The following Community Health Needs Assessment findings are based on the defined primary service area (Josephine County) for Asante Three Rivers Medical Center, Grants Pass, OR.

This document is amended and approved by the Asante Board of Directors as of May 2019. The amended document includes Evaluation of Past Activities to reflect subsequent implementation of the Community Health Improvement Plan.

The following document contains:

- 2016 Community Health Needs Assessment Report prepared by PRC, Inc.
- 2017 Implementation Strategy (CHIP) amended May 2019
Summary Report

2016 Community Health Needs Assessment Report

Josephine County, Oregon

Prepared for:
Asante Three Rivers Medical Center

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2016-4491-02
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Introduction
About This Assessment

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2011 and 2014, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in Josephine County, the service area of Asante Three Rivers Medical Center. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

This assessment was conducted on behalf of Asante Three Rivers Medical Center by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an Online Key Informant Survey of various community stakeholders.

PRC Community Health Survey

Survey Instrument

The survey instrument used for this study is based largely on the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS), as well as various other public health surveys and customized questions addressing gaps in indicator data relative to health promotion and disease prevention objectives and other recognized health issues. The final survey instrument was developed by Asante and PRC.

Community Defined for This Assessment

The study area for the survey effort is defined as each of the residential ZIP Codes comprising Josephine County. This community definition, determined based on the ZIP Codes of residence of recent patients of Asante Three Rivers Medical Center, is illustrated in the following map.
Sample Approach & Design
A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the PRC Community Health Survey. Thus, to ensure the best representation of the population surveyed, a mixed-mode methodology was implemented. This included surveys conducted via telephone (landline and cell phone), as well as through online questionnaires.

The sample design used for this effort consisted of a random sample of 300 individuals age 18 and older in Josephine County. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent Josephine County as a whole. All administration of the surveys, data collection and data analysis was conducted by PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 300 respondents is ±5.7% at the 95 percent confidence level.

Sample Characteristics
To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to “weight” the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias.
The following chart outlines the characteristics of the Josephine County sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child’s healthcare needs, and these children are not represented demographically in this chart.]

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household (e.g., the 2016 guidelines place the poverty threshold for a family of four at $24,300 annual household income or lower). In sample segmentation: “low income” refers to community members living in a household with defined poverty status or living just above the poverty level and earning up to twice (<200% of) the poverty threshold; “mid/high income” refers to those households living on incomes which are twice or more (≥200% of) the federal poverty level.

The sample design and the quality control procedures used in the data collection ensure that the sample is representative. Thus, the findings may be generalized to the total population of community members in the defined area with a high degree of confidence.

**Online Key Informant Survey**

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Asante; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.
Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 33 community stakeholders took part in the Online Key Informant Survey for Josephine County, as outlined below:

<table>
<thead>
<tr>
<th>Key Informant Type</th>
<th>Number Invited</th>
<th>Number Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Leader</td>
<td>48</td>
<td>18</td>
</tr>
<tr>
<td>Other Health Provider</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Physician</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Public Health Representative</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Social Services Provider</td>
<td>13</td>
<td>9</td>
</tr>
</tbody>
</table>

Final participation included representatives of the organizations outlined below.

- AllCare
- Asante Three Rivers Medical Center
- City of Grants Pass
- Grants Pass City Council
- Grants Pass Daily Courier
- Grants Pass Department of Public Safety
- Grants Pass Family YMCA
- Grants Pass Fire Rescue
- Grants Pass School District 7
- Habitat for Humanity
- Jerome Prairie Bible Church
- Josephine County
- Josephine County Board of Commissioners
- Josephine County Foundation
- Josephine County Public Health
- Josephine County School System
- Josephine Housing Council
- KAIROS
- Kid Zone Community Foundation
- Options for Southern Oregon
- Rogue Community College
- Siskiyou Community Health Center
- United Community Action Network (UCAN)
- YMCA Grants Pass

Through this process, input was gathered from several individuals whose organizations work with low-income, minority, or other medically underserved populations.

**Minority/medically underserved populations represented:**

- African-Americans
- Asians
- children
- the disabled
- Hispanics
- the homeless
- LGBT
- low income individuals
- Medicare/Medicaid recipients
- the mentally ill
- non-English-speaking
- older adults
- undocumented
- the uninsured/underinsured
- veterans
- victims of crime
In the online survey, key informants were asked to rate the degree to which various health issues are a problem in Josephine County. Follow-up questions asked them to describe why they identify problem areas as such, and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input regarding participants’ opinions and perceptions of the health needs of the residents in the county. Thus, these findings are not necessarily based on fact.

