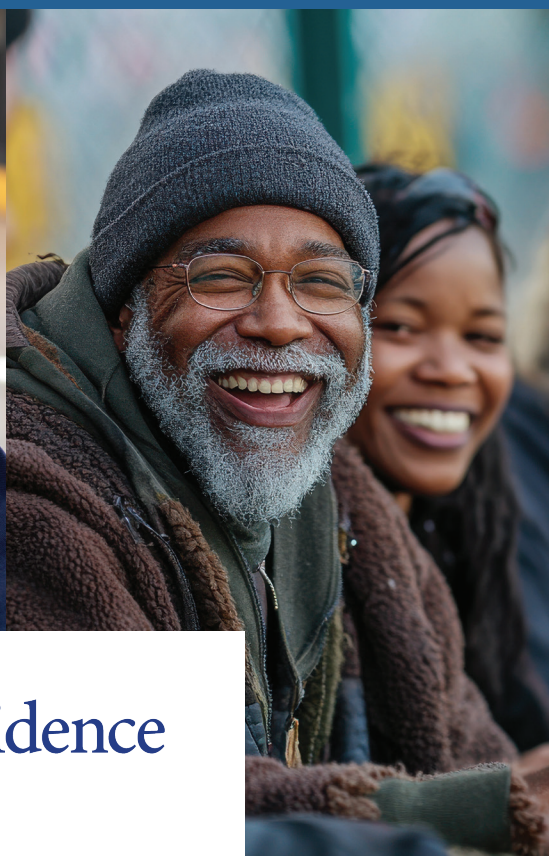
2025 Community Health Needs Assessment

Jackson and Josephine counties



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2025 COMMUNITY HEALTH NEEDS ASSESSMENT

Asante Ashland Community Hospital

UNDERSTANDING AND RESPONDING TO COMMUNITY NEEDS

Asante Ashland Community Hospital is owned and operated by Asante, a 501 (c) (3) organization operating in Jackson County, Oregon. Asante exists to provide quality health care services in a compassionate manner valued by the communities we serve. Asante Ashland is the only hospital in Ashland, Oregon, and is licensed for 49 inpatient beds. Services include primary care, surgical services, obstetrics and gynecology, diagnostic imaging, respiratory testing and emergency care. Its primary service area includes Jackson and Josephine counties, along with Asante's secondary service area of Curry, Douglas, Klamath and Lake counties in southern Oregon and Del Norte, Siskiyou and Modoc counties in northern California.

Knowing where to focus our resources begins with our Community Health Needs Assessment (CHNA). As part of the Affordable Care Act enacted into law in 2010, tax-exempt hospitals like ours must develop and make publicly available a CHNA at least every three years. The IRS encourages hospitals to collaborate with other health care providers within the region to conduct jointly sponsored Community Health Needs Assessments to identify and prioritize community health needs. As such, Asante's three hospitals joined Providence Medford Medical Center in the development of the 2025 CHNA to help identify and prioritize the most pressing needs, assets and opportunities in our region.

The 2025 Asante Ashland Community Hospital CHNA was approved by the Asante Board of Directors on Aug. 5, 2025 and was made publicly available on Sept. 30, 2025 at *www.asante.org.*

WHERE WE BEGAN: GATHERING COMMUNITY HEALTH DATA AND COMMUNITY INPUT

For the 2025 Community Health Needs Assessment, Asante Ashland Community Hospital partnered with Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center and Providence Medford Medical Center. Representatives from Jackson and Josephine County Public Health and Josephine County's Coordinated Care Organization, AllCare Health, participated in our CHNA core group, bringing their unique experience, expertise and insight to the process through all phases of the collaborative assessment. Using a mixed-method approach, our teams assessed both quantitative and qualitative data from a variety of sources to identify community needs. Public health data sources accessed for this report included the American Community Survey, Centers for Disease Control and Prevention, County Health Rankings & Roadmaps, ESRi Updated Demographics, Oregon Health Authority, Oregon Student Health Survey (2022) and the U.S. Census, among others. In addition to an online and paper community survey that engaged more than 350 residents of Jackson and Josephine Counties, approximately 56 individuals from multi-sector organizations, residents and community stakeholders participated in key informant interviews and listening sessions to offer feedback on community strengths, challenges and priority health concerns. To ensure representation across all sectors of the community, we worked closely with community-based organizations to ensure representation of people with a variety of identities and experiences including older adults, young people, people who identify as LGBTQIA+, Hispanic/Latino/a/x people, Native Americans, people of color, people experiencing homelessness, and

people experiencing mental illness and substance use concerns. We made paper surveys available to those without internet access and to those for whom answering an electronic survey would be prohibitive due to vision, dexterity, learning or communication concerns. The online survey was made available to the community at large and marketed through community partners via email and paper flyers. Providence also created posts that could be shared through regional community partners' social media channels. Listening sessions and community health surveys were offered in both English and Spanish. From this quantitative and qualitative data, key findings include:

- Key informants and community members alike affirmed a need for more primary care providers and specialists, bilingual and bicultural providers, and care coordination across the region. They emphasized cost, service restrictions, limited clinic hours and proximity as notable barriers to care across the region They voiced concern about staffing and retention concerns and resultant lengthened wait times. They highlighted health disparities for vulnerable and minority community members, with a special focus on transportation for elders, rural residents, individuals with disabilities and the unhoused.
- 52% of survey respondents who completed the question on diagnosed conditions reported at least one mental health condition, with anxiety, depression and/or PTSD specified by name, another 4% disclosed concerns with substance use. 16% reported difficulty concentrating or making decisions because of a physical, mental or emotional condition; 10% disclosed difficulty completing errands or appointments independently for such conditions; 12% reported serious difficulty with mood, intense feelings, controlling their own behavior and/or experiencing delusions and hallucinations. Among parents responding to the survey, 26% disclosed one or more mental health diagnoses for a child or children under 18.
- Stakeholders expressed concern over mental health impacts for community members navigating economic instability, chronic illness, disability and housing issues or homelessness. Key informants, and community members alike, voiced concern about the availability of mental health resources in the region, citing long wait times, limited provider selection, preference for in-person care, dissatisfaction with telehealth solutions, and concerns with cultural competence as barriers to appropriate care.
- Only 9% of survey respondents noted that they had never been diagnosed with one of the identified chronic illnesses surveyed. The majority noted at least one chronic health condition, with the top physical conditions that would benefit from specialty care noted as high blood pressure, high cholesterol and diabetes. Statistically, Jackson and Josephine Counties have higher recorded prevalence of heart disease, cancer, COPD, asthma, diabetes and mental health concerns. More than 70 write-in comments were received for chronic conditions not named in the survey.
- Only 43% of respondents stated their children had never been diagnosed with a health condition. As previously indicated, the top concern was behavioral or mental health conditions which included anxiety, depression, PTSD, ADHD, Autism. Over 10% also disclosed developmental delays or learning disabilities. The top physical ailment cited was asthma, with 16% of parents reporting the condition. Parent respondents disclosed several other chronic

physical conditions impacting their children: diabetes, scoliosis, kidney disease, lupus and allergies.

IDENTIFYING TOP HEALTH PRIORITIES FOR OUR SHARED COMMUNITY

Asante and Providence employed various methods to create the CHNA in Josephine and Jackson counties including, Social Determinants of Health Framework, a Health Equity Framework and a modified Mobilizing for Action through Planning and Partnerships (MAPP) model. MAPP is a community-based strategic planning process that relies on collaborative partnership; Asante and Providence' modified approach includes four assessment components to inform planning: Community Health Status Assessment; Community Themes and Strengths Assessment; Forces of Change Assessment; and Local Public Health System Assessment.

Once the community's top concerns were identified, Asante and Providence engaged in their own internal processes to identify the community health needs each organization would focus on during the upcoming three-year cycle.

While other significant concerns in the eyes of our community did arise during the CHNA (homelessness and housing instability; behavioral health challenges and access: substance use / misuse, disability inclusion and support for people with disabilities, economic security, access to childcare and economic insecurity), Asante hospitals elected to focus resources on needs specifically related to health care. Asante Ashland Community Hospital, Asante Rogue Regional Medical Center and Asante Three Rivers Medical Center leaders reviewed the CHNA findings and agreed upon the following priority areas: Access to care, Chronic Conditions and Mental Health.

For a complete description of significant health needs identified through this CHNA, visit the "Community Needs" section of Appendix 1 on page 84. A list of potential resources is available for each identified priority area and can be found under "Existing Assets and Resources" throughout each Key Theme section and in Appendix 4 on page 152 of the collaborative CHNA report.

ASANTE ASHLAND COMMUNITY HOSPITAL PRIORITY NEEDS

The 2025 CHNA identified a wide spectrum of priority areas, some of which are more appropriately addressed by other community partners. Considering Asante Ashland Community Hospital's ongoing focus on identified health needs that remain in the forefront of community concern and the hospital's unique capabilities, community partnerships and potential areas of collaborative community impact, we are committed to continue addressing the following priorities:

Priority 1: Access to care. Focus on availability of primary and specialty care providers through alternate access such as telehealth; intentional inclusivity of marginalized populations; reduced barriers to care; improved care coordination; and enhanced access for people without the means to pay for care.

Priority 2: Chronic Conditions. Focus on prevention and treatment of diabetes, hypertension, high cholesterol, asthma, cancer and other chronic conditions.

Priority 3: Mental Health. Focus on prevention, education and treatment for depression, anxiety and PTSD; increased availability of crisis care; stigma mitigation through community health education,

improved access for youth and elders; and enhanced relationships with community partners to improve access to mental health care across community sectors.

While care was taken to gather and analyze data that would accurately tell the story of the hospital's service area, it is important to recognize information limitations and gaps that can occur. A comprehensive accounting of data limitations identified can be found starting on page 18 of the full Asante and Providence collaborative CHNA report. The Asante Ashland Community Hospital Community Health Improvement Plan (CHIP) will consider the prioritized health needs identified through this CHNA and develop strategies to address needs considering resources, community partnerships, capacity and core competencies.

MEASURING OUR SUCCESS: RESULTS FROM THE 2022 CHNA AND 2023 CHIP

This report also evaluates the results from Asante Ashland Community Hospital's most recent CHNA and CHIP. Identified priority needs from the previous CHNA included: Access to health care services, chronic conditions and mental health. Asante Ashland responded by making investments in new infrastructure and equipment, as well as time and resources to programs that were most likely to have an impact on these prioritized needs. This summary includes just a few highlights of our efforts. A more comprehensive review is available on page 72 of the full CHNA report.

To address identified health needs across all priority areas, Asante Ashland worked in concert with Asante Rogue Regional Medical Center and Asante Three Rivers Medical Center. Asante hospitals focused on increasing the availability of primary and specialty care providers, reducing wait times, expanding locally available medical treatments and services and reducing barriers to care by improving care coordination and enhancing access for people without the means to pay for care. Asante Ashland's efforts focused on improving these services and experiences for residents in southern Jackson County.

Asante successfully increased the number of Asante-employed primary and specialty providers as well as aiding community-based Asante Health Network providers with recruitment and retention, resulting in reduced wait times for community members to receive primary care for routine or emergent needs and to consult with a specialist, post-diagnosis throughout the service area.

Asante Ashland expanded locally available, hospital-based medical care to meet the uniquely evolving needs of our region's growing community with several key initiatives during the most recent CHNA and CHIP cycle. To better address the needs of our community's aging population, the hospital pursued, and was awarded, the designation of Age-Friendly Health System, signifying a level of specialized care aligned with the unique needs and goals of community members aged 65 and above. This focused care for our area's elders is carried out in tandem with the hospital's existing services and designations, such as the Baby-Friendly designation achieved in our previous CHNA cycle and is a vital component in providing care to all ages of the population, ranging from newborns to our geriatric community. Asante Ashland also expanded telemedicine capabilities, connecting on-site providers with the necessary specialists in real time to locally treat patients needing an advanced level of medical expertise.

Asante Ashland, Asante Rogue Regional and Asante Three Rivers continued to support expanding demands for medical professionals in our community by providing clinical internships and externships

and required licensure experiences for medical techs, allied health care professionals, nurses and advanced providers at all Asante hospitals throughout the three-year CHNA and CHIP cycle.

To address community needs around chronic conditions, Asante Ashland invested in community education on chronic health conditions through a variety of programs, including physician educational talks in concert with our local university's lifelong learning institute and a Coffee and Conversation series focused on health topics relevant to older adults.

To address identified community concerns around mental health, Asante Ashland focused resources on education, prevention and treatment for depression, anxiety and PTSD, improving access to mental health care for elders and addressing deficits in the social determinants of health. At Asante Ashland, embedded social workers within service lines facilitated access to support across the care continuum, including coordinating with outside agencies who specialize in addressing health-related social needs.

Asante Ashland worked in concert with Asante Hospice to support the mental health of community members and their families through wrap-around social, emotional and mental health support with in-home end-of-life care and individual and group support throughout the bereavement process regardless of their affiliation to Asante.

Asante invited written comments from the community on the 2022 CHNA and 2023 CHIP reports through website and published contact information, made widely available to the public, as well as direct invitation through our collaborative Asante and Providence 2025 community health survey and key informant survey. Excerpts from the feedback received on the 2022 CHNA and 2023 CHIP from key stakeholders in the community is highlighted below. Additional results for Asante Ashland Community Hospital are available in Appendix 2.

With regard to Access to Care, community stakeholders suggested Asante could:

- "Consider adding a Mother's Milk Bank and mental health services specifically targeting issues that arise from being pregnant and after; whether it is perinatal depression, loss of a child, loss of the planned birth experience, etc."
- "Beware of falling into service area silos that make those connections and warm handoffs to appropriate services unavailable to patients who may be unable to connect to them because of medical and/or behavioral health issues."

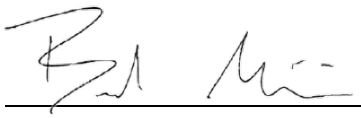
With regard to Chronic Conditions, key informants suggested Asante could:

- "Work one-on-one with individuals to address these [chronic] conditions."
- "Include behavioral health conditions [in the list of 'other chronic' conditions] in order to serve the whole person."

With regard to Mental Health, key stakeholders suggested Asante could:

- "Give people a place where they feel safe in participating with their own health care."
- "Partner and sponsor out in the community and invite in for community support presentations other organizations that have been doing similar work."
- "Add an activity/action around addiction and substance misuse."

2025 CHNA GOVERNANCE APPROVAL



Sept. 30, 2025

Brandon Mencini

Date

Senior Vice President and Chief Executive Officer

Asante Ashland Community Hospital

Sept. 30, 2025

Angie Simonson, Ed.D

Date

Senior Vice President of Strategy and Operations

Asante

CHNA/CHIP contact

Robert Reyes

Director

Asante Finance

731 Black Oak

Medford, OR 97504

robert.reyes@asante.org

Sheri Croy

Community Benefit Specialist

Asante Finance

731 Black Oak

Medford, OR 97504

sheri.croy@asante.org

CHNA@asante.org

INTRODUCTION

Background

OVERVIEW OF THE HOSPITAL PARTNERSHIP

Asante and Providence Medford Medical Center (Providence) are two not-for-profit health systems dedicated to creating health care access for everyone and improving health outcomes for the communities we serve. Striving to treat each person with compassion and dignity, Asante and Providence each operate a network of hospitals and acute care clinics spanning Jackson and Josephine counties.

Asante's health system in the region includes:

- Asante Ashland Community Hospital in Ashland
- Asante Rogue Regional Medical Center in Medford
- Asante Three Rivers Medical Center in Grants Pass
- Asante Physician Partners clinics throughout Jackson and Josephine counties

Providence Health & Services system in the region includes:

- Providence Medford Medical Center in Medford
- Providence Urgent Care in Medford and Central Point
- Providence Medical Group clinics throughout Jackson County

The goal of the Asante and Providence partnership is to produce a comprehensive assessment of our communities' most pressing needs, share our findings with the broader public, develop new relationships and strengthen existing relationships, leading to a healthier community.

This 2025 community health needs assessment (CHNA) represents the second iteration conducted exclusively as a partnership between Asante and Providence. Before engaging in a collaborative process, a set of Principles of Collaboration were agreed to:

- Collaborate to identify key health needs and issues in Jackson and Josephine counties.
- Focus on community engagement and collaborative participation.
- Avoid community partner burnout with respect to qualitative data collection through a collective approach to listening sessions and key informant interviews.
- Commitments of cash and/or in-kind resources from both parties; committed resources to be used to develop a CHNA that satisfies regulatory requirements.

PURPOSE AND SCOPE OF 2025 ASSESSMENT

In collaboration, Asante and Providence conducted a community health needs assessment in Jackson and Josephine counties to serve as the guiding document when developing improvement strategies and making targeted investments in the community. The organizations invited and were able to secure the

support of Jackson County Public Health, Josephine County Public Health and AllCare Health in the development of their collaborative 2025 CHNA.

Establishing a shared understanding of community needs serves as the foundation for developing a community health improvement plan (CHIP) for each individual hospital. In addition, both Asante and Providence are required by section 501(r) of the Internal Revenue Service Code, as tax-exempt 501(c)3 organizations that operate one or more hospital facilities, to conduct a CHNA at least once every three years for each hospital.

Our Commitment to Community

Asante and Providence dedicate resources to improving the health and quality of life for the communities we serve. During 2024, Asante and Providence provided $91,000,000 and $29,000,000, respectively, in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those our health systems serve. Of that amount, Asante Ashland Community Hospital invested more than $2,500,000 in community benefit expenditures to support vulnerable populations in Ashland and surrounding communities in fiscal year 2024.

Asante and Providence demonstrate organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs. The staff dedicated to working on hospital community benefit are responsible for ensuring the compliance of State and Federal 501(r) requirements. They also support community and hospital leaders, physicians, and others who work together to plan and implement the resulting community health improvement plan (CHIP) for each hospital.

[1] Per federal reporting and guidelines from the Catholic Health Association.

CHNA FRAMEWORK AND PROCESS

Overview

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering information on the communities served by Asante and Providence, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited key stakeholders and community members to provide additional context to the quantitative data through qualitative data in the form of interviews, listening sessions and a community health survey. As often as possible, equity is at the forefront of our conversations and presentation of the data, which often have biases based on collection methodology.

We recognize there are often geographic areas where the conditions for supporting health are substantially poorer than other areas in the region. Data within this document is largely reported at the county level. More granular data is available online through Providence's Southern Oregon 2025 CHNA Data Hub. This supplemental tool maps data points at the zip code or census tract level, allowing us to better understand the neighborhood level needs of our communities and better address inequities within and across communities when planning programs to address community need.

Approach and Methods

The following section describes the assessment framework used for community engagement, data collection, and analysis.

HEALTH EQUITY FRAMEWORK

Asante and Providence acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by addressing the underlying causes of racial and economic inequities and health disparities. To improve the health of our communities, we acknowledge we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[2]).

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

The CHNA is an important tool we use to better understand health disparities and inequities within the communities we serve, as well as the community strengths and assets (see Figure 2 for definition of terms[3]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

Figure 1. Factors contributing to overall health and well-being

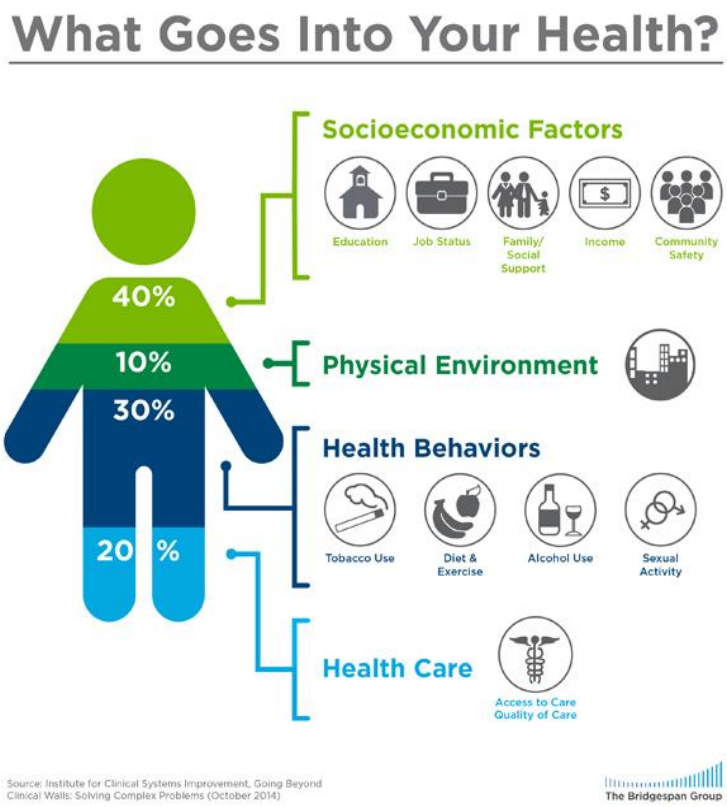


Figure 2. Definitions of key terms

Health Equity

A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups." (Braverman, et al., 2017)

Health Disparities

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

[3] Braveman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

To ensure that equity is foundational to our CHNA, we developed an equity framework that outlines the best practices that each of our hospitals will implement when completing a CHNA. These practices include, but are not limited to the following:

Approach

Explicitly name our commitment to equity.

Take an asset-based approach, highlighting community strengths.

Use people first and non-stigmatizing language.

Community Engagement

Actively seek input from the communities we serve using multiple methods.

Implement equitable practices for community participation.

Report findings back to communities.

Quantitative Data

Report data at the block group level to address masking of needs at county level.

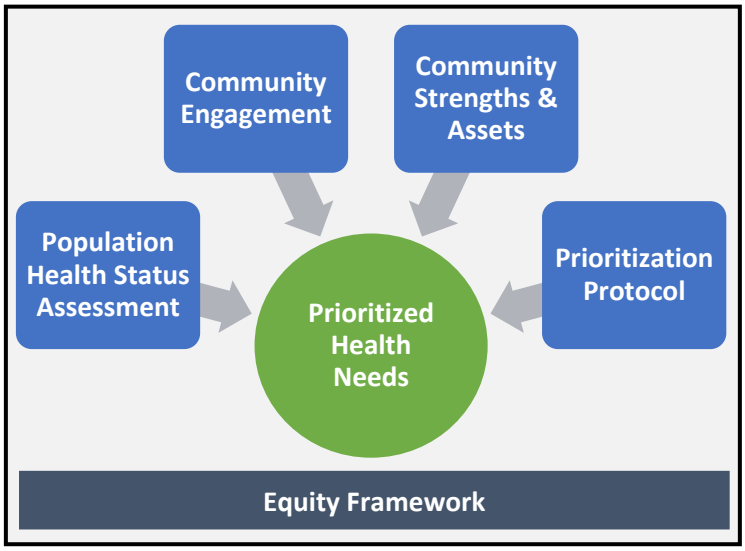
Disaggregate data when responsible and appropriate.

Acknowledge inherent bias in data and screening tools.

MODIFIED MOBILIZING FOR ACTION THROUGH PLANNING AND PARTNERSHIPS (MAPP) FRAMEWORK

Asante and Providence used a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) model as a framework to guide the CHNA process. Using a mixed-methods approach allowed us to consider several key elements necessary to determine prioritized health needs including:

- Population health data
- Community engagement
- Community strengths & assets
- Prioritization protocol



DATA COLLECTION AND ANALYSIS METHODS

Stakeholder Interviews and Community Listening Sessions

Providence and Asante contracted with the Rede Group to conduct stakeholder interviews and community listening sessions. Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The Rede Group conducted 13 stakeholder interviews including 24 participants, people who are invested in the well-being of the community and have first-hand

knowledge of community needs and strengths. They also conducted 4 listening sessions with a total of 32 community members. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

The Rede Group conducted stakeholder interviews and listening sessions between December 2024 and February 2025. Stakeholders were selected based on their knowledge of the community and engagement in work that directly serves people who are economically disadvantaged, or otherwise marginalized or vulnerable. Providence and Asante aimed to engage stakeholders from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives. Included in the interviews was the Program Manager for Communicable Disease and Epidemiology Data and Performance from Jackson County Public Health.

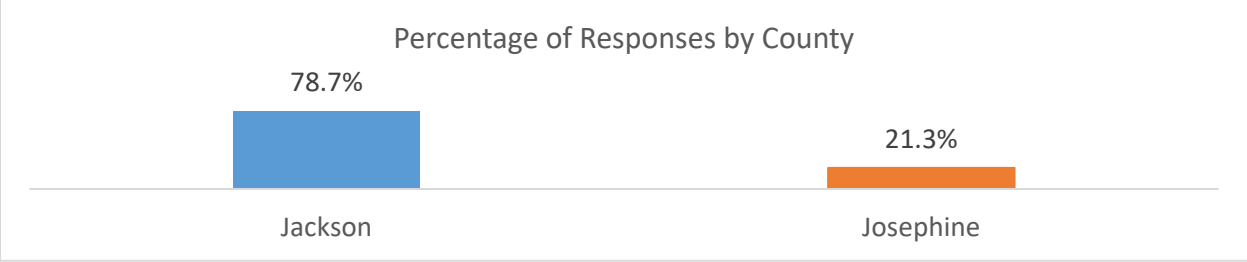
Full details on the protocols, findings, and attendees are available in Appendix 1.

Community Health Survey

The community health survey was open from February 7th to March 31st, distributed in both paper and electronic formats, and available in English and Spanish. The survey captured key information on health and lifestyle factors, community needs, and barriers to accessing health and social services in Jackson and Josephine counties. Out of 353 survey responses, 277 were taken by respondents within Jackson County, 75 within Josephine County; 1 paper Spanish survey was not specified as being from either county. Of the submitted surveys, 47% were paper surveys completed with the support of community partners. While only 21% of total responses were submitted by Josephine County residents, 38% of paper respondents were from Josephine County. There were 26 paper surveys submitted in Spanish total, from the total of 31 estimated Spanish responses, with Jackson County responses (23) outnumbering Josephine County (2) despite efforts to engage community members with Spanish as their primary language.

The survey was conducted electively, in purposeful partnership with community-based partner organizations. While efforts were made to engage the diverse populations of our primary service area, survey results are not representative of demographics in the general population. The tables below highlight demographic information for survey respondents.

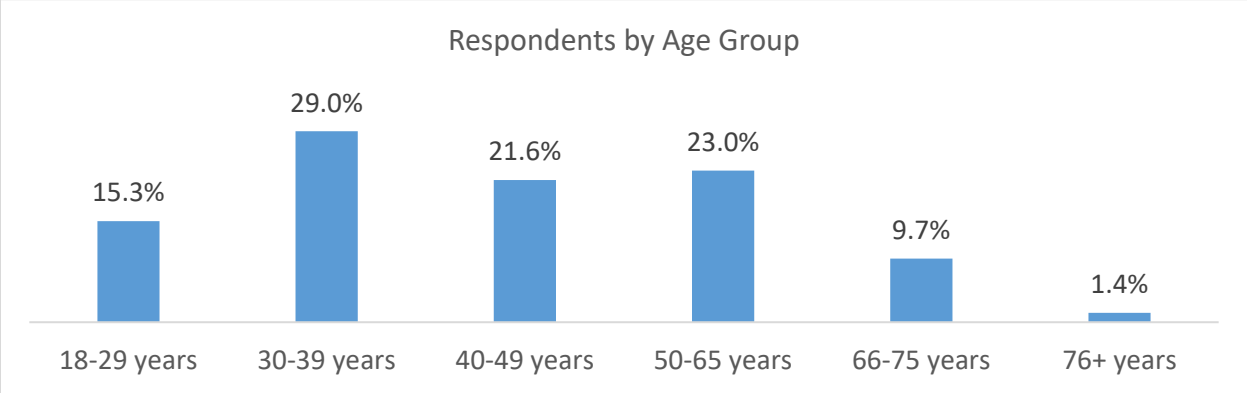
Figure 3. Respondents by County, English and Spanish Survey



DATA SOURCE: Community Health Needs Assessment Survey, 2025

The largest age group of respondents was between the ages of 30-39 (29.0%). The second largest age group of respondents was ages 50-65 (23.0%).

Figure 4. Respondents by Age Group, English and Spanish Survey



DATA SOURCE: Community Health Needs Assessment Survey, 2025

The largest group of respondents by gender was female (70.3%). The high percentage of female survey respondents differs from the percentage of females in the general population, approximately 51%.

Table 1. Respondents by Gender

Gender Identity	Percentage
Woman	70.3%
Woman, Cisgender	2.3%
Woman, man, other	0.3%
Woman, Non-binary	0.3%
Woman, Transgender	0.3%
Gender Queer	0.6%
Gender Queer, Non-binary	0.3%
Man	22.4%
Man, Cisgender	0.6%
Man, Non-binary, Transgender	0.3%
Non-binary	1.4%
Prefer not to answer	1.1%

DATA SOURCE: Community Health Needs Assessment Survey, 2025

The largest group of respondents by sexual orientation was Heterosexual or Straight (69.8%). The second largest group (8.8%) chose not to answer this question. Collectively, 21.5% self-identified as one or more recognized LGBTQIA+ orientations.

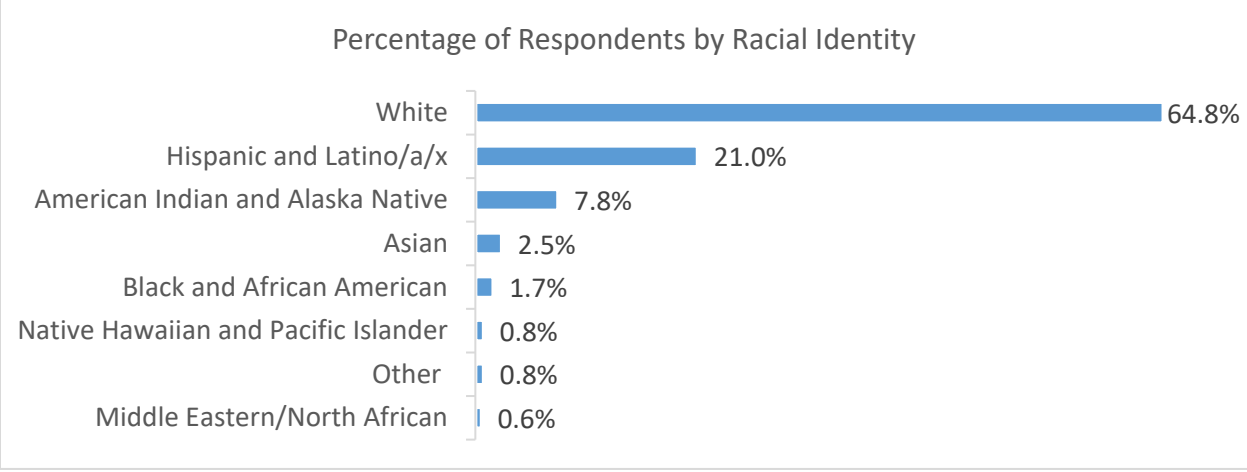
Table 2. Respondents by Sexual Orientation

Sexual Orientation	Percentage
Aromantic	4.5%
Bisexual	6.6%
Gay	1.5%
Heterosexual or straight	69.8%
Lesbian	2.1%
Other	3.3%
Pansexual	1.5%
Prefer not to answer	8.8%
Queer	1.2%
Questioning	0.6%

DATA SOURCE: Community Health Needs Assessment Survey, 2025

The largest group of respondents by race was White (64.80%), with the second largest group being Hispanic and Latino/a/x (20.9%). American Indians and Alaskan Natives comprised 7.82% of the respondent population; while all other identities were indicated by fewer than 6 total respondents, resulting in percentages from 0.28% for subgroups to 2.51% over overarching racial categories.

Table 3. Respondents by Racial Identity



DATA SOURCE: Community Health Needs Assessment Survey, 2025

Nearly 25% of respondents reported an income of $100,000 or more, with 47% reporting incomes of less than $50,000. In 2024, the median household income in Jackson County, Josephine County, and Oregon was $71,443, $59,097, and $80,426 respectively.

Table 4. Respondents by Household Income

Household Income	Percentage
Less than $20,000	21.0%
$20,001 to $40,000	16.9%
$40,001 to $60,000	18.6%
$60,001 to $80,000	11.8%
$80,001 to $100,000	6.8%
$100,000 and over	24.9%

DATA SOURCE: Community Health Needs Assessment Survey, 2025

Review of Secondary Data

This CHNA incorporated quantitative data on health conditions, health behaviors, and social determinants of health. Data was pulled from local, state, and national levels to identify how health trends have changed over time. Data sources in this CHNA include:

- American Community Survey
- Centers for Disease Control and Prevention
- County Health Rankings & Roadmaps
- ESRi Updated Demographics
- Oregon Health Authority
- Oregon Student Health Survey (2022)
- U.S. Census

Data Limitations and Information Gaps

While care was taken to select and gather data that would tell the story of Asante and Providence's service areas, it is important to recognize the limitations and gaps in information that naturally occur, including the following:

- Not all desired data were readily available, so sometimes we had to rely on tangential or proxy measures or not have any data at all. For example, there is limited community-level data on the incidence of mental health or substance use.
- While most indicators are relatively consistent from year to year, other indicators are changing quickly (such as percentage of people uninsured) and the most recent data available are not a good reflection of the current state.

- Reporting data at the county level can mask inequities within communities. This can also be true when reporting data by race, which can mask what is happening within racial and ethnic subgroups.
- Survey responses were voluntary, with respondents being able to skip questions they did not wish to answer. As such, not all questions were answered by all participants, which may have skewed overall data.
- For the 2025 survey, Asante and Providence elected to mirror the REALD race and ethnicity designations used by community partners in the recent regional Community Health Survey. Race and ethnicity data was collected with a series of voluntary open-ended and multiple-choice questions. Respondents had the option to skip questions as well as "check all that apply." This methodology, combined with the survey's small sample size, resulted in a large variation of responses that limited the statistical significance of less dominant groups and resulted in difficulty providing an accurate graphic portrayal of participants' race and ethnicity distinctions as well as alignment to the population of the larger community.
- Data gathered through interviews and surveys may be biased depending on who is willing to respond to the questions and whether they are representative of the population as a whole.
- The accuracy of data gathered through interviews and surveys depends on how consistently the questions are interpreted across all respondents and how honest people are in providing their answers.
- Asante and Providence elected to partner with community-based organizations for survey participant recruitment, rather than supporting the survey with social media advertising as had been done with the 2022 survey, to avoid skewing results to a more affluent demographic. Despite this effort, 25% of respondents to the 2025 survey disclosed an income of $100,000 or greater, compared to 20% on the 2022 survey.
- While paper surveys were intended to engage the vulnerable members of our community seeking support through community partner organizations, not all paper surveys returned were indicative of economic vulnerabilities. This could have been due to efforts to engage organizations by population, such as parents with young children, those seeking services through the United Way or those engaged with behavioral health treatment services, who may have been participating in the programs for reasons other than financial necessity.
- While paper surveys were intended for marginalized individuals, including those in poverty, those without sufficient access to the internet, or those exhibiting reading, comprehension or dexterity issues that would have prevented online participation, this was not enforceable. Paper survey responses indicate some percentage of the surveys returned were completed by individuals beyond this target population.
- Paper survey participation was limited to community members engaged with specific partnering organizations. While we did share parameters for participant recruitment designed to survey a broader swath of the community, we were ultimately limited to the populations partner organizations had the staff, time and opportunity to survey. Decisions on what participants to survey were at the discretion of the partner organization. In some cases, this resulted in

multiple surveys that reflected similar life experience, demographic and socio-economic factors, rather than the wider range of lived experiences we hoped to learn from. In other cases, this resulted in surveying of populations who were already represented in partnerships with other organizations. For example, one arrangement with a broad service organization intended to engage elders and families seeking support services was pivoted to the branch of their organization serving the unhoused. At least four other community partners across the two-county region were already surveying the unhoused population, but redirection was not possible.

- While staff members were not the intended service population for the paper survey opportunity, intersections between employed staff and program participation do exist. Many employees of social service and community partner organizations live on the edge of vulnerability themselves. Multiple survey responses indicated employment with participating partner agencies.
- Paper surveys revealed data discrepancies that would not be reflected in the on-line survey due to pre-populated responses and programmed skip-logic in the form. One example is the question addressing the necessity for a second job to meet living expenses. In the paper form, multiple respondents indicated they did not currently have a second job, but *did need one* to meet their basic living expenses. In the on-line form, if a respondent indicated they only had one job, the follow-up question about the necessity of a second job would not be displayed, therefore deeper insight into this issue was not possible. Similarly, on the paper survey, many indicated they did not have children under 18 years of age. In the on-line survey, that response concluded the section on children's health. In the paper survey, many respondents went on to indicate conditions their children had been diagnosed with, either as children or in their adulthood. These paper survey responses were not included in the final survey results due to the skip logic limitations of the online form. This also indicates other on-line participants may have had children who were diagnosed with one or more physical or behavioral health concern, but the question was omitted when they asserted that they did not have children under 18.
- The online form had restricted opportunity for open-ended response. Paper surveys, in general, exhibited many explanatory comments and margin notes that were not possible within the confines of the online form. Comments on paper surveys addressed access to health care or prescriptions, co-pays and other medical costs and the health of adult children among others.
- Engaging community partners in our CHNA processes continues to be a challenge. Regional partners just completed a two-year data collection and reporting cycle with the regional All in For Health collaborative Community Health Assessment and related Community Health Improvement Plan. Staff members of these organizations have been in near-constant connection with the process and accompanying periodic requests for additional information and survey completion around those processes.
- Additionally, due to fiscal year alignment, our qualitative data collection period coincides with the winter holidays. Winter is a high-demand time of year for community partners, who see a rise in need among those they serve at that time of year. It's also a high-stress time of year for

community members whose input we sought to include in our research. Regrettably, some of our target partners, collaborators, and community members were not able to participate within the allotted timeframe.

- Engaging with Spanish-speaking community members proved challenging, as the timing of our planned Spanish listening sessions, as well as our survey deployment, coincided with changes in leadership and policy at the national level that required prompt response at the local level. Josephine County was able to host a listening session for Spanish-speaking residents, but the planned Spanish listening session in Jackson County was first shifted from community members to Spanish-speaking community leaders and organizers, and eventually cancelled, due to emergent needs in the community.
- Most Spanish surveys were paper surveys completed through a community partner. The vast majority were from an organization working with families with young children. More Spanish surveys were collected in Jackson County than Josephine County. There were a couple of Spanish surveys completed where responses indicated the person was completing the Spanish version electively to practice their Spanish comprehension and writing skills rather than requiring Spanish as a primary language of communication.
- Survey responses were voluntary. Not all respondents elected to answer all questions, therefore there are natural gaps in the data collected. Additionally, the intentional recruitment among vulnerable populations results in surveying populations who may already experience discomfort, concern or distrust about the information being sought. As such, the data collected is limited by the respondents' comfort with providing information, their framing of their own experiences and their comprehension of the question. Besides the ability to skip questions entirely, respondents were also able to provide neutral answers on many questions such as "not applicable," "don't know," "prefer not to answer," "other," or "neutral," which may have skewed final results.
- The 2025 survey allowed for county affiliation, but not affiliation to zip code. Additionally, the number of surveys returned was significantly reduced from 2022 totals. The small sample size made subdivision by county and language challenging, resulting in significantly reduced data samples for Josephine County and for Spanish language respondents, when isolated. Therefore, community health survey data has been reflected using aggregate regional totals for the 2025 CHNA report, except in limited circumstances where it was possible to extract precise information, such as in open-ended comments citing city or region.
- While deliberate efforts were made to actively engage a broad cross-section of the community, final demographic information continues to demonstrate majority participation by White, middle-aged, heterosexual, cis-gender women. As such, data received through the survey may not be wholly reflective of the broader needs of the community.

Process for Gathering Comments on Previous CHNA and Summary of Comments Received

Written comments were solicited on the 2022 CHNA and 2023 CHIP reports in several ways, which were made widely available to the public via posting on the internet upon publication of those documents. For Asante, those dates were September 2022 (CHNA) and February 2023(CHIP); for Providence, December 2022 (CHNA) and May 2023 (CHIP), as well as through various channels with our community-based organization partners. There were three methods employed to collect public comments on the previous CHNA and CHIP:

- Allowing visitors to Asante and Providence's websites to submit public comment via email to the appropriate community benefit teams.
- Encouraging respondents of the CHNA Survey to follow links to both Asante and Providence's community benefit webpages where previous CHNAs and CHIPs are publicly accessible.
- Conducting key informant surveys with professionals from different sectors including, but not limited to, health care, government, social services, and education. Results from the key informant surveys are below.

