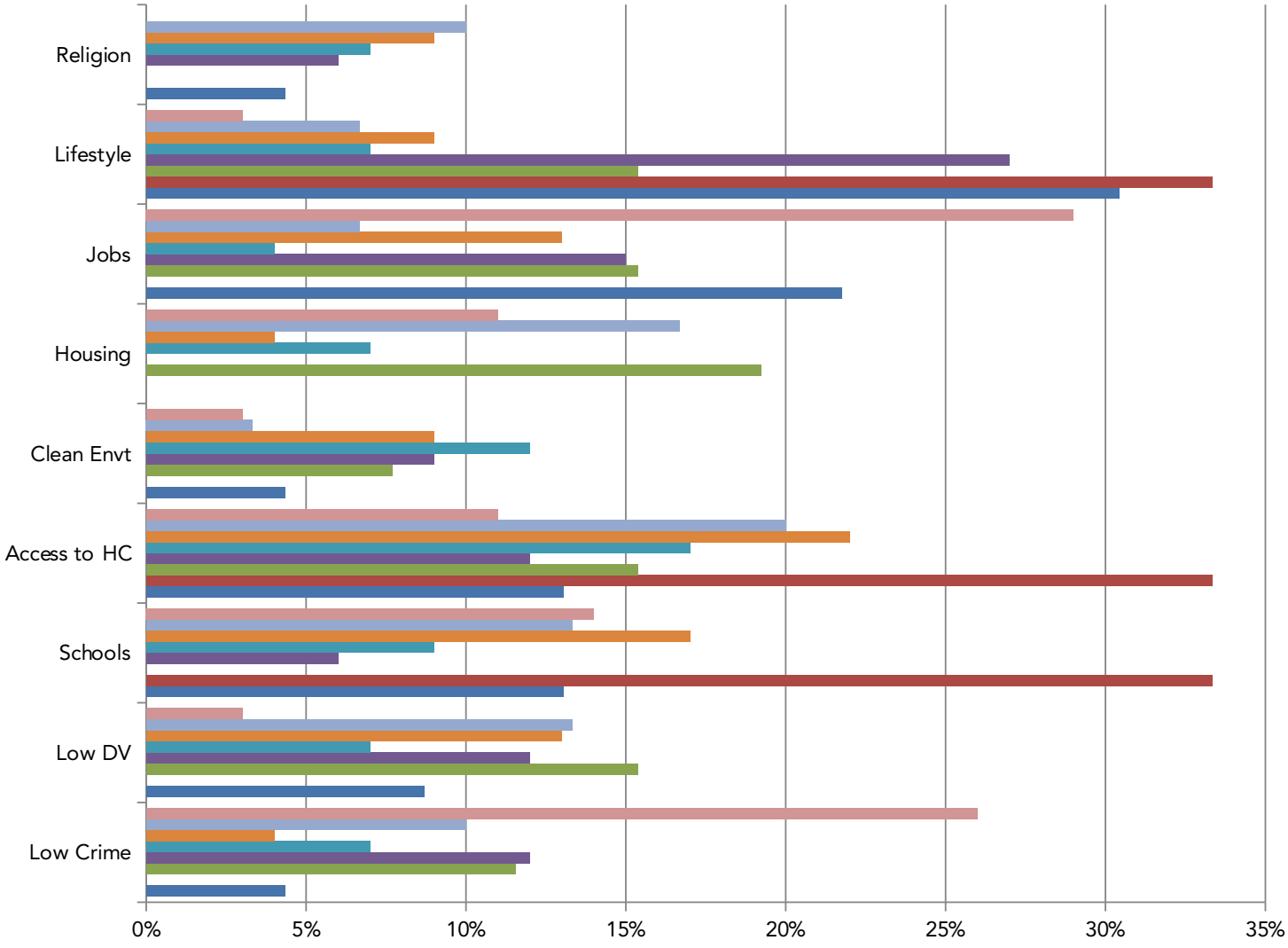
A majority of participants described themselves as unhealthy.