Public Health, Vital Statistics & Other Data
A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for Josephine County were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics
Benchmark Data

Trending
A similar survey was administered in Josephine County in 2011 and 2014 by PRC on behalf of Asante. Trending data, as revealed by comparison to prior survey results, are provided throughout this report whenever available. Historical data for secondary data indicators are also included for the purposes of trending.

State Risk Factor Data
Statewide risk factor data are provided where available as an additional benchmark against which to compare local survey findings; these data are reported in the most recent BRFSS (Behavioral Risk Factor Surveillance System) Prevalence and Trend Data published by the Centers for Disease Control and Prevention and the US Department of Health & Human Services. State-level vital statistics are also provided for comparison of secondary data indicators.

Nationwide Risk Factor Data
Nationwide risk factor data, which are also provided in comparison charts, are taken from the 2015 PRC National Health Survey; the methodological approach for the national study is similar to that employed in this assessment, and these data may be generalized to the US population with a high degree of confidence. National-level vital statistics are also provided for comparison of secondary data indicators.

Healthy People 2020
Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. The Healthy People initiative is grounded in the principle that setting national objectives and monitoring progress can motivate action. For three decades, Healthy People has established benchmarks and monitored progress over time in order to:

- Encourage collaborations across sectors.
- Guide individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Healthy People 2020 is the product of an extensive stakeholder feedback process that is unparalleled in government and health. It integrates input from public health and prevention experts, a wide range of federal, state and local government officials, a consortium of more than 2,000 organizations, and perhaps most importantly, the public. More than 8,000 comments were considered in drafting a comprehensive set of Healthy People 2020 objectives.

Determining Significance
Differences noted in this report represent those determined to be significant. For survey-derived indicators (which are subject to sampling error), statistical significance is determined based on confidence intervals (at the 95 percent confidence level) using question-specific samples and response rates. For the purpose of this report, “significance,” of secondary data indicators (which do not carry sampling error but might be subject to reporting error) is determined by a 5% variation from the comparative measure.
Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community’s health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.
**IRS Form 990, Schedule H Compliance**

For non-profit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals’ reporting on IRS Form 990 Schedule H, the following table cross-references related sections.

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Part V Section B Line 3a</strong>&lt;br&gt;A definition of the community served by the hospital facility</td>
<td>5</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3b</strong>&lt;br&gt;Demographics of the community</td>
<td>32</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3c</strong>&lt;br&gt;Existing health care facilities and resources within the community that are available to respond to the health needs of the community</td>
<td>141</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3d</strong>&lt;br&gt;How data was obtained</td>
<td>5</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3e</strong>&lt;br&gt;The significant health needs of the community</td>
<td>14</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3f</strong>&lt;br&gt;Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups</td>
<td>Addressed Throughout</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3g</strong>&lt;br&gt;The process for identifying and prioritizing community health needs and services to meet the community health needs</td>
<td>15</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3h</strong>&lt;br&gt;The process for consulting with persons representing the community’s interests</td>
<td>7</td>
</tr>
<tr>
<td><strong>Part V Section B Line 3i</strong>&lt;br&gt;Information gaps that limit the hospital facility’s ability to assess the community’s health needs</td>
<td>10</td>
</tr>
</tbody>
</table>
Summary of Findings
**Significant Health Needs of the Community**

The following “Areas of Opportunity” represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in Healthy People 2020. From these data, opportunities for health improvement exist in the county with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community stakeholders (key informants) giving input to this process.