Four key informants from a variety of community organizations provided an overall rating on Asante Ashland Community Hospital's efforts to address priorities identified in its 2023 Community Health Improvement Plan (CHIP). The overall ratings for each priority are summarized in the table below. Additional results from the key informant survey can be found in Appendix 2.

Table 5. Key Informant Ratings on How Asante Ashland Community Hospital Is Addressing Their CHIP Priorities

2023 CHIP Priorities	Poor	Fair	Good	Very Good	Excellent
Access to Healthcare	0%	25%	0%	50%	25%
Chronic Conditions	0%	0%	50%	25%	25%
Mental Health	50%	0%	0%	25%	25%

DATA SOURCE: Asante Ashland Community Hospital Key Informant Survey, 2025

Key stakeholders suggested Asante Ashland Community Hospital could improve service to the community by:

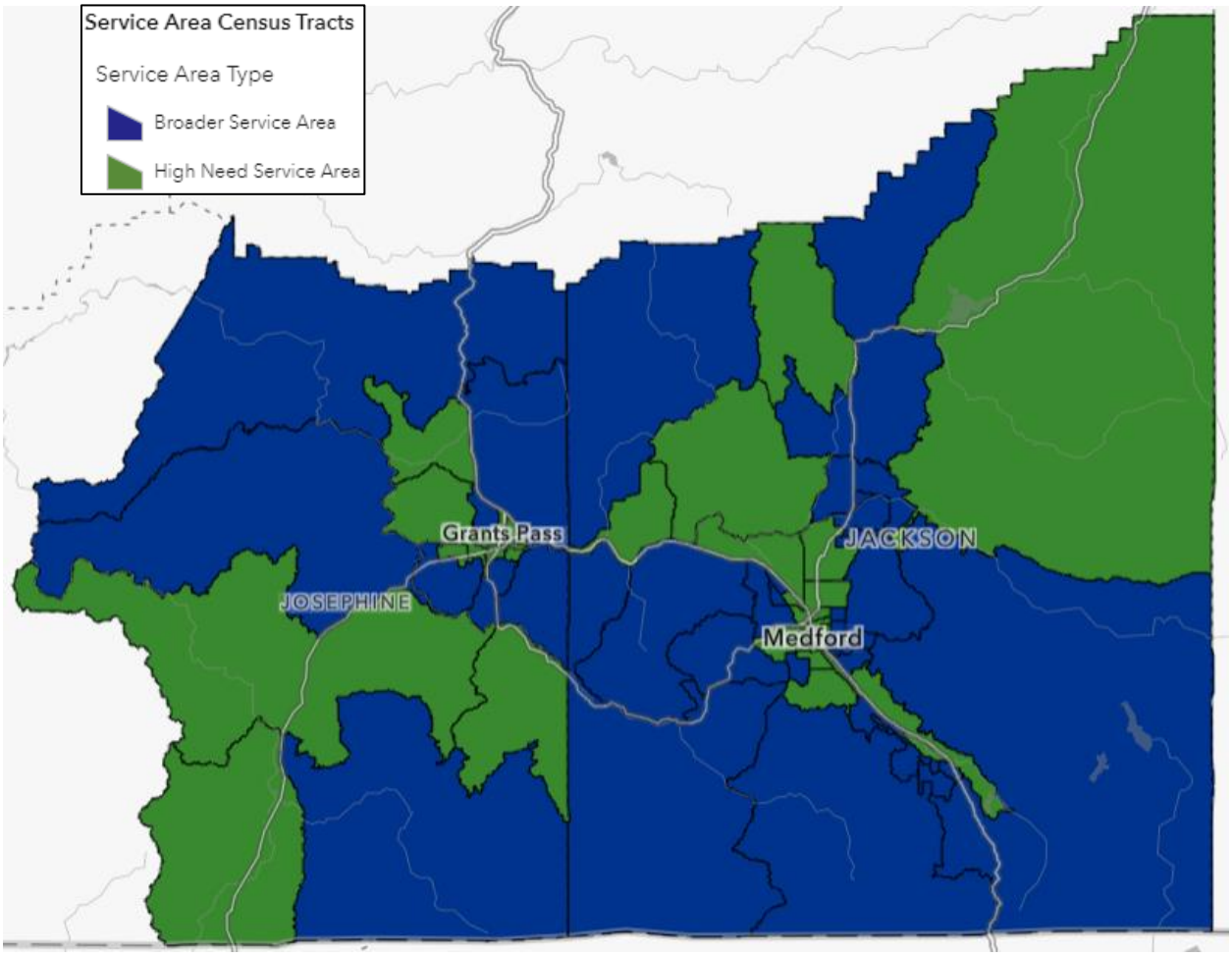
- Adding a Mother's Milk Bank and mental health services for pregnant and perinatal mothers

- Providing attentive navigation and warm handoffs to appropriate services, especially for patients with medical and/or behavioral health issues that keep them from independent access
- Providing one-on-one education and support for individuals navigating chronic illness
- Adding activity/action around addiction and substance misuse
- Supporting LGBTQIA+ individuals in the community, in particular, youth
- Partnering and sponsoring out in the community and inviting relevant community partners in to support community health education initiatives

REGIONAL SNAPSHOT – OUR COMMUNITY

Hospital Service Area and Community Served

Asante and Providence Medford Medical Center provide care to Jackson and Josephine Counties, which includes a population of approximately 309,607 people across both counties. Based on the availability of data, geographic access to these facilities and primary care, and other hospitals in neighboring counties, Jackson and Josephine Counties serve as the boundary for Asante's primary service area and Providence Medford Medical Center's primary and secondary service areas. Asante Ashland Community Hospital primarily serves Jackson County's 220,768 residents—21,061 of whom reside in Ashland. Josephine County and other surrounding counties serve as the secondary service area for this hospital. See map below for further detail, including communities identified as higher need.



Community Demographics

The tables and graphs below provide basic demographic and socioeconomic information about Jackson and Josephine counties. Providence developed a dashboard that maps each CHNA indicator at the census tract level for Jackson and Josephine Counties. Click here [4]to access the dashboard. All in for Health developed a community focused data dashboard that includes data for Jackson and Josephine Counties. Click here[5] to access the Jackson County dashboard. Click here[6] to access the regional data.

Table 6. Total Population and Percent Change, by County and State, 2024

	2020	2024	% Change
Oregon	4,237,256	4,272,371	0.8%
Jackson County	223,259	221,331	-0.9%
Josephine County	88,090	88,276	-0.2%

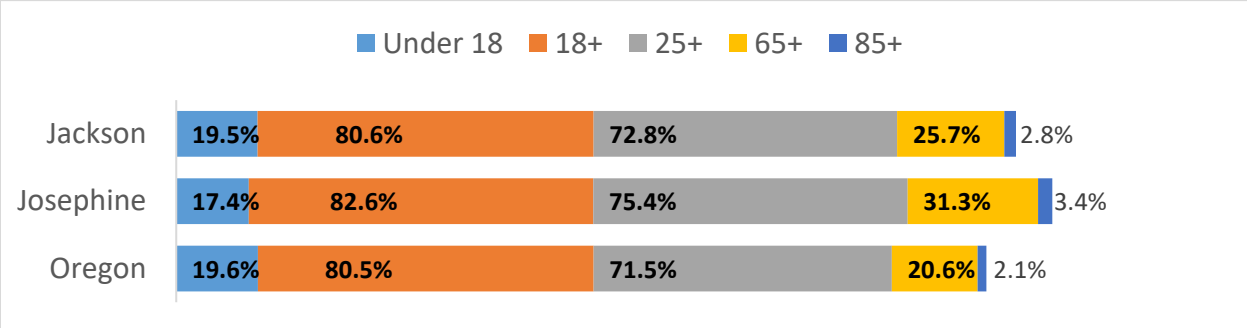
DATA SOURCE: 2024 American Community Survey 5-year Estimates

Table 7. Population by Sex, 2024

Indicator	Jackson County	Josephine County	Oregon
Female Population	114,082	44,820	2,159,147
Male Population	108,511	43,259	2,114,695
% Female Population	51.25%	50.89%	50.52%
% Male Population	48.75%	49.11%	49.48%

DATA SOURCE: 2024 American Community Survey 5-year Estimates

Figure 5. Age Distribution, by County and State, 2024



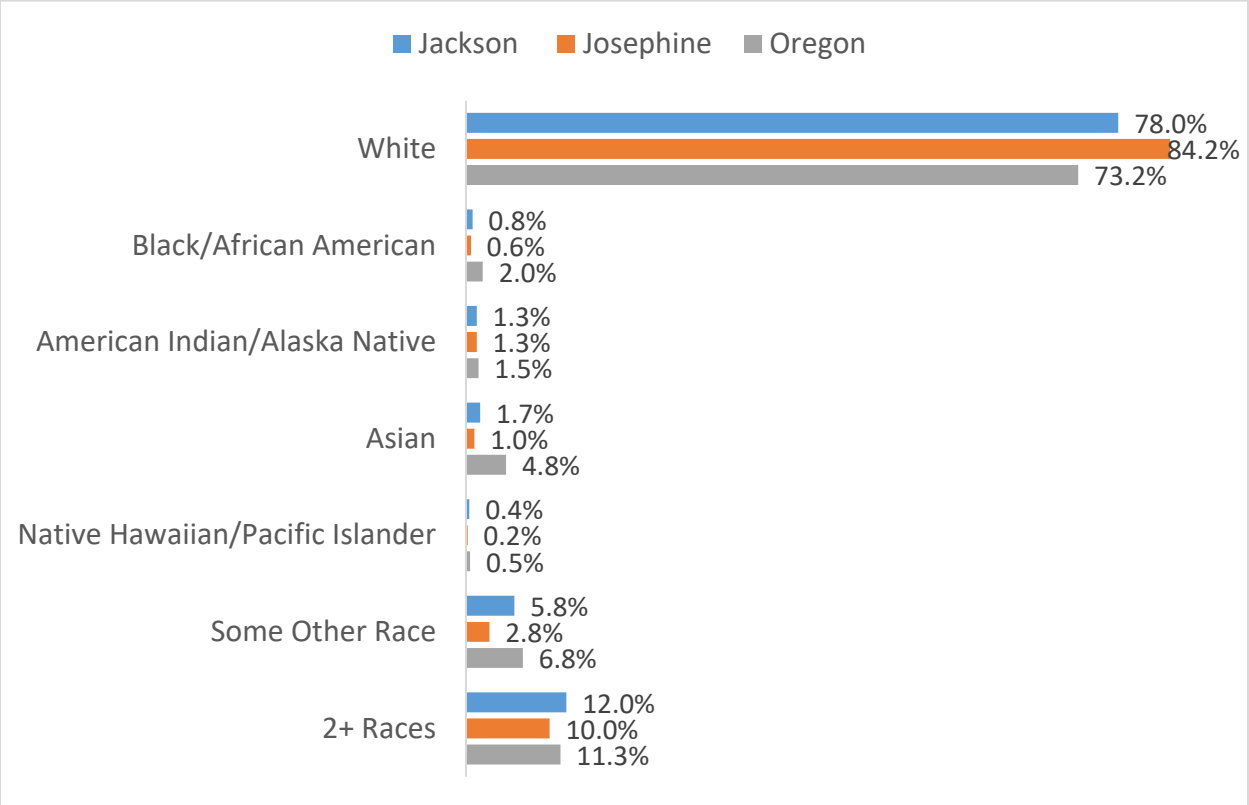
DATA SOURCE: 2024 American Community Survey 5-year Estimates

[4] URL: https://www.asante.org/ProvidenceCHNADataHub

[5] URL: https://www.asante.org/AIFH-JacksonCountyData

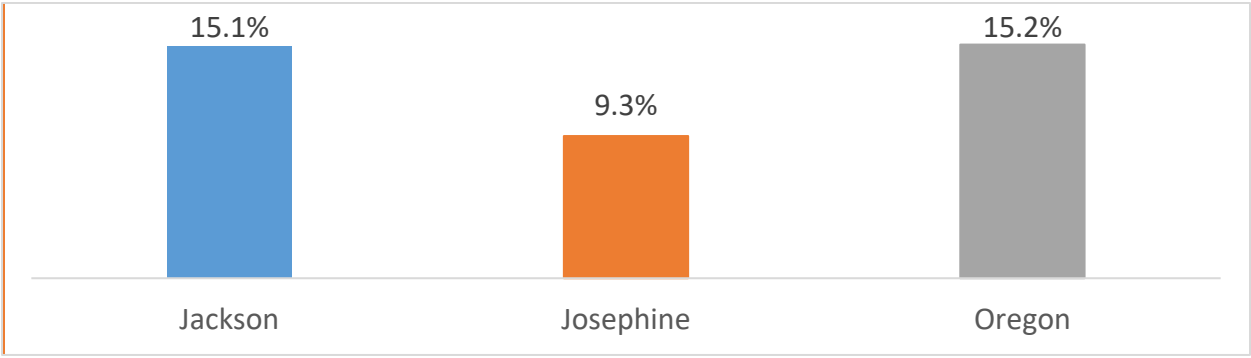
[6] URL: https://www.asante.org/AIFH-RegionalData

Figure 6. Population by Race and Ethnicity, 2024



DATA SOURCE: 2024 American Community Survey 5-year Estimates

Figure 7. Population by Hispanic Ethnicity, 2024



DATA SOURCE: 2024 American Community Survey 5-year Estimates

Table 8. Average Household Income by Race/Ethnicity, 2024

Race/Ethnicity	Jackson County	Josephine County	Oregon
All	$87,961	$75,958	$107,172
White	$83,735	$74,558	$97,735
Black/African American	$62,297	$48,432	$76,434
American Indian/Alaskan Native	$64,666	$70,512	$76,787
Asian	$82,652	$94,346	$118,590
Native Hawaiian/Pacific Islander	$72,991	$35,978	$99,393
Some Other Race	$83,601	$46,507	$81,634
2+ Races	$77,784	$65,991	$90,900
Hispanic/Latino	$68,770	$54,707	$75,303
Non-Hispanic/Latino	$90,124	$77,439	$110,870

DATA SOURCE: 2024 American Community Survey 5-year Estimates

Table 9. Housing Cost Burden – Renters Spending 30% or More of Household Income on Rent, 2023

Indicator	Jackson County	Josephine County	Oregon
Percent of Households	14.4%	17.1%	15.2%

DATA SOURCE: 2023 American Community Survey 5-year Estimates

MORTALITY

In 2023, the leading causes of mortality in Jackson and Josephine Counties and Oregon were cancer, heart disease, chronic lower respiratory disease, accidents, Alzheimer's disease, and cerebrovascular diseases.

Table 10. Top Five Leading Causes of Death, Crude Death Rate Per 100,000 Population, 2023

Rank	Jackson County	Josephine County	Oregon
1	Cancer 230.1	Cancer 313.1	Cancer 198.3
2	Heart Disease 215.2	Heart Disease 268.7	Heart Disease 185.1
3	Accidents 91.0	Chronic Lower Respiratory Disease 110.5	Accidents 87.1
4	Chronic Lower Respiratory Disease 66.6	Accidents 104.8	Cerebrovascular Diseases 56.2
5	Alzheimer's Disease 62.1	Cerebrovascular Diseases 84.3	Chronic Lower Respiratory Disease 47.8

DATA SOURCE: United States Census Bureau, Population Division, 2023.

HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSA) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Jackson and Josephine Counties are both located in a HPSA. See Appendix 3 for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

COMMUNITY INPUT

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, the Rede Group, on behalf of Asante and Providence, conducted 13 stakeholder interviews including 24 participants, and four listening sessions with community members. All community input was collected in between December of 2024 and March of 2025. Below is a high-level summary of the findings of these sessions; full details on the protocols, findings, challenges, and attendees are available in Appendix 1.

Community-Defined Health and Strengths

Community members and key informants were asked to highlight community strengths. Community members were also asked to describe their vision for a healthy community:

Vision for a Health Community
•People support one another and are involved in their community •Basic needs are met and there are local resources available •Inclusion and respect are foundational •Safety •People can access health care services

Community Strengths
•Organizations and resources available to support people •Strong relationships and respect •Community engagement and people helping people •Community knowledge and wisdom •Collaborative relationships between local organizations and agencies •Resilience and adaptability

Community Needs

Listening session participants discussed a variety of needs, but the three most common were **access to health care services**, **homelessness and housing instability and behavioral health**. Access to health care services was the most common need mentioned and included needing more affordable medical care, more health care providers to ease access, and more financial assistance. Participants shared a need for more affordable housing, as well as more transitional and supportive housing. While the fifth anniversary of the 2020 Almeda and Obenchain fires is approaching, community members continue to reference the fires' lasting impacts on housing. These fires destroyed thousands of homes in Jackson County; many of which have still not been replaced. Listening session participants emphasized concern for neighbors experiencing homelessness and shared a need for more resources, hygiene facilities and restrooms, and mental health support. Other needs discussed in detail included **disability inclusion and support for people with disabilities, economic security, access to childcare, and food security.** Additional detail can be found in the Key Themes section below.

Challenges in Obtaining Community Input

While video conferencing does facilitate information sharing, there were challenges creating the level of dialogue that would take place in person. As such, in-person sessions were planned for designated

populations to enhance participation. Unfortunately, due to our timeline coinciding with the winter season, when many of our partner organizations are in high demand for support, and many vulnerable community members are facing times of additional difficulty, participant recruitment was challenging. Many organizations expressed limited capacity. Scheduling interviews and listening sessions required additional resources and engagement over the previous cycle. In-person sessions were successfully planned and recruited for, but severe inclement weather necessitated the rescheduling of those planned in-person sessions. One planned in-person session was pivoted to an online session. One had to be cancelled entirely, due to weather and other unexpected challenges impacting that organization's service population. This necessitated last-minute engagement with two additional organizations in hopes of replacing this lost opportunity. Those organizations were unfortunately not able to gather as many participants as may have been possible with a longer lead time. The resulting listening sessions were not as robust as they could have been, with one having only 4 participants.

KEY THEMES

This Key Themes section describes the highest priority needs determined through an analysis of qualitative data (key stakeholder interviews, listening sessions), community health survey data, and publicly available population-level data. The key themes below are listed in order of highest priority as identified by community participants.

Homelessness and Housing Instability

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

County Health Rankings and Roadmaps explains the link between health and housing in the following way: "There is a strong and growing evidence base linking stable and affordable housing to health. As housing costs have outpaced local incomes, households not only struggle to acquire and maintain adequate shelter, but also face difficult trade-offs in meeting other basic needs. When the majority of a paycheck goes toward the rent or mortgage, it makes it hard to afford doctor visits, healthy foods, utility bills, and reliable transportation to work or school. This can, in turn, lead to increased stress levels and emotional strain."[7]

KEY FINDINGS

Qualitative Data

Key informants and community members identified homelessness and housing stability as a critical community need. They shared affordable housing is important for people being able to meet their basic needs, recruiting and retaining workforce, and addressing behavioral health needs. Wildfires destroyed housing, worsening this need and affecting insurability. Though it has been five years since wildfires wiped out a significant number of affordable housing units in the valley, recovery has been slow. Key informants shared there is a need for more housing units across the spectrum, including shelter beds, supportive housing, transitional housing, and low-income housing. There is also a need for shared definitions and language regarding housing types, more resources and funding to address homelessness, more coordinated homeless services, and more focus on prevention. Community members would like to see more homeless services, including public restrooms and showers, along with support for people navigating housing resources and filling out applications.

> *"There is a shortage of housing stock across the continuum of incomes from those that are seeking to buy, those that are seeking to rent. It's not affordable and there's not enough of it." – Key Informant*

Barriers to addressing housing stability include the high cost of housing and a lack of housing stock. System barriers to addressing housing needs include administrative burden associated with

[7] DATA SOURCE: County Health Rankings & Roadmaps, 2025 County Health Rankings, 2025.

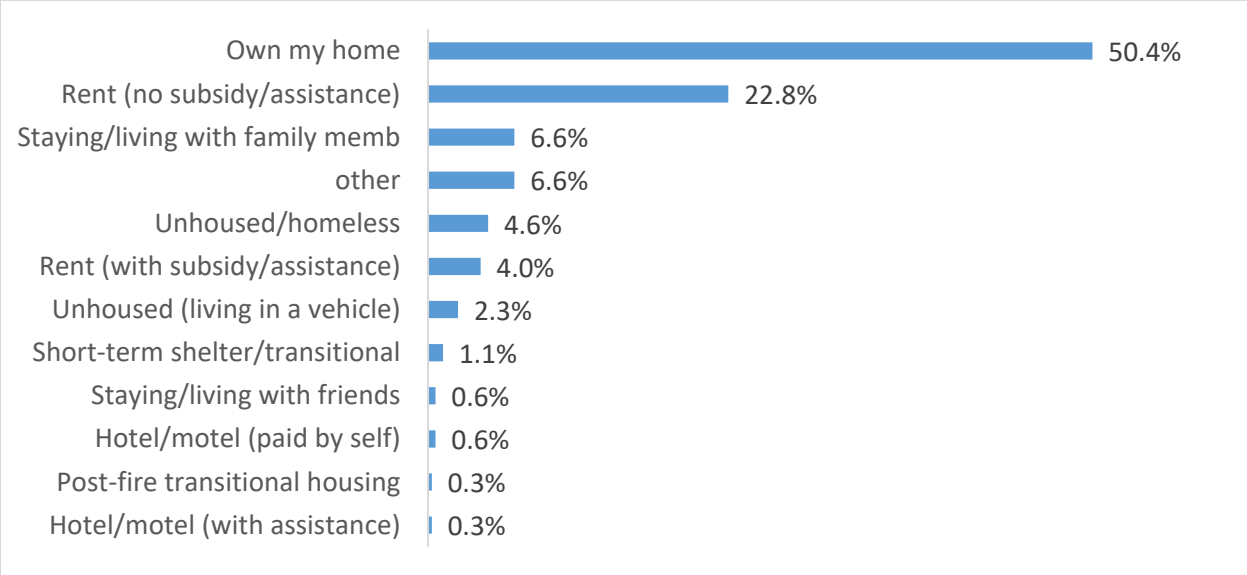
sources of funding, a lack of funding, and a focus on short-term solutions. Young people experiencing homelessness, older adults, people with disabilities, people living in rural areas, Native American peoples, and people identifying as LGBTQIA+ may experience additional barriers to stable housing.

Survey Data

Community members responding to the Community Health Survey reiterated the housing concerns introduced by community stakeholders with an emphasis on the needs of more vulnerable community members, such as, the elderly and those living with mental health challenges. Respondents mentioned the need for low barrier housing and supports for community members navigating homelessness alongside mental illness, addiction and recovery. Cost is a concern, with community members referencing high costs of living and the need to prioritize the limited funds available between rent, food, health care and other essentials. Community members identify increased difficulty navigating these issues with children.

Just over 50% of survey respondents own their home, 22.8% reported renting, and 16.4% reported some form of homelessness.

Figure 8. Percent of Survey Respondents Reporting Housing Status, 2025



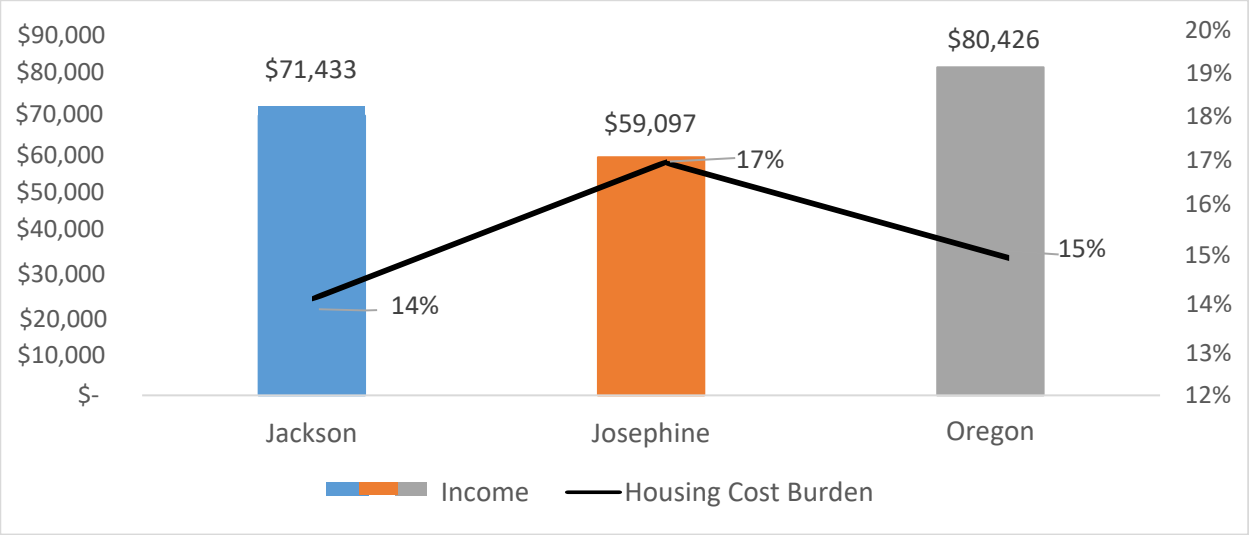
DATA SOURCE: Community Health Needs Assessment Survey, 2025

Secondary Data

The median household income in Jackson ($71,443) and Josephine ($59,097) counties is much lower than Oregon's median income of $80,426. Low-income households have an increased chance of experiencing severe housing cost burden, which is defined as renters who spend 50% or more of their income on housing. In Oregon, 15% of renters experience severe housing cost burden. In Jackson

County, 12,580 households experience severe housing cost burden, while in Josephine County, 6,031 households are impacted (14% and 17%, respectively).

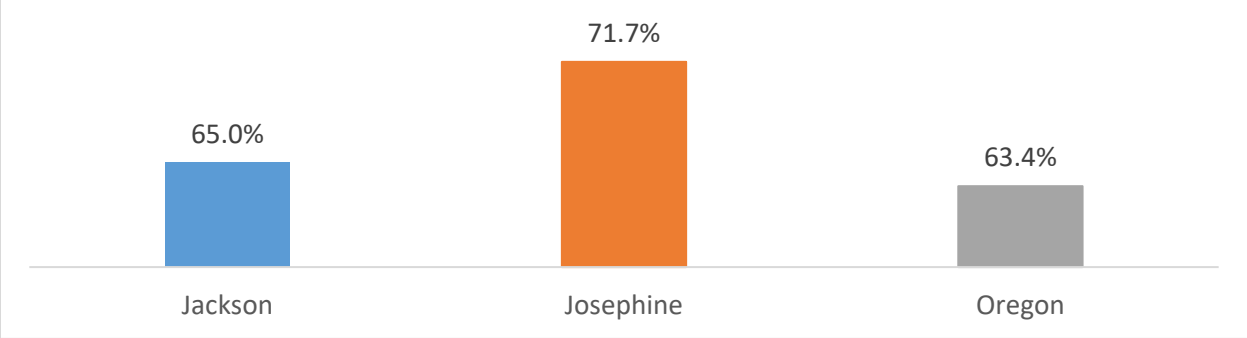
Figure 9. Median Household Income and Percent Households Where Housing Costs are 50% or More of Income by County and State, 2023



DATA SOURCE: Providence Data Hub, 2023 American Community Survey, 5-Year Estimate

Josephine County had the highest proportion of owner-occupied housing units (71.7%) compared to Jackson County and Oregon.

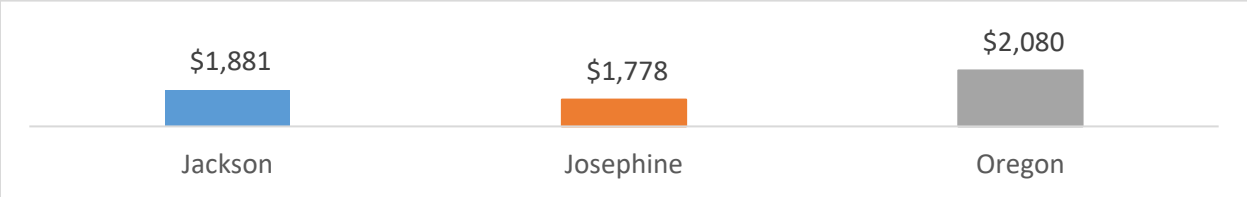
Figure 10. Percent Owner Occupied Housing Units, by County and State, 2023



DATA SOURCE: U.S. Census Bureau, Quick Facts, 5-Year Estimates, 2019-2023

The median monthly housing costs for owners with a mortgage were lower in Jackson County ($1,598) and Josephine County ($1,467) compared to Oregon ($1,741) and the U.S. ($1,621). Similar trends were observed for renter occupied housing units.

Figure 11. Median Monthly Owner Costs with a Mortgage, by County and State, 2023



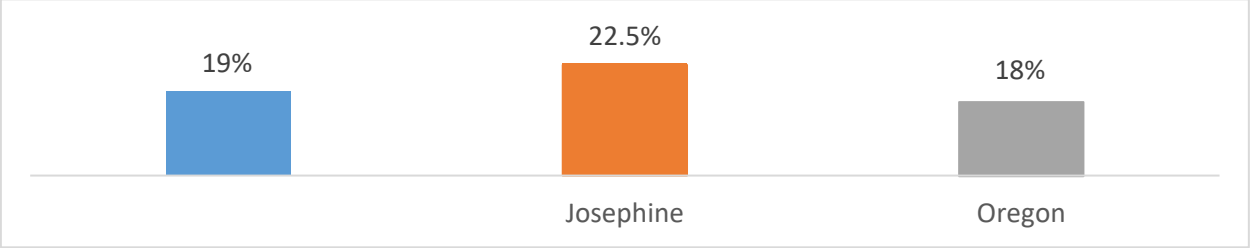
DATA SOURCE: U.S. Census Bureau, Quick Facts, 5-Year Estimates, 2019-2023

County Health Rankings & Roadmaps defines households with 'Severe housing problems' as experiencing at least one of the following four problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities. Severe housing problems can lead to health problems such as infectious and chronic diseases, injuries, and poor childhood development.[8]

The following chart (Figure 12) shows the percentage of households that qualify as having severe housing problems in Oregon, Jackson County, and Josephine County.

"As a single parent, the rent is too high to afford. I've been on the HUD waitlist for 10yrs, they keep finding reasons to kick me off. Why don't they call us instead of using an address when they know we are HOMELESS? So now I have two children in a home I know I won't be able to afford to keep as my rent is $1,600 a month. "— Community Member

Figure 12. Percent Households with Severe Housing Problems, by County and State, 2024



DATA SOURCE: Data USA, County and State Profiles 2024

[8] DATA SOURCE: County Health Rankings & Roadmaps, County Health Rankings. Data from 2017-2021 used for this measure, 2025.

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing homelessness in Jackson and Josephine counties:

- ACCESS
- City of Grants Pass Housing Task Force
- Hearts with a Mission
- Housing Authority of Jackson County
- Illinois Valley Living Solutions
- Jackson County Continuum of Care
- Jackson County Homeless Task Force
- Josephine County Housing and Community Development Council
- Journey Home
- Magdalene Home
- Maslow Project
- MINT – Mobile Integrative Navigation Team
- OHRA – Opportunities for Housing, Resources & Assistance
- OnTrack Rogue Valley
- Rogue Retreat
- Salvation Army
- Unite Community Action Network (UCAN)

Note: This list of assets was provided by assessment participants and community stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, while some resources are available in both Jackson and Josephine Counties, some are only available in one county or the other. Additionally, some are only available within select cities or geographical regions of Jackson County or Josephine County.

Access to Health Care Services

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Primary care resources include community clinics, pediatricians, family practice physicians, internists, nurse practitioners, pharmacists, telephone advice nurses, urgent care clinics, emergency departments, and other similar resources. Primary care services are typically the first point of contact when an individual seeks non-emergency health care. These services are the front line in the prevention and treatment of common diseases and injury in a community.

Specialty care refers to health services that focus on a specific area of medicine or a group of patients who share the same symptoms or conditions. Specialty care resources include physicians, advanced practice providers and other specialists such as nurses and physical therapists. In most cases, patients are referred to specialty care only after being first evaluated by a primary care provider or through another point of entry, such as the emergency room or another specialty care provider.

"One of the reasons the complexity of patients is so high for primary care is sometimes they don't have anywhere they can send them…. I know that we've tried to find places for patients that need neurology and it's like, 'Sorry,' and they end up back with primary care. Then primary care is maybe managing something that they're not entirely comfortable with."—Key Informant

Discussions of access to health care extend beyond the simple consideration of primary and specialty care to factors regarding insurance and insurability; care, coverage and medication restrictions; affordability of insurance, copays, deductibles and prescriptions; wait times—both to establish care and while in the waiting room for scheduled or emergent care; availability, capacity, quality and cultural competence, among others.

KEY FINDINGS

Qualitative Data

Key informants and community members shared accessing primary and specialty care in Jackson and Josephine Counties is difficult with long wait times, particularly for specialty appointments. Key informants shared there is a need for more care navigation, particularly after a hospital discharge. Barriers that contribute to access to care related needs include challenges with recruitment and retention of health care workforce, a lack of culturally responsive and linguistically appropriate care, a need for more representation in health care leadership to ensure more inclusive spaces, a lack of transportation options, fear and distrust of health care and days and hours of service that don't meet the needs of community members. People with disabilities experience barriers related to a lack of transitional care and accessing Durable Medical Equipment (DME) and specialists, particularly pediatric specialists. Migrant and seasonal workers, older adults, people experiencing homelessness, and Trans+ youth may experience additional barriers to care.

Survey Data

Community Health Survey respondents expressed significant concern over access to care when answering open-ended questions. Availability of primary care providers and specialists, extensive wait times, limited days and hours of service, insurance restrictions, authorization and referral issues, clinic closures, provider departures and quality of care were all cited as barriers to receiving appropriate, timely health care. Issues around accessing mental health care were prominent across the range of respondents in both counties.

"Medical access is an issue. My primary care provider left the practice. My 'new patient appointment' is one year away. Company provided health insurance SAYS they cover needed vaccines like shingles, pneumonia etc.

BUT THEY DO NOT. "

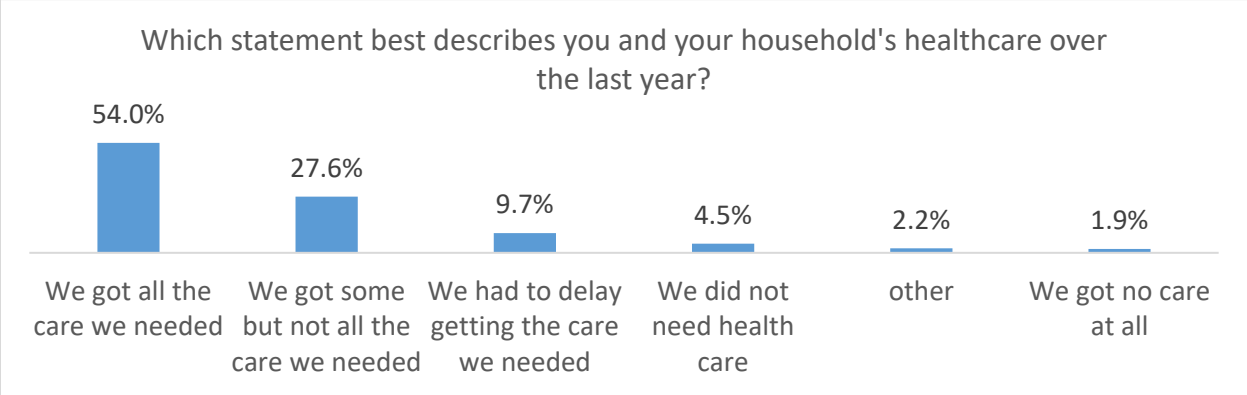
- Community Member

Respondents also repeatedly mentioned difficulties with accessing dental and vision care. There is a need for qualified Spanish-speaking medical personnel with appropriate medical training to support Spanish-speaking community members in their health care journeys. There is also a need for non-discriminatory, inclusive care for people with disabilities, those experiencing mental health and/or substance use disorders and LGBTQIA+ community members. Respondents note discrimination related to race, culture and socioeconomic class.

Community members expressed concern over having to travel for care, both within our region, and to more distant locations for higher levels of care. Those in more remote areas expressed a need for clinics and hospitals closer to home, referencing time and travel costs, inconvenience and decreased safety for elders and other vulnerable populations who live in more remote areas or lack transportation to access care. Respondents cited concern for establishing care, noting difficulties with insurance and care navigation, provider turn-over and lack of choice. The cost of care was referenced, with some respondents stating that the cost of care is so prohibitive they do not seek care when needed. Respondents noted the lack of affordable dental and vision care, costs of assistive devices necessary for daily living and the cost of prescription medications as areas of concern for our community.

Over half of the survey respondents got all the health care they needed in the past year (54%). Nearly 28% reported not getting all the care they needed, and 10% had to delay getting care. Approximately 4.5% reported health care was not needed during the last year.

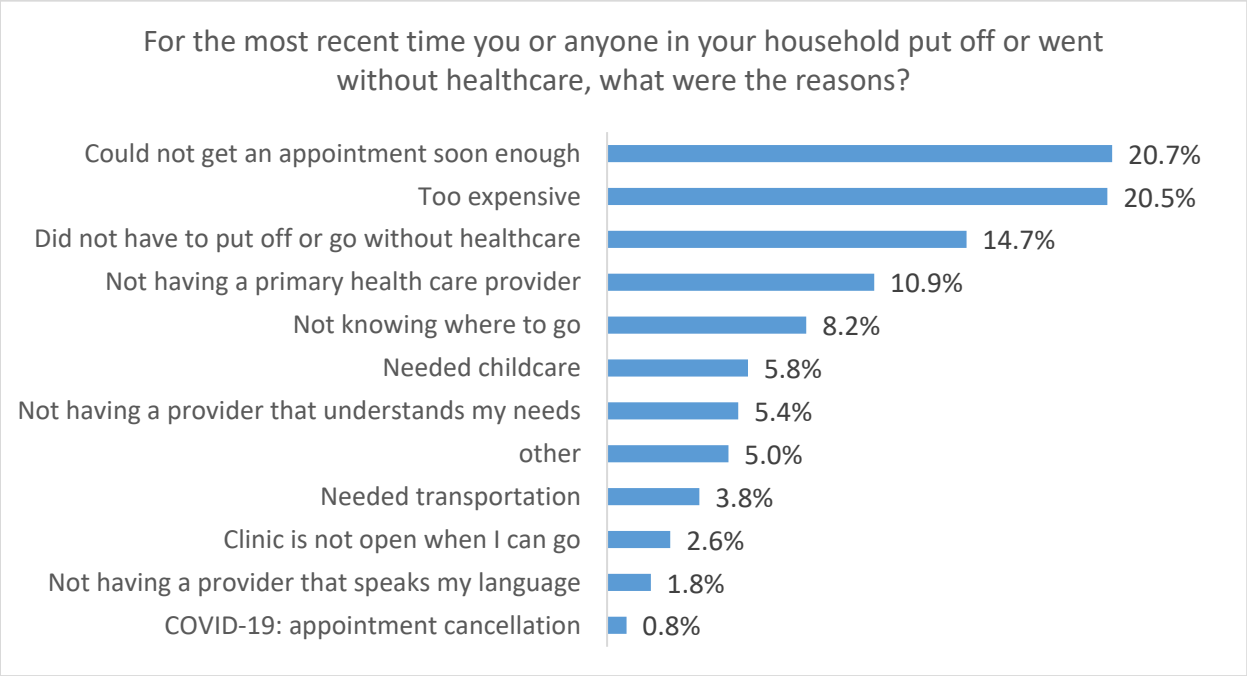
Figure 13. Percent of Survey Respondents Needing Healthcare in the Last Year, 2025



DATA SOURCE: Community Health Needs Assessment Survey, 2025

The main reasons for delaying care or going without care was associated with the inability to get an appointment (20.7%) and cost (20.5%). Nearly 11% reported the reason as not having a primary healthcare provider.