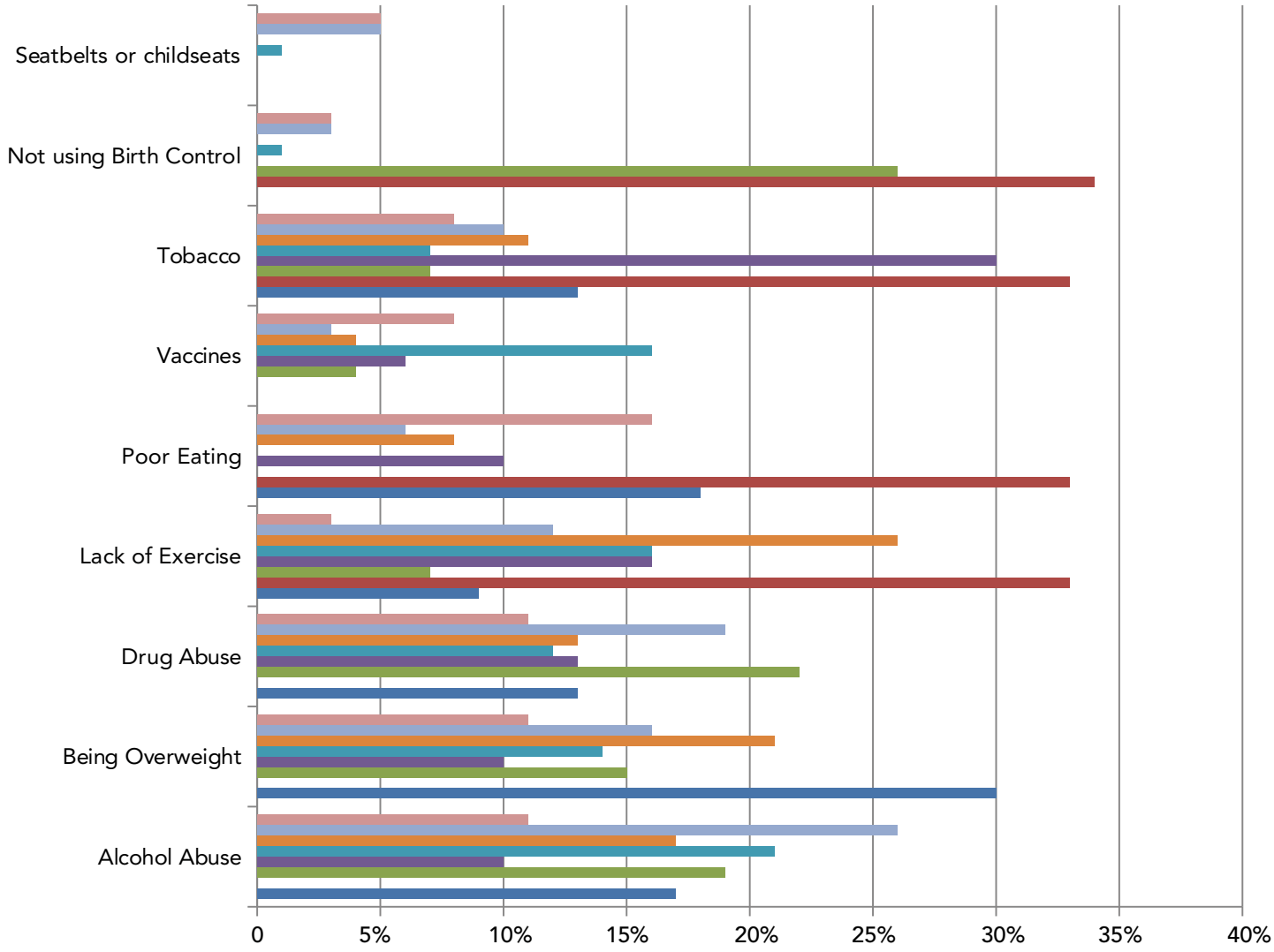
Participants were then asked to select three most important health problems, perceived risk factors and conditions that influenced a healthy community. Although most data from focus groups is aggregated, the rating questions varied greatly between groups and are worthy of pulling out exceptional data trends.

Community Perceptions

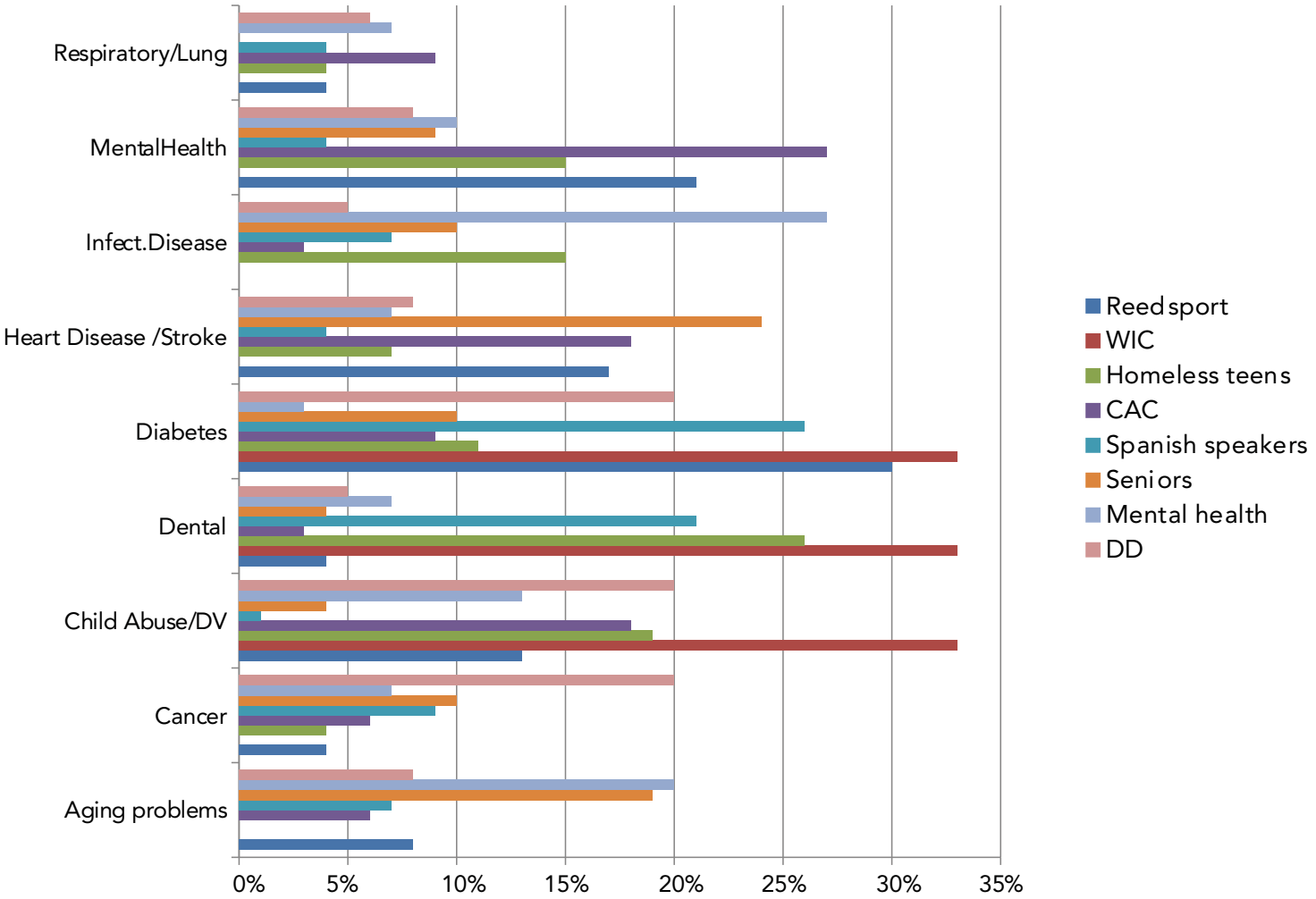
Variance between groups is notable. Higher socioeconomic groups (such as the CAC) rate lifestyle and the jobs as the biggest factors relating to health whereas those groups representing individuals living in poverty or those with health disparities listed access to health care, domestic violence and housing as major concerns.