<table>
<thead>
<tr>
<th>Areas of Opportunity Identified Through This Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Health Services</strong></td>
</tr>
<tr>
<td>• Barriers to Access</td>
</tr>
<tr>
<td>○ Cost of Prescriptions</td>
</tr>
<tr>
<td>○ Finding a Physician</td>
</tr>
<tr>
<td><strong>Cancer</strong></td>
</tr>
<tr>
<td>• Cancer is a leading cause of death.</td>
</tr>
<tr>
<td>• Cancer Deaths</td>
</tr>
<tr>
<td>• Cancer Incidence</td>
</tr>
<tr>
<td>○ Including Lung Cancer and Female Breast Cancer Incidence</td>
</tr>
<tr>
<td>• Cancer (Non-Skin) Prevalence</td>
</tr>
<tr>
<td>• Female Breast Cancer Screening [Age 50-74]</td>
</tr>
<tr>
<td>• Cervical Cancer Screening [Age 21-65]</td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
</tr>
<tr>
<td>• Diabetes Deaths</td>
</tr>
<tr>
<td>• Prevalence of Borderline/Pre-Diabetes</td>
</tr>
<tr>
<td><strong>Heart Disease &amp; Stroke</strong></td>
</tr>
<tr>
<td>• Cardiovascular disease is a leading cause of death.</td>
</tr>
<tr>
<td>• Stroke Deaths</td>
</tr>
<tr>
<td>• Stroke Prevalence</td>
</tr>
<tr>
<td>• High Blood Pressure Prevalence</td>
</tr>
<tr>
<td>• High Blood Pressure Management</td>
</tr>
<tr>
<td>• Overall Cardiovascular Risk</td>
</tr>
<tr>
<td>• Heart Disease &amp; Stroke ranked as a top concern in the Online Key Informant Survey.</td>
</tr>
<tr>
<td><strong>Infant Health &amp; Family Planning</strong></td>
</tr>
<tr>
<td>• Infant Deaths</td>
</tr>
<tr>
<td><strong>Injury &amp; Violence</strong></td>
</tr>
<tr>
<td>• Unintentional Injury Deaths</td>
</tr>
<tr>
<td>○ Including Motor Vehicle Crash Deaths</td>
</tr>
<tr>
<td>• Falls [Age 45+]</td>
</tr>
<tr>
<td>• Firearm-Related Deaths</td>
</tr>
<tr>
<td>• Neighborhood Is “Slightly/Not At All Safe”</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
</tr>
<tr>
<td>• Diagnosed Depression</td>
</tr>
<tr>
<td>• Suicide Deaths</td>
</tr>
<tr>
<td>• Mental Health ranked as a top concern in the Online Key Informant Survey.</td>
</tr>
<tr>
<td><strong>Nutrition, Physical Activity, &amp; Weight</strong></td>
</tr>
<tr>
<td>• Overweight &amp; Obesity [Adults]</td>
</tr>
<tr>
<td>• Trying to Lose Weight (Overweight Adults)</td>
</tr>
</tbody>
</table>

-continued on next page-
AOOs Continued

**Potentially Disabling Conditions**
- Activity Limitations
- Arthritis/Rheumatism Prevalence [Age 50+]
- Sciatica/Chronic Back Pain Prevalence
- Blindness/Vision Trouble
- Deafness/Hearing Trouble
- Caregiving

**Respiratory Diseases**
- Chronic Lower Respiratory Disease (CLRD) Deaths
- Flu Vaccination [Age 65+]
- Flu Vaccination [High-Risk Age 18-64]

**Substance Abuse**
- Cirrhosis/Liver Disease Deaths
- Drinking & Driving
- Drug-Induced Deaths
- Personal Impact from Substance Abuse (Self or Other’s)
- Substance Abuse ranked as a top concern in the Online Key Informant Survey.

**Tobacco Use**
- Tobacco Use ranked as a top concern in the Online Key Informant Survey.

### Prioritization of Health Needs

**Community Feedback**

On February 16, 2017, Asante, acting as the legal owner and operator of Asante Three Rivers Medical Center, convened a group of 29 community stakeholders (representing a cross-section of community-based agencies and organizations) to evaluate, discuss and prioritize health issues for community, based on findings of this Community Health Needs Assessment (CHNA). Professional Research Consultants, Inc. (PRC) began the meeting with a presentation of key findings from the CHNA, highlighting the significant health issues identified from the research (see Areas of Opportunity above).

Following the data review, PRC answered any questions and facilitated a group dialogue, allowing participants to advocate for any of the health issues discussed. A hospital representative also provided guidance to the group, describing existing activities, initiatives, resources, etc., relating to the Areas of Opportunity. Finally, participants were provided an overview of the prioritization exercise that followed.

In order to assign priority to the identified health needs (i.e., Areas of Opportunity), a wireless audience response system was used in which each participant was able to register his/her ratings using a small remote keypad. The participants were asked to evaluate each health issue along two criteria:

- **Scope & Severity** — The first rating was to gauge the magnitude of the problem in consideration of the following:
  - How many people are affected?
  - How does the local community data compare to state or national levels, or Healthy People 2020 targets?
  - To what degree does each health issue lead to death or disability, impair quality of life, or impact other health issues?
Ratings were entered on a scale of 1 (not very prevalent at all, with only minimal health consequences) to 10 (extremely prevalent, with very serious health consequences).

- **Ability to Impact** — A second rating was designed to measure the perceived likelihood of the hospital having a positive impact on each health issue, given available resources, competencies, spheres of influence, etc. Ratings were entered on a scale of 1 (no ability to impact) to 10 (great ability to impact).