Figure 14. Reasons Survey Respondents Put Off or Went Without Healthcare, 2025

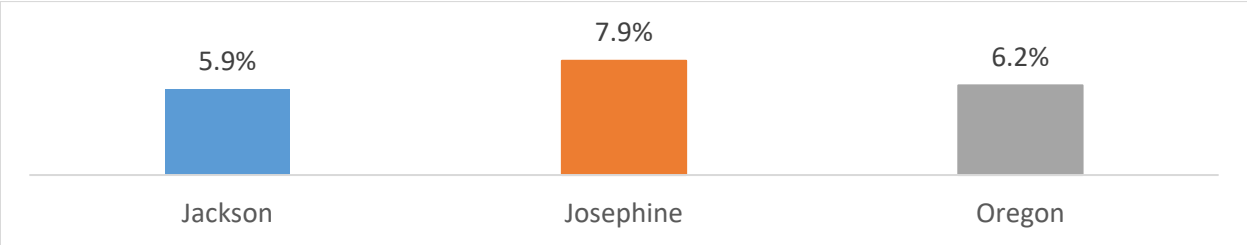


DATA SOURCE: Community Health Needs Assessment Survey, 2025

Secondary Data

In Jackson County 13,131 persons are reported to be uninsured while 6,878 are uninsured in Josephine County. Across the state a total of 261,323 Oregonians are reported to be uninsured. Uninsured adults are less likely to receive preventive services for chronic conditions such as diabetes, cancer, and cardiovascular disease. Similarly, children without health insurance coverage are less likely to receive appropriate treatment for conditions like asthma or critical preventive services such as dental care, immunizations, and well-child visits that track developmental milestones.

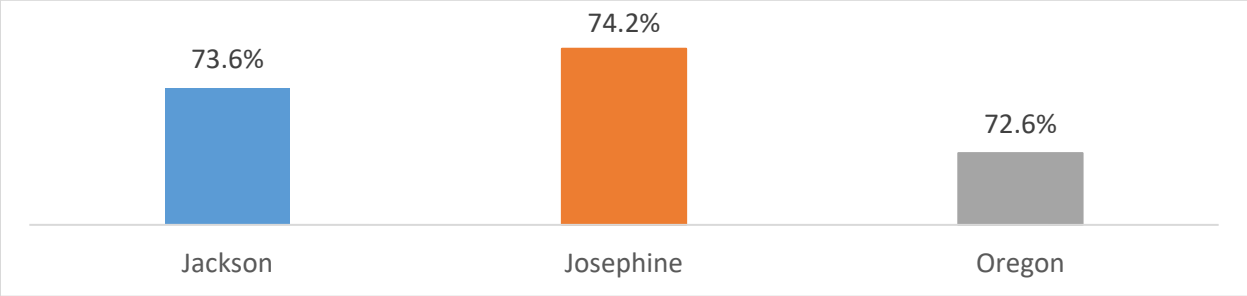
Figure 15. Percent of Population Uninsured, by County and State, 2023



DATA SOURCE: Providence Data Hub, 2023 American Community Survey, 5-Year Estimate

In 2022, 73.6% and 74.2% of adults over the age of 18 reported having been to a doctor for a routine checkup in Jackson and Josephine Counties, respectively. Both percentages are higher than Oregon as a whole.

Figure 16. Percentage of Adults who have had a Routine Checkup, by County and State, 2022



DATA SOURCE: PLACES. Center for Disease Control and Prevention Indicator uses crude prevalence for year 2022 estimates.

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing access to care through the provision of health care services in Jackson and Josephine Counties:

- AllCare Health (CCO)
- CareOregon
- Community Volunteer Network
- Jackson Care Connect (CCO)
- Jackson County Health & Human Services
- Josephine County Health & Human Services
- La Clinica
- Rogue Community Health
- Siskiyou Community Health Center

Below is a list of community resources addressing access to care through the provision of transportation in Jackson and Josephine counties:

- Rogue Valley Medical Transport
- Valley Lift (Rogue Valley Transportation District)

Note: This list of assets was provided by assessment participants and community stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, while some resources are available in both Jackson and Josephine Counties, some are only available in one county or the other. Additionally, some are only available within select cities or geographical regions of Jackson County or Josephine County.

Behavioral Health Challenges and Access

Mental Health and Substance Use/Misuse

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Mental disorders, especially depressive disorders, are strongly correlated to the occurrence of many chronic diseases, including diabetes, cancer, cardiovascular disease, asthma, and obesity. Mental health conditions affect the body's response to stress, influence lifestyle choices and ultimately impact the likelihood of successful treatment as well as the ultimate course of disease.

There's high comorbidity of mental health conditions and substance use or misuse. Many adults and youth who develop substance use disorders also receive diagnoses of mental health disorders such as generalized anxiety disorder post-traumatic stress disorder, depression, and bipolar disorder. Research shows 25% of people with serious mental illness also have a co-occurring substance use disorder.[9] In addition to co-occurring mental health, chronic health conditions often co-occur with substance use disorder including chronic pain, cancer, and heart disease, the latter which is independently associated with increased risk from substance use[10].

KEY FINDINGS

Qualitative Data

Key informants and community members identified behavioral health as a challenge in the community, including mental health and substance use/misuse, along with barriers to accessing treatment. Key informants shared that childhood trauma and Adverse Childhood Experiences (ACEs), stress related to not being able to meet basic needs, and social isolation can be contributing factors to behavioral health needs. There is a need for more substance use disorder (SUD) treatment and recovery

> *"The evolution of services to people with substance use disorders and services to folks with mental health disorders has been bifurcated for so long. The system response is not yet together, yet the human beings needing our care are experiencing those conditions together, and our service offerings are still not meeting their needs. There isn't really a lot of good options for somebody who needs a residential level of care who has high, high needs in both of those spaces, let alone outpatient care."*
>
> *—Key Informant*

[9] Common Comorbidities with Substance Use Disorders Research Report. Part 1: The Connection Between Substance Use Disorders and Mental Illness.

[10] Common Comorbidities with Substance Use Disorders Research Report. Part 2: Co-occurring Substance Use Disorder and Physical Comorbidities.

programs, as well as residential treatment centers for behavioral health needs. Community members spoke to needing more detox centers and treatment for people with co-occurring behavioral health needs.

There is a lack of culturally responsive and culturally matched behavioral health services, a shortage of behavioral health providers, and administrative burden that is prohibitive to providing quality care and retaining workforce. People with low incomes and those with a lack of social or community safety nets may have increased behavioral health needs and barriers to accessing services. Certain populations may experience more barriers to meeting their behavioral health needs, including older adults, young people, Native American peoples, Spanish-speaking individuals, and people experiencing homelessness. Community members were particularly concerned about ensuring access to care for young people and people experiencing homelessness.

Survey Data

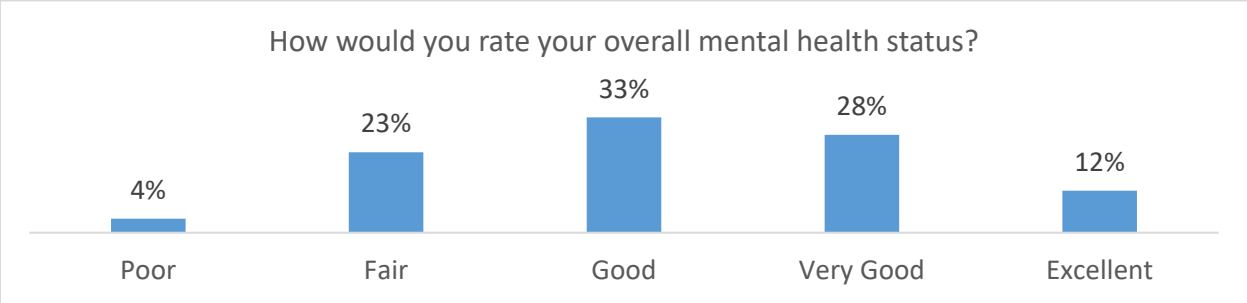
> *"Mental health resources for children are severely lacking. My child was on waitlists for about four years before getting a diagnosis and services."*
>
> *—Community Member*

Survey respondents echoed stakeholder concerns noting the importance of having accessible, affordable and timely mental health care and substance use treatment available for all members of the community. Overall, community survey responses were more directed to mental health (38) than substance use treatment or intervention (6). Respondents identified a clear need for mental health care for children and teens, including in-person opportunities, as well as a need for culturally competent care for the Latino/a/x and Native American communities.

Respondents expressed dismay with telehealth solutions and lack of in-person opportunities, stating many telehealth providers are from out of the area and don't understand local culture and that children and teens need in-person therapy. Community members identified a lack of mental health services available for individuals experiencing intellectual or development disabilities, Autism and ADHD. Both private insurance and OHP were mentioned as limiting access to effective mental health care. Wait times, insurance coverage, number of providers, provider qualifications, quality and availability were all cited as barriers to receiving prompt, effective and appropriate mental health care. Community members also referenced barriers to care such as insurance restrictions, limited provider choice, unrealistic registration or participation expectations, and challenges with obtaining essential mental health prescriptions. While community members were able to speak of mental health needs for themselves or a family member; when referencing substance use and the need for treatment, resources or intervention, most comments focused on 'others.' Beyond access to care for mental health and substance use issues, survey respondents acknowledged the need for better training for law enforcement and health professionals in mental health, disabilities and de-escalation.

When asked about personal overall mental health, the highest number of survey respondents self-reported their mental health as "good" followed by "very good". The next highest status was reported as "fair" followed by "excellent." Only 4% of respondents to this question self-reported as having poor mental health overall.

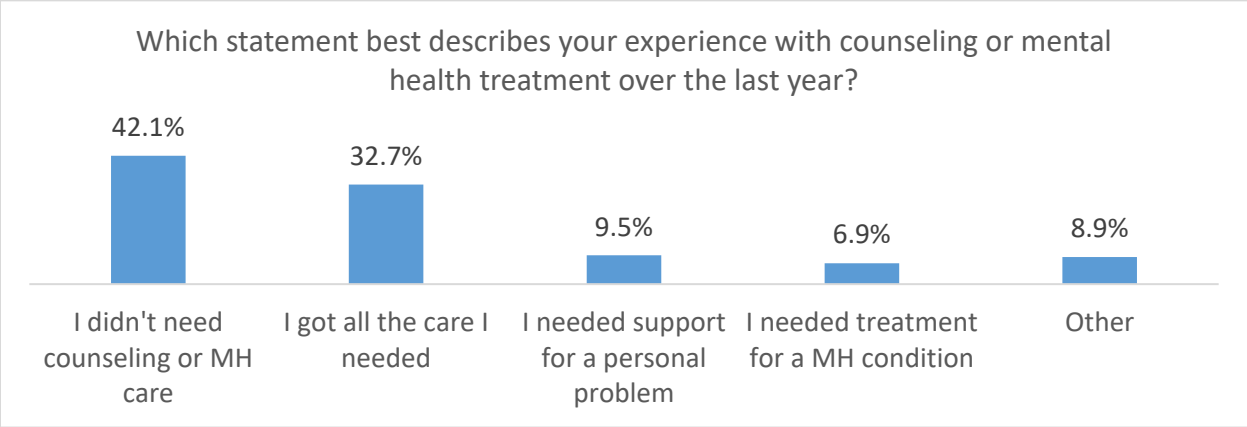
Figure 17. Percent of Survey Respondents Reporting Overall Mental Health Status, 2025



DATA SOURCE: Community Health Needs Assessment Survey, 2025

Just over 42% of survey respondents reported not needing counseling or mental health care while nearly 33% reported getting all the care they needed.

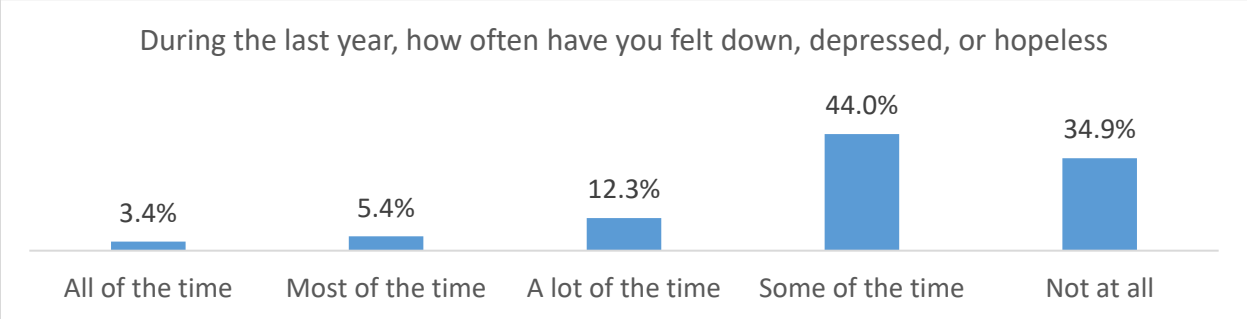
Figure 18. Percentage of Survey Respondents Reporting Needing Counseling or Mental Health Services in the Last Year, 2025



DATA SOURCE: Community Health Needs Assessment Survey, 2025

For respondents who reported not receiving counseling or mental health care, just over 47% and almost 39% did not receive treatment for a mental health condition or support for a personal problem, respectively.

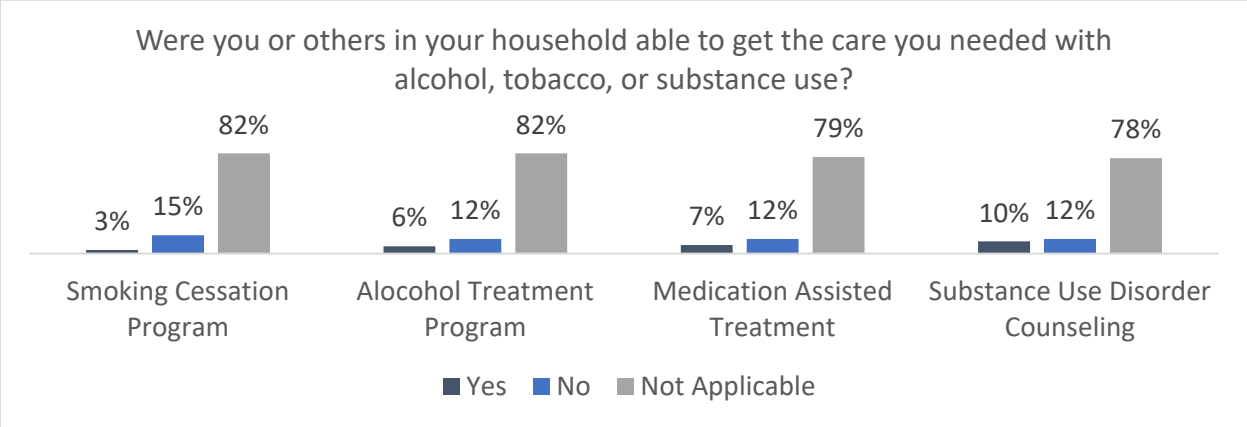
Figure 19. Percentage of Survey Respondents Reporting Feeling Down, Depressed, or Hopeless, 2025



DATA SOURCE: Community Health Needs Assessment Survey, 2025

The distribution of individuals or household members reporting their ability to get care for alcohol, tobacco, or substance in the last year were similar between treatment programs.

Figure 20. Percent of Survey Respondents Reporting Ability to Get Care for Alcohol, Tobacco, or Substance Use in the Last Year, 2025

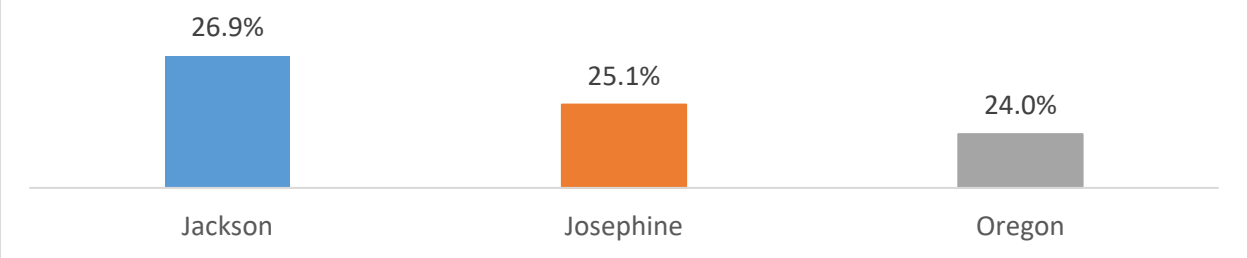


DATA SOURCE: Community Health Needs Assessment Survey, 2025

Secondary Data – Mental Health

Depression, and more broadly mental health concerns, were frequently mentioned in stakeholder interviews and listening sessions with community members. As shown in Figure 21, Jackson and Josephine Counties had a higher prevalence of depression, 26.9% and 25.1% respectively, when compared to Oregon State (24.0%). This measure is defined by the number of respondents aged 18 years and older who reported having been told by a doctor, nurse, or other health professional that they had a depressive disorder.

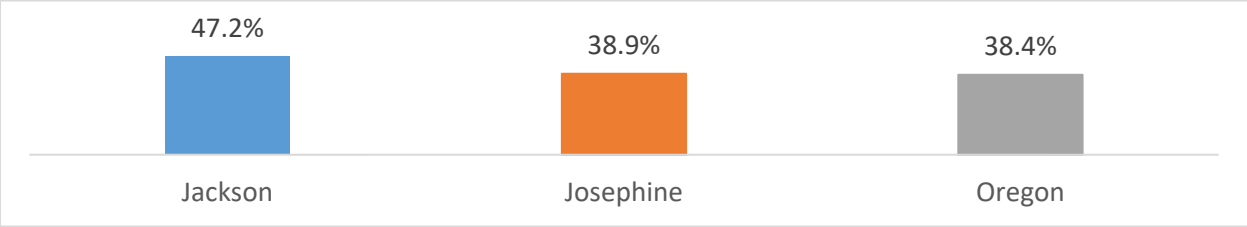
Figure 21. Depression Crude Prevalence (%) Among Adults Aged 18 Years and Older, 2022



DATA SOURCE: PLACES. Center for Disease Control and Prevention Indicator Uses Crude Prevalence for Year 2022.

Mental health was a significant health concern among youth as reported in the 2022 Student Wellness Survey among 11th grade students in Oregon. Jackson and Josephine counties had higher rates of students reporting signs of depression, 47.2% and 38.9% respectively, than Oregon state (38.4%).

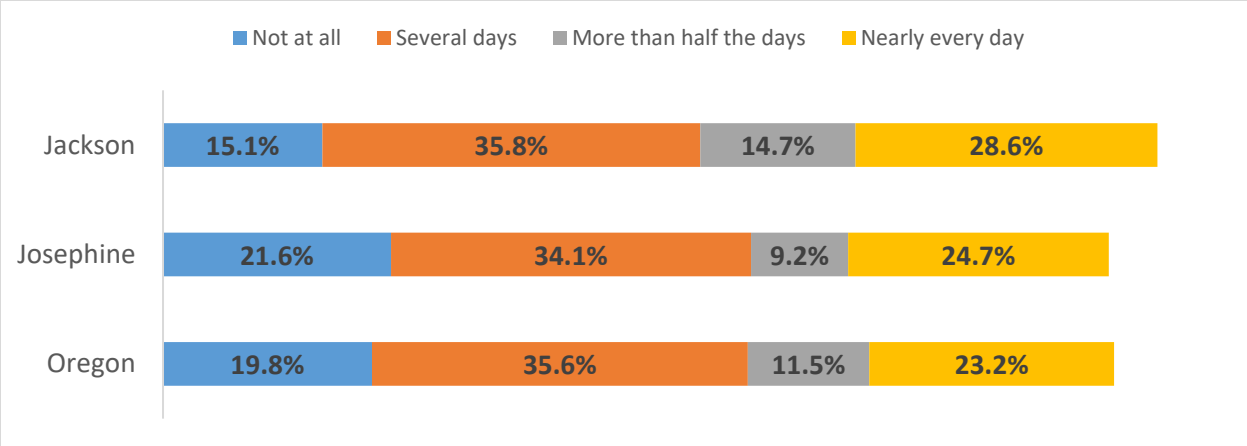
Figure 22. Percent 11th Grade Students Reported Signs of Depression, by County and State, 2022



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2022

In 2022, 11th grade students reported varying levels of feeling nervous, anxious, or on edge within the previous 30 days from when the Student Wellness Survey was conducted. Most 11th grade students in Jackson and Josephine Counties reported feeling anxious during this 30-day period.

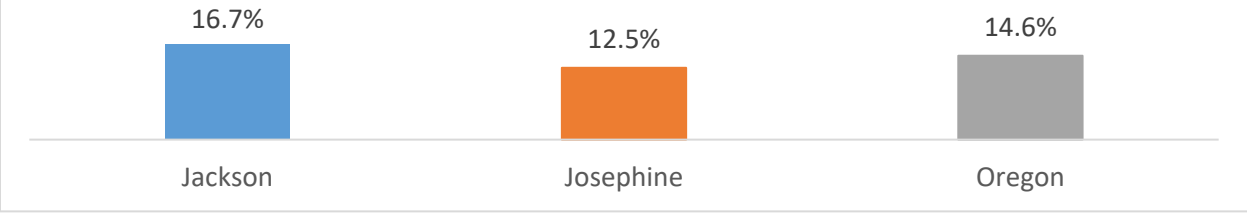
Figure 23. Percent 11th Grade Students Reported Signs of Anxiety, by County and State, 2022



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2022

In 2022, 11th grade students in Jackson County were more likely to report seriously considering attempting suicide (16.7%), compared to 12.5% in Josephine County and 14.6% in Oregon (Figure 24).

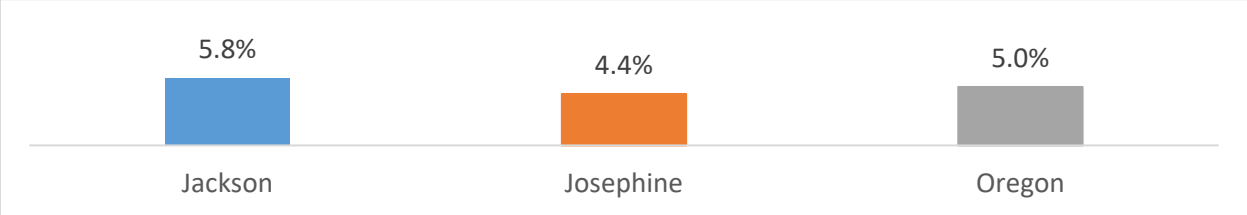
Figure 24. Percent 11th Grade Students Reported Seriously Considering Attempting Suicide, by County and State, 2022



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2022

In 2022, 11th grade students in Jackson County (5.8%) reported to have attempted suicide, which was more than 11th grade students in Josephine County (4.4%) and Oregon (5.0%).

Figure 25. Percent 11th Grade Students Actually Attempting Suicide, by County and State, 2022

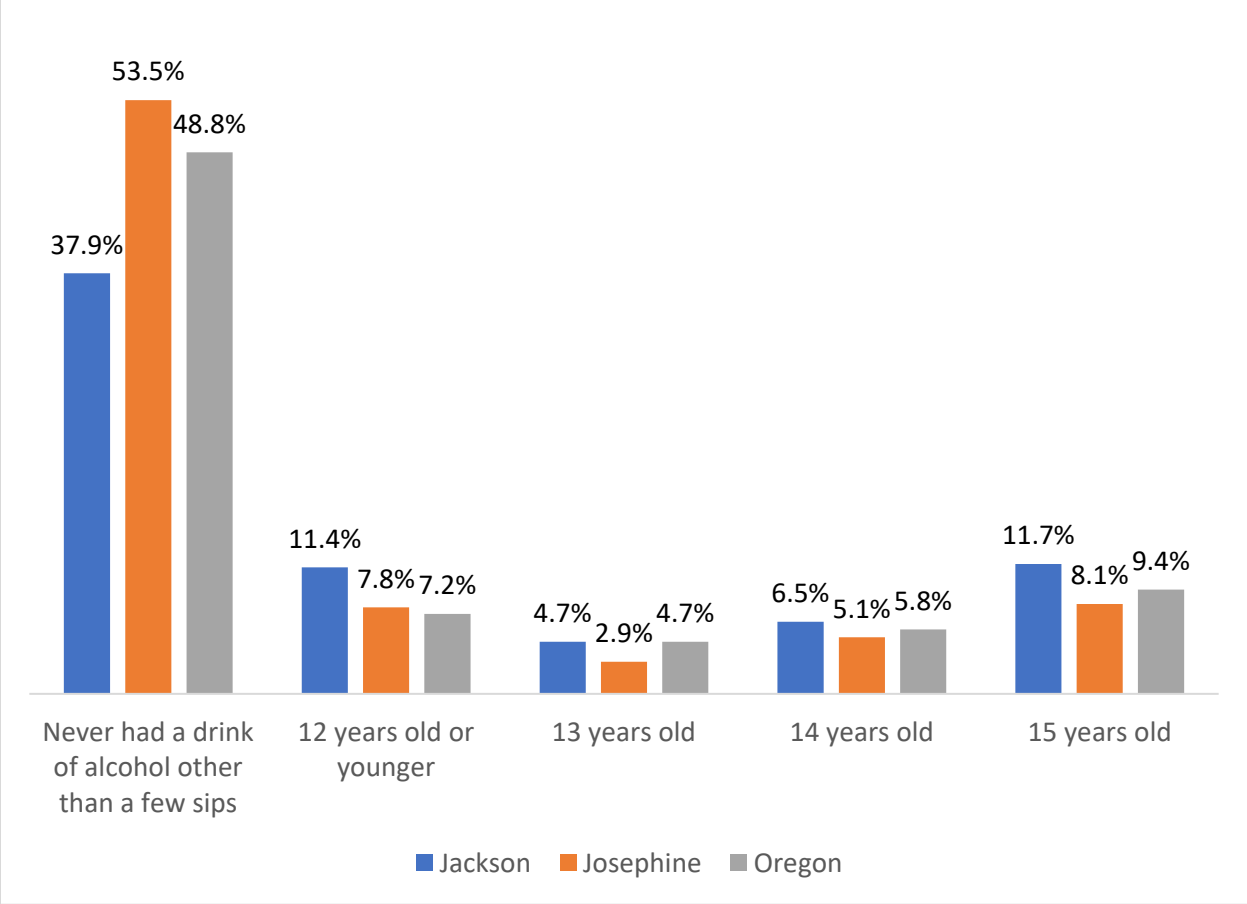


DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2022

Secondary Data – Substance Use

A greater percentage of 11th graders in Jackson (11.4%) and Josephine (7.8%) Counties first drank alcohol at 12 years old or younger compared to Oregon state (7.2%).

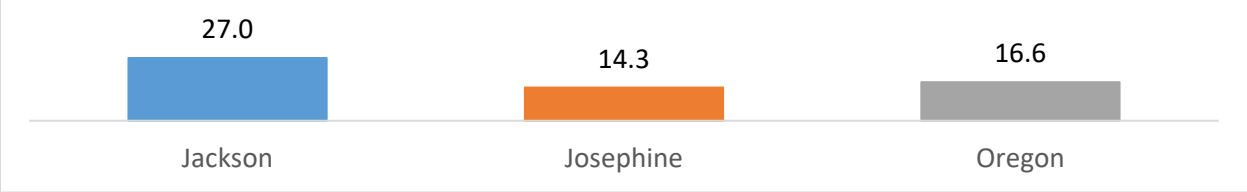
Figure 26. Percent 11th Graders Reported Age When First Consuming Alcohol, by County and State, 2022



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2022

In addition to the age when alcohol was first consumed, 11th graders in Jackson County (27.0 days) reported a greater number of days having at least one drink of alcohol in the last 30 days compared to Oregon (16.6 days).

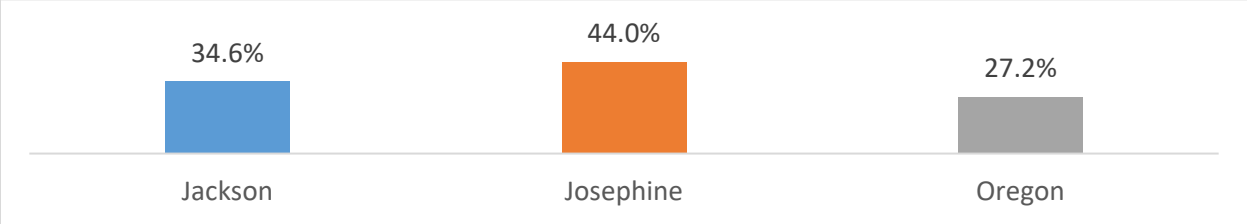
Figure 27. Number of Days 11th Graders Reported Having At Least One Drink of Alcohol in the Last 30 Days, by County and State, 2022



DATA SOURCE: Oregon Health Authority, Student Wellness Survey, 2022

The most recent county and state-level data reveals motor vehicle crash deaths with alcohol involvement exceed state percentages (27.2%) in Jackson County (34.6%) and Josephine County (44%).

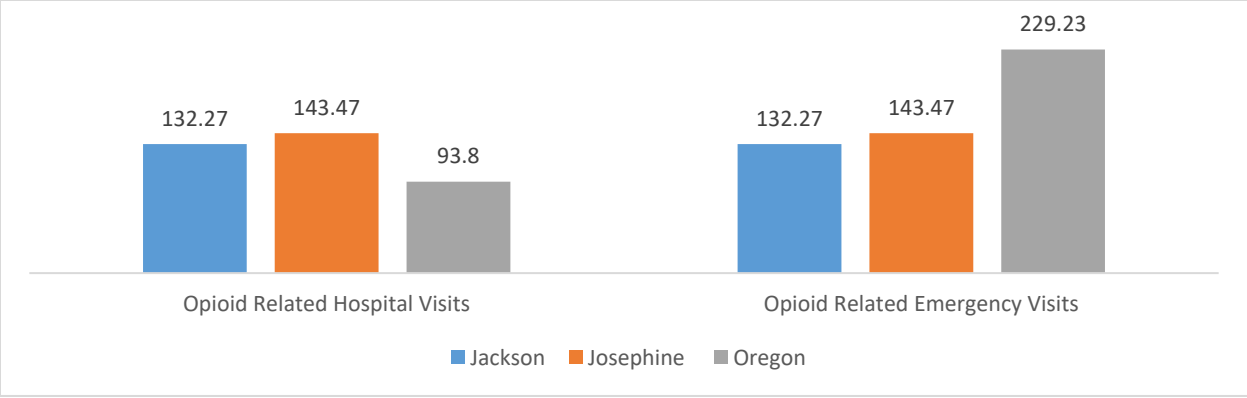
Figure 28. Percentage of Motor Vehicle Crash Deaths with Alcohol Involvement, by County and State, 2018-2022



DATA SOURCE: Fatality Analysis Reporting System, County Health Rankings, 2018-2022

The state-wide rate of opioid related emergency visits (229.23) is more than double the rate of opioid related hospital visits (93.8). These measures are equal at the county level: Jackson (132.27) and Josephine (143.47).

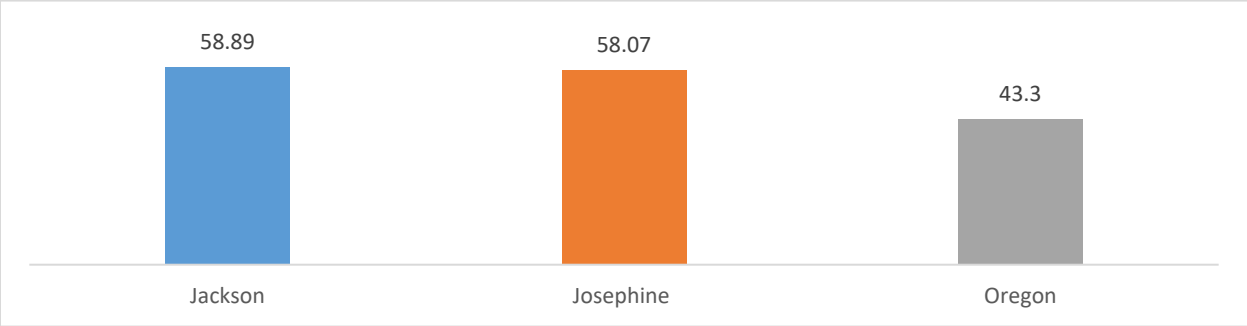
Figure 29. Rate of Opioid Related Hospital and Emergency Visit per 100,000 by County and State, 2024



DATA SOURCE: Oregon Health Authority, Oregon Overdose Data Dashboard, 2024

Jackson and Josephine County trend higher than Oregon in both opioid related hospital visits and fatal overdose.

Figure 30. Rate of Fatal Overdose per 100,000 by County and State, 2023



DATA SOURCE: Oregon Health Authority, Oregon Overdose Data Dashboard, 2023

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing Behavioral Health in Jackson and Josephine counties:

- Adapt
- Addictions Recovery Center
- Columbia Care Services
- Compass House
- Crisis Resolution Center
- Family Nurturing Center
- Family Solutions
- Hope Village
- Integrative Health Center at Rogue Community Health
- Jackson County Health & Human Services Crisis Hotline
- Jackson County Mental Health
- Kairos
- La Clinica
- Mercy Flights
- Oasis Center of the Rogue Valley
- OnTrack
- Options for Southern Oregon
- Rogue Community Health
- Rogue Retreat
- Southern Oregon Veterans Rehabilitation Center & Clinics

Note: This list of assets was provided by assessment participants and community stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, while some resources are available in both Jackson and Josephine Counties, some are only available in one county or the other. Additionally, while many offer support for both facets of Behavioral Health, some focus primarily on Mental Health and others primarily on Substance Use.

Disability Inclusion and Support for People w/ Disabilities

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Disability inclusion and support are critical in addressing various health issues impacting individual and public health outcomes. Inclusive healthcare ensures equitable access to medical services, preventing unmet health needs and worsening conditions. It promotes preventive care and tailored health education, preventing complications and improving quality of life. Addressing mental health is vital, as individuals with disabilities often face stress and anxiety due to societal barriers. Disability inclusion also affects social determinants of health, enhancing independence and social participation for better well-being. It aims to reduce health disparities by advocating for policies that ensure equitable treatment and access. Many disabilities are linked to chronic conditions, requiring effective management, which inclusive support systems facilitate. It is important to note that disabilities are not restricted to those present at birth, nor to a single category. People living with disabilities may be experiencing physical disabilities, sensory disabilities, cognitive disabilities, behavioral disabilities, or any combination of conditions from those four overarching categories. Disability can impact community members at any age, regardless of previous health history. Disability also often extends from the individual to their family and close community, with new incidence of disability or increasing challenges resulting in the need for lifestyle changes and accommodations to preserve the person and the family's health, dignity and quality of life. Moreover, inclusion in public health ensures emergency preparedness accommodates those with disabilities, protecting health during crises. Overall, disability inclusion fosters a more equitable health system, improving outcomes and reducing disparities in communities.

KEY FINDINGS

Qualitative Data

> *"For any recreation or getting out in the community, there's just not accessible transportation options." –Community Stakeholder*

Key informants discussed the resources that are needed in the community to increase disability inclusion and meet the health care, housing, transportation, and other needs of people with disabilities. To improve access to care, more specialists (particularly neurologists and pediatric specialists) and therapists (speech, physical, and occupational) are needed locally. There is also a need for more education of providers related to disabilities, transitional support and education after leaving inpatient rehab, easier access to durable medical equipment (DME) and other accessibility items, in-home caregivers, support for costly travel for specialists, and accessible medical scales. There is a need for more community spaces that are inclusive of disabled people and non-disabled peers, along with more support for parents with children with disabilities. People with disabilities and their families may experience increased barriers to economic security due to costs not covered by insurance, Medicaid income requirements, and caregiving responsibilities. There are limited accessible transportation options outside of the public bus operating hours. There is a need for more accessible housing for disabled people. The stress and challenges of navigating these systems that are not accessible can affect mental health. Older adults with disabilities may experience additional barriers, like technology.

Survey Data

> *"My daughter experiences intellectual and developmental disabilities. Mental Health care is one of her greatest challenges. It doesn't appear to be an area of focus for MH providers."*
> *–Community Member*

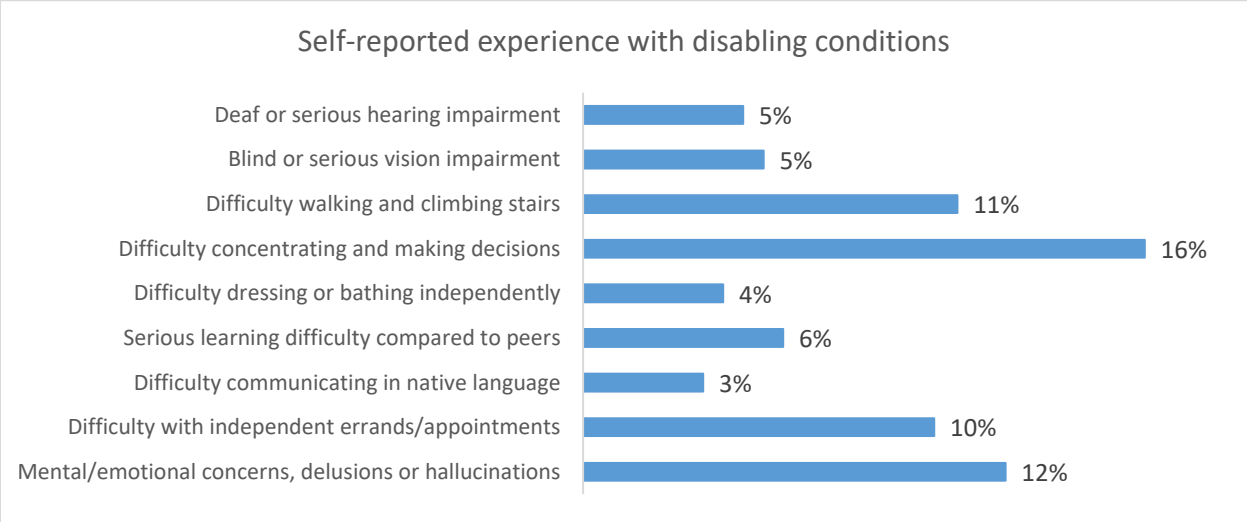
Survey respondents voiced concerns about access to care for individuals living with disabilities, particularly with regard to mental health and specialty care. They noted a lack of mental health services for Autistic and ADHD individuals, with both Medicaid and commercially insured community members having inadequate access to care and service. Within the community, there is not enough allotted parking for those with mobility issues and not enough electric shopping carts for those who don't already have their own to navigate our area's large grocery stores. Respondents acknowledged the need for support for unhoused individuals who are also navigating intellectual, developmental and physical disabilities.

On the community health survey, respondents were asked about their personal experiences with developmental and physical disabilities, including hearing and vision impairment, difficulty walking or navigating stairs, difficulty concentrating, and more. Many indicated they had been navigating issues since childhood, with others having faced disabling events later in life that compromised their hearing, vision, mobility or cognitive functioning. Respondents with children under 18 years of age were asked what types of health diagnoses their children had received from a health care professional. Hearing, vision, speech impairment and physical disability were not formally included in the multiple-choice responses regarding children's health conditions and therefore may not have been disclosed accurately. While just over 10% of respondents indicated developmental delay or learning disability for their child under 18 at this time, it's important to note that mental health diagnoses, physical disabilities or limitations and chronic illness do impact overall health and development and can have lasting impacts resulting in temporary or permanent disability in later life.

Of all responses received regarding functional difficulties, 250 indicated some level of limitation that impacted daily life, with some individuals indicating multiple limiting conditions and others reported isolated concerns. Of the approximately 350 people who completed this section of the survey, 15.9% reported serious personal difficulty concentrating, remembering or making decisions because of a physical, mental or emotional condition. 11% indicated difficulty walking or climbing stairs, 10% reported difficulty performing errands or seeking services independently because of a disabling condition. 5% indicated hearing problems and another 5% indicated vision impairment. 4% indicated difficulties with dressing or bathing themselves. Behavioral health concerns significantly impacted 12% and cognitive functioning limitations impacted 9% of respondents.

Respondents who had identified that they had children in the home under 18 years of age were asked whether they have been told by a health care professional if any of their children have any of the following: asthma, behavioral or mental health diagnosis, developmental delay or a learning disability, diabetes or high blood sugar, or post-traumatic stress disorder. Of 196 responses received, 20 reported their child had been diagnosed with a developmental delay or a learning disability; 51 reported a mental health diagnosis (depression, anxiety, ADHD, post-traumatic stress disorder, Autism, Schizoaffective Disorder); and 3 reported chronic illness or physical conditions that are often associated with disability in adulthood.