What do you think are the three most important factors for a healthy Community? Results by Individual focus group.



What do you think are the three biggest risk factors for health in your community? Results by Individual focus group.



What do you think are the three health problems in your community? Results by Individual focus group.

Participant Commentary

Several hundred comments were collected during the eight focus groups. The CACC workgroup reviewed all comments and upon analysis, recognized several universal themes. Focus group participant responses are presented in six categories.

1. Health behavior and lifestyle
2. Social Determinants of health
3. The Community's health
4. Access to health and medical services
5. Health literacy
6. Individual health, including mental health

Health Behavior and Lifestyle

Participants of all groups consistently focused on the effects of their choices on their own individual health and how that contributed to their community's health.

Nutrition and Healthy Food Choices

Access to healthy food and its affect on general nutrition was a consistent theme among all focus groups.

"Our poor diet from birth to senior citizens (affects our health). Being low income means you can't buy the fresh stuff. Organic celery is 60% more than regular and celery is on the dirty dozen list."

"People can't afford vegetables here. I wish we had a Sherms or Winco here. I think just seeing fresh produce at a store makes me feel better!"

"Our economics affects our health. Affording good food is expensive so if you are on a tight budget you buy cheaper starches and pastas instead of fresh vegetables and fruits."

"Weight, food and access to healthy food is a problem. Corn dogs in schools— I think our schools skipped the new change in school food plan. My son is 6 and I feed him healthy at home but it is hard to compete with chocolate milk and corn dogs, he won't take a lunch to school. "

"My parents are elderly and they have the same access issues, access to the doctor, access to good food. My dad has Chrohn's disease and it's almost impossible to find Almond milk that isn't expired in town."

Physical Activity and Exercise

The need for exercise and physical activity was clearly recognized in all groups. Moving from knowing to actually increasing physical activity was a point of discussion in many groups.

"We have a lack of exercise in our schools—where is the old value of physical activity for kids daily?"

"We have a lot of poor lifestyles, nobody is out there walking on sunny days. I go to the park on sunny days and nobody is there except in Myrtle Creek where they have Tai Chi in the park."

"We need people to help instill the practice of better lifestyles, helping and bringing people to action and change."

"It is great to have a gym again, we haven't had one here for 15 years!"

"We have no excuse—we have plenty of physical activity options here."

Tobacco and Smoking

"Kids are still starting to smoke early—that is a big, huge problem."

"Tobacco [is our biggest health concern] if we could just reduce it by even half we would have tremendous impact."

Social Determinants of Health

The factors that contribute to the health of individuals and communities are varied. Poverty, access to medical care, social and economic factors, physical environment challenges were all listed consistently by participants and are considered to be social determinants of health. They influence an individual's health and are generally social issues that are beyond what one individual is able to change on their own.

Poverty

"Not a lot of group activities here with global low income and loss of hope so we smoke, use drugs and eat crap."

"Sometimes people think being healthy means you have to have money to buy the right food and have gym memberships."

"Hope, you have to have hope, without it, without seeing options people won't change or make choices that affect their health."

Housing and Homelessness

"Homeless means if you don't have an address, you can't get OHP."

"Housing is our biggest problem."

"New vets housing is good but still not enough."

"I see homeless people in need everywhere" There are homeless women living in their car at the park."

Transportation

"It takes an hour and half to get to Roseburg on public transportation-we need better medical transportation options, it needs to be more organized and have a back up driver in case the regular driver can't do it."

"Translink (is a problem). Can't get it unless you have OHP Plus, that is ridiculous."

The Community's Health

Participants often brought up how factors such as air quality, damp dreary weather and bike and hiking trails were factors in a community's health.

Environment

"We have a lot of cancer, everyone I know here has cancer, it has to have to do with the old mines."

"We can walk or bicycle almost every day of the year."

"I can think of a half a dozen people with MS that is made worse by our lack of sunshine and dampness."

Access to Health and Medical Services

Dental

"We need dental and vision for adults. All dentists what to do is pull adults teeth out."

"Dental, everyone's teeth are rotting out and its not just meth mouth. Kids with chocolate milk and mountain dew in their bottles is not right."

Physician Availability

"Retention of doctors is a problem, my mom had her doctor changed several times in a year and that is hard for older people."

"People (providers) don't speak Spanish, the ones that do have huge lists and I could die before I get there."

"Access to doctors (is a problem). They don't speak my language so I have to get a child or friend to go with me."

Uninsured/underinsured

"We are not very healthy, people procrastinate when they don't have insurance."

"Some people don't get any health insurance and really need it, not a lot of assistance for those without insurance that don't get OHP."

"I made $4 too much for OHP because I helped at a homeless shelter, and I still need insurance."

"We don't have an adequate number of health care providers, mental health or dental."

"The entire family gets sick but only one person gets medication and they share it with the entire family—and does no good. We need to figure out how to get the entire family on medication."

Health Literacy

Accessing and understanding health education information and the knowledge to take care of oneself affects how involved and engaged individuals are in their own health. Information accessibility in Spanish, coordination of education materials and opportunities and specific understandable information on diabetes were common themes with participants.

Spanish language medical information

"There is a lack of information in Spanish about Diabetes and nutrition."

"A lot of doctors don't listen or talk to us (Spanish speakers), they just tell us to take Tylenol or Ibuprofen."

"We share everything in our family, including sickness. Cross contamination is a problem and we need a way to treat the entire family. We need information in Spanish about how to avoid cross contamination. "

Diabetes

"Diabetes care of all kinds is lacking—no specialists, no diabetes doctor for kids."

"My mom is diabetic and she has trouble understanding what she is told about her diet-it is too complicated to retain."

Coordination of Resources

"We need to coordinate with resources. People don't know what is out there, they are in the dark, we need to map it all out."