Plotting these overall scores in a matrix illustrates the intersection of the Scope & Severity and the Ability to Impact scores. Below, those issues placing in the upper right (shaded) quadrant represent health needs rated as most severe, with the greatest ability to impact.

This community input was taken into account in determining the finalized priority of health needs for Asante Health.

**Final Prioritization**

The Asante board of directors reviewed, approved and adopted the 2016 CHNA report on April 3, 2017, including the below prioritization of community needs.

1. **Access to Health Care Services**: Improve access to comprehensive, quality health care services.
2. **Mental Health & Substance Abuse**: Improve mental health through prevention and by ensuring access to appropriate, quality mental health services. Reduce substance abuse to protect the health, safety and quality of life for all, especially children.
3. **Heart Disease and Stroke**: Improve cardiovascular health and quality of life through prevention, detection and treatment of risk factors for heart attack and stroke; early
identification and treatment of heart attacks and strokes; prevention of repeat cardiovascular events’ and reduction in deaths from cardiovascular disease.

4. **Infant Health and Family Planning**: Improve the health and well-being of women, infants, children and families. Improve pregnancy planning and spacing, and prevent unintended pregnancy.

5. **Diabetes**: Reduce the disease burden of diabetes and improve the quality of life for all persons who have, or are at risk for, diabetes.

6. **Nutrition, Physical Activity and Weight**: Promote health and reduce chronic disease risk through the consumption of healthful diets, and achievement and maintenance of healthy body weights. Improve health, fitness and quality of life through daily physical activity.

7. **Respiratory Diseases**: Promote respiratory health through better prevention, detection, treatment and education efforts.

8. **Cancer**: Reduce the number of new cancer cases, as well as the illness, disability and death caused by cancer.

9. **Disability and Health**: Maximize health, prevent chronic disease, improve social and environmental living conditions, and promote full community participation, choice, health equity and quality of life among individuals with disability of all ages.

10. **Injury and Violence Prevention**: Prevent unintentional injuries and violence, and reduce their consequences.

11. **Tobacco Use**: Reduce illness, disability and death related to tobacco use and secondhand smoke exposure.

**Hospital Implementation Strategy**

Asante will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the above prioritized needs.

*Note: An evaluation of the hospital’s past activities to address the needs identified in prior CHNAs can be found as an appendix to this report.*
## Summary Data

### Comparisons With Benchmark Data

The following tables provide an overview of indicators in Josephine County. These data are grouped to correspond with the Focus Areas presented in Healthy People 2020.

#### Reading the Data Summary Tables

- In the following charts, Josephine County results are shown in the larger, blue column. For survey-derived indicators, this column represents the ZIP Code–defined area; for data from secondary sources, this column represents findings for the county as a whole. *Tip: Indicator labels beginning with a “%” symbol are taken from the PRC Community Health Survey; the remaining indicators are taken from secondary data sources.*

- The columns to the right of the Josephine County column provide trending comparisons (trending from the earliest data year available), as well as comparisons between local data and any available state and national findings, and Healthy People 2020 targets. Symbols indicate whether Josephine County compares favorably (☉), unfavorably (تبادل), or comparably (☉) to these external data.

*Note that blank table cells signify that data are not available or are not reliable for that area and/or for that indicator.*

<table>
<thead>
<tr>
<th>Social Determinants</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>TEND</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>vs. OR</td>
<td>vs. US</td>
<td>vs. HP2020</td>
</tr>
<tr>
<td>Linguistically Isolated Population (Percent)</td>
<td>0.4</td>
<td>☉</td>
<td>☉</td>
<td>3.4</td>
</tr>
<tr>
<td>Population in Poverty (Percent)</td>
<td>19.7</td>
<td>☐</td>
<td>☐</td>
<td>16.7</td>
</tr>
<tr>
<td>Population Below 200% FPL (Percent)</td>
<td>47.4</td>
<td>☠</td>
<td>☠</td>
<td>37.0</td>
</tr>
<tr>
<td>Children Below 200% FPL (Percent)</td>
<td>60.8</td>
<td>☠</td>
<td>☠</td>
<td>46.3</td>
</tr>
<tr>
<td>No High School Diploma (Age 25+, Percent)</td>
<td>11.3</td>
<td>☐</td>
<td>☐</td>
<td>10.5</td>
</tr>
<tr>
<td>Unemployment Rate (Age 16+, Percent)</td>
<td>6.9</td>
<td>☠</td>
<td>☠</td>
<td>5.7</td>
</tr>
</tbody>
</table>
# COMMUNITY HEALTH NEEDS ASSESSMENT