Figure 31. Percentage of Individuals Reporting Functional Difficulty, Impairment or Disability, 2025

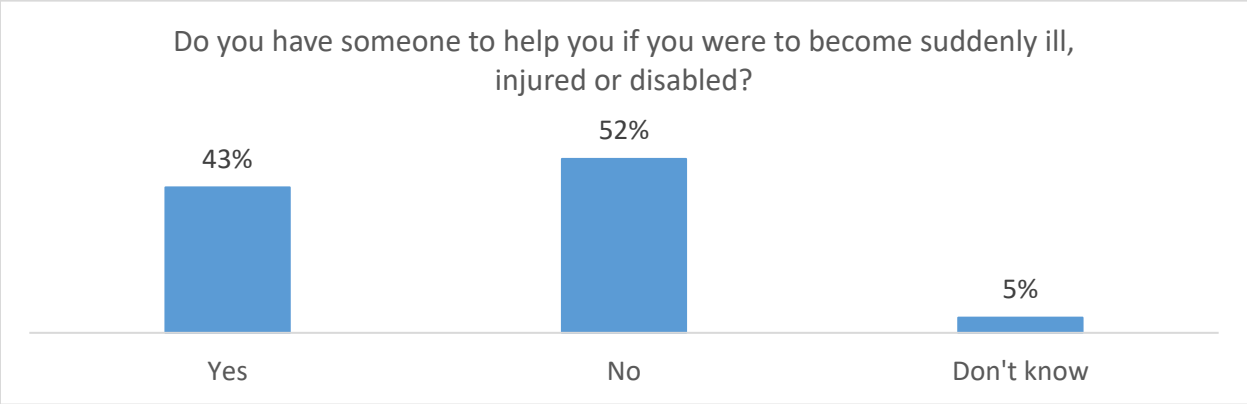


DATA SOURCE: Community Health Needs Assessment Survey, 2025

Figure 31 reflects percentage of "yes" responses to the following 9 questions:

1. Are you deaf or do you have serious difficulty hearing?
2. Are you blind or do you have serious difficulty seeing, even when wearing glasses?
3. Do you have serious difficulty walking or climbing stairs?
4. Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?
5. Do you have difficulty dressing or bathing?
6. Do you have serious difficulty learning how to do things most people your age can learn?
7. Using your usual (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?
8. Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?
9. Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?

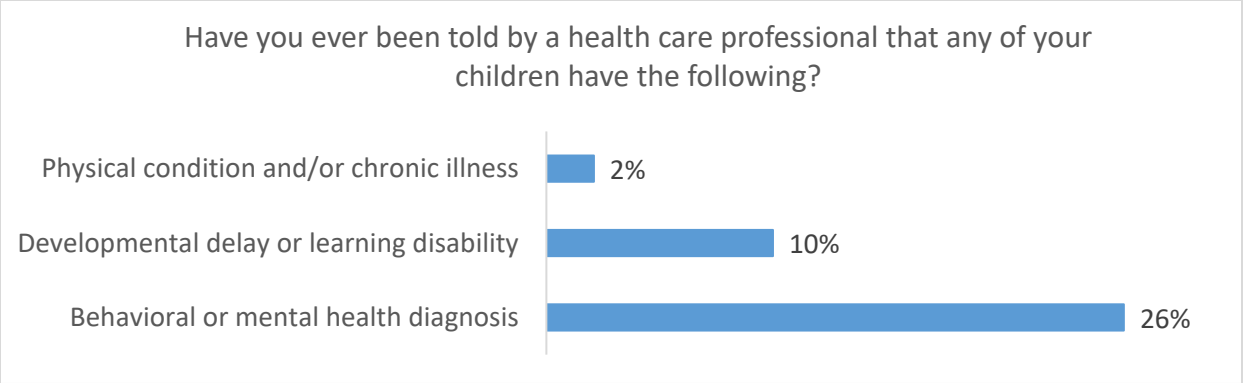
Figure 32. Personal Expectation of Support System in the Event of Disabling Illness or Injury, 2025



DATA SOURCE: Community Health Needs Assessment Survey, 2025

Of 196 parental responses received, only 85 indicated their children under 18 years of age had never been diagnosed with any health condition. Approximately 10% of respondents indicated developmental delay or learning disability. Just over 26% disclosed diagnosis with a mental health condition such as depression, anxiety, ADHD or PTSD; additional write-in responses included Autism and Schizoaffective Disorder. Potentially disabling physical conditions or chronic illness were indicated for 2% of respondents' children. Cited conditions included lupus, kidney disease, scoliosis and diabetes. The survey did not capture this information for parents whose children had already reached 18 years of age.

Figure 33. Parental disclosure of health conditions and/or learning or developmental disabilities, 2025

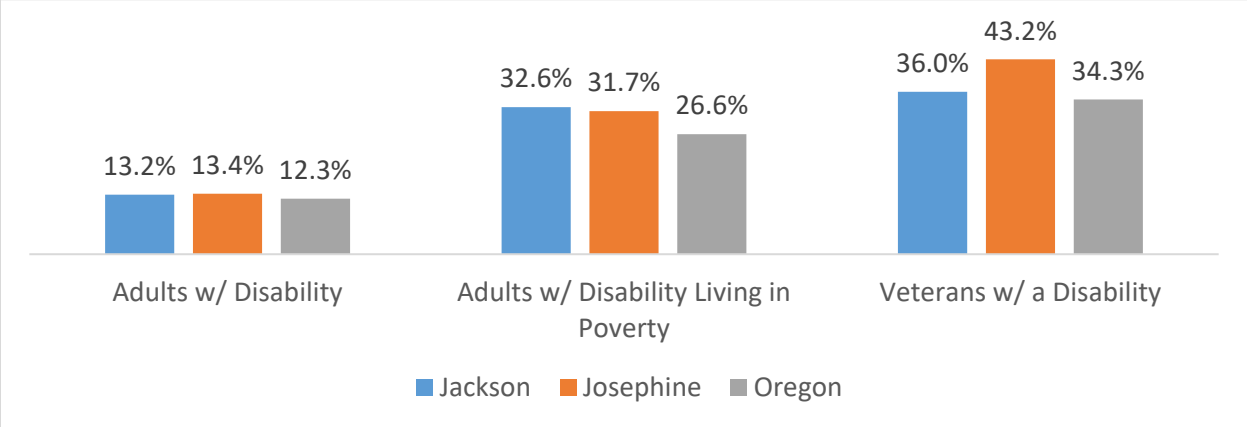


DATA SOURCE: Community Health Needs Assessment Survey, 2025

Secondary Data

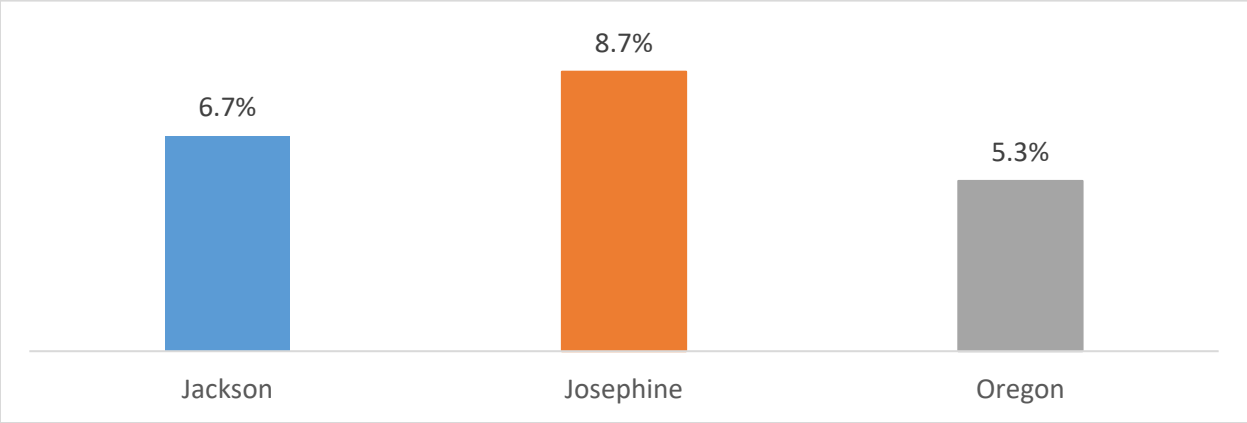
In Jackson and Josephine counties, there is a higher percentage of adults with disabilities, adults with disabilities living in poverty and veterans with a disability, compared to Oregon. Disabilities among children under 18 are also higher than the rest of the state. Statistics do not indicate the full scope of the disabilities included in the metric.

Figure 34. Adults and Veterans with Disabilities and Adults with Disabilities Living in Poverty, 2023



DATA SOURCE: American Community Survey 5-Year, 2019-2023

Figure 35. Prevalence of Disability in Children Under 18, by County and State, 2023



DATA SOURCE: American Community Survey 5-Year, 2019-2023

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing disability inclusion and support for people with disabilities in Jackson and Josephine counties:

- ACCESS
- Connections NW
- Community Life LLC
- Community Living Case Management
- Creative Supports
- Encompass Person Centered
- Jackson County Development Disability Services
- HASL Center for Independent Living
- Impact of Oregon
- Living Opportunities
- OSCI (Oregon Spinal Cord Injury Connection)
- Premier Community Supports
- Rogue Valley Council of Governments Senior and Disability Services
- Sensory Space Grants Pass by MEC Disabilities
- Southern Oregon Aspire
- Special Olympics Oregon

Note: This list of assets was derived from research of existing resources in Jackson and Josephine Counties and is not an exhaustive list of all resources available. Some are only available to community members with formal disability diagnoses, others are only available to community members qualified for and receiving state or federal disability services. Finally, while some resources are available in both Jackson and Josephine Counties, some are only available in one county or the other. Still others may be available only within select cities or geographical regions of Jackson County or Josephine County.

Economic Security

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Access to affordable and clean housing, stable employment, quality education, and adequate food are vital for good health. Research shows that the social determinants of health — such as quality housing, adequate employment and income, food security, education, and social support systems — influence individual health as much as health behaviors and access to clinical care. Without access to meeting these basic needs, individuals cannot experience full and healthy lives.

KEY FINDINGS

Qualitative Data

> *"The income and assets restrictions that are in place for somebody to be on Medicaid with a disability that wants to work, that's capable of working, but you can't because then you lose your health insurance, which is super important…. You get stuck in this thing where you can't get a job and better yourself. You're stuck in poverty. That really affects mental health when people feel who've worked their whole life and want to work and then they feel a little useless. Even though they're not, but it's easy to feel that way."—Key Informant*

Key informants shared concerns about seeing economic insecurity grow as a result of increasing cost of food, gas, rent, and more. They described incomes as not keeping up with the increased cost of living. There is a need for living wage jobs to ensure families can meet their basic needs. They were particularly concerned about economic security for families with children under the age of five. Social service providers may be paid a wage low enough to qualify them for their own services. For families with a disabled child, often only one parent can work, putting strain on the family to afford all of the care and supplies needed. For adults with disabilities, they may need to keep their income below a threshold to qualify for Medicaid. Key informants are seeing more older adults unable to afford their cost of living.

Survey Data

Affordability was a key concern among survey respondents. There were mentions of the cost of health insurance, co-pays, deductibles, medications and related services. Costs related to dental work were highlighted in several comments with insufficient dental insurance coverage or care limitations prohibiting adequate access to preventive and corrective dental care. Vision care also raises cost concerns as not all interventions are covered by insurance. The costs of elder and childcare were of concern for working families. There is a need for low or no-cost services for vulnerable community members, people of color, children, families and elders. Respondents noted a lack of resources for those who work and earn too much to qualify for support but may not earn enough to live comfortably. When asked whether they had enough financial resources to meet basic needs, 27% of respondents

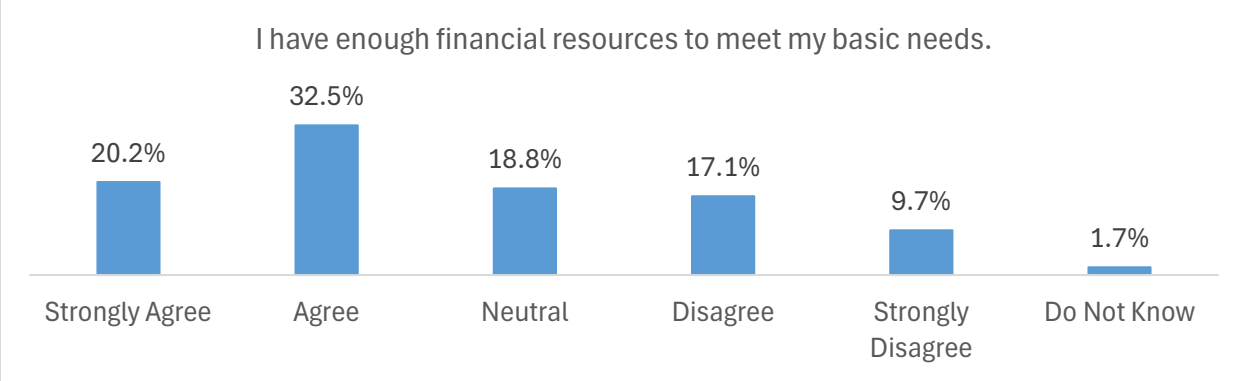
"Medical insurance is skyrocket high, food prices and rent are outrageous. We have to choose in between having healthcare, a home and food sometimes. It's hard with children."

– Community Member

disagreed, with 10% strongly disagreeing. Looking more deeply at the implications of this issue, the number one unmet need was dental care, followed by medical care and transportation, then food, then housing. Of those noting a need for childcare, 18% reported difficulty affording it over the previous year. Notably, many respondents to that portion of the survey reporting 'going without' in multiple categories over the course of the previous year. Survey comments reflected challenges with the cost of food, fuel, housing, and medical costs such as deductibles, copays and prescription costs, as well as wages, inflation and their concerns over their ability to sustainably provide for their families.

Over a quarter of respondents (26.8%) indicated they did not have enough financial resources to meet their basic needs; another 18.8% voiced a neutral opinion and 1.7% indicated they did not know. Just over half (52.7%) of respondents agreed or strongly agreed they had sufficient financial resources.

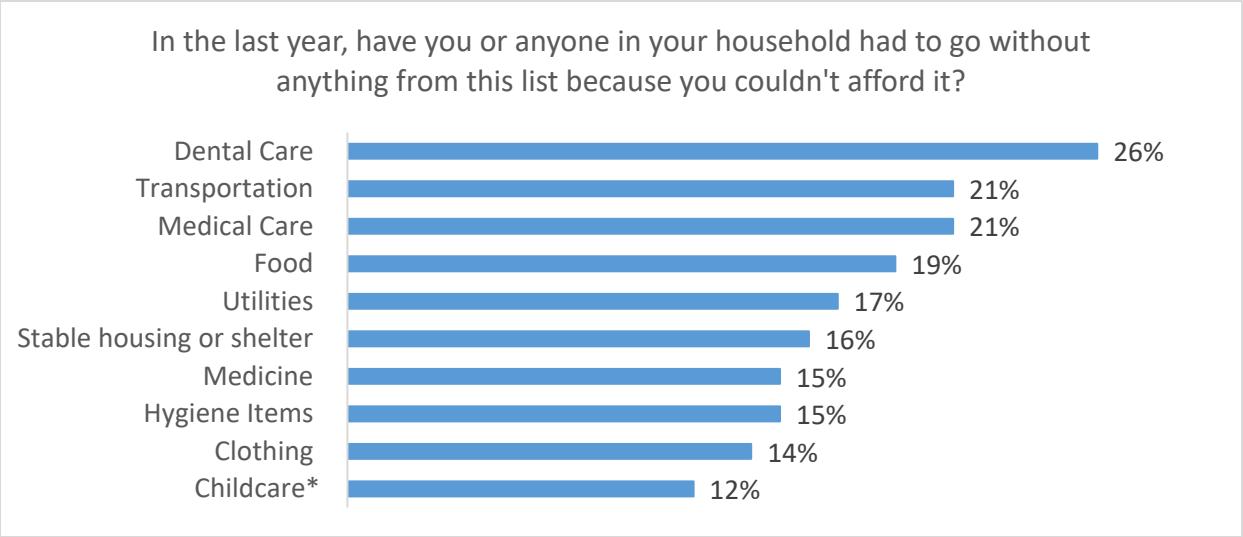
Figure 36. Number of Respondents Reporting Ability to Afford Basic Needs, 2025



DATA SOURCE: Community Health Needs Assessment Survey, 2025

Of those reporting forgoing basic needs due to financial concerns, 26% reported going without dental care. Transportation and medical care were the second highest categories reported with 21% of respondents forgoing these necessities. Respondents were encouraged to mark all categories that applied. Most respondents confirming the need to go without reported doing so in more than one category.

Figure 37. Prevalence of Forgoing Basic Necessities due to Financial Concerns Over Past Year, 2025



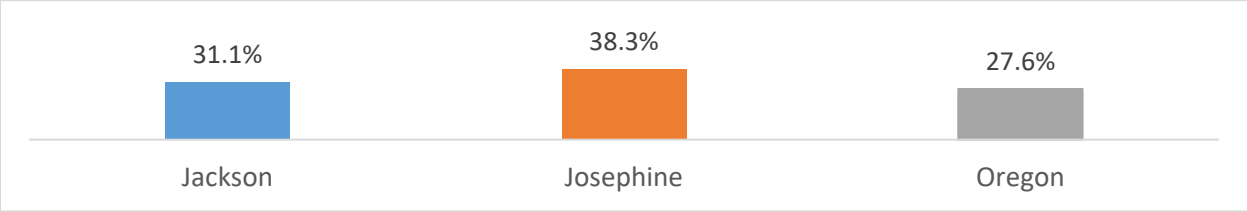
DATA SOURCE: Community Health Needs Assessment Survey, 2025

* If 'Not Applicable' responses are removed, prevalence of forgoing necessary childcare increases to 18%. In general, 'N/A' responses across all categories averaged 6%. For childcare, that percentage was 29%

Secondary Data

In Jackson County 68,202 people are reported to be living below 200% of the Federal Poverty Level while 33,279 are living below the poverty level in Josephine County. Statewide, 1,146,463 Oregonians are reported to be living below 200% of the Federal Poverty Level. For reference, in 2022, 200% Federal Poverty Level was equivalent to an annual household income of $55,500 or less for a family.

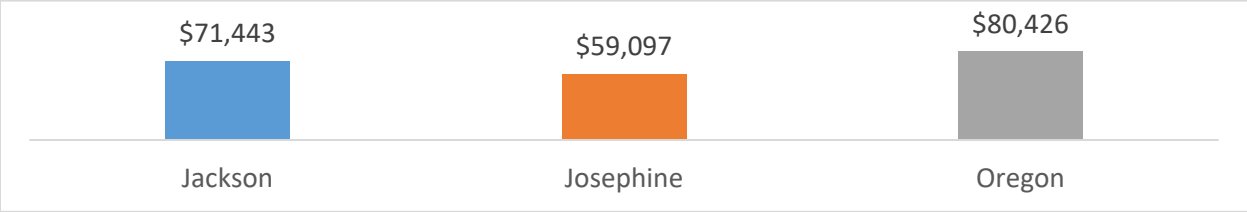
Figure 38. Percentage of the Population below the 200% Federal Poverty Level, by County and State, 2023



DATA SOURCE: Providence Data Hub, 2023 American Community Survey, 5-Year Estimate

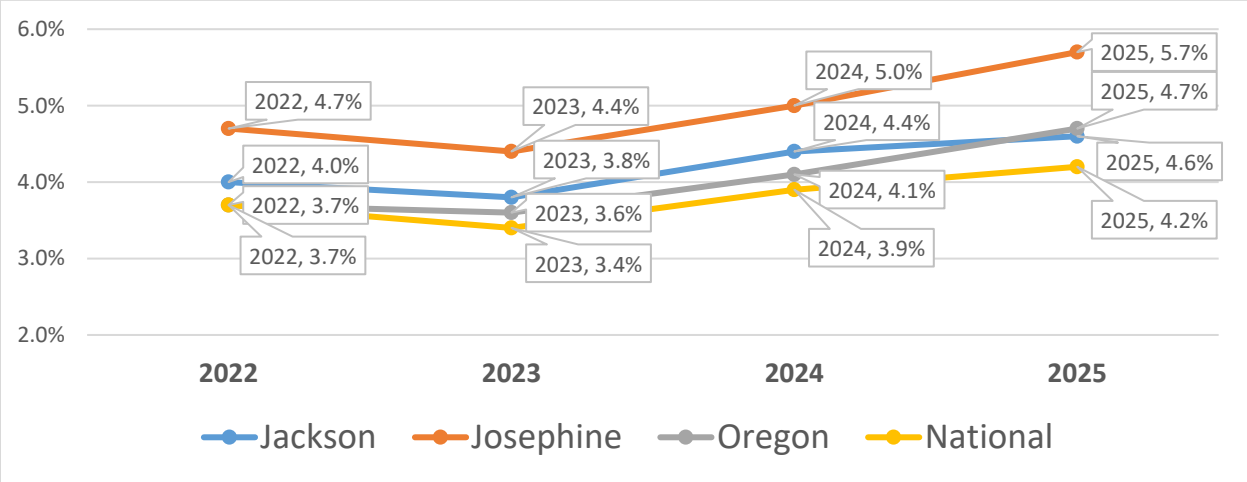
Household median income includes the income of the householder and all other individuals 15 years old and over in the household, whether they are related to the householder or not. Because many households consist of only one person, average household income is usually less than average family income. Jackson and Josephine counties show significantly lower median income than reported elsewhere in Oregon.

Figure 39. Household Median Income, by County and State, 2023



DATA SOURCE: Providence Data Hub, 2023 American Community Survey, 5-Year Estimate

Figure 40. Trend in April's Unemployment Rate, by County, State, U.S., 2022 – 2025



DATA SOURCE: for U.S. data, U.S. Bureau of Labor Statistics, Current Population Survey, 2022-2025 and for county and state data, U.S. Bureau of Labor Statistics, Local Area Unemployment Statistics, 2022-2025

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing economic insecurity in Jackson and Josephine counties:

- ACCESS
- Confident Staffing
- Express Employment Professionals
- Goodwill Employment and Training Center
- Maslow Project
- Oregon Employment Department
- Rogue Retreat
- St. Vincent de Paul
- United Way
- WorkSource Rogue Valley

Note: This list of assets was provided by assessment participants and community stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, while some resources are available in both Jackson and Josephine Counties, some are only available in one county or the other. Additionally, some are only available within select cities or geographical regions of Jackson County or Josephine County.

Affordable Childcare

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Quality, accessible, and affordable childcare promotes healthy development and well-being, allows parents to work to support their families, and creates a strong economy. The Annie E. Casey Foundation produces the Kids Count Data Book which measures the well-being of children nationally and at the state level[11]. In this report, states are ranked based on economic, education, health, and family and community well-being. The 2023 report showed on a national level; child well-being has declined since the pandemic and our country is unable to provide early childhood education to over half of its children (54%). In a state-to-state comparison of overall child well-being, Oregon ranked 26th and ranked even lower in the economic and education well-being categories (30th and 44th respectively)[12].

KEY FINDINGS

Qualitative Data

> *"We used to be able to recruit from other areas, and they look at the housing costs, they look at the childcare costs, and they say, 'No, thank you.'"*
>
> *—Key Informant*

Stakeholders prioritized affordable childcare and preschools because it is foundational for family stability and well-being, which are essential for community well-being. Reliable and affordable childcare allows caregivers to return to work or pursue education and attend needed health care services. Key informants described affordable childcare as a critical community need, particularly infant and toddler care. Accessing childcare is difficult and there are long waitlists. This affects the local workforce and the ability to recruit workforce to the area. A lack of childcare options also affects maternal mental health and family stability. There is a need to build the early childhood workforce to create more community capacity.

[11] Annie E. Casey Foundation, Kids Count Data Book, 2023. https://assets.aecf.org/m/resourcedoc/aecf-2023kidscountdatabook-2023.pdf

[12] First Five Years Fund, Lack of Access to Child Care Impacts Child Well-Being, August 2023. https://www.ffyf.org/resources/2023/08/lack-of-access-to-child-care-impacts-child-well-being/

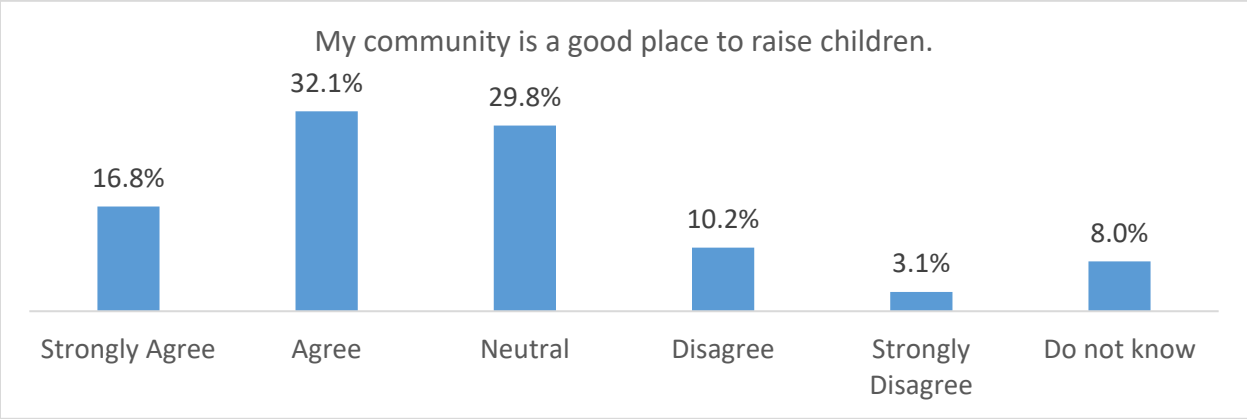
Survey Data

Community members responding to the community health survey corroborated stakeholder concerns around childcare, citing cost and availability as a prominent concern. Lack of adequate childcare presents a barrier to both employment and seeking necessary medical care. Transportation, cost and availability are all factors. Respondents noted increasing costs across the spectrum of basic living expenses as a factor in childcare affordability. They also reference lengthy waitlists, age restrictions and capacity and service issues for families seeking care for school-age children. Of survey respondents indicating the need to forgo basic needs or services due to limited financial resources, 18% for whom childcare was necessary reported going without due to affordability over the previous year.

> *"I don't have adequate childcare. My children are 4 and 9 years old. There's [sic] no daycares with openings for after school or summer care, or the days school isn't in session. This is a HUGE barrier." —Community Member*

Nearly 50% of survey respondents reported that their community is a good place to raise children when considering the quality and safety of schools, childcare, after-school programs and places to play in their neighborhood.

Figure 41. Perception of the Safety and Quality of the Community for Raising Children, 2025



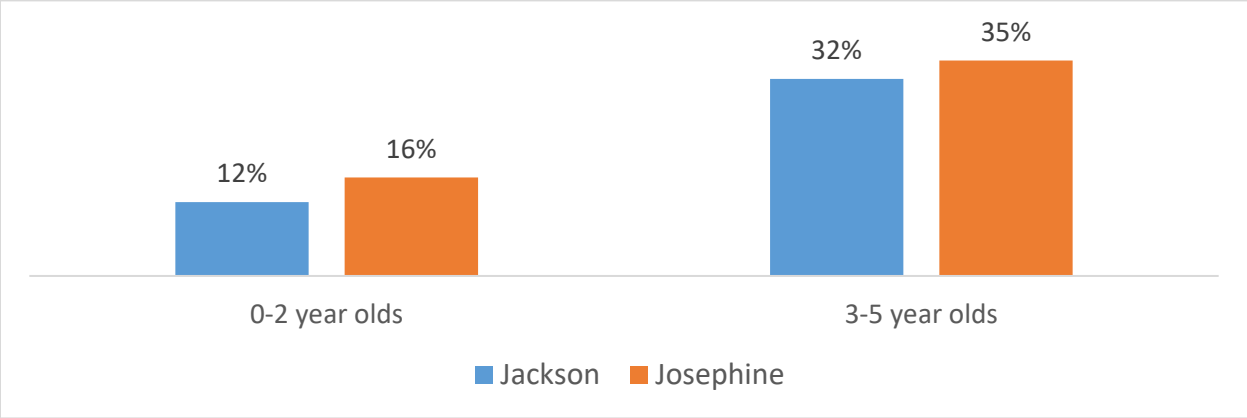
DATA SOURCE: Community Health Needs Assessment Survey, 2025

Secondary Data

A county is considered a childcare desert if there are more than three children for every regulated childcare slot. Regulated care includes childcare centers and home-based providers that are licensed by the state. Jackson County is classified as a 'childcare desert' with only 12% of children ages 0–2-years and 32% of children ages 3–5-years with potential access to a regulated childcare slot. Josephine County is only slightly better with the 'childcare desert' classification (16% and 35% respectively).

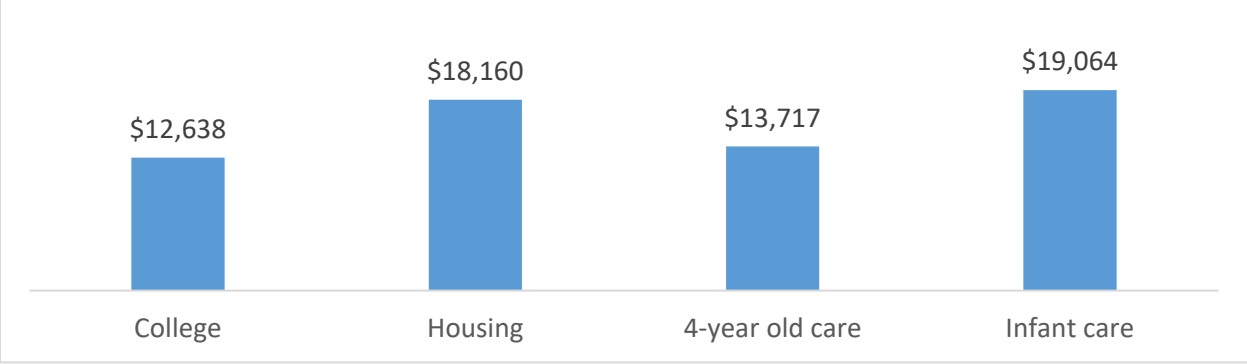
In addition to the lack of regulated childcare slots in Jackson and Josephine Counties, there is a limited number of publicly funded childcare slots. Examples have traditionally included Head Start, Preschool Promise, Baby Promise, Federal Land Tribal Head Start, Oregon Child Development Coalition and Federal Migrant and Seasonal Head Start. Publicly funded childcare allows families to pay less out of pocket. With limited publicly funded slots, few low-income families have access to affordable childcare. Recent changes to federal policy and funding regulations may ultimately reduce the availability of these publicly funded slots.

Figure 42. Percent of Children with Access to a Regulated Childcare Slot, by County, 2022



DATA SOURCE: Access to child care is calculated by taking the Estimated Supply of Child Care in Oregon as of December 2022 (Analysis by Oregon Child Care Research Partnership, Oregon State University using data collected by the R&R system) and dividing it by the population of children in the county who fall in the age group (2022 Annual Population Report Tables, Portland State University Population Research Center)

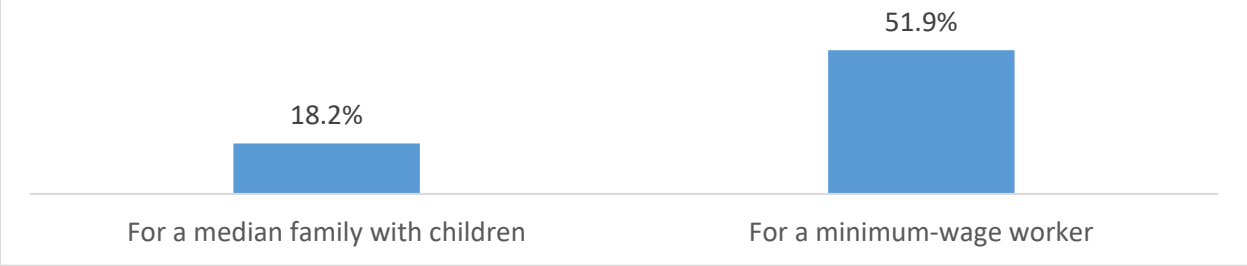
Figure 43. Average Annual Costs of Child Care Compared to Housing and College in Oregon, 2025



DATA SOURCE: Economic Policy Institute, Child Care Costs in the United States, 2025

The Department of Health and Human Services Affordability Standard states childcare should cost no more than 7% of a family's income. In Oregon, childcare is unaffordable for typical families because infant care for one child would cost 18.2% of a median family's income. If two children need childcare, a typical family would spend 31.3% of their income.

Figure 44. Infant Care Costs as a Share of Income in Oregon, 2025



DATA SOURCE: Economic Policy Institute, Child Care Costs in the United States, 2025

EXISTING ASSETS AND RESOURCES

Below is a list of community resources addressing affordable childcare and education in Jackson and Josephine counties:

- Boys and Girls Club
- Family Nurturing Center
- Kids Unlimited
- Oasis Center of the Rogue Valley
- Oregon Child Development Coalition
- Southern Oregon Head Start
- Southern Oregon Education Services District – Childcare Resource Network
- Southern Oregon Child and Family Council
- YMCAs

Note: This list of assets was provided by assessment participants and community stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, while some resources are available in both Jackson and Josephine Counties, some are only available in one county or the other. Additionally, some are only available within select cities or geographical regions of Jackson County or Josephine County.

Food Security

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Food security is closely linked to various health issues, affecting nutritional, mental, and public health. Lack of access to sufficient, safe, and nutritious food leads to malnutrition, which includes undernutrition, resulting in stunted growth and weakened immunity, and overnutrition, causing obesity and chronic conditions like diabetes. The stress of food insecurity can worsen mental health issues such as depression and anxiety. It also impacts children's growth, cognitive development, and school

performance. Food insecurity is associated with chronic diseases, as individuals often rely on cheaper, less nutritious food, increasing the risk of obesity and conditions like heart disease. During pregnancy, it can lead to adverse outcomes like low birth weight and preterm birth. On a broader scale, food insecurity strains public health systems, increases health care costs, and contributes to health disparities. Limited food access might also lead to consuming unsafe food, resulting in foodborne illnesses. Addressing food security through improved access, sustainable agriculture, and nutrition education is vital for enhancing health outcomes and fostering healthier communities.

KEY FINDINGS

Qualitative Data

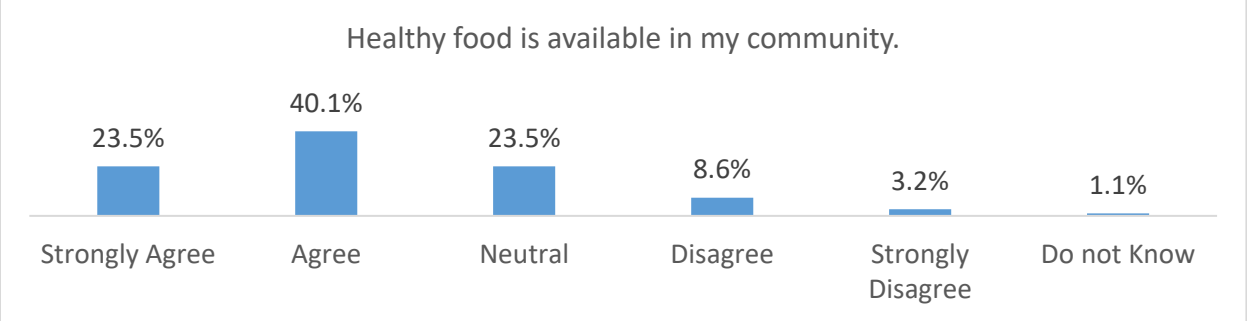
Key informants shared the cost of food, along with the cost of living, is increasing, which is affecting food security. Community members shared many people cannot afford food and Supplemental Nutrition Assistance Program (SNAP) benefits have not increased to keep up with the rising cost. While food pantries are addressing food insecurity, there are barriers to those resources, specifically, hours of operation and location. Transportation barriers also contribute to food insecurity; there are limited options outside of public buses and those that exist have limitations on how many bags people can bring. There is a need for home delivery of food, but funding is a barrier to implementing this.

> *"We have people call on a weekly basis asking for home delivery for food. They're either homebound or they're maybe recovering from surgery. They have kids, whatever the reason might be."*
> *–Community Stakeholder*

Survey Data

Survey respondents indicate a need for access to affordable, healthy food and mentioned food costs among the other rising costs of living competing for their financial resources. Over 60% agreed that healthy food was available in their community, while 12% stated there was not. The existence and availability of healthy food does not necessarily equate to its affordability. Of those community members stating they had to go without one or more basic essential during the previous year, 19% reported going without food.

Figure 45. Percentage of Survey Respondents Reporting the Availability of Healthy Food, 2025

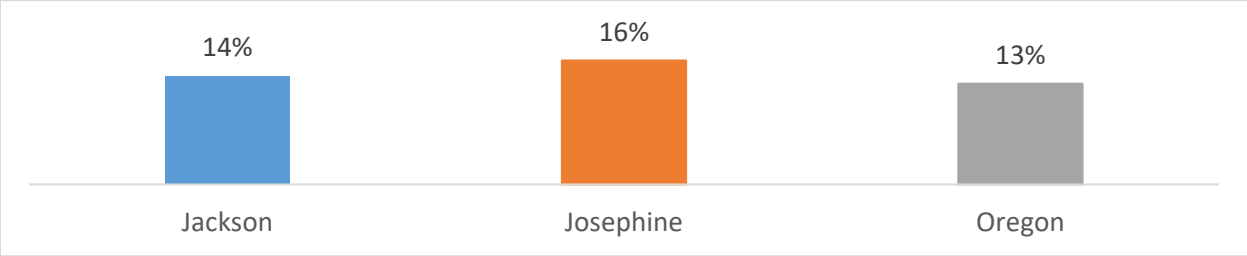


DATA SOURCE: Community Health Needs Assessment Survey, 2025

Secondary Data

Jackson and Josephine counties had higher rates of food insecurity, defined as the percentage of population who lack adequate access to food, when compared to Oregon.

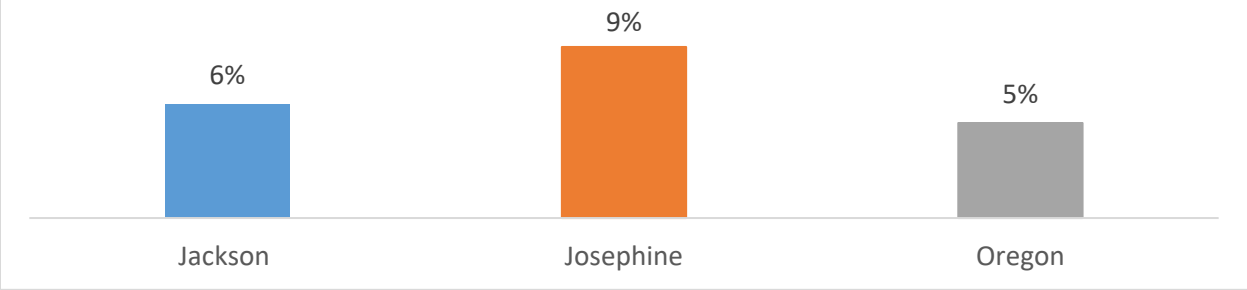
Figure 46. Food Insecurity, by County and State, 2022



DATA SOURCE: County Health Rankings & Roadmaps, County Health Rankings. Data from 2022.

Jackson and Josephine counties had higher rates of limited access to healthy food, defined as the percentage of population who are low-income and do not live close to a grocery store, when compared to Oregon. The most recent non-survey data available is from 2019.

Figure 47. Limited Access to Healthy Foods, by County and State, 2019



DATA SOURCE: County Health Rankings & Roadmaps, by State and County. Data from 2019.

Chronic Conditions

IMPORTANCE AND CONNECTION TO OTHER HEALTH ISSUES

Extended care services, which include specialty care, are focused on the treatment of a particular disease. Primary and specialty care go hand in hand, and without access to specialists, people are often left to manage chronic diseases such as diabetes, hypertension, obesity, and heart disease on their own. When people lack access to primary care, specialists or adequate information on how to prevent, manage, and control their health conditions, those conditions tend to worsen. Additionally, people focused on essentials of living, such as economic instability, housing, childcare, food insecurity or other basic needs may not have the time, money and energy to dedicate to managing health conditions.

KEY FINDINGS

Qualitative Data

This key theme was not prioritized by the community; however, community participants frequently highlighted the lack of specialists in Southern Oregon, resultant wait times to be seen and the need to travel out of the area for care. Community members mentioned need in endocrinology, gastroenterology, rheumatology, and neurology. While addressed separately under behavioral health, it is worth noting that both mental health and substance use can become a chronic condition for those who are navigating those concerns. When comorbid with chronic physical illness, all conditions are exacerbated. Beyond that, delays in care or simply going without medical treatment results in worsening of chronic conditions and overall health decline, necessitating increasingly complex interventions.