"We have a lack of education on healthy lifestyles. We need a community center with good topics and classes like cooking classes where somebody could try a healthy receipt instead of spending 20 to make it and not have it turn out."

Individual Health

Additional topics such as alcohol and drug abuse and mental health were also discussed by every group.

Alcohol/Drug Abuse

"ATOD-alcohol and tobacco are the highest, marijuana is too accessible."

"As long as I stay sober I can stay out of trouble and be healthy."

"Everybody I know gets high or drinks, I stopped and it is hard...I am tempted every day."

Mental health and social connections

"In the 80's, we (people with mental health conditions) were treated like guinea pigs, I was on 32 medications then, but now services are so different, awesome personnel."

"Mental health services are dynamite—they have helped me stay healthy since I was 18, I'm in my 50's now. I finally decided to stay on my meds so I don't get sick

and in the hospital."
"I affect my family's health because I am a schizophrenic. It affects my family, my brother is a payee and he has PTSD real bad."

"My depression is severe. I work full time and have a son with special needs. I'm not making enough to provide for me and my son, he gets OHP but I make $3 too much to get it and can't get meds for my depression. Sometimes I don't eat so he can. The fight has gone out of me."

Community Engagement in Solutions

Another reoccurring theme in all the groups was a sense of concern about their community and how they could contribute to making the factors we had talked about better. Several solutions and positive comments were stated in every group, some of those comments are as follows:

Suggestions

"We need a brochure about where to exercise."

"Create a social walking club!"

"We need a place to exercise inside when its pouring rain. Like the program in Fossil Oregon where they collected gym equipment and monitored weight loss with a giant thermometer like the United Way sign. That was grassroots success!"

"We need support groups for our mind, not just our bodies. Stress, depression and exercise. "

"More recycling centers and incentives for people to improve their health by recycling."

"Empower people to start their own groups while also emphasizing an outsider influence to start the interest/fire."

"Train high school students to be community health workers."

"More things like this would be good—we have a voice and I like to talk and give my opinion."

Positive comments

"WIC and parenting classes are great."

"Mental health is a real life saver I think." (6 other people chimed in and agreed)

"Having a dog makes me healthier."

"We have to continue to do what we are doing, not abusing the things we do get from OHP, follow through with our care, what we do for ourselves makes us healthy day and night."

Key Informant Interviews
System of Care Strengths and Opportunities

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

Individuals and organizations were chosen based on their organization affiliation, role in providing medical, mental, behavioral or addictions treatment to Douglas county residents.

Organizations represented in the key informant interviews
Umpqua Health Alliance
Douglas County Mental Health
Douglas County Public Health
Advantage Dental
Adapt and SouthRiver Community Health Center
DCIPA
Umpqua Community Health Clinic
Mercy Medical Center
GOBHI (Greater Oregon Behavioral Health Inc.)

Key Informant Questions

All key informants were asked the following questions:

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

Themes

Key informants universally talked about collaboration and coordinating services, changing paradigms to improve care, desire to reduce barriers to care and prevention activities when discussing their organization's contributions to the community and system of care.

> *"We have some of the same people at the table, but we are talking differently now about how we work together to make patient care more seamless and make better use of our dollars"*
> *—Key Informant*

While the spirit of collaboration and integration was strong, the challenges that come with changing payment systems, legislative pressures and changes, culture of poverty of many patients, and consistently poor health status of patients and the community at large were listed by all key informants.

> *"Significant things and elements of our business are changing so fast I don't know how it is all going to pan out. Sometimes we just want to put our head down and get the work done but we can't because things change so quickly that we'll miss something if we don't stay at the table, it is exhausting."*
> *—Key Informant*

Priority Areas of Improvement and CHIP Next Steps

Utilizing CHA for Planning: CHIP and Tying CHA to Triple Aim

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

The CHA was the first step in an ongoing process of community health assessment, planning and improvement. The natural progression of the community planning process is to prioritize health status issues and indicators and stragies to improve them.

Priority Area and Indicator	Data Set for Baseline
Adults who smoke cigarettes	*BRFSS*
Adults who are obese	*BRFSS*
Adults engaging in physical activity	*BRFSS*
Adults with asthma	*BRFSS*
Adult fruit and vegetable consumption	*BRFSS*
Adults with diabetes	*BRFSS*
Alcohol and Drug Misuse	*CCO Metric*
Follow-up after mental health hospitalization	*CCO Metric*
Prenatal Postpartum Care	*CCO Metric*
Outpatient and Emergency Dept Utilization	*CCO Metric*
Colo-rectal Cancer Screening	*CCO Metric*
Adolescent Well Child Care Visits	*CCO Metric*
Access to Care	*CCO Metric*
Child Immunization	*Public Health Metric*
Oral Health	*TBD*

The list of suggested prioritized health status issues and indicators are the preliminary set of priorities developed through the CHA process. Priorities were chosen that had regular data sets available or data that was already being collected locally. This will aid in reducing duplication of effort and provide a mechanism for more consistent and continuous measurement of progress. Priorities are also consistent with focus group themes, key informant interviews and health status data for Douglas County.

The next step of the process will entail community discussion and priority setting about the suggested priority areas and establishing short term, intermediate and long-term strategies to address the indicators. This process is expected to happen from September 2013-May 2014.

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

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

Appendix

Douglas County Community Health Assessment
Focus Group Guide and Questions

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

The Umpqua Health Alliance and Douglas County Public Health are sponsoring these groups, and the information will be used to increase our understanding of community health issues and for planning our programs and services so that they fit the needs of the community. There will be lots of questions today, most that we won't be able to answer today. We will record your questions and they will be included in our report.