## Josephine County vs. Benchmarks

### Overall Health

<table>
<thead>
<tr>
<th>Metric</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>vs. OR</td>
</tr>
<tr>
<td>% &quot;Fair/Poor&quot; Physical Health</td>
<td>21.0</td>
<td>15.6</td>
</tr>
<tr>
<td>% Activity Limitations</td>
<td>32.3</td>
<td>25.6</td>
</tr>
<tr>
<td>% Caregiver to a Friend/Family Member</td>
<td>34.2</td>
<td>20.9</td>
</tr>
</tbody>
</table>

### Access to Health Services

<table>
<thead>
<tr>
<th>Metric</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>vs. OR</td>
</tr>
<tr>
<td>% [Age 18-64] Lack Health Insurance</td>
<td>7.2</td>
<td>13.5</td>
</tr>
<tr>
<td>% [Insured 18-64] Have Coverage Through ACA</td>
<td>15.9</td>
<td></td>
</tr>
<tr>
<td>% Difficulty Accessing Healthcare in Past Year (Composite)</td>
<td>40.5</td>
<td></td>
</tr>
<tr>
<td>% Inconvenient Hrs Prevented Dr Visit in Past Year</td>
<td>9.9</td>
<td></td>
</tr>
<tr>
<td>% Cost Prevented Getting Prescription in Past Year</td>
<td>15.1</td>
<td></td>
</tr>
<tr>
<td>% Cost Prevented Physician Visit in Past Year</td>
<td>11.5</td>
<td></td>
</tr>
<tr>
<td>% Difficulty Getting Appointment in Past Year</td>
<td>20.2</td>
<td></td>
</tr>
<tr>
<td>% Difficulty Finding Physician in Past Year</td>
<td>13.5</td>
<td></td>
</tr>
<tr>
<td>% Transportation Hindered Dr Visit in Past Year</td>
<td>6.4</td>
<td></td>
</tr>
<tr>
<td>% Skipped Prescription Doses to Save Costs</td>
<td>13.7</td>
<td></td>
</tr>
</tbody>
</table>
## Access to Health Services (continued)

<table>
<thead>
<tr>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>vs. OR</td>
<td>vs. US</td>
</tr>
<tr>
<td>% Difficulty Getting Child's Healthcare in Past Year</td>
<td>3.5</td>
</tr>
<tr>
<td>Primary Care Doctors per 100,000</td>
<td>84.0</td>
</tr>
<tr>
<td>% [Age 18+] Have a Specific Source of Ongoing Care</td>
<td>77.8</td>
</tr>
<tr>
<td>% [Age 18-64] Have a Specific Source of Ongoing Care</td>
<td>75.3</td>
</tr>
<tr>
<td>% [Age 65+] Have a Specific Source of Ongoing Care</td>
<td>81.8</td>
</tr>
<tr>
<td>% Have Had Routine Checkup in Past Year</td>
<td>72.6</td>
</tr>
<tr>
<td>% Child Has Had Checkup in Past Year</td>
<td>91.5</td>
</tr>
<tr>
<td>% Two or More ER Visits in Past Year</td>
<td>12.1</td>
</tr>
<tr>
<td>% Rate Local Healthcare &quot;Fair/Poor&quot;</td>
<td>14.3</td>
</tr>
<tr>
<td>% Have Completed Advance Directive Documents</td>
<td>38.6</td>
</tr>
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</table>