> *"There's so many people that are just feeling super overwhelmed because they have these [health] issues and cannot get into a specialist and have a really hard time even getting to the grocery store and getting healthy food. It's like all these things compound on top of 'I'm paralyzed and already facing other barriers in the world.' I think it just wears on people, which tends to make them socially isolate more. It just starts that cycle of depression."—Key Informant*

Survey Data

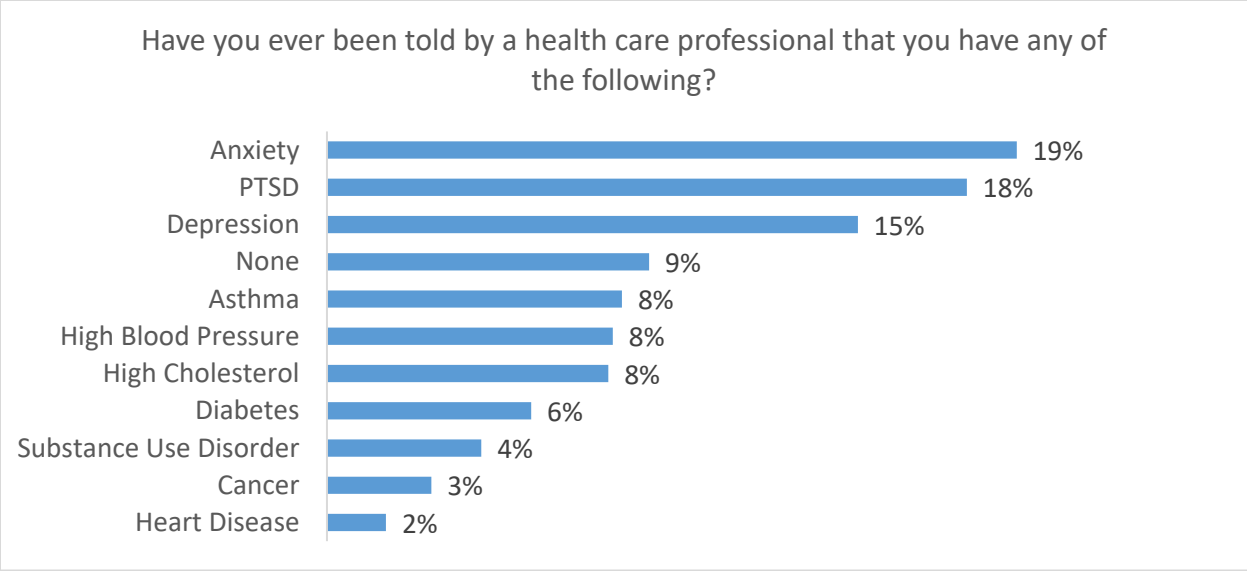
Survey respondents voiced concern over lengthy wait times to establish with a specialty care provider and the need to travel out of the area for quality, timely, consistent care. Some shared about difficulties navigating chronic conditions while having to switch insurers, exacerbating wait times for essential care and delaying access to necessary prescriptions. Respondents cited a multitude of ongoing health concerns when asked about professional diagnosis of chronic conditions. Mental health concerns had the highest prevalence among the self-reported diagnoses, with respondents citing a combined 52% for anxiety, depression, and/or PTSD. Only 9% of respondents indicated they had never been diagnosed with any of these conditions. Over 70 respondents wrote in one or more condition that was not pre-populated on the survey. Ongoing health issues they reported included autoimmune, neurologic, cardiovascular and thyroid conditions, among others. Of diagnoses reported for children under 18 years of age, just under 45% reported a diagnosis that would be considered a chronic condition, with 26% of those related to mental health and just over 18% related to ongoing physical conditions such as asthma, diabetes, kidney disease, allergies or lupus.

> *"I have a chronic illness that is rare and difficult to treat. The wait times and experience level of the medical professionals in the Rogue Valley are inadequate to care for me."—Community Member*

Among the pre-populated conditions included on the community health survey, mental health conditions were the most commonly indicated, with depression (15%), PTSD (18%) and anxiety (19%) all

reported at near double or more the rate of the top physical condition. The most commonly indicated physical conditions were tied at 8%: asthma, high blood pressure and high cholesterol. Nearly 20% of respondents wrote-in issues not provided in the pre-populated list. Write-in conditions indicated a number of chronic conditions including autoimmune, congenital, cardiovascular, gastrointestinal, neurological and thyroid issues, among others.

Figure 48. Percentage of Survey Respondents Reporting Chronic Conditions, 2025

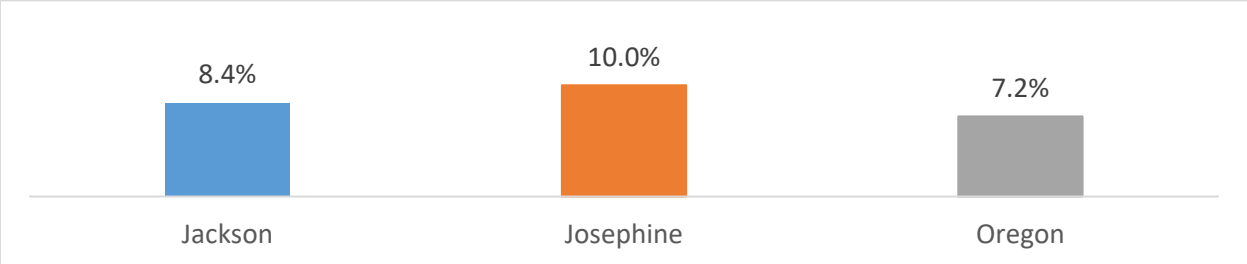


DATA SOURCE: Community Health Needs Assessment Survey, 2025

Secondary Data

According to the U.S. Centers for Disease Control and Prevention, heart disease is the leading cause of death for men, women and people of most racial and ethnic groups in the United States. Coronary heart disease (CHD) is the most common type of heart disease, killing over 370,000 people annually. Heart disease is the leading cause of death for people of most ethnicities in the US, including African Americans, Hispanics, and whites. For American Indians or Alaska Natives or Pacific Islanders, heart disease is second only to cancer. Jackson and Josephine counties report significantly higher rates of heart disease than the rest of Oregon.

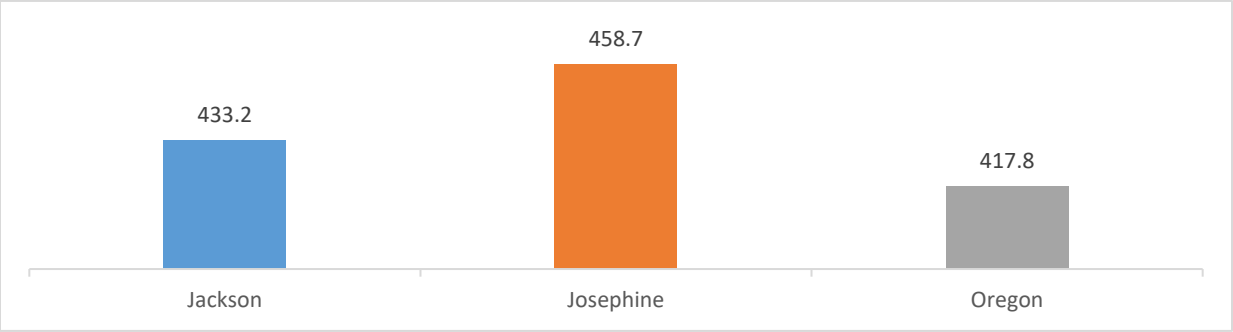
Figure 49. Coronary Heart Disease Crude Prevalence, by County and State, 2022



DATA SOURCE: PLACES. Center for Disease Control and Prevention Indicator uses crude prevalence for year 2022 estimates.

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers from 1975-2006. Among people who develop cancer, more than half will be alive in 5 years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease. Cancer diagnoses in Jackson and Josephine counties exceed Oregon rates.

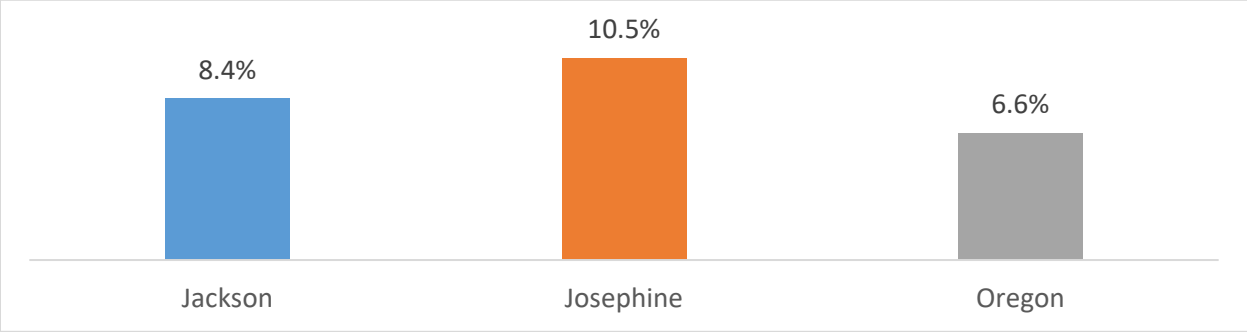
Figure 50. Age-adjusted Rates of All Cancers per 100,000 Population, by County and State, 2017-2021



DATA SOURCE: Oregon Health Authority. Public Health Division. Diseases and Conditions. Chronic Disease Data Reports 2017-2021.

In 2022, 6.8% (17 million) of adults aged ≥18 years reported that they had COPD nationwide. Tobacco smoking, occupational and environmental exposures, respiratory infections, and genetics are all considered major risk factors. COPD can be treated and managed to slow declining lung function, improve exercise tolerance, and prevent and treat exacerbations.

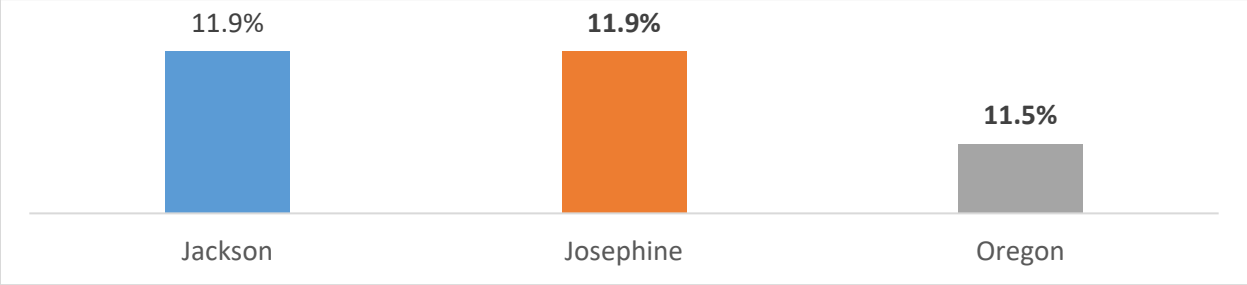
Figure 51. COPD Crude Prevalence, by County and State, 2022



DATA SOURCE: Providence Data Hub, PLACES. Center for Disease Control and Prevention Indicator uses crude prevalence for year 2022 estimates.

Community members exhibiting asthma have a higher likelihood of adverse outcomes including emergency department visits, hospitalizations, and death. Compared with persons without asthma, persons with asthma have more days of activity limitation and missed school and missed work and are more likely to report comorbid depression. Asthma rates in Jackson and Josephine Counties now outpace the state, whereas they were lower than the rest of Oregon three years ago.

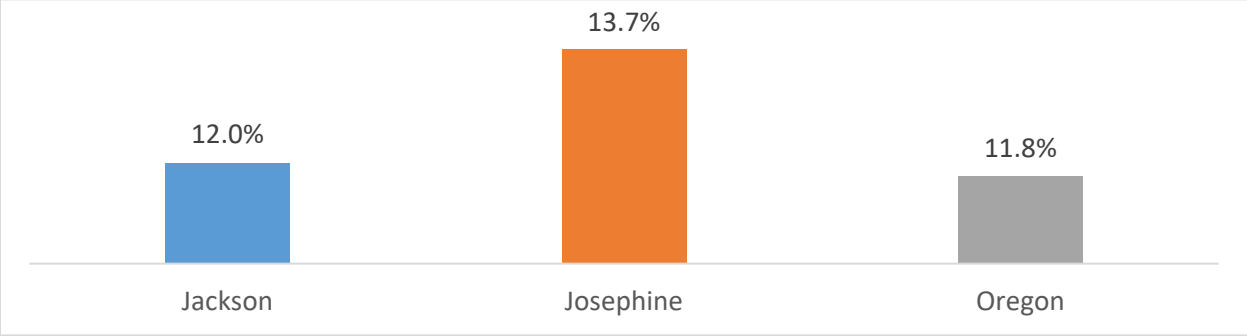
Figure 52. Asthma Crude Prevalence, by County and State, 2022



DATA SOURCE: Providence Data Hub, PLACES. Center for Disease Control and Prevention Indicator uses crude prevalence for year 2022 estimates.

The impact of diabetes has increased with the increasing prevalence of obesity. Substantial differences in diabetes prevalence exist by age, race, and ethnicity. Multiple long-term complications of diabetes can be prevented through improved patient education and self-management and provision of adequate and timely screening services and medical care. Jackson and Josephine Counties showed a significantly higher incidence of diabetes compared to elsewhere in Oregon.

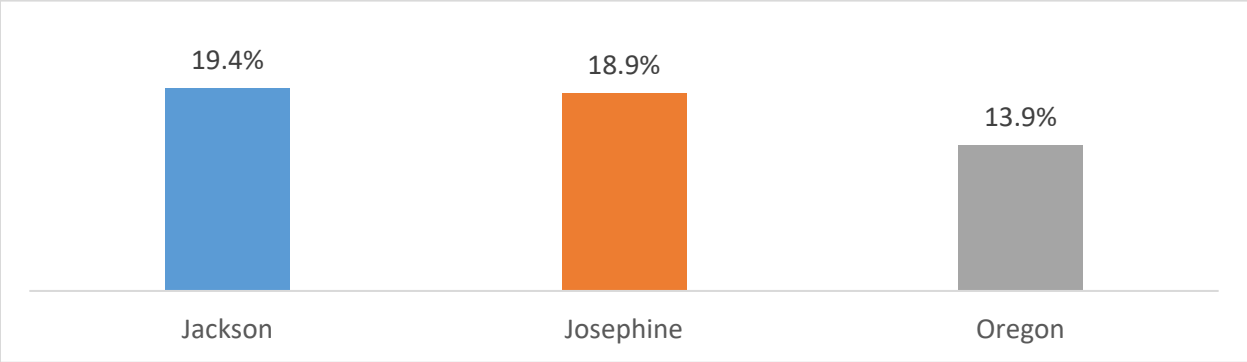
Figure 53. Diabetes Crude Prevalence, by County and State, 2022



DATA SOURCE: Providence Data Hub, PLACES. Center for Disease Control and Prevention Indicator uses crude prevalence for year 2022 estimates.

Only about 17% of U.S. adults are considered to be in a state of optimal mental health. While Jackson and Josephine Counties only trend slightly higher than national rates for self-reported mental health issues, it is important to note the lasting impact poor mental health can have on physical health and chronic disease. Evidence has shown that mental disorders, especially depressive disorders, are strongly related to the occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity and many risk behaviors for chronic disease, such as, physical inactivity, smoking, excessive drinking, and insufficient sleep.

Figure 54. Frequent Mental Health Crude Prevalence, by County and State, 2022



DATA SOURCE: Providence Data Hub, PLACES. Center for Disease Control and Prevention Indicator uses crude prevalence for year 2022 estimates.

EXISTING ASSETS AND RESOURCES

Below is a list of community resources that may assist with managing chronic conditions:

- AllCare Health
- Jackson Care Connect
- La Clinica
- Oregon Wellness Network
- Rogue Community Health
- Rogue Valley Council of Governments Area Agency on Aging
- Siskiyou Community Health

Note: This list of assets was provided by assessment participants and community stakeholders. It is not meant to be an exhaustive list of all resources available. Also note, while some resources are available in both Jackson and Josephine Counties, some are only available in one county or the other. Additionally, some are only available within select cities or geographical regions of Jackson County or Josephine County.

Next Steps

The 2025 community health needs assessment of Jackson and Josephine Counties serves multiple purposes. Among these purposes, the assessment enables Asante and Providence to:

- Investigate current health status, health priorities, and new and emerging concerns among Jackson and Josephine County community members and service providers
- Identify the social determinants of health most affecting our region and explore how these factors are impacting overall health and vitality of our communities
- Hear individual and group voices from a broad cross-section of the community to develop a deeper understanding of current and emerging health issues
- Observe the shifting patterns of these health issues over time in Jackson and Josephine Counties
- Identify assets and resources as well as gaps and needs in services to help set funding and programming priorities
- Fulfill the CHNA requirements for Asante and Providence hospitals
- Use the data gathered to inform and involve our community partners and community members in the community health improvement process

This assessment lays the foundation for the Community Health Improvement Plans (CHIPs) that will be developed for Asante Ashland Community Hospital, Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center and Providence Medford Medical Center in fiscal year 2026. The quantitative and qualitative data presented in this report and the priority community health needs identified can guide the development of goals, objectives, strategies, and performance measures. Each hospital will engage in their own processes to further evaluate this work and identify objectives and strategies they will engage in over the next three-year cycle toward meaningful positive impact.

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

ENGAGING COMMUNITY STAKEHOLDERS IN PRIORITIZATION

Throughout the qualitative data collection process, stakeholders were offered the opportunity to rank needs that have been identified through previous years' CHNA processes and continue to impact the communities in Jackson and Josephine Counties. Thirty-six community members and leaders representing diverse perspectives and multiple sectors from throughout our region participated in these ranking exercises. The results of these ranking exercises were taken into consideration when finalizing the list of key themes included in Asante's and Providence's collaborative Community Health Needs Assessment as well as Asante Ashland Community Hospital's final prioritization of identified needs. The key themes are presented below; themes with direct correlation to health are in bold.

- Homelessness and housing instability
- **Access to health care services**
- **Behavioral health challenges and access**
- **Mental health and substance use/misuse**
- **Disability inclusion and support for people with disabilities**
- Economic security
- Affordable childcare
- Food security
- **Chronic conditions**

Members of Asante's executive and leadership team convened to review and discuss the preliminary results of the CHNA and identify priorities that will be used in developing each hospital's Community Health Improvement Plan. Asante leadership received an overview of the key themes that emerged in the collection of qualitative and quantitative data. While each key issue identified through the CHNA is important, some issues are better managed by existing community resources operating in aligned areas of service and expertise. The issues selected for Asante Ashland Community Hospital's health improvement implementation plan represent a health-focused set of goals, objectives and strategies aligned with the hospital's current strategic priorities and vision for the health of our community. The prioritization process used a method of rating the key issues against established criteria and then selecting those health issues that are most appropriate for health improvement planning by our hospital.

PRIORITIZATION AND SELECTION CRITERIA

■ Strategic fit with Asante's Mission and Vision and Values.

Mission: *Asante exists to provide quality health care services in a compassionate manner, valued by the communities we serve.*

Vision: *To be your trusted health partner for life—every person, every time.*

Values: *Excellence, in everything we do*

Respect, for all

Honesty, in all our relationships

Service, to the community and each other

Teamwork, always

■ Alignment with Asante's Strategic Priorities.

Culture, Quality and Safety, Financial Sustainability, Strategy and Growth

■ Operational fit with Asante Ashland Community Hospital's service offerings.

■ Broad and high community demand.

■ Opportunity to impact: Organizational commitment, partnership, and/or scale of need.

■ Potential to deepen and leverage community partnerships in addressing prioritized needs.

2025 Priority Health Needs

The list below summarizes the rank ordered significant health needs identified through the 2025 Community Health Needs Assessment process:

Priority 1: Access to care. Focus on availability of primary and specialty care providers through alternate access such as telehealth; intentional inclusivity of marginalized populations; reduced barriers to care; improved care coordination; and enhanced access for people without the means to pay for care.

Priority 2: Chronic Conditions. Focus on prevention and treatment of diabetes, hypertension, high cholesterol, asthma, cancer and other chronic conditions.

Priority 3: Mental Health. Focus on prevention, education and treatment for depression, anxiety and PTSD; increased availability of crisis care; stigma mitigation through community health education, improved access for youth and elders; and enhanced relationships with community partners to improve access to mental health care across community sectors.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include Jackson and Josephine County Departments of Public Health, Asante Ashland Community Hospital, Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center and Providence Medford Medical Center. In addition, there are numerous social service community-based agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. See Appendix 4 for a list of potential resources available to address significant health needs.

EVALUATION OF 2023 CHIP IMPACT

Hospital Evaluation of 2023 Community Health Improvement Plan

This report evaluates the results from Asante Ashland Community Hospital's most recent CHNA and CHIP. Identified priority needs from the 2022 CHNA included: access to care, chronic conditions and mental health. Asante Ashland responded to these needs by making investments of time, resources and direct funding to internal and external programs addressing these prioritized needs.

To address identified health needs across all priority areas, Asante Ashland worked in concert with Asante Rogue Regional Medical Center and Asante Three Rivers Medical Center. Asante hospitals focused on increasing the availability of primary and specialty care providers, reducing wait times, expanding locally available medical treatments and services and reducing barriers to care by improving care coordination and enhancing access for people without the means to pay for care. Asante Ashland's efforts focused on improving these services and experiences for residents in southern Jackson County.

Asante successfully increased the number of Asante-employed primary and specialty providers as well as aiding community-based Asante Health Network providers with recruitment and retention, resulting in reduced wait times for community members to receive primary care for routine or emergent needs and to consult with a specialist, post-diagnosis, throughout the service area. Another facet of improving access to care is ensuring patients have access to insurance. Asante Ashland Community Hospital's certified application counselors work directly with community members in the completion of Oregon Health Care applications. Across the three hospitals, nearly 16,000 community members have received support with this process since 2022.

Asante Ashland expanded locally available, hospital-based medical care to meet the uniquely evolving needs of our region's growing community with several key initiatives during the most recent CHNA and CHIP cycle. To better address the needs of our community's aging population, the hospital pursued, and was awarded, the designation of Age-Friendly Health System, signifying a level of specialized care aligned with the unique needs and goals of community members aged 65 and above. This focused care for our area's elders is carried out in tandem with the hospital's existing services and designations, such as the Baby-Friendly designation achieved in our previous CHNA cycle, and is a vital component in providing care to all ages of the population, ranging from newborns to our geriatric community. Asante Ashland also expanded telemedicine capabilities, connecting on-site providers with the necessary specialists in real time to locally treat patients needing an advanced level of medical expertise.

Asante Ashland, Asante Rogue Regional and Asante Three Rivers continued to support expanding demands for medical professionals in our community by providing clinical internships and externships and required licensure experiences for medical techs, allied health care professionals, nurses and advanced providers at all Asante hospitals throughout the three-year CHNA and CHIP cycle.

To address community needs around chronic conditions, Asante Ashland collaborated with Asante Rogue Regional and Asante Three Rivers to focus efforts on education, prevention and treatment of diabetes, hypertension, high cholesterol, asthma, cancer and other chronic conditions both with independent programs and through investment in the efforts of community partners. Asante Ashland

worked to expand locally available, specialized cancer care through the provision of low and no-cost breast cancer screenings for uninsured and underinsured community members. Asante Ashland also invested in community education on chronic health conditions through a variety of programs, including physician educational talks in concert with our local university's lifelong learning institute and a Coffee and Conversation series focused on health topics relevant to older adults.

To address identified community concerns around mental health, Asante Ashland focused resources on education, prevention and treatment for depression, anxiety and PTSD, improving access to mental health care for elders and addressing deficits in the social determinants of health that prevent vulnerable community members from thriving. At Asante Ashland, embedded social workers within service lines facilitated access to support across the care continuum. Staff at Asante Ashland worked with colleagues at Asante Rogue Regional and Asante Three Rivers to develop means for evaluating patient needs and identifying deficits in social determinants of health, including coordinating with outside agencies who specialize in addressing these essential needs.

Asante Ashland worked in concert with Asante Hospice to support the mental health of community members and their families through wrap-around social, emotional and mental health support with in-home end-of-life care and individual and group support throughout the bereavement process.

During the 2022-2025 CHNA and CHIP cycle, Asante Ashland was also able to expand locally available psychiatry access in the emergency department and hospital, through the integration of a tele-psychiatry model.

Community Partner and Key Informant Insights

Asante Ashland Community Hospital invited community representatives to review and evaluate the hospital's 2023 Community Health Improvement Plan as part of a larger key informant survey with Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center and Providence Medford Medical Center. Invitations were sent out to representatives from the business, education, government, health care, social service and public service sectors in Jackson and Josephine Counties. Key informants from Asante Ashland's 2022 CHNA process were invited, along with new informants identified through 2025 CHNA process, affiliation with the collaborative 2023 All in for Health Community Health Assessment, Asante executive leadership advisement and collaboration with Providence, Jackson County Public Health, Josephine County Public Health and AllCare Health. More than 150 direct invitations were sent to Jackson County contacts, with 30 directed specifically to Ashland contacts. All invitation recipients in both Jackson and Josephine County had the option of responding to multiple hospital surveys, as many partner organizations serve both counties. Key informants received an initial invitation along with reminder emails throughout the survey period, and had the option of forwarding the survey to colleagues within their organization or other contacts in the community they felt would have valuable insight. The survey was anonymous.

Key informants were invited to review each hospital's CHIP and the initiatives described there-in. Four key informants elected to participate in the survey, providing an overall rating on Asante Ashland's efforts to address priorities identified in its most recent Community Health Improvement Plan.

The tables below summarize the findings of Asante Ashland Community Hospital's key informant survey, outlining community stakeholder's impressions of the hospital's efforts to address access to health care, chronic conditions and mental health. Asante Ashland Community Hospital's CHIP follows Table 13 on page 75. See Appendix 2 for additional results of the key informant survey including comments on identified health needs.

Table 11. Identification of key informants

Agencies and organizations represented	• Ashland Community Health Foundation • Medford United Church of Christ • NAMI Southern Oregon • Rogue Retreat
Sectors represented	• Faith-based/religious • Health care • Social service
Populations represented	• Elderly/Seniors • Hispanic/Latino/a/x • Homeless/Unhoused community members • Low-income community members • Medically underserved • Minority populations • LGBTQ+ • People with disabilities • People with mental health diagnoses and their families • Women • Veterans

DATA SOURCE: Asante and Providence Collaborative Key Informant Survey, 2025

Table 12. Key informant awareness

Prior to reviewing Asante Ashland Community Hospital's Community Health Improvement Plan, how aware were you of how the hospital is addressing each of the following needs in the community?

2023 CHIP Priorities	Not Aware At All	Somewhat Aware	Very Aware
Access to Healthcare	50%	25%	25%
Chronic Conditions	75%	0%	25%
Mental Health	50%	25%	25%

DATA SOURCE: Asante Ashland Community Hospital Key Informant Survey, 2025

Table 13. Key informant impressions

Overall, how would you rate Asante Ashland Community Hospital's effort to address these health needs in the community?

2023 CHIP Priorities	Poor	Fair	Good	Very Good	Excellent
Access to Healthcare	0%	25%	0%	50%	25%
Chronic Conditions	0%	0%	50%	25%	25%
Mental Health	50%	0%	0%	25%	25%

DATA SOURCE: Asante Ashland Community Hospital Key Informant Survey, 2025

2023

Community Health Improvement Plan

Implementation Strategy

Asante Ashland Community Hospital

Introduction

The following Implementation Strategy (Community Health Improvement Plan) is based on the defined primary service area of Jackson County for Asante Ashland Community Hospital, Ashland, Oregon.

The implementation strategy was formulated to address the identified priority health care needs within the Asante Ashland Community Hospital 2022 Community Health Needs Assessment prepared by the hospital and approved on Aug. 16, 2022 by the Asante Board of Directors, acting in the capacity of the authorized body of Asante Ashland Community Hospital. That same Board approved this implementation strategy during its meeting on Feb. 7, 2023.

Introduction

The Asante Ashland Community Hospital 2023 implementation strategy set forth below is a plan to address the significant health needs identified in the AACH 2022 Community Health Needs Assessment (CHNA).

The AACH 2022 CHNA identified a wide spectrum of priority areas. Considering Asante Ashland Community Hospital's unique capabilities, community partnerships and potential areas of collaborative community impact, we are committed to addressing the following priorities: access to care, chronic conditions and mental health. Some of the needs identified in AACH's CHNA—homelessness and housing instability, affordable childcare and preschool, economic insecurity and substance use—are more appropriately addressed by community partners with existing specialized focus in these areas.

The AACH 2023 implementation strategy (1) describes the actions AACH has recently taken and intends to take to address the health needs and the anticipated impact of those actions; (2) identifies the resources AACH plans to commit to address the health needs; and (3) describes planned collaboration between AACH and other facilities or organizations in addressing the health needs.

Priority 1: Access to care

To address identified health needs around access to health care, Asante will focus on the availability of primary and specialty care providers; expand locally available medical treatments and services; foster intentional inclusivity of marginalized populations; reduce barriers to care; improve care coordination; and enhance access for people without the means to pay for care.

Increase availability of primary care providers and reduce patient wait times.

- Increase the number of Asante-employed providers.
- Increase the duration of new provider engagement and retention.
- Balance patient panels to ensure access to primary care providers for emergent needs within a reasonable time frame.
- Aid community-based Asante Health Network providers in establishing patient panels to increase overall number of providers throughout the community.
- Reduce wait times to establish with an Asante-employed provider.

Increase availability of specialty care providers and reduce wait times.

- Increase the number of Asante-employed specialty care providers.
- Increase duration of new provider retention and engagement.
- Reduce wait times to consult with a specialist.
- Provide educational opportunities for providers in training and licensure programs to ensure continual certification of qualified medical staff in our service area.
- Coordinate with community-based specialists to improve wait times for seeing a specialist throughout the community.

Expand locally available, hospital-based medical care.

- Establish AACH as an Age-Friendly hospital by providing care in alignment with the unique needs and goals of our elder community members.
- Facilitate physician access to tele-intensivists for patients who need an advanced level of expertise, and offer telemedicine for specialties such as infectious disease and neurology.
- Increase the number of qualified staff members available to support critical care needs by hiring and providing clinical internships and externships and required licensure experiences for medical techs and other health care personnel.

Priority 1: Access to care

Anticipated impact of intended actions addressing access to care:

- Increased access to primary care, specialty care and hospital-based services.
- Reduced wait time for appointments with primary or specialty care providers.
- Improved health care experience for community members.

Asante resources to support this health need:

- Asante employees and health care providers

Collaborative partners:

- Asante Health Network members

Priority 2: Chronic conditions

To address community needs around chronic conditions, Asante will focus on education, prevention and treatment of diabetes, hypertension, high cholesterol, asthma, cancer and other chronic conditions both with independent programs and through investment in the efforts of our community partners.

Expand locally available, specialized cancer care.

- Improve early detection and intervention with low and no-cost breast cancer screenings for uninsured and underinsured community members.
- Increase the number of staff members trained to serve cancer patients by hiring and providing clinical internships and externships and required licensure experiences for medical techs and other health care personnel.

Educate and empower community members on chronic health conditions.

- Develop distribution channels for educational health content, including Better Health, Asante Health Blog, webinars, social media channels, panel discussions, etc.
- Provide educational content on chronic conditions in a variety of media at no charge.
- Increase community members' knowledge of chronic health conditions and how to address and manage them effectively.
- Support improved personal health, prevention, intervention and effective maintenance of chronic health conditions such as diabetes, cardiovascular disease, cancer and others.

Anticipated impact of intended actions addressing chronic conditions:

- Improved health and quality of life through prevention, detection and treatment of risk factors for chronic conditions such as asthma, diabetes, heart disease and others.
- Improved community members' awareness of and ability to navigate chronic health conditions through education, outreach and publication of free health information.

Asante resources to support this health need:

- Asante employees and health care providers.
- Community benefits funding for specified organizations and programs.

Collaborative partners:

- Asante Health Network members
- KOBI TV "Better Health" PSAs

Priority 3: Mental health

To address identified community concerns around mental health, Asante will focus resources on education, prevention and treatment for depression, anxiety and PTSD; increase availability of crisis care; improve access to mental health care for youth and elders; enhance relationships with community partners to improve access to mental health care across community sectors; and address deficits in the social determinants of health that prevent our most vulnerable community members from thriving.

Improve outlook, experience and outcomes for patients and community members through social work and social determinants of health support.

- Embed social workers with clinicians and in service lines to facilitate access across the care continuum, including in clinics; upon hospitalization or discharge; and upon a terminal diagnosis from evaluation and qualification for hospice services.
- Evaluate patient needs and identify deficits in social determinants of health (food, shelter, safety, transportation).
- Coordinate with outside agencies to help patients who have little to no means of support (financial, social, emotional) secure essential needs to facilitate healing.
- Increase patient stability and compliance with care and appointment attendance through coordination with or provision of stabilizing resources such as transportation, utility assistance, housing, food and other basic needs.
- Direct financial contributions to local organizations addressing social determinants of health, including food insecurity.

Support the mental health of community members at end-of-life, and their families.

- Ease a patient's end-of-life care, and help support their family, through wrap-around social, emotional and mental health support.
- Provide in-home hospice support for terminal patients and their families.
- Provide free one-on-one and group counseling support for members of the community navigating the loss of a loved one.

Facilitate access to mental health services.

- Address the need for outpatient mental health with a medical home model that embeds licensed clinical social workers in clinics.
- Collaborate with community agencies addressing mental health issues to help coordinate mental health care and increase services available across the community.
- Expand tele-psychiatry access in the emergency department and hospital.
- Direct funding to organizations that provide mental health support to vulnerable populations.

Priority 3: Mental health

Anticipated impact of intended actions addressing mental health:

- Increased peace of mind for patients navigating health concerns concurrently with financial or life stability issues, or both.
- Reduced negative impact of mental health issues on individuals, families and the community.
- Improved resources for individuals, families and the community who are affected by mental health concerns.
- Improved collaboration with community partners resulting in improved care for community members.

Asante resources to support this health need:

- Asante employees and health care providers.
- Community benefits funding for specified organizations and programs.

Collaborative partners:

- ACCESS
- KOBI TV "In This Together" suicide prevention public service campaign

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Addressing Identified Needs

Asante and Providence will develop individualized Community Health Improvement Plans (CHIPs) for each hospital within the Jackson and Josephine County service area. Asante Ashland Community Hospital, Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center and Providence Medford Medical Center will address the prioritized health needs each has identified through the 2025 CHNA and develop strategies to improve access to resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing how each Asante and Providence hospital plans to address their respective prioritized needs. If a hospital does not intend to address a need or plans to have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions each hospital intends to take, but also the anticipated impact of these actions and the resources the hospital plans to commit to address the health need.

Because partnership is important when addressing health needs, the CHIP will describe any planned collaboration between Asante, Providence and community-based organizations in addressing the prioritized needs. The CHIP will be approved and made publicly available no later than February 15, 2023, for Asante and May 15, 2023, for Providence.

APPENDICES

Appendix 1: Community Input

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Asante and Providence contracted the Rede Group to conduct 13 key informant[13] interviews with 24 representatives from community-based organizations and agencies serving Jackson and Josephine Counties, as well as 4 listening sessions with community members. All community input was collected in February and March of 2025.

See Appendix 2 for methodology, participant details, and in-depth findings

Community-Defined Health and Strengths

Community members and key informants were asked to highlight community strengths. Community members were also asked to describe their vision for a healthy community:

Vision for a Health Community
•People support one another and are involved in their community •Basic needs are met and there are local resources available •Inclusion and respect are foundational •Safety •People can access health care services

Community Strengths
•Organizations and resources available to support people •Strong relationships and respect •Community engagement and people helping people •Community knowledge and wisdom •Collaborative relationships between local organizations and agencies •Resilience and adaptability

Community Needs

HIGH PRIORITY UNMET HEALTH-RELATED NEEDS

Homelessness and housing stability	Key informants and community members identified homelessness and housing stability as a critical community need. They shared affordable housing is important for people being able to meet their basic needs, recruiting and retaining workforce, and addressing behavioral health needs. Wildfires destroyed housing, worsening this need and affecting insurability. Key informants shared there is a need for more housing units across the spectrum, including shelter beds, supportive housing, transitional housing, and low-income housing. There is also a need for shared definitions and language regarding housing types, more resources and funding to

[13] Key informants are defined as people with knowledge of community needs and strengths because of their experience as community leaders, professionals, and/or residents of Jackson and Josephine Counties. Key informants have a wide range of knowledge related to community health and well-being and work within organizations or agencies serving residents, including diverse communities, people with low incomes, and people experiencing barriers to care.

	address homelessness, more coordinated homeless services, and more focus on prevention. Community members would like to see more homeless services, including public restrooms and showers, along with support for people navigating housing resources and filling out applications. Barriers to addressing housing stability include the high cost of housing and a lack of housing stock. System barriers to addressing housing needs include administrative burden associated with sources of funding, a lack of funding, and a focus on short-term solutions. Young people experiencing homelessness, older adults, people with disabilities, people living in rural areas, Native American peoples, and people identifying as LGBTQIA+ may experience additional barriers to stable housing.
Access to health care services	Key informants and community members shared accessing primary and specialty care in Jackson and Josephine Counties is difficult with long wait times, particularly for specialty appointments. Key informants shared there is a need for more care navigation, particularly after a hospital discharge. Barriers that contribute to access to care related needs include challenges with recruitment and retention of health care workforce, a lack of culturally responsive and linguistically appropriate care, a need for more representation in health care leadership to ensure more inclusive spaces, a lack of transportation options, and fear and distrust of health care. People with disabilities experience barriers related to a lack of transitional care and accessing Durable Medical Equipment (DME) and specialists, particularly pediatric specialists. Migrant and seasonal workers, older adults, people experiencing homelessness, and Trans+ youth may experience additional barriers to care.
Behavioral health challenges and access (mental health and substance use/misuse)	Key informants and community members identified behavioral health as a challenge in the community, including mental health and substance use/misuse, along with barriers to accessing treatment. Key informants shared that childhood trauma and Adverse Childhood Experiences (ACEs), stress related to not being able to meet basic needs, and social isolation can be contributing factors to behavioral health needs. There is a need for more substance use disorder (SUD) treatment and recovery programs, as well as residential treatment centers for behavioral health needs. Community members spoke to needing more detox centers and treatment for people with co-occurring behavioral health needs. There is a lack of culturally responsive and culturally matched behavioral health services, a shortage of behavioral health providers, and administrative burden that is prohibitive to providing quality care and retaining workforce. People with low incomes and those with a lack of social or community safety nets may have increased behavioral health needs and barriers to accessing services. Certain populations may experience more barriers to meeting their behavioral health needs, including older adults, young people, Native American peoples, Spanish-speaking individuals, and people experiencing homelessness. Community members were particularly concerned about ensuring access to care for young people and people experiencing homelessness.
MEDIUM PRIORITY UNMET HEALTH-RELATED NEEDS	
Disability inclusion and	Key informants discussed the resources that are needed in the community to increase disability inclusion and meet the health care, housing, transportation, and

support for people with disabilities	other needs of people with disabilities. To improve access to care, more specialists (particularly neurologists and pediatric specialists) and therapists (speech, physical, and occupational) are needed locally. There is also a need for more education of providers related to disabilities, transitional support and education after leaving inpatient rehab, easier access to DME and other accessibility items, in-home caregivers, support for costly travel for specialists, and accessible medical scales. There is a need for more community spaces that are inclusive of disabled people and non-disabled peers, along with more support for parents with children with disabilities. People with disabilities and their families may experience increased barriers to economic security due to costs not covered by insurance, Medicaid income requirements, and caregiving responsibilities. There are limited accessible transportation options outside of the public bus operating hours. There is a need for more accessible housing for disabled people. The stress and challenges of navigating these systems that are not accessible can affect mental health. Older adults with disabilities may experience additional barriers, like technology.
Economic security	Key informants shared concerns about seeing economic insecurity grow as a result of increasing cost of food, gas, rent, and more. They described incomes as not keeping up with the increased cost of living. There is a need for living wage jobs to ensure families can meet their basic needs. They were particularly concerned about economic security for families with children under the age of five. Social service providers may be paid a wage low enough to qualify them for their own services. For families with a disabled child, often only one parent can work, putting strain on the family to afford all of the care and supplies needed. For adults with disabilities, they may need to keep their income below a threshold to qualify for Medicaid. Key informants are seeing more older adults unable to afford their cost of living.
Access to childcare	Key informants described affordable childcare as one of the greatest community needs, particularly infant and toddler care. Accessing childcare is difficult and there are long waitlists. This affects the local workforce and the ability to recruit workforce to the area. A lack of childcare options also affects maternal mental health and family stability. There is a need to build the early childhood workforce to create more community capacity.
Food security	Key informants shared the cost of food, along with the cost of living, is increasing, which is affecting food security. Community members shared many people cannot afford food and Supplemental Nutrition Assistance Program (SNAP) benefits have not increased to keep up with the rising cost. While food pantries are addressing food insecurity, there are barriers to those resources, specifically, hours of operation and location. Transportation barriers also contribute to food insecurity; there are limited options outside of public buses and those that exist have limitations on how many bags people can bring. There is a need for home delivery of food, but funding is a barrier to implementing this.