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

Polling Questions

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

Rank the top three (1 = greatest impact on health):

___ *Good place to raise children*
___ *Low crime / safe neighborhoods*
___ *Low level of child abuse*
___ *Good schools*
___ *Access to health care (e.g., family doctor)*
___ *Parks and recreation*
___ *Clean environment*
___ *Affordable housing*
___ *Arts and cultural events*
___ *Excellent race relations*
___ *Good jobs and healthy economy*
___ *Strong family life*
___ *Healthy behaviors and lifestyles*
___ *Low adult death and disease rates*
___ *Low infant deaths*
___ *Religious or spiritual values*
___ *Other*_____

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

Rank the top three (1 = greatest impact on health):

___ *Aging problems (e.g., arthritis,hearing/vision loss, etc.)*
___ *Cancers*
___ *Child abuse / neglect*
___ *Dental problems*
___ *Diabetes*
___ *Domestic Violence*
___ *Firearm-related injuries*
___ *Heart disease and stroke*
___ *High blood pressure*
___ *HIV / AIDS*
___ *Homicide*
___ *Infant Death*
___ *Infectious Diseases (e.g.,hepatitis, TB, etc.)*
___ *Mental health problems*
___ *Motor vehicle crash injuries*
___ *Rape / sexual assault*
___ *Respiratory / lung disease*
___ *Sexually Transmitted Diseases (STDs)*
___ *Suicide*
___ *Teenage pregnancy*
___ *Other* _____

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

Rank the top three (1 = greatest impact on health):

___ *Alcohol abuse*
___ *Being overweight*
___ *Dropping out of school*
___ *Drug abuse*
___ *Lack of exercise*
___ *Poor eating habits*
___ *Not getting "shots" to prevent disease*
___ *Racism*
___ *Tobacco use*
___ *Not using birth control*
___ *Not using seat belts / child safety seats*
___ *Unsafe sex*
___ *Other*_____

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

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

5. How would rate your own personal health?

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

Please answer questions #7-15 so we can see how different people feel about local health issues.

7. Do you live in Douglas County:

___ Yes
___ No

8. If you live outside the Roseburg City Limits, where do you live?

__ Drain
__ Yoncalla
__ Riddle
__ Sutherlin
__ Canyonville
__ Oakland
__ Glide
__ Glendale

9. Age:

___ 25 or less
___ 26 - 39
___ 40 - 54
___ 55 - 64
___ 65 or over

10. Sex: ___ Male ___ Female

11. Ethnic group you most identify with:

___ *African American / Black*
___ *Asian / Pacific Islander*
___ *Hispanic / Latino*
___ *Native American*
___ *White / Caucasian*
___ *Other _____*

12. Marital Status:

___ *Married / co-habitating*
___ *Not married / Single/Widowed*

13. Education

___ *Less than high school*
___ *High school diploma or GED*
___ *College degree or higher*
___ *Other_____*

14. Household income

___ *Less than $20,000*
___ *$20,000 to $29,999*
___ *$30,000 to $49,999*
___ *Over $50,000*

15.How do you pay for your healthcare? (check all that apply)

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

Discussion Questions:

Do you think people in your community are healthy? Why? Why not?

What affects the health of you and your family the most?

Tell me about your biggest health concern in your community?

What do you think we (as a community) can do to enhance health?

Do you believe that you have the ability to become involved in some of the solutions to these problems? How?

Douglas County CHA Contact: vanessa@vconsults.com

Douglas County Community Health Assessment Data Sources
Sampling of Available Data Sources 2012-2013

Category	Title	Source
Alcohol and Other Drugs	Report on Alcohol, Illicit Drugs and Mental Health, DC Oregon 2000-2006 DHS	http://www.localcommunities.org/lc/739/FSLO-1203731622-383739.pdf
	*Oregon Student Wellness Survey 2012	http://www.oregon.gov/oha/amh/2012%20Student%20Wellness/Douglas.pdf Underage Drinking: http://www.oregon.gov/oha/amh/ad/douglas-underage.pdf
	*Epidemiological Data on Alcohol, Drugs and Mental Health 2000 to 2012	http://www.oregon.gov/oha/amh/ad/data/douglas.pdf Adult Alcohol Use Fact Sheet: http://www.oregon.gov/oha/amh/ad/douglas-adult.pdf
	National Survey on Drug Use and Health State Rankings-Prescription Drug Use	http://www.samhsa.gov/data/2k12/NSDUH115/sr115-nonmedical-use-pain-relievers.htm
	2011 National Survey on Drug use and Health All drugs	http://www.samhsa.gov/data/NSDUH/2k11Results/NSDUHresults2011.pdf
Behavioral Health	Oregon's Healthy Future: A Plan for Empowering communities 2012	http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority5-substanceabuseandbehavioralhealth.pdf
	*DC Specific 2000-2012 Epidemiology Alcohol, Drugs, MH (also included in Alcohol and Drugs)	http://www.oregon.gov/oha/amh/ad/data/douglas.pdf
	SAMHSA Oregon State Brief	http://www.samhsa.gov/data/StatesInBrief/2k9/OREGON_508.pdf
	SAMHSA Adolescent Behavioral Health Brief-Oregon	http://www.samhsa.gov/data/StatesInBrief/2k9/OASTeenReportOR.pdf
	SAMHSA Data Sources-Various reports search functions-some state, some sub-state	http://www.samhsa.gov/data/States_In_Brief_Reports.aspx
Cancer	Cancer surveillance by County 2001-2010	http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Cancer/oscar/Pages/AR2010.aspx