### Arthritis, Osteoporosis & Chronic Back Conditions

<table>
<thead>
<tr>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>vs. OR</td>
<td>vs. US</td>
</tr>
<tr>
<td>% [50+] Arthritis/Rheumatism</td>
<td>44.1</td>
</tr>
<tr>
<td>% [50+] Osteoporosis</td>
<td>12.1</td>
</tr>
<tr>
<td>% Sciatica/Chronic Back Pain</td>
<td>29.5</td>
</tr>
<tr>
<td>Cancer</td>
<td>Josephine County</td>
</tr>
<tr>
<td>----------------------------------------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Cancer (Age-Adjusted Death Rate)</td>
<td>189.9</td>
</tr>
<tr>
<td></td>
<td>vs. OR</td>
</tr>
<tr>
<td></td>
<td>163.9</td>
</tr>
<tr>
<td>Prostate Cancer Incidence per 100,000</td>
<td>112.9</td>
</tr>
<tr>
<td></td>
<td>122.8</td>
</tr>
<tr>
<td>Female Breast Cancer Incidence per 100,000</td>
<td>136.6</td>
</tr>
<tr>
<td></td>
<td>128.4</td>
</tr>
<tr>
<td>Lung Cancer Incidence per 100,000</td>
<td>74.6</td>
</tr>
<tr>
<td></td>
<td>61.0</td>
</tr>
<tr>
<td>Colorectal Cancer Incidence per 100,000</td>
<td>40.4</td>
</tr>
<tr>
<td></td>
<td>38.3</td>
</tr>
<tr>
<td>% Skin Cancer</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>7.4</td>
</tr>
<tr>
<td>% Cancer (Other Than Skin)</td>
<td>12.7</td>
</tr>
<tr>
<td></td>
<td>7.9</td>
</tr>
<tr>
<td>% [Women 50-74] Mammogram in Past 2 Years</td>
<td>69.1</td>
</tr>
<tr>
<td></td>
<td>77.0</td>
</tr>
<tr>
<td>% [Women 21-65] Pap Smear in Past 3 Years</td>
<td>65.0</td>
</tr>
<tr>
<td></td>
<td>82.9</td>
</tr>
<tr>
<td>% [Age 50+] Sigmoid/Colonoscopy Ever</td>
<td>78.9</td>
</tr>
<tr>
<td></td>
<td>70.6</td>
</tr>
<tr>
<td>% [Age 50+] Blood Stool Test in Past 2 Years</td>
<td>19.2</td>
</tr>
<tr>
<td></td>
<td>17.0</td>
</tr>
<tr>
<td>% [Age 50-75] Colorectal Cancer Screening</td>
<td>72.8</td>
</tr>
<tr>
<td></td>
<td>66.8</td>
</tr>
</tbody>
</table>

**Legend:**
- **Better**
- **Similar**
- **Worse**
<table>
<thead>
<tr>
<th>Health Condition</th>
<th>County</th>
<th>vs. OR</th>
<th>vs. US</th>
<th>vs. HP2020</th>
<th>Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Kidney Disease</td>
<td>Josephine</td>
<td>8.0</td>
<td>7.1</td>
<td>13.2</td>
<td></td>
</tr>
<tr>
<td>Kidney Disease (Age-Adjusted Death Rate)</td>
<td>County</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Kidney Disease</td>
<td>Josephine</td>
<td>3.9</td>
<td>3.4</td>
<td>3.6</td>
<td>6.1</td>
</tr>
<tr>
<td>Dementias, Including Alzheimer's Disease</td>
<td>Josephine</td>
<td>21.6</td>
<td>27.9</td>
<td>24.2</td>
<td></td>
</tr>
<tr>
<td>Alzheimer's Disease (Age-Adjusted Death Rate)</td>
<td>County</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>Josephine</td>
<td>22.5</td>
<td>23.4</td>
<td>21.1</td>
<td>20.5</td>
</tr>
<tr>
<td>Diabetes Mellitus (Age-Adjusted Death Rate)</td>
<td>County</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Diabetes/High Blood Sugar</td>
<td>Josephine</td>
<td>16.8</td>
<td>9.0</td>
<td>14.5</td>
<td>11.1</td>
</tr>
<tr>
<td>% Borderline/Pre-Diabetes</td>
<td>Josephine</td>
<td>10.7</td>
<td>5.7</td>
<td></td>
<td>7.7</td>
</tr>
<tr>
<td>% [Non-Diabetes] Blood Sugar Tested in Past 3 Years</td>
<td>Josephine</td>
<td>53.9</td>
<td>55.1</td>
<td></td>
<td>61.3</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Josephine</td>
<td>35.2</td>
<td>30.8</td>
<td>36.6</td>
<td></td>
</tr>
<tr>
<td>Teen Births per 1,000 (Age 15-19)</td>
<td>County</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing &amp; Other Sensory or Communication Disorders</td>
<td>Josephine County</td>
<td>Josephine County vs. Benchmarks</td>
<td>TRENDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-----------------</td>
<td>---------------------------------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Deafness/Trouble Hearing</td>
<td>16.8</td>
<td>vs. OR 8.6 vs. US 15.1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Heart Disease &amp; Stroke</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>TRENDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the Heart (Age-Adjusted Death Rate)</td>
<td>139.3</td>
<td>vs. OR 132.5 vs. US 169.1 vs. HP2020 156.9</td>
<td></td>
</tr>
<tr>
<td>Stroke (Age-Adjusted Death Rate)</td>
<td>44.9</td>
<td>vs. OR 37.4 vs. US 36.5 vs. HP2020 34.8</td>
<td></td>
</tr>
<tr>
<td>% Heart Disease (Heart Attack, Angina, Coronary Disease)</td>
<td>8.5</td>
<td>vs. OR 6.9 vs. US 10.5</td>
<td></td>
</tr>
<tr>
<td>% Stroke</td>
<td>5.8</td>
<td>vs. OR 2.8 vs. US 4.3</td>
<td></td>
</tr>
<tr>
<td>% Blood Pressure Checked in Past 2 Years</td>
<td>97.1</td>
<td>vs. OR 93.6 vs. US 92.6 vs. HP2020 94.9</td>
<td></td>
</tr>
<tr>
<td>% Told Have High Blood Pressure (Ever)</td>
<td>43.1</td>
<td>vs. OR 31.8 vs. US 36.5 vs. HP2020 26.9</td>
<td></td>
</tr>
<tr>
<td>% [HBP] Taking Action to Control High Blood Pressure</td>
<td>80.2</td>
<td>vs. OR 92.5 vs. US 83.3</td>
<td></td>
</tr>
<tr>
<td>% Cholesterol Checked in Past 5 Years</td>
<td>87.1</td>
<td>vs. OR 74.4 vs. US 82.1 vs. HP2020 87.2</td>
<td></td>
</tr>
<tr>
<td>% Told Have High Cholesterol (Ever)</td>
<td>35.7</td>
<td>vs. OR 33.5 vs. US 31.4</td>
<td></td>
</tr>
<tr>
<td>% [HBC] Taking Action to Control High Blood Cholesterol</td>
<td>84.9</td>
<td>vs. OR 84.2 vs. US 80.9</td>
<td></td>
</tr>
<tr>
<td>% 1+ Cardiovascular Risk Factor</td>
<td>88.8</td>
<td>vs. OR 83.0 vs. US 84.7</td>
<td></td>
</tr>
</tbody>
</table>
### HIV