In addition to the above need areas, community members also identified the following:

- **Community resources and navigation:** Community members would like more community resources and support navigating those resources. They would like resources that help cover basic needs and more programming to bring people together.

Appendix 2: Community Input

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision for a Healthy Community

Community members shared their vision for a healthy community:

- **People support one another and are involved in their community**: Community members shared that in a health community people want to help one another and people can reach out when they need help. Examples of helping one another can be getting groceries or providing transportation for a neighbor. People are involved in the community through volunteering and social clubs. When people see suffering, community members try to help.
- **Basic needs are met and there are local resources available**: Community members discussed the importance of people having their basic needs met, including having access to food, and access to safety net services in the case of hardship.
- **Inclusion and respect are foundational**: In a healthy community, people are respected and can bring their strengths to the community. People can be themselves and there is a sense of unity.
- **Safety**: People feel safe in a healthy community.
- **People can access health care services**: In a healthy community people have access to affordable health care services, including mental health resources. People have transportation to get to care.

Community Strengths

Community members shared community strengths:

- **Organizations and resources available to support people**: Community members shared that the community has resources available, including food and clothes for people experiencing homelessness, churches that provide food, a library, opportunities for recreation, and more. They identified the following organizations as supporting community health: National Alliance on Mental Health (NAMI), churches, La Clinica, ACCESS, food pantries, Assertive Community Treatment (ACT) team, Rogue Retreat, farmer's market, Journey Home peer support group, YMCA, Siskiyou Community Health Center, ReadyRide, AllCare Health, Project Youth+, and the library.
- **Strong relationships and respect**: Community members described a tight-knit community, where people have friendships and know one another. There is respect and empathy for one another.
- **Community engagement and people helping people**: Community members shared that many people volunteer and work together for the common good. An example is how people came

together after the Almeda Fire to recover and rebuild. There are many events and opportunities for people to bring their interests and talents to the community, like through interest groups.

Unmet Health-Related Needs

Community members were asked to discuss community health-related needs. The following themes emerged:

High priority unmet health-related needs

- **Homelessness and housing stability:** Community members described housing and homelessness as one of the main challenges in the community. They shared a need for more shelters and low-income housing. They have seen homelessness increasing and the Almeda Fire contributed to more housing issues. They would like to see more homelessness services, including public bathrooms, showers and resting places, along with support for people navigating resources and filling out applications.
- **Access to health care services:** Community members discussed a shortage of providers locally, saying it can be very difficult to get connected to care and there are long wait times. People in more rural areas have to travel outside their towns to get to a hospital. There is a need for more street medicine for people experiencing homelessness. Transportation and language are barriers to care. There is also a need for health care services for children with autism.
- **Behavioral health challenges and access (mental health and substance use/misuse):** There are a lack of behavioral health services in the community, particularly support for crises. Community members shared there are long wait times to receive mental health care. The community needs more detox centers and residential treatment centers. Community members were particularly concerned about ensuring access to care for young people, people experiencing homelessness, and people with co-occurring mental health and substance use disorders.
- **Community resources and navigation:** Community members would like more community resources and support navigating those resources. They would like resources that help cover basic needs (e.g., bathrooms in town, public showers, public dumpsters to dispose of trash, and laundromats), as well as more social opportunities (e.g., programming for older adults and community gathering spaces).

Medium priority unmet health-related needs

- **Food security:** Community members shared many people cannot afford food. Supplemental Nutrition Assistance Program (SNAP) benefits have not increased to keep up with the rising cost of food.

Future Visioning

Community members were asked what they would like to see for their community in three years. The following themes emerged:

- **Community resources**: Community members would like to see more resources, including a senior center, community pool, and library. They would like to see more resource sharing.
- **Social connection and activities**: Community members would like to see more opportunities for people to be in community through a community center and groups. They would also like more creative opportunities including music and art.
- **Access to care**: Community members would like to see improved access to care and care coordination, including more communication between providers and more timely care. They would like to see improved access to care for older adults (long-term care), people living unsheltered (street medicine), and people that experience language barriers (bilingual health providers). They would also like to see expanded OHP coverage and more health care providers locally.
- **Homelessness and housing stability:** Community members would like to see people sheltered and more homeless services available, including bathrooms, warming centers, and street medicine.

FINDINGS FROM KEY INFORMANT INTERVIEWS

Community Strengths

The interviewer asked key informants to share one of the strengths they see in the community and discuss how we can leverage these strengths to address needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Community knowledge and wisdom

Key informants emphasized that community members have a wealth of knowledge and lived experience that they share with their community to help others overcome challenges. For example, community members with experience navigating social service systems help others navigate those same systems.

> *"People share their experiences and say, 'Oh, but have you tried this place?' and 'Oh, I had this experience.' Just those very natural conversations between peers, I think, really help support people in having the courage to know how to access any resource they need."—Key Informant*

People with lived experience with substance use disorders or homelessness support other people going through these experiences. A lot of service providers locally have lived experience with the challenges they are helping others navigate. For example, people that used to live unsheltered are now supporting people in the same situation. Some organizations even have a majority of staff with lived experience.

Elders have a lot of wisdom and knowledge to share with younger generations. In the Native American community, parents and elders have tribal knowledge, gifts, and information that they pass on to the rest of the community.

> *"[Native American elders and parents are] just a really beautiful community of givers, I would say. Giving their time, their knowledge, their guidance."—Key Informant*

To leverage this strength, key informants recommended giving community members "a seat at the table," allowing them to tell organizations what they need and what would work. An example of this is including people with disabilities in conversations when designing accessible spaces to leverage their lived experience.

Another recommendation is to create spaces for people to come together and share support and knowledge with one another. For the Native American community, this space could look like a longhouse where people can gather and care for one another.

Collaborative relationships between local organizations and agencies

Key informants shared that strong partnerships and collaboration between organizations are critical for meeting community needs. Across Jackson and Josephine Counties, there are many organizations that are serving the community, including nonprofits, churches, and schools.

> *"There's just example after example after example of people that get together and try to focus on something and make things better."—Key Informant*

They described a small community in Josephine County where people within organizations know one another and have relationships. These relationships help them find creative solution and braid together support and funding to address complex needs.

> *"[Josephine County is] small, and we all know each other fairly well. I think that is an advantage in having those relationships."—Key Informant*

In Medford, many organizations have come together to be part of the solution to addressing homelessness, building strong partnerships and relationships.

> *"To see the amount of people that have shown up to show support, the amount of organizations that have started developing to be part of that solution [to addressing homelessness], it's just impressed me the last year and a half. I will say that's probably Josephine County's strength."—Key Informant*

Behavioral health organizations locally dedicate a lot of effort and diligence to coordinating, sharing information, and partnering with each other, especially because there is no formal coordinating entity.

The police department and civic groups and agencies also have good partnerships, with law enforcement participating in local meetings and collaborating with other organizations.

To leverage this strength of collaboration, key informants suggested bringing more agencies into collaborative conversations to foster more engagement throughout the county. Focusing on building

relationships is also important because it builds trust which allows for having hard conversations. These relationships are especially important for address complex issues, like the childcare crisis.

Community engagement and people helping people

Key informants described a giving, engaged community of wonderful people that help others. People want to contribute to the community through in-kind giving and volunteering and to bring their gifts and talents to helping others.

> *"I think the strength of it is that people want to contribute to do their part in the community."—Key Informant*

> *"We have a lot of people wanting to be involved in the work in whatever way best suits them."—Key Informant*

People care about and share their knowledge with one another. For example, people with disabilities share tips and equipment with one another to help each other navigate systems.

> *"We're usually focused on a lot of what partners are doing for people, but really people are doing for people. I think that's very powerful and valuable. Yes."—Key Informant*

Additionally, people want to provide a good experience for children growing up in the community.

Resilience and adaptability

Key informants shared that they see many people overcome challenging circumstances and take back power to improve their own lives. They remain resilient and hopeful, even in difficult times. They described young people as particularly resilient and having a lot of hope.

For people with disabilities or injuries, they may have to learn how to navigate the world in an entirely new way. They are adaptable in navigating these challenges.

To leverage this strength, key Informants recommended teaching people to advocate for themselves and helping them feel empowered to ask for what they need.

High Priority Unmet Health-Related Needs

Three needs were talked about in great detail by a majority of key informant interview participants. Four additional needs were categorized as medium priority because they were discussed less frequently and in less detail. Key informants were most concerned about the following health-related needs:

1. Homelessness and housing stability
2. Access to health care services
3. Behavioral health challenges and access (mental health and substance use/misuse)

Homelessness and housing stability

Almost all key informants identified addressing homelessness and housing stability as an important need in the community. They shared the cost of housing is at an all time high and there is significant housing scarcity. They discussed how housing stability is connected to many other needs:

- **Economic security:** The cost of housing affects people's economic security and ability to meet their basic needs, like food, safety, and more.
- **Workforce:** Local organizations have a hard time recruiting because the housing costs deter people from relocating to the area. This affects health care and behavioral health workforce, among others.
- **Behavioral health**: Housing is a foundational need; people need safe housing to be able to address their behavioral health issues. Homelessness and behavioral health needs can also be co-occurring. There is a need for more trauma-informed understanding of homelessness, rather than stigmatizing it.

  "It's hard to become stable with behavioral health issues when there's no housing."—Key Informant

- **Environmental hazards**: Many housing units were destroyed in wildfires, exacerbating the need for more housing units. The threat of wildfires may also deter people from moving to the area, particularly because homes are becoming uninsurable due to wildfire danger.

To address homelessness and improve housing stability, key informants discussed the following needs:

- More housing units across the spectrum, including shelter beds, supportive housing, transitional housing, and low-income housing: Key informants described a housing crisis, sharing that the population of the community has grown faster than the housing stock. There is a need for more affordable housing, particularly affordable housing that is also accessible.

  "It really is a housing crisis more than a homeless problem."—Key Informant

  In Josephine County, there are no shelter programs and nowhere for people living unsheltered to go. There is a lack of space to build housing in general because of a lot of the undeveloped land is owned.

  "The housing issue for us is really just a matter of being able to build homes and build enough of them, be that single-dwelling homes or that being an apartment complex. Right now, we're busting at the seams for space."—Key Informant

  In Jackson County, there are a lack of adequate housing supports to meet the needs, including shelter beds, rapid rehousing case management, and housing in general. Wildfires destroyed about 3,000 housing units on top of what was already a housing deficit.
  There is a need for more supportive housing, particularly for people with behavioral health needs, and supportive housing to help move people into stable, permanent housing.

  "Even though we get people off the street, shelters are not homes and people need homes that they can go to and have privacy and rooms and be able to close their doors and have time to themselves."—Key Informant

- Common definitions and language for types of housing: Within the housing sector, there are a variety of terms, including emergency shelter, transitional shelter, permanent supportive housing, permanent housing, and more. Lack of shared definitions within the homelessness response system has led to challenges in the ways in which people experience navigating and qualifying for services.
- More resources and funding to address homelessness: Service providers do not have enough resources to meet all of the demands across Jackson and Josephine Counties.
- More coordinated homeless services: While there has been a lot of progress in Jackson County with case conferencing and using a coordinated entry system, there are still opportunities to streamline and coordinate services. This should prevent people from having to seek the same services from multiple providers and tell their stories multiple times.
- Homelessness prevention: A focus on supporting young people, particularly those that might be experiencing trauma or abuse is important for preventing homelessness. Key informants shared that substance use/misuse, dropping out of school, and other family issues can be precursors to adult homelessness. Service providers locally shared seeing a higher rate of former foster youth in adult homelessness programs compared to the general population.

Barriers to addressing housing stability include the high cost of housing and a lack of housing stock for both renters and homeowners.

> *"There is a shortage of housing stock across the continuum of incomes from those that are seeking to buy, those that are seeking to rent. It's not affordable and there's not enough of it."—Key Informant*

System barriers create additional challenges to addressing homelessness locally and keeping people stably housed:

- Administrative burden associated with sources of funding: Funding sources have a variety of requirements that create administrative burden for service providers trying to help people. Additionally, the varying eligibility requirements can cause confusion for the service recipient trying to navigate these systems. The bureaucracy of homeless services and the challenges of funding effect everyone in the community because it impacts how services are provided and can make accessing these services more difficult. It also affects the service providers by creating more administrative burden, contributing to provider burnout.

> *"We're often stuck in a place of like, do we provide more services or can we hire a person to help us provide the services? We end up having pretty big caseloads, or the work itself is really, really emotional and we have big caseloads, so we get burnt out."—Key Informant*

- **Funding**: Key informants identified a lack of funding as the biggest barrier to addressing housing challenges. Specifically, building low-income housing involves a lot of funding complexity as funding is provided in the form of a tax credit with other stipulations. It can be challenging and expensive to build affordable, low-income housing, particularly housing that is also accessible.

- **Politics**: Legislative decisions bring in one-time funding, which makes it difficult to plan for long-term sustainability of services. Additionally, funding often comes with metric targets that providers are expected to meet in a very short amount of time. Short-term, impactful outcomes rather than the long-term, slower improvements can be more appealing politically. Additionally, homelessness has been politicized and there are groups of people that do not want low-income housing built in their community and perpetuate stigma towards people experiencing homelessness.

Certain populations experience additional barriers to stable housing:

- Young people experiencing homelessness: There are fewer resources available to people newly experiencing homelessness or couch surfing and therefore less visible as experiencing homelessness. There is also less focus on prevention and making homelessness brief, which can mean people remain experiencing homelessness for longer and there is greater opportunity for trauma, exploitation, and Adverse Childhood Experiences (ACEs). This can also affect families with youth.

"The longer that kids are in this situation [of homelessness], the more likely they will be adults in this situation."—Key Informant

- Older adults: Service providers are seeing an increase in older adults experiencing homelessness. If a spouse dies, the remaining spouse may not be able to afford their living situation. There is a need for affordable, accessible housing for older adults. There are few places that can support older adults with disabilities, meaning they may cycle between a hospital or medical respite and a shelter.
- People with disabilities: There is a need for more affordable, accessible housing. Without it, disabled people may have no other option than to stay in a skilled nursing facility, which may contribute to secondary health conditions. Additionally, people are often financially penalized for making accessibility adjustments to a rental.
- People living in rural areas: There are fewer resources available in more rural areas of the counties.
- Native American peoples: There are long wait lists for families needing access to resources and Native American communities have an added layer of hardship accessing them due to the cultural disconnect with institutions.
- People identifying as LGBTQIA+: Fear engaging with social service organizations can prevent people identifying as LGBTQIA+ from seeking support and resources.

Access to health care services

Key informants spoke to a lack of primary care and specialty care services in Jackson and Josephine Counties:

- Primary care: It can be very difficult to access primary care, even for people with knowledge of the health care system, access to resources, and health insurance. Primary care providers have left the community or retired, and others are not accepting new patients, leading to a backlog of patients needing a primary care provider.

  "We're all talking about employees who get paid well, who have very good benefits, all having a difficult time accessing primary care."—Key Informant

- Specialty care: There are long wait times for specialists, sometimes up to eight months even for urgent needs. People end up in the Emergency Department while they are waiting for a specialty care appointment. Participants identified neurology, gastroenterology and endocrinology as specialties particularly lacking and in high demand in the community. The lack of specialty care puts a lot of burden on primary care providers who are managing patients for months before they can get a specialist appointment.

  "One of the reasons the complexity of patients is so high for primary care is sometimes they don't have anywhere they can send them…. I know that we've tried to find places for patients that need neurology and it's like, 'Sorry,' and they end up back with primary care. Then primary care is maybe managing something that they're not entirely comfortable with."—Key Informant

  Key informants shared there is also a lack of pediatric specialists, as well as pediatric therapists, including speech, physical, and occupational therapists.

There is also a need for the following health care related services in the community:

- Care navigation: Patients need more support navigating the complexity of the health care system, particularly people that experience language or cultural barriers, including the Latino/a/e community. Care navigation is especially important after discharge from the hospital to support follow-up appointments and help people to be self-sufficient. For people with disabilities and their families, support navigating resources and education to ensure they have support systems in place area needed. There are a lot of organizations in Southern Oregon that provide services, but people need support knowing which services are available and how to access them.
- Vision care: Community members need more access to eye exams and reading glasses.

Barriers that contribute to access to care related needs include the following:

- Workforce challenges: The high cost of housing and lack of affordable childcare affect recruitment and retention of health care professionals. There is competition between organizations to hire staff; this affects not only providers, but also Medical Assistants (MA) and other staff. Turnover impacts patients and continuity of care, contributing to longer wait times as patients are re-assigned to a new provider. It also puts pressure on the remaining staff, contributing to burnout.

- Culturally responsive and linguistically appropriate care: There is a need for increased offering of information in various languages besides English. There is also a need for more bilingual front-desk representatives to make it easier for patients to schedule an appointment and speak to a clinic in their preferred language. There is a need for more bicultural providers to support Latino/a/e and Native American patients. Key informants spoke to a lack of understanding and inclusion of Native American culture within medical spaces, for example, not being able to perform smudging rituals in the hospital and not having access to culturally relevant food. Patients, including Latino/a/e patients, may also have concerns about being judged for how their culture approaches health and medicine.
- Lack of representation in decision-making spaces: There needs to be increased representation on hospital boards and in leadership positions across health care to ensure more inclusive spaces. This representation needs to be meaningful and should respect and compensate people for their experience and knowledge.
- Fear and distrust of health care systems: People's experiences of not being treated well within health care systems creates fear that prevents people from accessing services or resources. Fear could be related to public charge, getting a bill they cannot pay, or navigating a system in a language that is not their own. For the Native American community, it is also related to the history of forced sterilization and mistreatment of Native American people.
- Transportation: Transportation can be a barrier for many people, but especially older adults and people experiencing homelessness. There is a need for accessible transportation besides the local buses. Outside of operating hours, there are few options for non-emergency medical transportation.

Some groups experience additional barriers to accessing needed care:

- People with disabilities: Disabled people experience barriers related to a lack of transitional care, accessing durable medical equipment (DME) and other accessibility items, and navigating inaccessible spaces. There is a need for more transitional care and education after leaving inpatient rehab because primary care providers are not typically equipped to provide all the support a disabled person needs. Getting in to see a specialist can take many months, leaving patients to navigate the transition alone. DME and other accessibility equipment, including wheelchairs and adaptive strollers, can be expensive and navigating insurance approvals is time consuming and often comes with wait times. It can take a lot of energy and time to fight to get necessary items approved by insurance.
  Patients with disabilities may need to travel within or out of state for care, which is costly and not always reimbursed. Within medical spaces, there are often no wheelchair accessible scales and dental chairs can be particularly challenging for people in wheelchairs to access.
- Older adults: Older adults may be more isolated and less mobile, making it more difficult to get to services, particularly if they do not have accessible transportation. Additionally, older adults may have less access to and comfort with technology needed to navigate resources, including telehealth appointments and remote technicians to support repair of DME.

- People experiencing homelessness: Transportation barriers and a lack of reliable communication can make scheduling and getting to appointments more difficult for people experiencing homelessness. Key informants spoke to seeing patients experiencing homelessness accessing care through the walk-in clinics rather than primary care services because of fewer barriers.
- Trans+ youth: Accessing care can be particularly challenging for youth identifying as Trans+.
- Migrant and seasonal workers. Migrant and seasonal workers may not be aware of the local health care resources available.

Behavioral health challenges and access (mental health and substance use/misuse)

Most key informants identified behavioral health as a challenge in the community, noting that both mental health and substance use/misuse are issues, along with barriers to accessing treatment.

> *"I think definitely behavioral health is the big thing, mental health. There's a huge need."—Key Informant*

Key informants shared that there are a variety of contributing factors to behavioral health challenges:

- Childhood trauma and ACEs: Adverse Childhood Experiences (ACEs) and other childhood traumas can contribute to adult behavioral health challenges.
- Stress of not being able to meet basic needs: When people are worried about meeting their other needs, like access to food, or stressed about navigating complex systems, like being seen by a specialist, people's mental health can suffer. This is also true for people that experience many barriers to accessing services, including disabled people.
- Social isolation: Many people experience social isolation, which can contribute to more behavioral health needs.

There is a need for increased access to behavioral health treatment, as well as care connections and coordination. There is a lack of substance use disorder (SUD) treatment and recovery programs, and often a lack of available beds for when patients are willing to engage in treatment. There is a lack of residential treatment for mental health and SUD. For patients with a dual diagnosis, the treatment services for mental health and SUD are not well integrated, although many patients need both services. Patients with significant mental health needs plus complex medical needs have few care options. Additionally, people with a SUD and severe mental illness that may be living unsheltered have few places to receive the long-term supports they need. More support for patients transitioning between behavioral health treatment and supportive services is needed.

> *"The evolution of services to people with substance use disorders and services to folks with mental health disorders has been bifurcated for so long. The system response is not yet together, yet the human beings needing our care are experiencing those conditions together, and our service offerings are still not meeting their needs. There isn't really a lot of good option for somebody who needs a residential level of care who has high, high needs in both of those spaces, let alone outpatient care."—Key Informant*

To increase access to behavioral health services, key informants recommended health care invest more in behavioral health services, including substance use navigators in hospitals, and better integrate behavioral health into primary care.

Barriers that contribute behavioral health related needs include the following:

- Lack of culturally responsive care and culturally matched behavioral health providers: There are a lack of Native American providers and providers that have an awareness of Native American culture. This may lead to diagnoses or framing of problems without taking the patient's culture into context. There is also a need for more bilingual and bicultural providers to support Spanish-speaking individuals.
- Workforce: There is a lack of behavioral health providers, particularly providers who are skilled at working in person with patients with serious and persistent mental illness and significant SUD needs, along with complex social needs. There is an acute shortage of providers to cover 24-hour care, which affects the security and safety of the staff doing this work. Workforce education and training does not always prepare staff for high-acuity behavioral health work.

  "There's misalignment there to prepare a workforce for this more emergency first responder, high acuity need that we have in the publicly funded behavioral health system."—Key Informant

  "Not only is there a shortage of the behavioral health provider workforce, but particularly in that milieu, residential care, as well as 24/7 alternate schedules in person and in the field. It distinguishes it a little bit from routine outpatient practice and telehealth."—Key Informant

- System barriers: There is a need for more acknowledgement of the unique strengths and challenges of Southern Oregon and how interventions that might work in more urban areas might not be able to be replicated in the same way locally. There is also a lot of administrative burden in the behavioral health space that is prohibitive to providing quality care and retaining workforce.

People with low incomes and those with a lack of social or community safety nets may have increased behavioral health needs and barriers to accessing services. Certain populations may experience more barriers to meeting their behavioral health needs, including the following:

- Older adults: There are few specialty services for older adults with chronic mental health needs. The population of older adults is continuing to grow and there are concerns about meeting the increasing needs of this population over the next decade. Medicare mental health benefits cover psychiatry and therapy, but people may have other needs that are not covered.
- Young people: Key informants shared there is a mental health crisis for young people, with more anxiety, depression, and suicidality. Young people of color, specifically Native American young people, experience racism in school, harming their mental health.
- Native American communities: Systems and services are not culturally responsive, and it can be exhausting for people to have to code switch and navigate these systems. There is a lack of

meaningful representation within systems. Not being valued and respected for their experience and knowledge is also harmful to people's mental health.

- Spanish speaking community: There are not enough bilingual and bicultural providers and peer support specialists.
- People experiencing homelessness: Key informants shared that a lack of stable housing affects people's ability to address their behavioral health needs. When living unhoused, people are exposed to more trauma and exploitation, which worsens behavioral health challenges. Key informants shared concerns about people experiencing homelessness with severe and persistent mental illness and co-occurring SUD that contribute to ongoing criminal-legal involvement and no long-term placement.

"It's hard to become stable with behavioral health issues when there's no housing."—Key Informant

Medium Priority Unmet Health-Related Needs

Four additional needs were often discussed by key informants:

4. Disability inclusion and support for people with disabilities
5. Economic security
6. Access to affordable childcare
7. Food security

Disability inclusion and support for people with disabilities

Key informants discussed the resources that are needed in the community to increase disability inclusion and meet the health care, housing, transportation, and other needs of people with disabilities.

To improve access to care, disabled people need the following resources and support:

- Specialists and therapists: There are a lack of neurologists and other specialists to meet the needs of the community, including people with disabilities. Notably, there are a lack of pediatric specialists and therapists (speech, physical, and occupational) to meet the needs. There are often long wait times to see providers which lead to delays in diagnoses and therefore delays in treatments that could improve quality of life. Families are waiting eight months to be seen for an autism or ADHD assessment. Telehealth appointments, like for speech therapy, are improving some access, but often families have to drive out of their community for services. Children with certain conditions need to be life-flighted to Portland on a regular basis for care.
- Education of providers related to disabilities: Increased education of providers could aid in accurate and timely diagnoses.
- Transitional support and education after leaving inpatient rehab: Once a patient leaves inpatient rehab, there are usually few transitional supports. Primary care providers are not equipped to provide all of the care and education necessary, but getting in to see a specialist can take many months, leaving patients to navigate the transition alone.

- Durable Medical Equipment (DME) and other accessibility items: The cost of DME and other accessibility items is typically high and getting insurance approvals can be a long and time intensive process. Wait times for necessary equipment like wheelchairs or Augmentative and Alternative Communication (AAC) devices are long. People may have to give a lot of time and energy to getting approval for a wheelchair, adaptive stroller, or other item.
- In-home caregivers: While Medicaid can cover in-home caregiving expenses, there are not many caregivers available. This is especially an issue because some people may not be able to get out of bed until their caregiver arrives.
- Costly travel for specialists: Travel within state or out of state for specialists can be expensive and is not always reimbursed.
- Accessible medical spaces: There are typically no wheelchair-accessible scales in doctor's offices and dental chairs are particularly inaccessible.

To improve inclusive community spaces, disabled people need the following resources and support:

- Community spaces that are inclusive of disabled people and non-disabled peers: The general public does not often have a lot of experience interacting with people with disabilities. Creating spaces for disabled people to be with non-disabled peers and not be segregated is critical.
- Support for parents with children with disabilities: Many parents of children with disabilities are very isolated. Creating community and opportunities for parents to learn from one another is important.
- Accessible school bathrooms: Disabled children may have to be pulled out of school if there is not an accessible bathroom.

People with disabilities and families with disabled members may experience increased barriers to economic security. Many expenses related to a disability are not covered by insurance, including the cost of specific foods or types of clothing, transportation for care, and sometimes travel expenses for specialty care. In many families with children with disabilities, only one parent can work, putting further strain on the household. If reliant on Medicaid, people with disabilities need to keep their income below a certain threshold to maintain their health insurance. Therefore, people with disabilities may be restricted to a low income to maintain their insurance, which affects mental health, particularly for people that want to work or have a more fulfilling career.

There is a lack of accessible transportation options to meet people's needs. There are few options for non-emergency medical transportation outside of the operating hours of public buses. There are some accessible transportation options that help take people grocery shopping, but riders are limited to two small bags of groceries they can take back. There are not accessible transportation options, outside of public buses, for people that want to participate in recreation and social activities.

> *"For any recreation or getting out in the community, there's just not accessible transportation options."—Key Informant*

There is a need for more accessible housing for disabled people. Without affordable, accessible housing, people may be stuck living in a skilled nursing facility. Renters may be penalized for making accessibility

adjustments to a rental. People spend a short amount of time in inpatient rehab and may not have enough time to get their house prepared to be accessible or to search for a new, accessible home.

The stress of navigating these systems that are not accessible can affect mental health. Concerns about finances, accessing specialists, navigating insurance, and more can be overwhelming. People with disabilities, or their families, may experience isolation as well.

Older adults with disabilities may experience additional barriers to meeting their needs. In Josephine County, there is a higher proportion of older adults and those with disabilities because people move to the area to retire. Key informants shared that older adults may experience more isolation and may have limited access to or comfort with technology, limiting their ability to connect with others and access resources.

Economic security

Key informants shared concerns about seeing economic insecurity grow as a result of increasing costs of food, gas, rent, and more. They described incomes as not keeping up with the increase in cost of living. Josephine County was historically a logging industry, but a lot of that has gone away. Now there is more tourism and agriculture in the county.

Many families may not have the financial resources they need to meet their basic needs. Key informants shared that there are a lot of families with children below the age of five that are below 200% of the Federal Poverty Level. There has been some success with giving families flexible dollars to use to meet their current needs. For example, buying materials necessary for their job or repairing their car.

Key informants agreed there is a need for living wage jobs to ensure families can access decent housing, food, and other basic necessities.

> *"Families just don't have the financial resources they need. It's painful. It's painful."—Key Informant*

Additionally, more access to education is important to support people in getting living wage jobs. Key informants shared there are lower levels of educational attainment in Josephine County in comparison to other areas of Oregon.

Certain populations may be disproportionately affected by challenges with economic security:

- Social service providers: Social service providers within non-profit organizations are sometimes paid a low enough income that they qualify for the services they provide.

  "Then as nonprofits, we don't often pay very well as much as these jobs are worth. I think that it's pretty common in this field for us to pay people a wage that qualifies them for our benefits, which feels like that in itself is unjust."—Key Informant

- People with disabilities: People with disabilities and families with disabled members may experience increased barriers to economic security. Many expenses related to a disability are not covered by insurance, including the cost of specific foods or types of clothing, transportation

for care, and travel expenses for specialty care. In many families with children with disabilities, only one parent can work, putting further strain on the household. If reliant on Medicaid, people with disabilities need to keep their income below a certain threshold to maintain their health insurance. Therefore, people with disabilities may be restricted to a low income to maintain their insurance, which affects mental health, particularly for people that want to work or have a more fulfilling career.

- Older adults: There is an increase in older adults experiencing homelessness. When a spouse dies, the remaining spouse may not be able to afford to stay in their living situation.

Access to affordable childcare

Key informants described affordable childcare as a critical community need, particularly infant and toddler care.

> *"Affordable childcare is huge. We lose people frequently because they just can't afford childcare."—Key Informant*

Accessing childcare is difficult because there are long waitlists. This affects not only people with low incomes, but all people who want to work and need childcare.

> *"You literally can't find childcare. Finding childcare takes a miracle. There's [sic] waitlists."—Key Informant*

A lack of childcare affects maternal mental health and family stability. Key informants shared that data have shown the lack of access to quality infant and toddler care is connected to maternal mental health.

Childcare is also connected to the local workforce and affects the ability to recruit staff. Along with a lack of affordable housing, a lack of affordable childcare hinders people from moving to the area, affecting all sectors.

> *"We used to be able to recruit from other areas, and they look at the housing costs, they look at the childcare costs, and they say, 'No, thank you.'"—Key Informant*

There is a need to build the early childhood workforce as well. There are some investments in a local college program for early childhood teachers that are working to address the issue.

Food security

Key informants shared the cost of food, along with the cost of living, is increasing, which is affecting food security. There are waitlists of families seeking resources related to food security. While this affects all populations, some communities that have more distrust and cultural disconnect from institutions, including Native American peoples, may experience greater barriers.

While food pantries are addressing food insecurity, there are barriers to those resources, specifically, hours of operation and location. There are a limited number of food pantries that operate after 5pm, making it difficult for working adults to access the resource. Some of the food pantries are difficult for people to reach because they are not in central locations.

Transportation barriers also contribute to food insecurity. There is a lack of transportation options outside of the bus operating hours. There is transportation available through insurance that can take people grocery shopping, but riders are limited to two small grocery bags. People may not be able to bring back enough food to meet their household needs.

> *"People can get rides through their insurance to go to medical places for appointments and also grocery shopping. Then once you get to the store, you're only allowed to bring back two small bags that have to fit into a milk crate. It creates a food desert for some people that have a hard time going shopping, to begin with, let alone you're very limited on what you can bring back."—Key Informant*

There is a need for home delivery of food to address these barriers, but funding is a barrier to this. People who are homebound, recovering from surgery, or have caregiver responsibilities would benefit from food delivery.

> *"We have people call on a weekly basis asking for home delivery for food. They're either homebound or they're maybe recovering from surgery. They have kids, whatever the reason might be."—Key Informant*

Future Visioning

Key Informants were asked what they would like to see for their community in three years. The following themes emerged:

Connection and integration: Increased connection between services and reduced siloing

Key informants spoke to a variety of ways they would like to see more connection and integration of services, including a hub of service providers, co-locating services in a multi-agency resource center, sharing data between agencies to gain a more holistic picture of needs, and pooling resources. These strategies would support better alignment across education, health care, housing, social services, and public services. They would also support more relationship building between service providers. These strategies would be especially beneficial within the homelessness sector and managing transitions of care across organizations.

> *"We piece pathways to success for people with all of us, like bringing our specialties to the table and putting maybe some egos and knocking down some silo walls and just saying, 'This is how we come together, and we hold our community.' I would like to see us building more of that."—Key Informant*

Housing and homelessness: Increased housing units and de-stigmatization of homelessness

Key informants would like to see more shelters and housing units, including permanent supportive housing and transitional housing. In three years, key informants would like to see the community able to house people experiencing homelessness and provide them with safety and support. Housing that supports aging in place is also important.

Participants shared they would like the community to have a better understanding of the circumstances that lead to people experiencing homelessness, as well as more compassion for and humanization of people living unhoused to reduce stigma.

"We tend to blame adults for their problems but feel sympathy to kids, and connecting those dots in people's mind I think is important."—Key Informant

Systems change: A focus on long-term solutions

Key informants would like to see more focus on prevention and long-term solutions, like creating stability for families and addressing poverty. They would like to leverage the unique strengths of Southern Oregon and address the specific challenges that exist locally to invest deeply in priorities for the long term.

"I would like to see more of a priority on prevention and healing communities, not just putting band-aid fixes on obvious problems. If we had more upstream approaches, we might need less crisis services, less mental health services, less people experiencing substance abuse and addictions, less people in poverty, crowding emergency rooms. The cost to society would be tremendous to actually invest in preventative and upstream measures. That's what I would want to see."—Key Informant

Behavioral health: Increased services and improved systems of care

Key informants would like to see more mental health options to better meet community needs. They would like to see more investment in behavioral health from health care and more integration of behavioral health services into primary care. They would also like to see less administrative burden that negatively affects quality of care.

Health care: Increased inclusion, care navigation, and collaboration

Key informants would like to see more collaboration between health systems, particularly related to recruitment and workforce development. They would like care to be more inclusive, increasing the number of Native American providers in the community and compensating Native American practitioners (elders and medicine people) appropriately as any provider would. They would like to see more focus on building trust with community members that fear health care to make services more welcoming and comfortable. They would also like more efforts by health care providers to understand the needs of patients with disabilities, rather than the burden falling to patients to advocate for their own needs. Additionally, they would like to see more navigation supports, particularly related to discharge.

Community spaces: Inclusive and designed to meet specific needs

Key informants shared they would like to see spaces that are designed for their communities. For the Native American people, this could be a longhouse, with room for events, Pow Wows, and more, where Native American people can gather in a safe and comfortable space. For people with disabilities, this looks like more accessible playgrounds, shopping centers, and medical spaces that are easy for disabled people to navigate.

STAKEHOLDER INTERVIEW QUESTIONS

1. Please state your name, title, and organization as you would like them included in the report.
2. How would you define the community that your organization serves?

3. While a community health needs assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization serves.
4. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health.
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [See table below.]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. What suggestions do you have for how we can leverage community strengths to address these community needs?
8. Please identify one or two community health initiatives or programs that you see currently meeting the needs of the community.
9. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
10. Is there anything else you would like to share?

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Access to health care services		Food insecurity
	Access to dental care		Gun violence
	Access to safe, reliable, affordable transportation		HIV/AIDS
	Affordable childcare and preschools		Homelessness/lack of safe, affordable housing
	Aging problems		Job skills training
	Bullying in schools		Lack of community involvement and engagement

	Chronic conditions: obesity, heart disease, stroke, and diabetes		Maternal and infant health
	Community violence; lack of feeling of safety		Mental health
	Disability inclusion		Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination
	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g., climate change, fires/smoke, pollution)		Safe streets for all users (e.g., crosswalks, bike lanes, lighting, speed limits)
	Few community-building events (e.g., arts and cultural events)		Substance use disorder
			Other:

LISTENING SESSION QUESTIONS

- What makes a health community? How can you tell when your community is healthy?
- What's needed? What more could be done to help your community be healthy?
- What's working? What are the resources that currently help your community be healthy?
- Is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?

COMMUNITY HEALTH SURVEY DATA

The community health survey was open from February 7th to March 31st, distributed in both paper and electronic formats, and available in English and Spanish. The survey captured key information on health and lifestyle factors, community needs, and barriers to accessing health and social services in Jackson and Josephine counties. The data below is for all 354 survey responses from both the English and Spanish surveys. The survey was conducted electively and while efforts were made to engage the

diverse populations of our primary service area, survey results are not representative of demographics in the general population. The tables below highlight demographic information for survey respondents.

1. What county do you live in?

	Percentage
Jackson County	78.47%
Josephine County	21.25%
Other	0.28%

2. To which age group do you belong?

	Percentage
18-29 years	15.34%
30-39 years	28.98%
40-49 years	21.59%
50-65 years	23.01%
66-75 years	9.66%
76+ years	1.42%

3. Do you have health coverage or insurance?

	Percentage
Yes	96.61%
No	3.39%

4. What kind of health coverage or insurance do you have?

	Percentage
Medicaid	14.70%
Medicare	23.10%
VA, TRICARE or other military health care	0.79%
Indian Health Service (IHS)	0.79%
Private coverage through an employer or family member's employer	38.85%
A private plan that I pay for myself	4.72%
I do not have any health insurance now	0.79%
I do not know	1.05%
Other	15.22%

Write-in responses: *4-AllCare, 1-BlueCross Blue Shield through healthcare.gov, 1-Indian Health Services, 5- Jackson Care Connect (JCC), 1-Medicare Advantage, 9-Oregon Health Plan (OHP), 2-OHP Plus, 1-Prescription Part D, 2-I am waiting to get coverage through a job*

5. If you do not have health coverage or insurance, what are the main reasons why?

	Percentage
It costs too much	60%
I do not think I need insurance	10%

I am waiting to get coverage through a job	0%
Signing up for insurance is too confusing	0%
I have not had time to sign up for insurance	20%
Other	10%

Write-in responses: *Had ACA (Moda) but premiums have doubled every year the last 3 years*

6. Which statement best describes you and your household's health care over the last year?

	Percentage
We did not need health care	4.46%
We got all the care we needed	54.04%
We got some but not all the care we needed	27.58%
We had to delay getting the care we needed	9.75%
We got no care at all	1.95%
Other	2.23%

Write-in responses: *2-OHP. Finding new providers accepting new patients is difficult. Just routine check-ups, nothing major. No RX coverage for 2024. I have it now! None, I keep coverage. We had waits for care but not because of an inability to pay for or lack of coverage…more in an issue with referral waits and referrals getting lost.*

7. For the most recent time you or anyone in your household put off or went without health care, what were the reasons?

	Percentage
Too expensive	20.48%
Not having a primary health care provider	10.93%
Not knowing where to go	8.15%
Could not get an appointment soon enough	20.68%
Clinic is not open when I can go	2.58%
Needed childcare	5.77%
Needed transportation	3.78%
Not having a health care provider that speaks my language	1.79%
Not having a provider that understands my needs	5.37%
COVID-19: appointment cancellation, concern of infection, or other related concerns	0.80%
My family and I have not had to put off or go without health care	14.71%
Other	4.97%

Write-in responses: *Accessibility, accommodation, discrimination. All appointments were filled with my PCP for a few months. Already have a $5,000 medical bill I am paying on. Anxiety. Care not covered by insurance. Couldn't get an endoscopy soon enough here, so my provider sent me to Springfield to get the procedure sooner. Did not qualify. Had to wait until this year for paying for Rx. Husband is expensive. Lack of providers in the service area. Loss of work and no health insurance. Needed to get time off work. Needing a referral from primary care that became a barrier. No native doctors. Struggle with insurance to authorize in a timely fashion. Too sick to go in, not sick enough to get treated in urgent care. Unemployed.*

8. A primary health care provider is the person you see if you need a health check-up, want advice about a health problem, or get sick or hurt. Do you have a primary care provider?