Category	Title	Source
Children/ Youth	Kindergarten Readiness- county specific tables on page 12	http://www.ode.state.or.us/gradelevel/kindergarten/2008kindergartenreadinesssurveyreportfinal.pdf
	**Children First for Oregon report 2011	http://www.cffo.org/images/pdf_downloads/county_data_books/Douglas%20County.pdf
	Free and Reduced Lunch ODE	http://www.ode.state.or.us/sfda/reports/r0061Select.asp (new link)
	Youth Suicide Attempts in Oregon Adolescent Data System 2007 Data Report	https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/2010%20ASADS%20suicidal%20attempt%20report%20version%2011%20edited%20april%2018.pdf (new link)
	*Oregon Healthy Teen Survey- County Specific data 2007-2008	http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2007/county/Documents/douglas8.pdf (8th grade) http://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/results/2007/county/Documents/douglas11.pdf (11th grade)
	*Oregon Student Wellness Survey 2012(duplicate)	http://www.oregon.gov/oha/amh/2012%20Student%20Wellness/Douglas.pdf
	National Survey of Children's Health (CDC)- LOTS of state specific data- Oregon Children's Profile Included as PDF	http://www.cdc.gov/nchs/slaits/nsch.htm
	*Kids Count Data Book 2012-Oregon data	http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=OR&group=Grantee&loc=5352&dt=1%2c3%2c2%2c4 (more specific link)
	Oregon Child Health 2010 Data & resource guide	http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/Documents/oregon-child-health-2010-data-and-resource-guide.pdf
	ICTS Eval Summary 2011	No link
	*2011 Child Welfare Data Book- County specific data on pages 28-37	http://www.oregon.gov/dhs/abuse/publications/children/2011-cw-data-book.pdf

Category	Title	Source
Community Assessments & Plans	Oregon Public Health Community Health Assessment Clearinghouse	http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/communityhealthassessmentclearinghouse/pages/index.aspx
	Public Health Annual Plan	http://public.health.oregon.gov/providerpartnerresources/localhealthdepartmentresources/documents/annual%20plans/douglas_%20county_2012_annual_plan.pdf
	Pathways to Healthy Communities- DC specific	http://www.co.douglas.or.us/health/PH/HP/HealthyActive/Pathways%20to%20Healthy%20Communities.pdf
	Oregon Health Improvement Plan 2010-2020	http://public.health.oregon.gov/ProviderPartnerResources/HealthSystemTransformation/OregonHealthImprovementPlan/Documents/hip_plan.pdf
	Douglas County Commission on Children & Families 2008-2014	http://www.co.douglas.or.us/dccf/CompPlan2010Update/2010%20Comprehensive%20Plan%20Update%20Data.pdf
	Oregon State Health Profile 2012	http://public.health.oregon.gov/About/Documents/oregon-state-health-profile.pdf (new link)
Crime	Oregon Annual Uniform Crime Reports- County Specific Tables throughout	http://www.oregon.gov/osp/CJIS/docs/2010/2010_annual_report.pdf (new link)
	*County Criminal Justice Fact Sheet- Oregon Criminal Justice Commission 9-2-2010	http://www.oregon.gov/CJC/docs/douglas_co_cj_fact_sheet.pdf
	*DUII Data Book for Oregon Counties, 1999-2008	http://library.state.or.us/repository/2009/200906301527262/1999-2008.pdf

Category	Title	Source
Chronic Disease	Oregon Living Well Data Report-2012	http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Documents/Reports/statedata12.pdf
	*Oregon Behavioral Risk Factor Surveillance System (BRFSS) County Level Data 2008-2011- limited data on chronic disease, preventable health screening, and modifiable risk behaviors among adults	http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Pages/pubs.aspx#data Chronic Conditions: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20I.pdf Modifiable Risk Among Adults: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20I.pdf Preventable Health Screenings: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20III.pdf Tobacco Prevalence: http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/Table%20IV.pdf
	Keeping Oregonians Healthy: Preventing Chronic Diseases by reducing tobacco, diet, promoting physical activity & preventive screenings 2007	http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Documents/healthor.pdf
	*Asthma-Oregon Asthma Surveillance Data 2010- county specific maps throughout	http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Asthma/Documents/burden/or_asthma2010.pdf
	*Oregon Arthritis Report 2011 – County Specific Data throughout report	http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/Arthritis/Documents/arthrpt11.pdf
	Diabetes-Oregon and DC data	http://apps.nccd.cdc.gov/ddtstrs/Index.aspx?stateId=41&state=Oregon&cat=prevalence&Data=data&view=TO&trend=prevalence&id=1 http://apps.nccd.cdc.gov/DDT_STRS2/CountyPrevalenceData.aspx?StateId=41&mode=DBT (link not work)
	Diabetes Atlas- National Data	http://www.idf.org/diabetesatlas/
	*Heart Disease & Stroke in Oregon 2010- Pages 7-10, County Specific Tables	http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/HeartDiseaseStroke/Documents/heartstroke_update2010.pdf
Communicable Disease	Flu/CD DHS Pandemic Influenza Emergency Management Plan 2008	http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/Influenza/Documents/panfluplan.pdf
	*Communicable Disease Summary 2011- great county level maps of infection throughout report	http://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/AnnualReports/arpt2011/Documents/ACD_report2011forWEB.pdf

Category	Title	Source
Compilations	*Oregon Behavioral Risk Factor Surveillance System(BRFSS) Survey 2006-2009 (ALL DATA)	https://public.health.oregon.gov/BirthDeathCertificates/Surveys/AdultBehaviorRisk/county/index/Pages/index.aspx
	*Oregon Health Authority Data Sets/Reports (data DHS client data, health data etc.)	http://www.oregon.gov/oha/pages/data/index.aspx
Demographic	*DC Census Quick Facts-2010 April	http://quickfacts.census.gov/qfd/states/41/41019.html
	*Oregon Vital Statistics County Data 2011	http://public.health.oregon.gov/BirthDeathCertificates/VitalStatistics/annualreports/CountyDataBook/cdb2011/Pages/index.aspx
	School Enrollment Data: Student Ethnicity 2011-2012 School Year (by district)	http://www.ode.state.or.us/sfda/reports/r0067Select2.asp
	Census: by zip code 2010	http://www.oregon.gov/dhs/spwpd/sua/docs/demographic/2010-state-zipcode-pop.xls
	*Oregon Office of Rural Health-Annual Report and community reports	http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/publications/upload/2009-Year-End-Report-Printable.pdf
	Household composition-By County. PSU Population Research Center	http://mkn.research.pdx.edu/2011/09/whos-home-a-look-at-households-and-housing-in-oregon/
	Migration & the economy trends Oregon & county. PSU Population Research Center 2011	http://mkn.research.pdx.edu/2011/05/slow-economy-tempered-oregon-population-growth-over-decade/
	Most recent Oregon Population Reports by county: PSU 2012	http://www.pdx.edu/prc/annual-oregon-population-report
	**Communities Reporter: Oregon-Best Viewed ON-LINE	http://oe.oregonexplorer.info/rural/CommunitiesReporter/
	Data on Disability: American Community Survey Douglas County	http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_1YR_S1810&prodType=table
Environmental Health	Public water systems-online data-not sure how useful	http://170.104.63.9/
	Adult Blood Lead Reporting in Oregon 2006-2010	https://public.health.oregon.gov/HealthyEnvironments/WorkplaceHealth/Documents/9563-AdultLeadReport-FINAL-web_version.pdf
	Oregon Department of Environmental Quality Air Quality Annual Report (city specific)	http://www.deq.state.or.us/aq/forms/2011AirQualityAnnualReport.pdf