<table>
<thead>
<tr>
<th>metric</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS (Age-Adjusted Death Rate)</td>
<td>1.2</td>
<td><img src="sun" alt="sun" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td>1.2 <img src="cloud" alt="cloud" /> 3.0 <img src="cloud" alt="cloud" /> 3.3 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>HIV Prevalence per 100,000</td>
<td>80.7</td>
<td><img src="sun" alt="sun" /> <img src="sun" alt="sun" /> <img src="sun" alt="sun" /></td>
<td><img src="cloud" alt="cloud" /> 162.3 <img src="sun" alt="sun" /> <img src="sun" alt="sun" /> 353.2 <img src="sun" alt="sun" /></td>
</tr>
</tbody>
</table>

### Immunization & Infectious Diseases

<table>
<thead>
<tr>
<th>metric</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>% [Age 65+] Flu Vaccine in Past Year</td>
<td>43.6</td>
<td><img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td><img src="sun" alt="sun" /> 56.6 <img src="sun" alt="sun" /> <img src="sun" alt="sun" /> 70.0 <img src="cloud" alt="cloud" /> 67.8 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>% [High-Risk 18-64] Flu Vaccine in Past Year</td>
<td>24.7</td>
<td><img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td><img src="sun" alt="sun" /> 48.0 <img src="sun" alt="sun" /> <img src="sun" alt="sun" /> 70.0 <img src="cloud" alt="cloud" /> 24.9 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>% [Age 65+] Pneumonia Vaccine Ever</td>
<td>77.4</td>
<td><img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td><img src="sun" alt="sun" /> 74.1 <img src="sun" alt="sun" /> <img src="sun" alt="sun" /> 90.0 <img src="cloud" alt="cloud" /> 65.1 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>% [High-Risk 18-64] Pneumonia Vaccine Ever</td>
<td>32.1</td>
<td><img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td><img src="sun" alt="sun" /> 38.7 <img src="sun" alt="sun" /> <img src="sun" alt="sun" /> 60.0 <img src="cloud" alt="cloud" /> 39.2 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>% Have Completed Hepatitis B Vaccination Series</td>
<td>35.8</td>
<td><img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td><img src="sun" alt="sun" /> 40.2 <img src="sun" alt="sun" /> <img src="sun" alt="sun" /> 35.5 <img src="cloud" alt="cloud" /></td>
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</table>