	Percentage
Yes	75.75%
No	22.25%

9. Have you ever been told by any health care professional that you have any of the following?

	Percentage
I have not been diagnosed with any health condition	8.99%
Anxiety	19.24%
Asthma	8.23%
Cancer	2.91%
Diabetes or high blood sugar	5.70%
Depression	14.81%
Heart disease	1.65%
High blood pressure	7.97%
High cholesterol	7.85%
Post-traumatic stress disorder (PTSD)	8.99%
Substance use disorder	4.30%
Other ongoing health condition	9.36%

Write-in responses: *Achilles tendon tightness; ADD; ADHD (3); AFib; Anorexia; Aneurism above heart; Arthritis; Autism/ASD(2); Autoimmune disorders; Cancer; Celiac; Chronic fatigue; Chronic pain; COPD; Dystonia; Ear issues; Fibromyalgia (2); Fusion L2-7 + C4-5; Generalized disordered eating; Hashimoto's Syndrome; Heart disease/complications/condition (3); Hepatitis C (2); Hereditary Spastic Paraplegia; Hernia; High Calcium; HIV; Hypertrophic cardiomyopathy; IBS; Intellectual disability; Intestinal issues; Irregular heart beat; Kidney issues/stones (2); Leg length discrepancy; Liver disease; Low blood pressure; Lupus; Manic bipolar; Migraines; Neuralgia; Neuropathy; OCD; Ocular migraines; Osteoporosis; Pancreatic insufficiency; PCOS; POTS; Quadriplegia; Rheumatoid arthritis (2); Scoliosis (2); Sjogren's; Spinal cord injury; Urologic issues; Thyroid issues (7); Tracheal Stenosis; Vertigo*

10. In the last year, did you receive care using any of the following?

	Percentage
I have not received any medical care	5.87%
Emergency department	13.12%
Primary care	31.83%
Primary or specialty care outside of my community	3.96%
Specialty care	16.39%
Telemedicine (video visit)	10.52%
Urgent or immediate care	18.31%

11. Which statement best describes your personal experience with counseling or mental health treatment over the last year?

	Percentage
I didn't need counseling or mental health treatment	42.12%
I got all the care I needed	32.66%
I needed support for a personal problem but didn't receive it	9.46%
I needed treatment for a mental health condition but didn't receive it	6.88%
Other	8.88%

Write-in responses: *Got counseling at OnTrack. Got counseling I needed, could not get medications adjusted in a timely manner. Had to jump through lots of hoops to finally get the care I needed. I do talk therapy over resolution/solution therapy by choice and I do get my meds filled by a psychiatrist. I go to Options. I go to Recover Café and Joy Church. I got help, but it was limited. I need specific support not available. I did therapy for years & was released. I need support for a personal problem and a mental health condition but didn't receive it. (9) I needed help for a personal problem but didn't receive it – no mental health in Spanish. I needed it but couldn't find the time. I received care less than I want or felt I needed because of high cost (my insurance covers very few MH providers, so I pay out of pocket). I received counseling, however the agency I went through does not provide the specific kind of therapy I would find most helpful (EMDR). I received help, but not adequate amount. It was also impossible to find care that was culturally responsive. I received treatment but had to wait a really long time to find a provider. I used my EAP for mental health. I used peer support because there were no local providers & the new one doesn't take my insurance yet. I'm not sure if I need it. Just started treatment at Columbia Care. Very disappointing. Partially received treatment, could not afford full treatment-health care is so expensive. The care I received was subpar and ineffective. I was in addiction.*

12. Were you or others in your household able to get the care you needed with alcohol, tobacco, or substance use?

	Yes	No	N/A
Smoking cessation program	2.95%	15.04%	82.01%
Alcohol treatment program	5.87%	12.02%	82.11%
Medication assisted treatment program	6.92%	11.87%	78.67%
Substance use disorder counseling and treatment	10.32%	11.54%	77.88%

13. Do you have any children (under 18 years of age)?

	Percentage
Yes	46.57%
No	53.43%

14. Have you ever been told by a health care professional that any of your children have any of the following?

	Percentage
My children have not been diagnosed with any health condition	43.37%
Asthma	15.31%
Behavioral or mental health diagnosis (such as depression, anxiety, or ADHD)	21.43%

Developmental delay or a learning disability (such as autism or dyslexia)	10.20%
Diabetes or high blood sugar	0.51%
Post-traumatic stress disorder (PTSD)	3.57%
Other ongoing health condition	5.61%

Write-in responses: *Allergies, ASD, ADHD, Kidney disease, Lupus, RSV (not ongoing), Schizoaffective disorder, Scoliosis*
(NOTE – above responses were integrated into the appropriate corresponding categories for inclusion in key theme discussion – see page 50 for further information.)

15. Where do you seek health care to support your children with this condition/these conditions?

	Percentage
I'm not currently seeking care for this condition/these conditions	27.01%
Emergency department	9.48%
Local pediatrician, doctor or specialist's office	38.39%
School nurse or counselor/school-based health clinic or center	6.64%
Specialist or doctor outside of my community	7.11%
Urgent or immediate care	11.37%

16. How would you rate these areas of your personal overall health?

	Excellent	**Very Good**	**Good**	**Fair**	**Poor**
Physical health	8.36%	30.84%	41.50%	17.29%	2.02%
Mental health	12.14%	28.32%	32.66%	22.83%	4.05%

17. During the last year, how often have you felt the following?

	Not at all	**Some of the time**	**A lot of the time**	**Most of the time**	**All of the time**
Loneliness or social isolation	34.66%	38.92%	15.34%	8.24%	2.84%
Little interest or pleasure in doing things	38.53%	39.09%	12.75%	6.80%	2.83%
Feeling down, depressed or hopeless	34.86%	44.00%	12.29%	5.43%	3.43%
Feeling nervous, anxious, or on edge	24.36%	41.83%	17.48%	10.32%	6.02%
Not being able to stop worrying	33.33%	36.75%	15.67%	8.55%	5.70%

18. The following questions are about where you live.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Do Not Know
My community has healthcare options available.	5.70%	13.68%	21.08%	36.47%	18.80%	4.27%
My community is a good place to raise children.	3.13%	10.23%	28.93%	32.10%	16.76%	7.95%
My community is a good place to grow old.	3.40%	12.75%	26.91%	32.86%	17.85%	6.23%
I feel safe in my home.	1.71%	3.70%	12.82%	35.90%	43.02%	2.85%
My community feels safe.	3.14%	11.43%	26.00%	39.14%	19.43%	0.86%
I feel prepared for an emergency.	3.12%	16.43%	24.65%	37.11%	17.56%	1.13%
People of all races, ethnicities, backgrounds and beliefs in my community are treated fairly.	11.40%	28.49%	26.50%	19.94%	8.55%	5.13%
People in my community can access mental health services and substance use disorder treatment.	9.92%	24.93%	19.83%	22.66%	13.60%	9.07%
Healthy food is available in my community.	3.15%	8.60%	23.50%	40.11%	23.50%	1.15%
There are places to be physically active near my home.	1.71%	5.13%	12.54%	38.89%	37.04%	3.70%
I have enough financial resources to meet my needs.	9.69%	17.09%	18.80%	32.48%	20.23%	1.71%

19. Including yourself, write the number of people currently living in your household.

	0	1	2	3	4	5	6+
Number of children (0-17 years)	51.2%	20.1%	16.6%	8.7%	3.2%	0.3%	0.0%
Number of adults (18-64 years)	13.0%	21.4%	46.1%	11.0%	5.5%	2.6%	0.3%
Number of older adults (65+ years)	77.5%	10.5%	10.8%	0.6%	0.3%	0.0%	0.3%

20. Which best describes the house you live in?

	Percentage
Single family.	66.67%
Multi-generational.	9.69%
Shared with other families.	7.12%
Shared with roommates.	6.84%
I live alone.	9.69%

21. What is the best description of your current housing situation?

	Percentage
Own my home	50.43%
Rent (no subsidy/assistance)	22.79%
Rent (with subsidy/assistance)	3.99%
Unhoused/homeless	4.56%
Unhoused (living in a vehicle)	2.28%
Hotel/motel (paid by self)	0.57%
Hotel/motel (emergency shelter voucher)	0.0%
Hotel/motel (with assistance)	0.28%
Post-fire transitional housing (trailer, hotel, other)	0.28%
Short-term shelter/transitional housing	1.14%
Staying/living with family members	0.57%
Staying/living with friends	6.55%
Other	6.55%

Write-in responses: *Caretaker job attached with housing; Communal/dorm living; Community residential treatment; Foster home; Group home; Homeless; Home jointly owned by family LLC and me; Live with my girlfriend/fiancé; Losing my house to foreclosure; Own manufactured home and pay for space; Rehab housing; Rent a room in a friend's house; Rent space in an RV park; Rent with family members (2), RV; Short-term transitional housing with friends or family members (2); Unpermitted structure on a friend's property; Van*

22. What is your current employment status?

	Percentage
Employed full time plus (more than 40 hours per week at one or multiple jobs)	34.29%
Employed full time (40 hours per week)	18.29%
Employed part time	10.57%
Seasonal, service industry, gig economy	0.57%
Self-employed	5.71%
Retired	8.29%
Unable to work due to illness, injury, disability	5.43%
Stay-at-home parent	4.57%
Unpaid caregiver/caretaker	0.29%
Student	0.57%
Unemployed	11.43%

23. Do you work more than one job?

	Percentage
Yes	89.66%
No	10.34%

24. Do you have to work more than one job to afford your living expenses?

	Percentage
Yes	82.96%
No	17.14%

(NOTE – in the online form, Question 24 only appeared when the answer to Question 23 was 'Yes.' The paper survey yielded many more affirmative responses to this question, even those who do not currently hold more than one job indicated they needed more than one to afford living expenses.)

25. What is your combined gross household income (the amount before taxes and deductions are taken out) for last year (2024)?

	Percentage
$0	5.33%
$1 to $10,000	9.47%
$10,001 to $20,000	6.21%
$20,001 to $30,000	9.17%
$30,001 to $40,000	7.69%
$40,001 to $50,000	9.17%
$50,001 to $60,000	9.47%
$60,001 to $70,000	6.51%
$70,001 to $80,000	5.33%%
$80,001 to $90,000	2.37%
$90,001 to $100,000	4.44%
$100,001 or more	24.85%

26. What is your education level?

	Percentage
Less than high school	10.29%
High school diploma/GED	18.29%
Trade School/apprenticeship/other certificate	5.14%
Some college/university education (no degree)	20.57%
Vocational or associate degree	8.00%
College/university bachelor's degree	22.86%
College/university post-graduate degree/certification	14.86%

27. In the last year, have you or anyone in your household had to go without anything from this list because you couldn't afford it?

	Yes	No	N/A
Food	18.91%	75.64%	5.44%
Utilities (water, electricity, heat)	16.52%	78.26%	5.22%
Transportation	21.04%	73.20%	5.76%
Clothing	13.79%	80.46%	5.75%
Personal hygiene items (soap, shampoo, toilet paper, feminine products, etc.)	15.03%	79.19%	5.78%
Stable housing or shelter	15.90%	78.90%	5.20%
Medical care	21.10%	72.83%	6.07%
Medicine	14.99%	78.10%	6.92%
Childcare	12.43%	58.38%	29.19%
Dental care	26.00%	67.14%	6.86%

28. This section will help us find health and service differences among people with and without functional difficulties. *NOTE: age ranges fluctuate with categories to better reflect community response.*

	Yes	No	Don't know	Prefer not to answer	Age of onset	
Are you deaf or do you have serious difficulty hearing?	4.53%	94.05%	0.85%	0.57%	*birth*	17%
					1-19	*8%*
					20-29	*25%*
					30-39	*0%*
					40-49	*17%*
					50-59	*25%*
					60+	*8%*
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	5.11%	94.03%	0.57%	0.28%	*birth*	38%
					1-19	13%
					20-39	0%
					40-49	13%
					50-59	13%
					60-69	13%
					70+	13%
Do you have serious difficulty walking or climbing stairs?	10.60%	88.83%	0%	0.57%	0-19	17%
					20-29	17%
					30-39	6%
					40-49	0%
					50-59	22%
					60-69	28%
					70+	11%

	Yes	No	Don't know	Prefer not to answer	Age of onset	
Because of a physical, mental or emotional condition, do you have serious difficulty concentrating, remembering or making decisions?	15.91%	81.82%	1.70%	0.57%	*birth*	22%
					1-10	22%
					11-15	17%
					16-19	13%
					20-29	9%
					30-39	13%
					40-49	4%
Do you have difficulty dressing or bathing?	3.97%	95.75%	0%	0.28%	*0-19*	25%
					20-29	50%
					30-39	0%
					40-49	25%
					50-59	0%
					60-64	0%
					65+	0%
Do you have serious difficulty learning how to do things most people your age can learn?	20.00%	92.92%	1.13%	0.28%	*birth*	40%
					1-10	0%
					11-15	20%
					16-19	20%
					20-39	0%
					41-49	20%
					50+	0%
Using your usual (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?	3.40%	95.47%	1.13%	0%	*birth*	75%
					1-19	0%
					20-29	0%
					30-39	0%
					40-49	25%
					50-59	0%
					60+	0%
Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	9.94%	89.20%	0.28%	0.57%	*birth*	24%
					1-10	0%
					11-19	29%
					20-29	6%
					30-39	12%
					40-49	6%
					50-65	24%
Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?	11.97%	87.18%	0.85%	0%	*birth*	18%
					1-5	9%
					6-10	0%
					11-15	36%
					16-18	18%
					19-20	9%
					20-25	9%

Do you have someone to help you with daily tasks of living if you were to become suddenly ill, injured or disabled?	43.47%	51.99%	4.55%	0%	

29. What language do you speak mostly at home?

	Percentage
English	86.53%
Spanish	11.17%
Other	2.29%

Write-in responses: *Both English and Spanish (8); English (2); English and Qulich/Lower Umpqua*

30. What language would you prefer to use when communicating (in person, phone, virtually) with someone outside the home about important matters such as medical, legal, or health information?

	Percentage of 'Spanish' and 'Other' Responders
English	26.09%
Spanish	65.22%
Other	8.70%

Write-in responses: *Both English and Spanish (2); English*

(NOTE: Question 30 only displayed if Question 29 was answered 'Spanish' or 'Other').

31. What language would you prefer to use to read important written information such as medical, legal, or health information?

	Percentage of 'Spanish' and 'Other' Responders
English	26.09%
Spanish	67.39%
Other	6.52%

Write-in responses: *Both English and Spanish; cannot read (community partner facilitated survey participation)*

(NOTE: Question 31 only displayed if Question 29 was answered 'Spanish' or 'Other').

32. What is your gender identity? *NOTE available selections: Agender, Cisgender, Gender Queer, Man, Non-binary, Transgender, Two-Spirit, Woman, Prefer not to answer and Prefer to self-describe.*

	Percentage
Woman	72.32%
Man	22.88%
LGBTQIA+ gender identity	3.39%
Prefer not to answer	1.13%
Prefer to self-describe	0.28%

Single selection gender identities: *Gender Queer (0.56%), Non-binary (1.41%)* ***Multiple-selection gender identities****: Gender Queer, Non-binary (0.28%); Man, Cisgender (0.56%); Man, Non-binary, Transgender (0.28%); Woman, Cisgender (2.26%); Woman, Man, Other (0.28%); Woman, Non-binary (0.28%); Woman, Transgender* ***(****0.28%)* ***Write-in responses:*** *Bi gender*

33. What is your sexual orientation?

	Percentage
Aromantic or asexual	4.40%
Bisexual	6.45%
Gay	1.47%
Heterosexual or straight	67.74%
Lesbian	2.05%
Pansexual	1.47%
Queer	1.17%
Questioning	0.59%
Prefer not to answer	8.50%
Prefer to self-describe	2.93%

Write-in responses: *Bisexual and heterosexual or straight (2); Demisexual/Panromantic, Androphilia, Aromatic or asexual, Gay, Pansexual, Queer; Not dating; Pansexual and Queer; Queer, Ace; Regular (2); Straight*

34. How do you identify your race, ethnicity, tribal affiliation, country of origin or ancestry?

Write in responses: *American; American White; American with parents from Lithuania, Italy, Scotland and England; Asian; Asian and White; Basque; Biracial; Black Man; Black, Native/indigenous (Yurok); Catholic; Caucasian (2) ; Caucasian – USA; Caucasian - White English/Scottish; Caucasian (White); Caucasian / White; Caucasian- eastern European descent; Caucasian, European; Caucasian/Jewish; Caucasian/Mexican; Caucasian/White; Cuban; English, French, Scottish, Viking, and more; Eurasian / White; European; European/Native; European, mostly British isles; Hispanic/Latino (4); Human; Celtic; Japanese American, white; Hispanic and White (2); Indigenous; Indigenous Mexican; Indigenous Mexican American; Irish and German; Japanese; Jewish; Korean American/White; Lakota - Native American; Latina, Mexican American (4); Latine; Mexican (6); Mexican and Mescaiero [sic] Apache; Mexican/ Hispanic and White; Mixed (3); Mixed Japanese, European, Dutch African; Multi Racial (4); Native American (3); Native American (Lower Umpqua/Tolowa) Scottish, Irish, Swedish; New Zealand European; Scotch Irish; Scottish; Spanish and Native American; United States (2); Western European; Western European American; White (4); White & Native American; White / Latino; White / non-Hispanic; White /Irish/ French; White American; White and Native American (2) ; White Anglo Saxon; White w/Spanish descent; White, England/Ireland; White, German; White, Native; White, Native American; White, United States citizen, Western European ancestry; White, USA; White/European; Yurok Chetco Cherokee*

35. What is your race? NOTE: Respondents were able to select all that applied. When more than one race was marked that was calculated as more than one race. See chart below for subgroup reporting.

	Percentage
American Indian and Alaska Native	0.58%
Asian	0.87%
Black and African American	0.58%
Hispanic and Latino/a/x	16.23%
White	59.13%
More than one race	14.78%
Don't know	2.03%
Other	2.32%
Prefer not to answer	3.48%

Asian	
Asian Indian Cambodian **Chinese – 11.11%** Communities of Myanmar **Filipino/a – 11.11%** **Hmong – 11.11%**	**Japanese – 22.22%** **Korean – 11.11%** Laotian South Asian **Vietnamese – 22.22%** **Other Asian – 11.11%**
American Indian and Alaska Native -	
Alaska Native – 3.57% **American Indian/Native American – 82.14%** Canadian Inuit, Metis or First Nation **Indigenous Mexican, Central American or South American – 10.71%** **Mixed Indigenous – 3.57%**	
Black and African American	
African American – 50.00% **Afro-Caribbean – 16.67%** Ethiopian Somali **Other African (Black) – 16.67%** **Other Black – 16.67%**	
Hispanic and Latino/a/x	
Central American – 9.46% **Mexican – 72.97%** **South American – 2.70%** **Other Hispanic or Latino/a/x – 8.11%** **Mixed Hispanic and Latino/a/x – 6.76%**	

Middle Eastern/North African
Middle Eastern – 50.00% North African **Mixed Middle Eastern and North African – 50%**
Native Hawaiian and Pacific Islander
Chamoru (Chamorro) Communities of the Micronesian Region Marshallese Native Hawaiian Samoan **Other Pacific Islander – 100%**
White
Eastern European – 10.48% **Slavic – 0.87%** **Western European – 46.72%** **Other White – 33.19%** **Mixed European – 7.42%** **Mixed Slavic European – 1.32%**
Other

Write in responses: *Central American born in El Salvador; Human; Jewish; Mixed; Slavic, Western European, Greek and Celtic; White*

36. If you checked more than one race above, is there one you think of as your primary racial or ethnic identity?

	Percentage
No. I identify as Biracial or Multiracial.	12.84%
No. I do not have just one primary racial or ethnic identity	11.28%
N/A I only checked one category above	47.86%
Don't know	12.84%
Prefer not to answer	8.95%
Other	6.23%

Write in responses: *Asian; Caucasian; Indigenous; Indigenous Mexican; Jewish; Latina/e; Mexican; Mexican-American; Native American; Scandinavian; White (3); White American; Yurok*

37. Is there anything more you would like to share about your health and wellness or the community's health and wellness that was not covered in this survey?

Number of comments reflecting areas of respondent concern *Many comments touched multiple areas of concern; this is not an exhaustive list. See "Select Illustrative Comments" for specific examples from select categories.*			
Access to Care	**64**	**Substance Use**	**8**
Mental Health	**38**	**Elders**	**8**
Marginalized Communities	**20**	**Disability**	**8**
Resources	**17**	**Medicare / Medicaid**	**7**
Wait Times	**15**	**Homelessness and Housing Instability**	**6**
Insurance	**15**	**Education**	**6**
Specialty Care	**14**	**Transportation**	**5**
Primary Care	**13**	**Chronic Conditions**	**4**
Community	**12**	**Prescriptions/Pharmacies**	**4**
Dental	**12**	**Public Safety**	**4**
Care and Service Restrictions	**11**	**Employment**	**4**
Cost of living	**10**	**Vision**	**3**
Child / Youth	**9**	**Food Security**	**3**
Health care costs	**8**	**Childcare**	**2**
Hospitals	**8**	**Preventive Care**	**1**

SELECT ILLUSTRATIVE COMMENTS

Access to Care

"Jackson and Josephine need a lot more options for mental and substance abuse healthcare. There is some help but not nearly enough. Providence Hospital needs to expand its hospital size because it's too small for this growing area."

“Medicaid being county specific has been one of the worst and hardest parts about getting healthcare. In today's economy, we go where the opportunities are. That often means moving at a moment's notice. As a Medicaid recipient who moves regularly following different gig or contract jobs, I have never been able to receive adequate care. I find a therapist for 6 months and then have to stop seeing them when I move counties. I find a dentist and can only get half of my necessary treatments because when I moved they stopped taking my insurance. The constant upheaval of my medical team and inability to continue seeing them once my insurance has changed to be county specific is disorienting and upsetting, especially w/ how long it takes to get an appointment. I'd rather drive 5 hours round-trip to see my Lane County dentist (who I also have a good relationship with) than wait 6 months to be seen by someone here. But I don't have that option since now my insurance is Jackson County specific.”

“Access to dental + vision is almost impossible if you are homeless. Especially if you don't have personal transportation.”

“This community needs more primary and specialized care, including mental health services, GI, PCPs, etc."

“In White City, they took away the hospital and now they're just blood and blood samples. In White City, we need the hospital open 24 hours a day. It's my turn to go to Medford and take my daughters when they're feeling sick.“ *(Original comment submitted in Spanish.)*

“The health system is very complex and not easy to navigate. Many folks might not get themselves to a doctor due to the complexity and the wait time to get an appointment. Also, there are not enough providers that are culturally responsive. Many clinics and hospitals haven't figured out how to best support patients with various linguistic needs, this is very frustrating.”

“There seems to be a shortage of doctors and specialty physicians in the valley. My primary care doctor cannot see me for illness because she's overbooked, I always have to go to Urgent care for antibiotics related to cold/UTI's. It took 6 months to be accepted as a patient and another three months to be seen by an endocrinologist. My urologist left the valley, and the clinic closed so I no longer have a urologist.”

“I have great fear about using the hospital for treatment with nursing and doctor shortages.”

Care and Service Restrictions

“The county has only one neuropsych and she refused to accept my case"

“There are very few counselors who work with people with autism. Some of them do not accept OHP.”

“The amount of time some doctors spent with you—5/10 minutes—is not always enough. The amount of time it takes for referrals and dental care, and not [being] able to have a needed surgery because you smoke.”

“Medical Community, in particular specialty, is too restrictive to serve all members of the community equally. [This] might be due to insurance reimbursement, or to willful obstruction, not sure what the reason might be to exclude members of the community due to choice of primary care. Certainly, the decision to exclude a large swath of this very small community, where choices of care are so limited, cannot be taken lightly.”

"I need serious dental help. It's a problem in my day-to-day life. My insurance will only cover extractions, and I don't qualify for a partial or dentures. I have no back teeth and it makes it hard to eat."

Cost

"I think our community could use more resources that are no cost barrier."

"Medical insurance is sky rocket high, food prices and rent are outrageous. We have to choose in between having healthcare, a home and food sometimes. It's hard with children."

"Medicare needs to cover scleral lenses for extreme dry eye. The $2,000 prescription deduction is too high. My eyedrops alone are $1600 for the year. I have to stretch them out. Dental coverage does not pay enough. I need a $5,000 implant and the alternative of a bridge is about the same cost. If I don't replace the tooth my other teeth surrounding missing tooth are at risk of failing also. I pay $185 in standard Medicare, $180 for plan G & $9 for dental, $26 for Vision care and have a prescription drug plan with a $0 monthly amount but does not kick in until I reach the $2,000 threshold. All this coverage and I struggle to get my medical care needs without wiping out my account and going into debt."

"The cost of Health care even by employer is ridiculously high. Most families that don't qualify for state assistance have high deductibles and the cost for care at various medical offices is outrageous. These costs are what cause people not to seek medical care for doctors, dentists, vision, mental health, etc. Plus, the schedule to see a medical provider is terrible. It can take up to 2 months just to see a medical provider, 3 months to see a dentist, and 4-6 months to see a specialist. Do better Oregon."

"Dental care is wildly expensive and health insurance basically only covers 1 root canal and that's it. People deserve dental treatment that will help them keep their teeth affordably."

"Rent burden affects access to medical care due to not having enough disposable income."

"The cost of healthcare, even with insurance, is ridiculous. It's way too expensive."

"Dental care is definitely hard to receive. Also, the copay for things like procedures or false teeth/crowns is very high even with a sliding scale. I am 24 almost 25 and all my back teeth are missing, and more are going making it hard to treat--however I can't afford a partial event with OHP."

"[There needs to be] low cost alternatives for child care and elder care."

Homelessness and Housing Instability

"Housing is difficult and I think there should be more independent living with work source available and not as many stipulations and rules."

"I wish that the Josephine County Homeless Community had more unity in this community in order to help us to navigate and take advantage of any and all resources available to us!"

“Our community is seriously lacking in its support of the homeless, mentally ill, and addicts. People live on the street all over Jackson County. They deserve housing, harm reduction services and counseling if they want it.”

“…as a single parent, the rent is too high to afford. I've been on the HUD waitlist for 10yrs, they keep finding reasons to kick me off. Why don't they call us instead of using an address when they know we are HOMELESS? So now I have two children in a home I know I won't be able to afford to keep as my rent is $1,600 a month…”

Elders

“Please provide local volunteer programs that provide services for older adults. Support Community Volunteer Network's Call-a-Ride program, Age Wise Age Well and SHIBA programs to improve access to care.”

“Having a mother who is 84, and as my husband and I age, I do have concerns about not having a hospital close by.”

“Housing. Too many seniors are homeless.”

Insurance

“I am transitioning from one medical insurance to another one (both commercial) and I am having an issue to refill my medication. It has been difficult to connect the services between both companies. Too much bureaucracy.”

“It's difficult to make the time to try to figure out primary care, even though I have health insurance. My mom also doesn't have great insurance, and I can't really put her on mine since insurance only counts children and spouses as family. She's the one that needs more care and it's frustrating.”

Marginalized Communities

“Hard to get help from non-Native providers that don't understand the culture, spiritual practices.”

“I do feel that I have to advocate for my gender and race in the health and wellness community.”

“The Illinois Valley needs more local providers who understand the culture of this region. Medical providers who will STAY and mental health providers, period. Children need IN PERSON therapy options!”

“There are no questions about feeling welcomed or treated with respect at your doctor's or medical professional's office when considering your gender identity, sexual orientation, age, race or ethnicity.”

“I filed a complaint about medical malpractice during my delivery, but it was simply filed and nothing was ever done. I believe the malpractice also included discrimination. All the medical staff treated me differently after I filed the complaint.” *(Original comment submitted in Spanish.)*

“Hire people who are truly bilingual—just because they say they are or come from Hispanic families. There are a lot of 'I DON'T KNOW' employees who don't actually help the Latino community.” *(Original comment submitted in Spanish.)*

Mental Health

“Extremely difficult to find counseling resources with any real level of education or expertise beyond the basics.”

“There are no in person mental health providers in the area. The one that has moved to the area has been waiting months to get on the insurance panels with no success. Options refers everyone to telehealth to providers out of state who don't understand our community challenges.”

“There needs to better training for law enforcement and health professionals in mental health, disabilities and de-escalation.”

“Diagnosis and care for teens & adults with ADHD or Autism is really inaccessible. Having private insurance limits accessibility to mental health services.”

“My daughter experiences intellectual and developmental disabilities. Mental health care is one of her greatest challenges. It doesn't appear to be an area of focus for mental health providers.”

“We need more help in the area of mental health in Spanish. How can you invest in paying for tuition for students in the mental health field?” *(Original comment submitted in Spanish.)*

"There needs to be more mental health support in Spanish. More resources for the Latino community.” *(Original comment submitted in Spanish.)*

“Mental health should be eaiser to access for anyone + everyone and all jobs should provide health care for employees + families.”

"Wish we had more options for inpatient or long-term mental healthcare.”

“I think that over the past several years the community health care providers have really come together to meet the needs of the community much more than they use to. I think there is still a shortage of mental health care in the community though as well.”

“It is very important to increase the number of mental health providers and services for the Latino community. It is very important to create, promote, and increase drug and alcohol rehabilitation centers for youth and adults. *MORE FUNDS SHOULD BE INVESTED IN PREVENTING CHRONIC DISEASES AND NOT IN LUXURY CENTERS TO CURE DISEASES LIKE CANCER, DIABETES, HIGH BLOOD PRESSURE, AND OBESITY.” *(Original comment submitted in Spanish.)*

“Resources for mental health crises are insufficient.”

"We very seriously need to offer more mental health services for our community that uses OHP than just Options. There are so many new effective treatment modalities that are not available because they are limited to one organization."

"Mental health resources for children are severely lacking. My child was on waitlists for about four years before getting a diagnosis and services."

"There needs to be a bigger focus and prioritization of mental health services. So many people who are homeless or struggle with addiction also have mental health issues that they cannot receive services for."

Primary Care

"Many of my elderly friends find it difficult to establish with a primary care provider. Many providers are leaving the area or the profession. There seems to be a shortage of primary care access for older adults."

"Both my wife and I lost our primary care doctor in the last year. Asante told me they do not have any primary care providers to assign us to in the Medford area. We are looking at moving out of Oregon to find better access to care and a community that cares about their residents enough to provide top healthcare, crime prevention, less tolerance to crime and open drug use, and lower taxes."

"Medical access is an issue. My primary care provider left the practice. My "new patient appointment" is one year away. Company provided health insurance SAYS they cover needed vaccines like shingles, pneumonia etc. BUT THEY DO NOT."

Preventive Care

"Our family prefers to practice preventive medicine vs. fixing our health after it's broken. We utilize massage, chiropractic, acupuncture, supplements and herbs along with enjoying healthy food rich in nutrients. Sometimes it's difficult to justify the cost, because insurance barely covers services based on wellness vs. illness."

Resources

"We need a community center! This would abate isolation, loneliness, and divisions in our community. This IS health."

"I know the community has so many resources for the addicts and homeless population in southern Oregon but I never see the information readily available in pamphlet or card form to be physically given to these people in the community. Not at hospitals, public places, clinics, etc. Even resources for the illegal immigrants we have here would be beneficial, counselors and social workers that can help them find jobs, learning English would be incredibly helpful to them, and any assistance."

Specialty Care

"There is a great need for more neurological services and neurologists in Jackson County."

"Our community has a massive shortage of cardiology specialists and mental health professionals who specialize in eating disorders."

"Would love a doctor familiar with fibromyalgia instead of my current nurse practitioner."

"Difficulty getting specialty care appointment. Example GI [gastrointestinal] over a year wait. And have had difficulty with quality specialists. Go to Portland for neurology and GI due to this."

"I would like to see more (many more) geriatricians in the area."

"Not enough specialists in the area. Not enough health care and dental care personnel."

Substance Use

"There needs to be better access to addiction recovery services and mental health services. There is a long wait list for both."

Transportation

"Transportation for the elderly and disabled is a serious issue with regards to getting to healthcare in our rural area. [It is] difficult for them to travel 30-60 miles for treatment when seriously ill."

Wait times

"The ability to become established with a primary care provider in this area can be difficult, as a lot of the doctors offices have a long wait list for new patients. Some of the dental offices in this area have long waits to make appointments as well, sometimes as long as 6 months - a year. This makes it difficult to get proper medical and routine dental care."

"The wait times to see a doctor or dentist are very long and difficult." *(Original comment submitted in Spanish.)*

"I have a chronic illness that is rare and difficult to treat. The wait times and experience level of the medical professionals in the Rogue Valley are inadequate to care for me. "

"There needs to be more resources available in the area for the less fortunate. There needs to be more doctors, waiting over 6 months to see a specialist is not acceptable."

2025 Community Health Needs Assessment (CHNA) Survey

Asante and Providence Health & Services would like to hear from you.
Please fill out this survey to let us know what is most important to you and your family. Your responses will also help us understand how we can support the community we serve.

Please answer each question as best you can and feel free to skip questions you do not want to answer. Your answers will be kept private.
Thank you.

Basic Demographic Questions

1. What county do you live in?
   - ❑ Jackson County
   - ❑ Josephine County
   - ❑ Other _____
2. To which age group do you belong?
   - ❑ 18-29 years
   - ❑ 30-39 years
   - ❑ 40-49 years
   - ❑ 50-65 years
   - ❑ 66-75 years
   - ❑ 76+ years

Health Care

3. Do you have health coverage or insurance?
   - ❑ Yes
   - ❑ No ***(If no, skip to question 5)***

4. What kind of health coverage or insurance do you have? ***Check all that apply.***
   - ❑ Medicaid
   - ❑ Medicare
   - ❑ VA, TRICARE or other military health care
   - ❑ Indian Health Service (IHS)
   - ❑ Private coverage through an employer or family member's employer
   - ❑ A private plan that I pay for myself
   - ❑ I do not have any health insurance now
   - ❑ I do not know
   - ❑ Other _____

5. If you do not have health coverage or insurance, what are the main reasons why? ***Check all that apply.***
   - ❑ It costs too much
   - ❑ I do not think I need insurance
   - ❑ I am waiting to get coverage through a job
   - ❑ Signing up for insurance is too confusing
   - ❑ I have not had time to sign up for insurance
   - ❑ Other _____

Survey continues next page.

6. Which statement best describes you and your household's health care over the last year?
   - ❑ We did not need health care
   - ❑ We got all the care we needed
   - ❑ We got some but not all the care we needed
   - ❑ We had to delay getting the care we needed
   - ❑ We got no care at all
   - ❑ Other _____

7. For the <u>most recent time</u> you or anyone in your household put off or went without health care, what were the reasons? ***Check all that apply.***
   - ❑ Too expensive
   - ❑ Not having a primary health care provider
   - ❑ Not knowing where to go
   - ❑ Could not get an appointment soon enough
   - ❑ Clinic is not open when I can go
   - ❑ Needed childcare
   - ❑ Needed transportation
   - ❑ Not having a health care provider that speaks my language
   - ❑ Not having a provider that understands my needs
   - ❑ COVID-19: appointment cancellation, concern of infection, or other related concerns
   - ❑ My family and I have not had to put off or go without health care
   - ❑ Other_____

8. A primary health care provider is the person you see if you need a health check-up, want advice about a health problem, or get sick or hurt. Do you have a primary care provider?
   - ❑ Yes ❑ No

9. Have you ever been told by any health care professional that you have any of the following? ***Check all that apply.***
   - ❑ I have not been diagnosed with any health condition
   - ❑ Anxiety
   - ❑ Asthma
   - ❑ Cancer
   - ❑ Diabetes or high blood sugar
   - ❑ Depression
   - ❑ Heart disease
   - ❑ High blood pressure
   - ❑ High cholesterol
   - ❑ Post-traumatic stress disorder (PTSD)
   - ❑ Substance use disorder
   - ❑ Other ongoing health condition _____

10. In the last year, did you receive care using any of the following? ***Check all that apply.***
    - ❑ I have not received any medical care
    - ❑ Emergency department
    - ❑ Primary care
    - ❑ Primary or specialty care outside of my community
    - ❑ Specialty care
    - ❑ Telemedicine (video visit)
    - ❑ Urgent or immediate care

Survey continues next page.

11. Which statement best describes your personal experience with counseling or mental health treatment over the last year?
    - ❑ I didn't need counseling or mental health treatment
    - ❑ I got all the care I needed
    - ❑ I needed support for a personal problem but didn't receive it
    - ❑ I needed treatment for a mental health condition but didn't receive it
    - ❑ Other_____

12. Were you or others in your household able to get the care you needed with alcohol, tobacco or substance use? ***Choose N/A if care was not needed.***

Health Service	Yes	No	Not Applicable
Smoking cessation program	❑	❑	❑
Alcohol treatment program	❑	❑	❑
Medication-assisted treatment program (for example Suboxone)	❑	❑	❑
Substance use disorder counseling and treatment(not including alcohol)	❑	❑	❑

13. Do you have any children (under 18 years of age)?
    - ❑ Yes
    - ❑ No ***(If no, skip to question 16)***

14. Have you ever been told by a health care professional that any of your children have the following? ***Check all that apply.***
    - ❑ My children have not been diagnosed with any health condition
    - ❑ Asthma
    - ❑ Behavioral or mental health diagnosis (such as depression, anxiety, or ADHD)
    - ❑ Developmental delay or a learning disability (such as autism or dyslexia)
    - ❑ Diabetes or high blood sugar
    - ❑ Post-traumatic stress disorder (PTSD)
    - ❑ Other ongoing health condition: _____

15. Where do you seek health care to support your children with this condition/these conditions? ***Check all that apply.***
    - ❑ I'm not currently seeking care for this condition/these conditions
    - ❑ Emergency department
    - ❑ Local pediatrician, doctor or specialist's office
    - ❑ School nurse or counselor/school-based health clinic or center
    - ❑ Specialist or doctor outside of my community
    - ❑ Urgent or immediate care

Survey continues next page.

Health & Lifestyle

16. How would you rate these areas of your personal overall health?

	Excellent	Very Good	Good	Fair	Poor
Physical health	❑	❑	❑	❑	❑
Mental Health	❑	❑	❑	❑	❑

17. During the last year, how often have you felt the following:

	Not at all	Some of the time	A lot of the time	Most of the time	All of the time
Loneliness or social isolation	❑	❑	❑	❑	❑
Little interest or pleasure in doing things	❑	❑	❑	❑	❑
Feeling down, depressed or hopeless	❑	❑	❑	❑	❑
Feeling nervous, anxious, or on edge	❑	❑	❑	❑	❑
Not being able to stop worrying	❑	❑	❑	❑	❑

18. The following questions are about where you live. ***Choose the number that best represents your opinion of each statement. If you do not know, please respond "DK".***

Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Do not Know
My community has health care options available. Think about the cost and quality of care, distance you need to travel, and availability of appointments.	1	2	3	4	5	DK
My community is a good place to raise children. Think about the quality and safety of school and childcare, after-school programs, and places to play in your neighborhood.	1	2	3	4	5	DK
My community is a good place to grow old. Think about senior housing, transportation to medical services, access to shopping centers and businesses, recreation, and services for seniors.	1	2	3	4	5	DK
I feel safe in my home. Think about everything that makes you feel safe, such as neighbors, presence of law enforcement, etc. and everything that could make you feel unsafe at home, including family violence, robbery, housing conditions, etc.	1	2	3	4	5	DK

Survey continues next page.

Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Do not Know
My community feels safe. Think about how safe you feel in and around your neighborhood, schools, playgrounds, parks, businesses, and shopping centers.	1	2	3	4	5	DK
I feel prepared for an emergency. Think about everything that makes you feel prepared, such as toolkits, smoke alarms, fire extinguishers, etc.	1	2	3	4	5	DK
People of all races, ethnicities, backgrounds, and beliefs in my community are treated fairly. Think about discrimination and programs that work to increase diversity.	1	2	3	4	5	DK
People in my community can access mental health services and substance use disorder treatment. Think about counseling services, support groups, and substance use disorder counseling and treatment centers.	1	2	3	4	5	DK
Healthy food is available in my community. Think about restaurants, grocery stores, supermarkets, corner stores, and farmers' markets that sell fresh fruits, vegetables, lean meats and other healthy options.	1	2	3	4	5	DK
There are places to be physically active near my home. Think about parks, trails, places to walk and playgrounds.	1	2	3	4	5	DK
I have enough financial resources to meet my basic needs. Think about income for purchasing food, clothing, housing, and utilities.	1	2	3	4	5	DK

Adapted from Lake County Community Health Assessment, 2018

About You and Your Family

19. Including yourself, write the number of people currently living in your household? ***If no one is in the age group, enter 0.***

_____Number of children (0-17 years)

_____Number of adults (18-64 years)

_____Number of older adults (65+ years)

Survey continues next page.

20. Which best describes the household you live in?

- ❑ Single family
- ❑ Multi-generational
- ❑ Shared with other families
- ❑ Shared with roommates
- ❑ I live alone

21. What is the best description of your current housing situation?
- ❑ Own my home
- ❑ Rent (no subsidy/assistance)
- ❑ Rent (with subsidy/assistance)
- ❑ Unhoused/homeless
- ❑ Unhoused (living in a vehicle)
- ❑ Hotel/motel (paid by self)
- ❑ Hotel/motel (emergency shelter voucher)
- ❑ Hotel/motel (with assistance)
- ❑ Post-fire transitional housing (camp trailer, hotel, other)
- ❑ Short-term shelter/transitional housing
- ❑ Staying/living with family members
- ❑ Staying/living with friends
- ❑ Other (tell us): _____

22. What is your current employment status?
- ❑ Employed full time plus (more than 40 hours per week at one or multiple jobs)
- ❑ Employed full time (40 hours per week)
- ❑ Employed part time
- ❑ Seasonal, service industry, gig economy
- ❑ Self-employed
- ❑ Retired
- ❑ Unable to work due to illness, injury, or disability
- ❑ Stay-at-home parent
- ❑ Unpaid caregiver/caretaker
- ❑ Student
- ❑ Unemployed

23. Do you work more than one job?
- ❑ Yes
- ❑ No ***(If no, skip to question 25)***

24. Do you **have to** work more than one job to afford your living expenses?
- ❑ Yes
- ❑ No

Survey continues next page.

25. What is your combined gross household income (the amount before taxes and deductions are taken out) for last year(2024)? ***Count all sources of household income. Your best guess is fine.***
    - ❑ $0
    - ❑ $1 to $10,000
    - ❑ $10,001 to $20,000
    - ❑ $20,001 to $30,000
    - ❑ $30,001 to $40,000
    - ❑ $40,001 to $50,000
    - ❑ $50,001 to $60,000
    - ❑ $60,001 to $70,000
    - ❑ $70,001 to $80,000
    - ❑ $80,001 to $90,000
    - ❑ $90,001 to $100,000
    - ❑ $100,001 or more
26. What is your educational level?
    - ❑ Less than high school
    - ❑ High school diploma/GED
    - ❑ Trade school/apprenticeship/other certificate
    - ❑ Some college/university education (no degree)
    - ❑ Vocational or associate degree
    - ❑ College/university bachelor's degree
    - ❑ College/university post-graduate degree / certification
27. In the last year, have you or anyone in your household had to go without anything from this list because you couldn't afford it?

	Yes	No	N/A
Food	❑	❑	❑
Utilities (water, electricity, heat)	❑	❑	❑
Transportation	❑	❑	❑
Clothing	❑	❑	❑
Personal hygiene items (soap, shampoo, toilet paper, feminine products, etc.)	❑	❑	❑
Stable housing or shelter	❑	❑	❑
Medical care	❑	❑	❑
Medicine	❑	❑	❑
Childcare	❑	❑	❑
Dental care	❑	❑	❑

Survey continues next page.

28. This section will help us find health and service differences among people with and without functional difficulties.

	Yes	If yes, at what age did the condition begin?	No	Don't know	Prefer not to answer
Are you **deaf** or do you have **serious difficulty hearing?**	❑		❑	❑	❑
Are you **blind** or do you have **serious difficulty seeing**, even when wearing glasses?	❑		❑	❑	❑
Do you have **serious difficulty walking or climbing stairs**?	❑		❑	❑	❑
Because of a physical, mental or emotional condition, do you have **serious difficulty concentrating, remembering or making decisions**?	❑		❑	❑	❑
Do you have **difficulty dressing or bathing**?	❑		❑	❑	❑
Do you have **serious difficulty learning how to do things most people your age can learn**?	❑		❑	❑	❑
Using your **usual (customary) language**, do you have **serious difficulty communicating** (for example understanding or being understood by others)?	❑		❑	❑	❑
Because of a **physical, mental or emotional condition**, do you have **difficulty doing errands alone** such as visiting a doctor's office or shopping?	❑		❑	❑	❑
Do you have **serious difficulty** with the following: **mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations**?	❑		❑	❑	❑
Do you have **someone to help you** with daily tasks of living **if you were to become suddenly ill, injured or disabled**?	❑		❑	❑	❑

29. What language do you speak mostly at home? ***Skip to question 32 if you indicate English only.***

❑ English ❑ Spanish ❑ Other_____

30. What language would you prefer to use when communicating (in person, phone, virtually) with someone outside the home about important matters such as medical, legal, or health information?

❑ English ❑ Spanish ❑ Other_____

31. What language would you prefer to use to read important written information such as medical, legal, or health information?

❑ English ❑ Spanish ❑ Other_____

Survey continues next page.

32. What is your gender identity?
Check all that apply.

- ❑ Woman
- ❑ Man
- ❑ Agender
- ❑ Cisgender
- ❑ Gender Queer
- ❑ Non-binary
- ❑ Transgender
- ❑ Two-spirit
- ❑ Prefer not to answer
- ❑ Prefer to self-describe_____

33. What is your sexual orientation?
Check all that apply.

- ❑ Aromantic or asexual
- ❑ Bisexual
- ❑ Gay
- ❑ Heterosexual or straight
- ❑ Lesbian
- ❑ Pansexual
- ❑ Queer
- ❑ Questioning
- ❑ Prefer not to answer
- ❑ Prefer to self-describe_____

Race and Ethnicity

34. How do you identify your race, ethnicity, tribal affiliation, country of origin or ancestry? _____

35. What is your race? ***Check all that apply.***

Hispanic and Latino/a/x	American Indian and Alaska Native
❑ Central American ❑ Mexican ❑ South American ❑ Other Hispanic or Latino/a/x	❑ Alaska Native ❑ American Indian/Native American ❑ Canadian Inuit, Metis or First Nation ❑ Indigenous Mexican, Central American or South American
Native Hawaiian and Pacific Islander	**Black and African American**
❑ Chamoru (Chamorro) ❑ Communities of the Micronesian Region ❑ Marshallese ❑ Native Hawaiian ❑ Samoan ❑ Other Pacific Islander	❑ African American ❑ Afro-Caribbean ❑ Ethiopian ❑ Somali ❑ Other African (Black) ❑ Other Black
White	**Middle Eastern/North African**
❑ Eastern European ❑ Slavic ❑ Western European ❑ Other White	❑ Middle Eastern ❑ North African
Asian	
❑ Asian Indian ❑ Cambodian ❑ Chinese ❑ Communities of Myanmar ❑ Filipino/a ❑ Hmong	❑ Japanese ❑ Korean ❑ Laotian ❑ South Asian ❑ Vietnamese ❑ Other Asian
Other	
❑ Don't know	❑ Prefer not to answer
❑ _____	

Survey continues next page.

36. If you checked more than one race above, is there one you think of as your primary racial or ethnic identity?
    - ❑ No. I identify as Biracial or Multiracial.
    - ❑ No. I do not have just one primary racial or ethnic identity.
    - ❑ N/A I only checked one category above.
    - ❑ Don't know
    - ❑ Prefer not to answer
    - ❑ Yes. ***Please identify*** _____

Short Answer

37. Is there anything more you would like to share about your health and wellness or the community's health and wellness that was not covered in this survey?

_____

_____

_____

_____

_____

_____

_____

_____

_____

End of survey

If you would like to make a public comment about Asante or Providence's current Community Health Needs Assessment and Community Health Improvement Plan, please contact sheri.croy@asante.org or kyle.roesler@providence.org.

Thank you for completing the 2025 Community Health Needs Assessment (CHNA) survey.

Appendix 2: Key Informant Survey Data

Key Informant Survey Results

Question 1. Prior to reviewing Asante Ashland Community Hospital's Community Health Improvement Plan, how aware were you of how the hospital is addressing each of the following needs in the community?

2023 CHIP Priorities	Not Aware At All	Somewhat Aware	Very Aware
Access to Healthcare	50%	25%	25%
Chronic Conditions	75%	0%	25%
Mental Health	50%	25%	25%

Question 2. Overall, how would you rate Asante Ashland Community Hospital's effort to address these health needs in the community?

2023 CHIP Priorities	Poor	Fair	Good	Very Good	Excellent
Access to Healthcare	0%	25%	0%	50%	25%
Chronic Conditions	0%	0%	50%	25%	25%
Mental Health	50%	0%	0%	25%	25%

Question 3. What else could Asante Ashland Community Hospital do to improve access to health care in the community?

- "Access to primary and specialty care is top concern for people. The strategy listed in the current activities report seems sound, however it is unclear how it is being implemented."
- "Consider adding a Mother's Milk Bank and mental health services specifically targeting issues that arise from being pregnant and after; whether it is perinatal depression, loss of a child, loss of the planned birth experience, etc."

- “ACH's CHIP document lists key goals, then adds: "Some of the needs identified . . . -- homelessness and housing instability, affordable childcare and preschool, economic insecurity and substance use--are more appropriately addressed by community partners with existing specialized focus in these areas." BUT those patients have to have access to those other services. Therefore, appropriate and attentive navigation is often required to ensure that they make the connections that may save their lives. In other words, ACH please beware of falling into service area silos that make those connections and warm handoffs to appropriate services unavailable to patients who may be unable to connect to them because of medical and/or behavioral health issues.”

Question 4. What else could Asante Ashland Community Hospital do to improve chronic conditions in the community?

- “There is a high focus on education in the current activities report. However, I didn't note a specific action to work one-on-one with individuals to address these conditions.”
- “Start a Blue Zones Project like many others and the one in Klamath Falls. Also, our community includes the health of the workers. I would be very interested to know more about how this has been incorporated into the operations of Asante.”
- “Do the “other chronic conditions” include behavioral health conditions? Chronic conditions need to include behavioral health conditions in order to serve the whole person.”

Question 5. What else could Asante Ashland Community Hospital do to improve mental health in the community?

- “Add an activity/action around addiction and substance misuse.”
- “Support LGBTQIA+ individuals in the community in particular youth. Give people a place where they feel safe in participating with their own health care. Stop interpreting a threat to commit suicide as are they threatening in the moment. Partner and sponsor out in the community and invite in for community support presentations other organizations that have been doing similar work. Above all put a large amount of dollars towards supporting the mental health of your employees with generous time off, compassion fatigue training, regular debriefing, and communicating an atmosphere that it is okay if they are human.”
- “Please do not silo mental health care without substance use disorder treatment. Co-morbidities are very common. They must be treated together for the greatest success.”

Question 6. Is there any OTHER health issue, that has not already been covered in this survey, that you feel is a major problem in this community?

No: **75%**
Yes: **25%**

Question 7. If you answered ‘yes’ above, what is that health issue? Please list only ONE health issue.

- Trauma, drug and alcohol use, chronic homelessness. Transportation to get to these services. Mobile clinics will be so much better.

Question 8. Why do you feel this issue above is a major problem in your community?

- There is no really good system to catch people that experience these issues if they have underlying mental health issues.

Question 9. Now that you've had a chance to consider the community health needs identified by our previous CHNA process, as well as identify a need you felt was missing, please help us rank the needs in OUR community. *Consider the alphabetized table of common needs below. Please select the top 5 needs you see in our community.*

Answers	Count	Percentage
Homelessness/lack of safe, affordable housing	6	27%
Environmental concerns (climate change, fires/smoke, pollution)	3	13.6%
Access to health care services	2	0.9%
Economic insecurity (lack of living wage jobs and unemployment)	2	0.9%
Disability inclusion	2	0.9%
Racism and discrimination	2	0.9%
Substance use disorder	2	0.9%
Aging problems	1	0.5%
Maternal and infant health	1	0.5%
Lack of community involvement and engagement	1	0.5%

Question 10. Please choose the sector that most accurately describes your business or organization:

Answers	Count
Business sector	0
Government	0
Education	0
Faith-based/Religious	1
Health care	1
Industry	0
Public Service	0
Social service	2

Question 11. Please identify which of these populations are served by your organization:

Low-income residents – 75%

Minority populations – 75%

Medically underserved – 50%

Question 12. In the spaces below, please LIST up to 5 types of minority or medically underserved populations served by your organization. If answers are NO, skip this question.

Individual Responses
LGBTQ+, Hispanic, Unhoused, Disabled, Elderly
People living on the streets, in shelters; those who are living with a mental health condition and their families and loved ones; homeless, court ordered, women, vets, etc. We serve everyone.
Homeless people, LBGTQ+

Question 13. For reporting purposes, ONLY the name of your organization will appear in the next Community Health Needs Assessment report. How would you like that to appear?

Individual Responses
Ashland Community Health Foundation
Medford United Church of Christ
Rogue Retreat
NAMI Southern Oregon

Question 14. If you have any other comments that were not addressed in this survey, please feel free to share them below.

- No answers

Key Informant Survey Questions

INTRODUCTION

Thank you for your participation in this online questionnaire. This online questionnaire is part of a collaborative community health improvement effort between Asante and Providence and seeks to evaluate each organization's recent work around specific health issues. Your feedback is essential to helping our local hospitals meet federal regulations. Asante and Providence are seeking the input of local professionals with this questionnaire. Your responses, along with those of other respondents, will be combined and not shared individually.

This online questionnaire should take approximately 10-15 minutes to complete.

If you have any questions or difficulties completing the questionnaire, please contact kyle.roesler@providence.org or sheri.croy@asante.org.

As noted in the email you received, we ask that you first review the current activities that each hospital is working on as part of its Community Health Improvement Plan. If you have not yet reviewed this information, please copy and paste the URL provided for each hospital to open the website in a new

window and review the plan. Then, PLEASE RETURN TO THIS WINDOW TO COMPLETE THE SURVEY.

Asante Ashland Community Hospital

This part of the questionnaire pertains to Asante Ashland Community Hospital's previous community health needs assessment and community health implementation plan.

1. Prior to reviewing Asante Ashland Community Hospital's Community Health Improvement Plan, how aware were you of how the hospital is addressing each of the following needs in the community?

	Very Aware	Somewhat Aware	Not At All Aware
Access to Health Care			
Chronic Conditions			
Mental Health			

2. Overall, how would you rate Asante Ashland Community Hospital's effort to address these health needs in the community?

	Excellent	Very Good	Good	Fair	Poor
Access to Health Care					
Chronic Conditions					
Mental Health					

3. What else could Asante Ashland Community Hospital do to improve access to health care in the community?

_____

_____

4. What else could Asante Ashland Community Hospital do to improve chronic conditions in the community?

_____

_____

5. What else could Asante Ashland Community Hospital do to improve mental health in the community?

_____

_____

6. Is there any OTHER health issue, that has not already been covered in this survey, that you feel is a major problem in this community? (Yes/No)

7. If you answered 'yes' above, what is that health issue? Please list only ONE health issue.

_____

_____

8. Why do you feel the issue above is a major problem in your community?

_____

_____

9. Now that you've had a chance to consider the community health needs identified by our previous CHNA process, as well as identify a need you felt was missing, please help us rank the needs in OUR community. *Consider the alphabetized table of common needs below. Please select the top 5 needs you see in our community.*

Please select at most 5 options.

- Access to health care services
- Access to dental care
- Access to safe, reliable, affordable transportation
- Aging problems
- Bullying in schools
- Chronic conditions: obesity, heart disease, stroke and diabetes
- Community violence
- Disability inclusion
- Domestic violence, child abuse/neglect
- Economic insecurity (lack of living wage jobs and unemployment)
- Environmental concerns (climate change, fires/smoke, pollution)
- Few community building events
- Food insecurity
- Gun violence
- HIV/AIDS
- Homelessness/lack of safe, affordable housing
- Job skills training
- Lack of community involvement and engagement
- Maternal and infant health
- Opportunity gap in education
- Racism and discrimination
- Safe and accessible parks/recreation
- Safe streets for all users
- Substance use disorder
- Other

DEMOGRAPHICS

The next questions are about your organization and are for classifying purposes only.

10. Please choose the sector that most accurately describes your business or organization:

_____Business sector (skip to question 22) **_____Health care**

_____Government **_____Industry (skip to question 22)**

_____Education **_____Public service**

_____Faith-based / religious **_____Social service**

11. Please identify which of these populations are served by your organization:

Low-Income Residents (Yes/No)

Minority Populations (Yes/No)

Medically Underserved (Yes/No)

12. In the spaces below, please LIST up to 5 types of minority or medically underserved populations served by your organization. If answers are NO, skip this question.

Minority/Medically Underserved Population #1: _____

Minority/Medically Underserved Population #2: _____

Minority/Medically Underserved Population #3: _____

Minority/Medically Underserved Population #4: _____

Minority/Medically Underserved Population #5: _____

13. For reporting purposes, ONLY the name of your organization will appear in the next Community Health Needs Assessment report. How would you like that to appear?

_____

14. If you have any other comments that were not addressed in this survey, please feel free to share them below:

_____

End of Survey

If you would like to review the complete findings from Asante and Providence's 2022 Community Health Needs Assessments, please use the links below.
Asante Ashland Community Hospital

Asante Rogue Regional Medical Center

Asante Three Rivers Medical Center

Providence Medford Medical Center

If you'd like to provide public comment on the previous CHNA for any of our southern Oregon hospitals, please connect. For Asante hospitals, email CHNA@asante.org. For Providence Medford, email kyle.roesler@providence.org. Thank you very much for your time and cooperation. Your help and insight are greatly appreciated.

Appendix 3: Quantitative Data

POPULATION LEVEL DATA

Population Below 200% Federal Poverty Level

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Percent of Population Below 200% Federal Poverty Level	31.1% (68,202 individuals)	38.3% (33,279 individuals)	28.6% (41,139 individuals)	38.8% (60,342 individuals)	27.6% (1,146,463 individuals)

Data Source: 2023 American Community Survey, 5-Year Estimates

Limited English Households

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Percent of Population Age 5+ Living in a Limited English-Speaking Household	1.1% (954 households)	3.0% (990 households)	0.7% (421 households)	1.1% (723 households)	2.3% (38,607 households)

Data Source: 2023 American Community Survey, 5-Year Estimates

Percent of Population with A High School Education

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Percent of Population Age 25+ With at Least a High School Education	91.3% (146,721 individuals)	90.2% (59,299 individuals)	92.4% (100,874 individuals)	89.8% (105,146 individuals)	91.7% (2,770,789 individuals)

Data Source: 2023 American Community Survey, 5-Year Estimates

Percent of Households Receiving SNAP Benefits

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Percent of Households Receiving Supplemental Assistance Program (SNAP) Benefits	17.6% (15,890 households)	24.2% (8,783 households)	15.2% (9,002 households)	23.9% (15,761 households)	15.4% (261.284 households)

Data Source: 2023 American Community Survey, 5-Year Estimates

Asthma Prevalence

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Asthma Crude Prevalence	11.9%	11.9%	11.4%	12.2%	11.5%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Obesity Prevalence

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Obesity Crude Prevalence	35.5%	32.5%	32.8%	35.0%	30.9%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Tobacco Use (Current Smoking)

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Smoking Crude Prevalence	16.7%	17.6%	14.3%	18.1%	12.4%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Alcohol Consumption (Binge Drinking)

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Binge Drinking Crude Prevalence	16%	15.6%	15.5%	15.9%	18%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Physical Inactivity

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Physical Inactivity Crude Prevalence	21.7%	22.9%	20.5%	24.0%	19.0%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

Diabetes Prevalence

Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Diabetes Crude Prevalence	12.0%	13.7%	12.2%	12.9%	11.8%

Data Source: PLACES. Center for Disease Control and Prevention - Indicator uses crude prevalence for year 2022 estimates

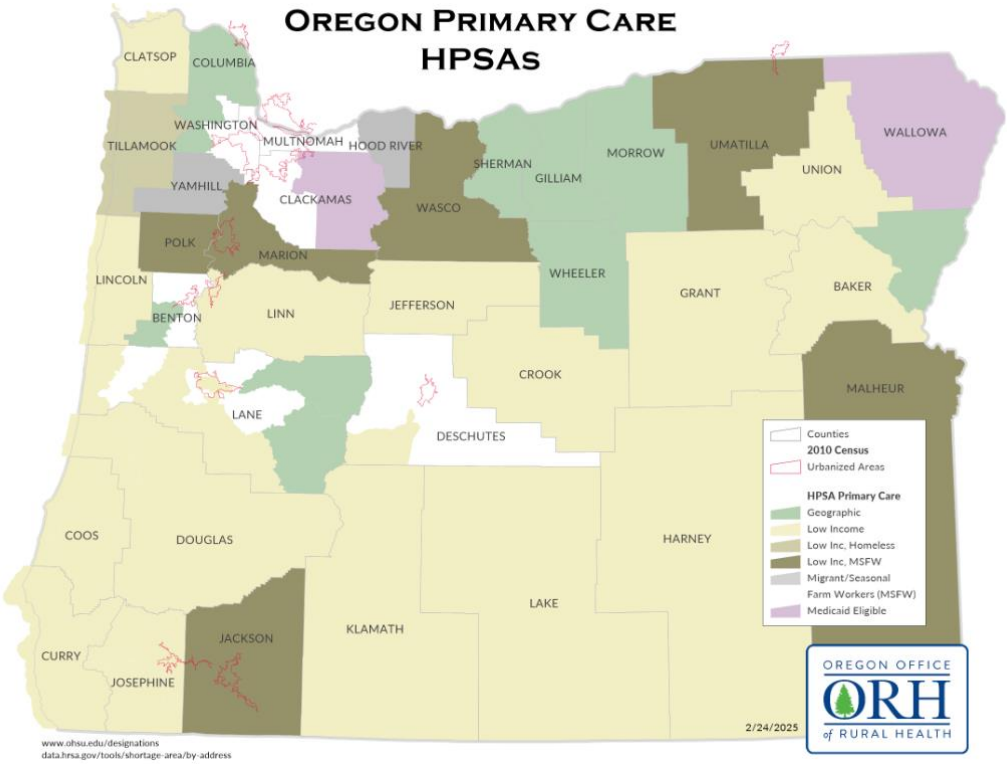
Households without Internet Access

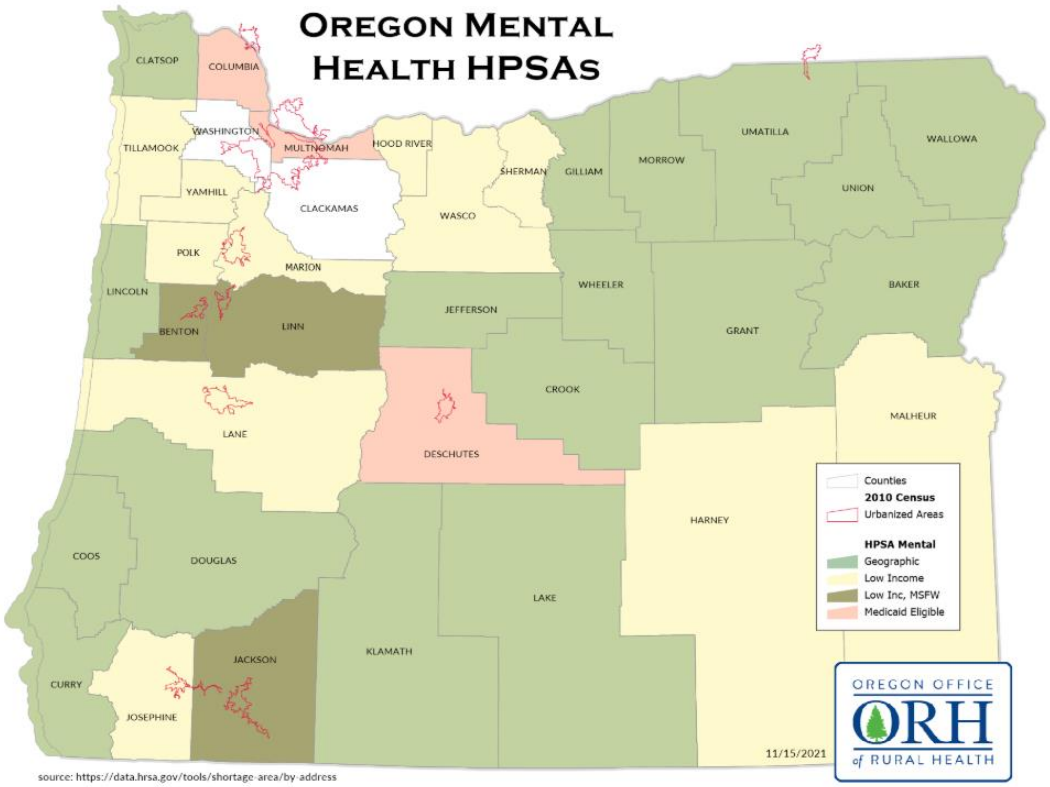
Indicator	Jackson County	Josephine County	Combined Broader Service Area	Combined High Need Service Area	Oregon
Households without Internet Access	6.2% (5,598 households)	7.5% (2,729 households)	6.0% (3,414 households)	7.5% (4,913 households)	5.6% (95,898 households)

Source: 2023 American Community Survey, 5-Year Estimates

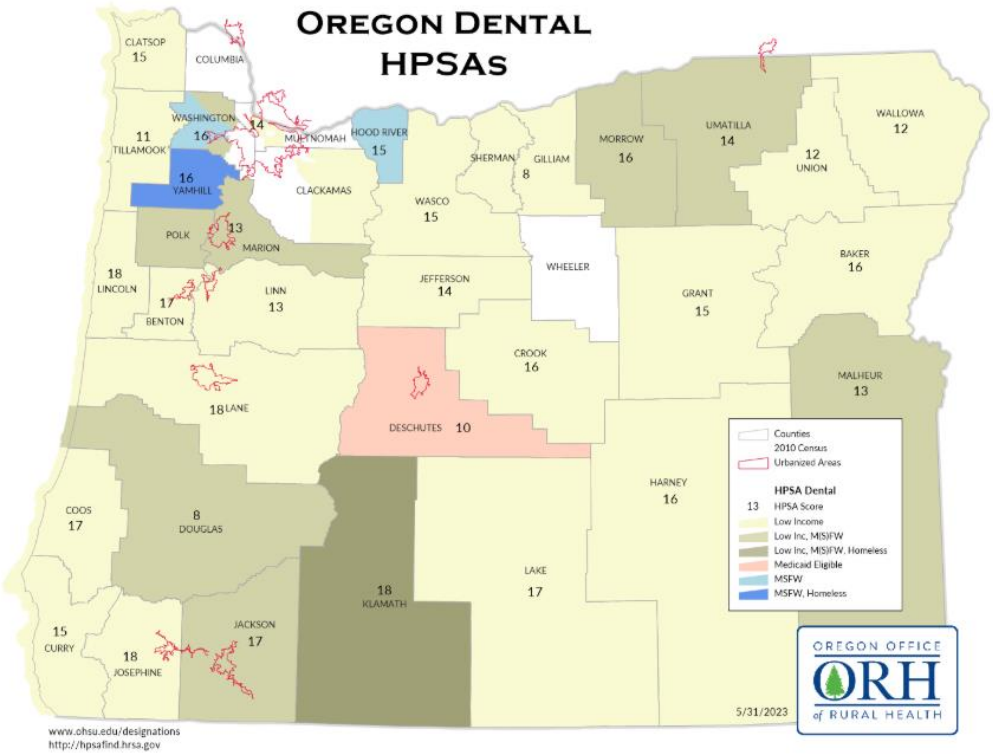
HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Jackson and Josephine Counties are both located in a HPSA. The map below depicts these shortage areas relative to the locations of Ashland Community Hospital, Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center and Providence Medford Medical Center.





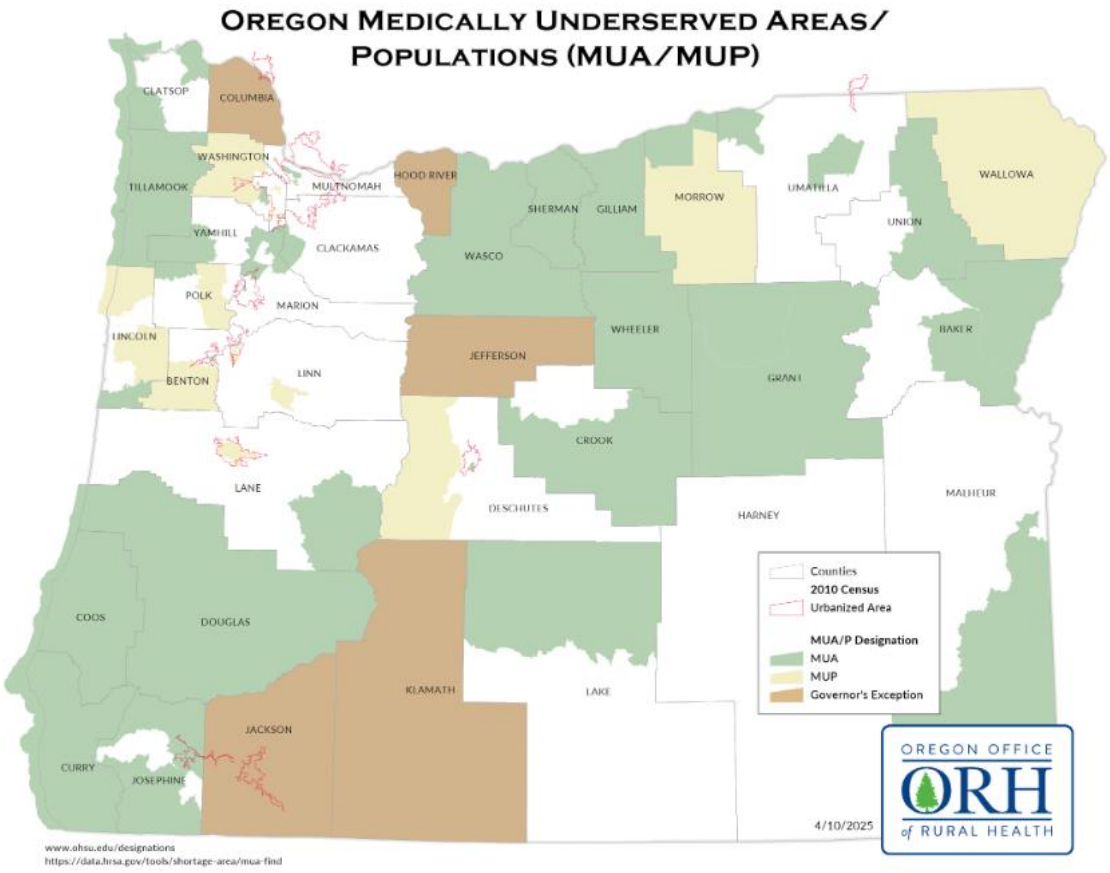
source: https://data.hrsa.gov/tools/shortage-area/by-address



www.ohsu.edu/designations
http://hpsafind.hrsa.gov

MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary. The following map depicts the MUAs and MUPs in Oregon State.



Appendix 4: Community Resources Available to Address Significant Health Needs

Asante and Providence cannot address all of the significant community health needs by working alone. Improving community health requires collaboration across community stakeholders and with community engagement. Below outlines a list of community resources potentially available to address identified community needs.

Access to Health Services

Organization or Program Name	Website
AllCare Health (CCO)	https://www.allcarehealth.com/?locale=en
Care Oregon	https://www.careoregon.org/
Community Volunteer Network	https://www.prsliving.org/about/volunteer-network
Jackson Care Connect (CCO)	https://jacksoncareconnect.org/
Jackson County Health & Human Services	https://jacksoncountyor.gov/departments/health___human_services/index.php
Josephine County Health & Human Services	http://www.co.josephine.or.us/Page.asp?NavID=1222
La Clinica	https://laclinicahealth.org/
Rogue Community Health	https://roguecommunityhealth.org/
Rogue Valley Medical Transport (Provides transportation only)	https://myrvmt.com/
Siskiyou Community Health Center	https://siskiyouhealthcenter.com/
Valley Lift (Rogue Valley Transportation District) (Provides transportation only)	https://rvtd.org/accessible-transportation/valley-lift/

Affordable Childcare and Preschools

Organization or Program Name	Website
YMCA	https://rvymca.org/
Kids Unlimited	https://kuaoregon.org/
Boys and Girls Club	https://begreat4kids.com/
Oasis Center of the Rogue Valley	https://oasiscenterroguevalley.org/
Oregon Child Development Coalition	https://www.ocdc.net/locations/#Jackson%20County
Southern Oregon Head Start	https://www.socfc.org/
Southern Oregon Education Services District – Childcare Resource Network	https://www.soesd.k12.or.us/childcare-resource-network/
Family Nurturing Center	https://familynurturingcenter.org/
Southern Oregon Child and Family Council	https://headstartprograms.org/detail/193720_southern_oregon_child_and_family_council_inc_central_point_or.html

Chronic Conditions

Organization or Program Name	Website
AllCare Health	https://www.allcarehealth.com/?locale=en
Jackson Care Connect	https://jacksoncareconnect.org/
La Clinica	https://laclinicahealth.org/
Oregon Wellness Network	http://www.o4ad.org/oregon-wellness-network.html

Rogue Community Health	https://roguecommunityhealth.org/
Rogue Valley Council of Governments Area Agency on Aging	https://rvcog.org/home/sds-2/advocacy/
Siskiyou Community Health Center	https://siskiyouhealthcenter.com/

Disability Inclusion and Support for People w/ Disabilities

Organization or Program Name	Website
ACCESS	https://accesshelps.org/services/
Connections NW	https://connections-nw.org/
Community Life LLC	https://communitylife.llc/
Community Living Case Management	https://www.clcmoregon.org/josephine-county/
Creative Supports	https://creativesupports.org/
Encompass Person Centered	https://www.encompasspersoncentered.com/
Jackson County Development Disability Services	https://jacksoncountyor.gov/departments/health__human_services/programs_and_services/developmental_disability_services/index.php
HASL Center for Independent Living	https://haslonline.org/
Impact of Oregon	https://www.impact-or.org/
Living Opportunities	https://livingopps.org/
OSCI (Oregon Spinal Cord Injury Connection)	https://www.oregonsci.org/
Premier Community Supports	https://premieror.com/
Rogue Valley Council of Governments Senior and Disability Services	https://rvcog.org/home/sds-2/

Sensory Space Grants Pass by MEC Disabilities	https://mecdisabilities.org/sensory-space-grants-pass
Southern Oregon Aspire	https://soaspire.org/
Special Olympics Jackson County	https://programs.soor.org/jackson-county/
Special Olympics Josephine County	https://programs.soor.org/josephine-county/

Economic Insecurity

Organization or Program Name	Website
ACCESS	https://www.accesshelps.org/
Confident Staffing	https://confidentstaffing.com/
Express Employment Professionals	https://www.expresspros.com/MedfordOR/?utm_source=gmb&utm_medium=organic&utm_campaign=Qiigo
Goodwill Job Connections Centers	https://www.sogoodwill.org/job-connections/
Josephine County Food Bank	https://www.jocofoodbank.org/
Maslow Project	https://www.maslowproject.com/
Oregon Employment Department	https://www.oregon.gov/EMPLOY/Pages/default.aspx
Rogue Retreat	https://www.rogueretreat.org/
St. Vincent de Paul	http://www.stvincentdepaulmedford.info/
United Way	https://unitedwayofjacksoncounty.org/
WorkSource Rogue Valley	https://worksourcerogue.org/

Homelessness and Housing Instability

Organization or Program Name	Website
ACCESS	https://www.accesshelps.org/
Hearts With a Mission	https://heartswithamission.org/
Housing Authority of Jackson County	https://hajc.net/
Illinois Valley Living Solutions	https://ivlivingsolutions.org/about/
Jackson County Continuum of Care	https://jacksoncountyorcoc.org/
Jackson County Continuum of Care: Jackson County Homeless Task Force	https://jacksoncountyorcoc.org/resources/
Josephine County Housing and Community Development Council	https://www.jhcdc.net/
Magdalene Home	https://www.magdalenehome.org/
Maslow Project	https://www.maslowproject.com/
MINT – Mobile Integrative Navigation Team	https://mintjoco.org/
OHRA – Opportunities for Housing, Resources & Assistance	https://ohrahelps.org/
On Track Rogue Valley	https://ontrackroguevalley.org/
Rogue Retreat	https://www.rogueretreat.org/
Salvation Army	https://jacksoncounty.salvationarmy.org/
United Community Action Network (UCAN)	https://www.ucancap.org/

Mental Health

Organization or Program Name	Website
Adapt	https://adaptoregon.org/
Addictions Recovery Center	https://www.addictionsrecovery.org/
Asante Rogue Regional Medical Center for Behavioral Health Services	https://www.asante.org/Locations/location-detail/behavioral-health-clinic-medford/
Columbia Care Services	https://www.columbiacare.org/
Compass House	https://socompasshouse.org/
Family Nurturing Center	https://www.familynurturingcenter.org/
Family Solutions	https://familysolutionsoregon.org/
Hope Village	https://www.hopemedford.com/
Integrative Health Center at Rogue Community Health	https://roguecommunityhealth.org/integrativehealth/
Jackson County Health & Human Services Crisis Hotline	https://jacksoncountyor.org/hhs/Mental-Health/Welcome
Jackson County Mental Health	https://www.jacksoncountyor.gov/departments/health___human_services/programs_and_services/mental_health/index.php
Jackson County Public Health Syringe Exchange	https://www.jacksoncountyor.gov/departments/health___human_services/programs_and_services/public_health/jackson_county_syringe_exchange_program/index.php
Kairos	https://kairosnw.org/programs-and-services/
La Clinica	https://laclinicahealth.org/
Maslow Project	https://www.maslowproject.com/

Mercy Flights	https://www.mercyflights.com/
OnTrack Rogue Valley	https://ontrackroguevalley.org/
Options for Southern Oregon Crisis Resolution Center	http://www.optionsonline.org/crisis-resolution
Rogue Community Health Integrative Health Center	https://roguecommunityhealth.org/integrativehealth/
Rogue Retreat	https://www.rogueretreat.org/
Southern Oregon Veterans Rehabilitation Center & Clinics	https://www.va.gov/southern-oregon-health-care/health-services/

Substance Use

Organization or Program Name	Website
Adapt	https://adaptoregon.org/
Addictions Recovery Center	https://www.addictionsrecovery.org/
Asante Rogue Regional Medical Center for Behavioral Health Services	https://www.asante.org/Locations/location-detail/behavioral-health-clinic-medford/
Columbia Care Services	https://www.columbiacare.org/
Compass House	https://socompasshouse.org/
Family Solutions	https://familysolutionsoregon.org/
Integrative Health Center at Rogue Community Health	https://roguecommunityhealth.org/experience-true-healing-with-our-integrative-health-services-medford-or/

Jackson County Health & Human Services Crisis Hotline	https://jacksoncountyor.gov/departments/health___human_services/programs_and_services/mental_health/index.php
Jackson County Public Health Syringe Exchange	https://www.jacksoncountyor.gov/departments/health___human_services/programs_and_services/public_health/jackson_county_syringe_exchange_program/index.php
Kairos	https://kairosnw.org/programs-and-services/
La Clinica	https://laclinicahealth.org/
OnTrack	https://ontrackroguevalley.org/
Options for Southern Oregon Crisis Resolution Center	http://www.optionsonline.org/crisis-resolution
Rogue Community Health	https://roguecommunityhealth.org/
Rogue Retreat	https://www.rogueretreat.org/
Southern Oregon Veterans Rehabilitation Center & Clinics	https://www.va.gov/southern-oregon-health-care/

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