Category	Title	Source
Health Equity	Oregon's Healthy Future: A Plan for Empowering communities 2012	http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority1-healthequity.pdf
	*NW Health Foundation State of Equity report 2011	http://nwhf.org/images/files/Oregon_State_of_Equity_Report.pdf
	OHA Health Equity Report 2012	http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/healthequity.pdf
	CHI Advancing equity in Health Care Reform Implementation 11-2012	http://www.chausa.org/Pages/Publications/Catholic_Health_World/Catholic_Health_World_Archive/2012/November_1/Forum_advances_equity_in_health_care_reform_implementation/
	*Institute of Medicine Unequal Treatment: Confronting Racial & Ethnic Disparities in HC: Administrators Brief	http://www.iom.edu/~/media/Files/Report%20Files/2003/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care/DisparitiesAdmin8pg.pdf
	OHP Enrollment by Race/Ethnicity 2013	http://www.oregon.gov/oha/healthplan/DemographicRpts/May%202013%20-%20Race.pdf
Health Rankings	Oregon Benchmarks 2009	http://benchmarks.oregon.gov/BMCountyData.aspx
	*County Health Rankings 2012	http://www.countyhealthrankings.org/sites/default/files/states/CHR2012_OR.pdf
Intimate Partner Violence and Child Abuse	Costs of Intimate Partner Violence in Oregon 2005	No link
	Oregon Violence Against Women Violence Prevention Plan 2005	http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/vawplan.pdf (link dead-does not appear to be still on line)
	*IPV Deaths-OHA report 2012	http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/intimpartnerviolence.pdf
	Oregon DHS Child Welfare 2010 Data Book- Page 28-38, County Specific Data (duplicate)	http://www.oregon.gov/dhs/abuse/publications/children/2010-cw-data-book.pdf
Injury	Oregon Health Authority Trauma Registry 2010-2011- Page 22, County level data	http://public.health.oregon.gov/ProviderPartnerResources/EMSTraumaSystems/TraumaSystems/Documents/reports/otr-report.pdf
	State Injury Prevention Policy Report 2012	http://healthyamericans.org/reports/injury12/release.php?stateid=OR

Category	Title	Source
Obesity, Physical Activity and Nutrition	Oregon's Healthy Future: A Plan for Empowering communities 2012	http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority3-obesity.pdf
	*Oregon Overweight, Obesity, Physical activity & Nutrition(PAN) Facts, 2012 DHS- county specific table on pages 50-57	http://public.health.oregon.gov/PreventionWellness/PhysicalActivity/Documents/Oregon_PANfactst_2012.pdf
	Healthy Active Oregon: Statewide Physical Activity & Nutrition Plan 2007-2012	http://public.health.oregon.gov/PreventionWellness/PhysicalActivity/Documents/PAN_rpt_07.pdf
	Oregon DMV Records Report: Obesity Surveillance 2012	http://public.health.oregon.gov/HealthyEnvironments/TrackingAssessment/EnvironmentalPublicHealthTracking/Documents/Reports/DMV%20Report.pdf
	Food Insecurity by County	www.feedingamerica.org/mapthegap
Occupational Injury	Occupational Health in Oregon 2009	https://public.health.oregon.gov/HealthyEnvironments/WorkplaceHealth/Documents/OPHP_Occupational%20health%20in%20Oregon.pdf
	Oregon Occupational Health Indicators 2000-2009 data	http://public.health.oregon.gov/HealthyEnvironments/WorkplaceHealth/Documents/OHI_2000_2009.pdf
Oral Health/ Dental	Oregon's Healthy Future: A Plan for Empowering communities 2012	http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/ship/oregonshealthyfuture-priority4-oralhealth.pdf
	Oregon Smile Survey 2007- Note: new data should be out in Spring 2013	http://public.health.oregon.gov/PreventionWellness/oralhealth/Documents/smile_2007.pdf
	OCF Oral Health Needs Assessment-County Data	http://www.oregoncf.org/Templates/media/files/rai_materials/SW%20Valley/ocf_NeedsAssmt_swv_final_report.pdf
	Pew States Report on Dental Sealants 2013	http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/Pew_dental_sealants_report.pdf
	Burden of Oral Disease in Oregon 2006	http://www.orohc.org/pdfs/burden.pdf

Category	Title	Source
Poverty & Economy	2011 Report on Poverty-Oregon Housing & Community Services	http://www.oregon.gov/ohcs/isd/ra/docs/2011_oregon_poverty_report.pdf
	Ending Homelessness-10-year plan to end Homelessness in Oregon	http://www.oregon.gov/ohcs/pdfs/2011_ehac_annual_report.pdf
	UCAN Community Needs Assessment 2009	http://www.ucancap.org/_files/Community_Needs_Assessment-DC.pdf
	Key Workforce Challenges: More Severe in Oregon's Rural Areas November 2012	http://www.qualityinfo.org/olmisj/ArticleReader?itemid=00008442
	Homelessness Count: OHCS 2010	http://www.ode.state.or.us/news/announcements/announcement.aspx?=6056
	Labor Trends Report: State Employment Department	http://www.qualityinfo.org/olmisj/PubReader?itemid=00000046&areac
Prenatal/ Maternal Health	Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) 1998-2008 data by topic-state data	https://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/prams/Pages/topics.aspx
	Oregon Perinatal Data Book 2007	http://public.health.oregon.gov/HealthyPeopleFamilies/DataReports/PerinatalDataBook/Documents/databook_2007.pdf
	*Oregon Home Visiting Needs Assessment Report 2012-County Specific starts on page 50	http://public.health.oregon.gov/HealthyPeopleFamilies/Babies/HomeVisiting/Documents/Douglas.pdf
	Women, Infant and Children (WIC) Program County Specific Fact Sheets	http://public.health.oregon.gov/HealthyPeopleFamilies/wic/Documents/annual/annual_douglas.pdf
	ALERT Childhood Immunization Rates- 2 year old completion(County Specific)	http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Documents/county/Douglas.pdf

Category	Title	Source
Rural Health Care Access	OHA Report: Oregon's Uninsured Analysis 2011. County Level Data, Pages 10-14 OHA Report: How Many Oregonians are Uninsured 2011	http://www.oregon.gov/oha/OHPR/RSCH/docs/uninsured/oregonuninsured_2009finalreport.pdf http://www.oregon.gov/oha/OHPR/RSCH/docs/uninsured/ewingestimatesoforegonsuninsuredtechnicalbrief.pdf
	Oregon Health Plan Managed Care Enrollment Reports-Monthly by County- View On-line	http://www.oregon.gov/oha/healthplan/pages/data_pubs/enrollment/main.aspx http://www.oregon.gov/oha/healthplan/OHPEligibility/2013-05-totals.pdf
	OHA Economically Disadvantaged & Uninsured Populations 2012	http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/ses.pdf
	Oregon Federally Qualified Rural Health Clinic Report 2011	http://www.ohsu.edu/xd/outreach/oregon-rural-health/clinics/upload/2011-RHC-Report-for-the-web.pdf
	*Oregon Office of Rural Health 2012 Areas of Unmet HC Need in Rural Oregon Report- County Specific Tables throughout	http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/2012-Unmet-Need-Report.pdf
	*SUMMARY- 2012 MUA, HPSA and Unmet Need report Oregon by city/county	http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/Designations-of-Health-Care-Shortage-Report.pdf
Tobacco	Oregon Tobacco Facts & Laws 2011	http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tobfacts.pdf
	OHP Tobacco Cessation Services Report 2012	http://www.oregon.gov/oha/healthplan/data_pubs/reports/cessation2012.pdf
	Oregon Tobacco Quit Line Data	https://www.box.com/quitlinereports/
	*Oregon County Tobacco Fact Sheet	http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/countyfacts/dougfac.pdf
	Oregon Quit line Utilization Dashboard County Report- NOVEMBER 2012 report	http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/dashboard-11-2012.pdf (link does not work correctly- only showing Baker county) all months site link: http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx#quitlinedashboard
	Burden of Tobacco among Medicaid clients in Oregon	http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/medicaidburden.pdf
	*Vital Signs: Current Cigarette Smoking Among Adults Aged >18 Years with Mental Illness- United States 2009-2011	http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a2.htm?s_cid=mm6205a2_w 4 page consumer fact sheet: http://www.cdc.gov/VitalSigns/pdf/2013-02-vitalsigns.pdf

Category	Title	Hyperlink
Rural Health Care Access	OHA Report: Oregon's Uninsured Analysis 2011. County Level Data, Pages 10-14 OHA Report: How Many Oregonians are Uninsured 2011	http://www.oregon.gov/oha/OHPR/RSCH/docs/uninsured/oregonuninsured_2009finalreport.pdf http://www.oregon.gov/oha/OHPR/RSCH/docs/uninsured/reviewingestimatesoforegonsuninsuredtechnicalbrief.pdf
	Oregon Health Plan Managed Care Enrollment Reports-Monthly by County- View On-line	http://www.oregon.gov/oha/healthplan/pages/data_pubs/enrollment/main.aspx http://www.oregon.gov/oha/healthplan/OHPEligibility/2013-05-totals.pdf
	OHA Economically Disadvantaged & Uninsured Populations 2012	http://public.health.oregon.gov/ProviderPartnerResources/PublicHealthAccreditation/Documents/indicators/ses.pdf
	Oregon Federally Qualified Rural Health Clinic Report 2011	http://www.ohsu.edu/xd/outreach/oregon-rural-health/clinics/upload/2011-RHC-Report-for-the-web.pdf
	*Oregon Office of Rural Health 2012 Areas of Unmet HC Need in Rural Oregon Report- County Specific Tables throughout	http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/2012-Unmet-Need-Report.pdf
	*SUMMARY- 2012 MUA, HPSA and Unmet Need report Oregon by city/county	http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/upload/Designations-of-Health-Care-Shortage-Report.pdf

Category	Title	Hyperlink
Tobacco	Oregon Tobacco Facts & Laws 2011	http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tobfacts.pdf
	OHP Tobacco Cessation Services Report 2012	http://www.oregon.gov/oha/healthplan/data_pubs/reports/cessation2012.pdf
	Oregon Tobacco Quit Line Data	https://www.box.com/quitlinereports/
	*Oregon County Tobacco Fact Sheet	http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/countyfacts/dougfac.pdf
	Oregon Quit line Utilization Dashboard County Report- NOVEMBER 2012 report	http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/dashboard-11-2012.pdf (link does not work correctly- only showing Baker county) all months site link: http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx#quitlinedashboard
	Burden of Tobacco among Medicaid clients in Oregon	http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/medicaidburden.pdf
	*Vital Signs: Current Cigarette Smoking Among Adults Aged >18 Years with Mental Illness- United States 2009-2011	http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6205a2.htm?s_cid=mm6205a2_w 4 page consumer fact sheet: http://www.cdc.gov/VitalSigns/pdf/2013-02-vitalsigns.pdf