### Injury & Violence Prevention

<table>
<thead>
<tr>
<th>metric</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unintentional Injury (Age-Adjusted Death Rate)</td>
<td>57.6</td>
<td><img src="sun" alt="sun" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td>40.3 <img src="cloud" alt="cloud" /> 39.7 <img src="cloud" alt="cloud" /> 36.4 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>Motor Vehicle Crashes (Age-Adjusted Death Rate)</td>
<td>18.7</td>
<td><img src="cloud" alt="cloud" /> <img src="sun" alt="sun" /> <img src="sun" alt="sun" /></td>
<td>8.3 <img src="sun" alt="sun" /> 10.6 <img src="sun" alt="sun" /> 12.4 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>% [Age 45+] Fell in the Past Year</td>
<td>39.3</td>
<td><img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td><img src="sun" alt="sun" /> 28.2 <img src="sun" alt="sun" /> <img src="sun" alt="sun" /> <img src="cloud" alt="cloud" /> 9.3 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>Firearm-Related Deaths (Age-Adjusted Death Rate)</td>
<td>17.3</td>
<td><img src="sun" alt="sun" /> <img src="cloud" alt="cloud" /> <img src="cloud" alt="cloud" /></td>
<td>11.2 <img src="cloud" alt="cloud" /> 10.4 <img src="cloud" alt="cloud" /> 9.3 <img src="cloud" alt="cloud" /></td>
</tr>
<tr>
<td>Injury &amp; Violence Prevention (continued)</td>
<td>Josephine County</td>
<td>Josephine County vs. Benchmarks</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------</td>
<td>--------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Homicide (Age-Adjusted Death Rate)</strong></td>
<td>3.7</td>
<td>🌡️ 2.7 5.6 5.5 🌡️</td>
<td></td>
</tr>
<tr>
<td><strong>Violent Crime per 100,000</strong></td>
<td>210.1</td>
<td>🌡️ 250.0 395.5 🌡️</td>
<td></td>
</tr>
<tr>
<td><strong>% Victim of Violent Crime in Past 5 Years</strong></td>
<td>3.1</td>
<td>🌡️ 2.3 🌡️ 6.8 🌡️</td>
<td></td>
</tr>
<tr>
<td><strong>% Perceive Neighborhood as “Slightly/Not At All Safe”</strong></td>
<td>32.2</td>
<td>🌡️ 15.3 🌡️ 🌡️</td>
<td></td>
</tr>
<tr>
<td><strong>% Victim of Domestic Violence (Ever)</strong></td>
<td>18.5</td>
<td>🌡️ 15.1 🌡️ 20.2 🌡️</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maternal, Infant &amp; Child Health</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low Birthweight Births (Percent)</strong></td>
<td>5.8</td>
<td>🌡️ 6.1 8.2 7.8 🌡️</td>
</tr>
<tr>
<td><strong>Infant Death Rate</strong></td>
<td>9.1</td>
<td>🌡️ 5.1 5.9 6.0 🌡️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health &amp; Mental Disorders</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% “Fair/Poor” Mental Health</strong></td>
<td>14.4</td>
<td>🌡️ 15.5 🌡️ 14.4 🌡️</td>
</tr>
<tr>
<td><strong>% Diagnosed Depression</strong></td>
<td>24.7</td>
<td>🌡️ 24.0 17.9 🌡️ 28.0 🌡️</td>
</tr>
<tr>
<td><strong>% Symptoms of Chronic Depression (2+ Years)</strong></td>
<td>31.4</td>
<td>🌡️ 29.9 🌡️ 34.6 🌡️</td>
</tr>
<tr>
<td><strong>Suicide (Age-Adjusted Death Rate)</strong></td>
<td>23.4</td>
<td>🌡️ 17.7 12.7 10.2 🌡️ 28.0 🌡️</td>
</tr>
</tbody>
</table>
### Mental Health & Mental Disorders (continued)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Have Ever Sought Help for Mental Health</td>
<td>28.3</td>
<td>vs. OR: 27.4, vs. US: 25.8</td>
</tr>
<tr>
<td>% [Those With Diagnosed Depression] Seeking Help</td>
<td>79.9</td>
<td>vs. OR: 91.7</td>
</tr>
<tr>
<td>% Taking Rx/Receiving Mental Health Trtmt</td>
<td>11.5</td>
<td>vs. OR: 13.6</td>
</tr>
<tr>
<td>% Unable to Get Mental Health Svcs in Past Yr</td>
<td>2.7</td>
<td>vs. OR: 4.4</td>
</tr>
<tr>
<td>% Typical Day Is &quot;Extremely/Very&quot; Stressful</td>
<td>7.7</td>
<td>vs. OR: 11.7, vs. US: 12.9</td>
</tr>
</tbody>
</table>

### Nutrition, Physical Activity & Weight

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Eat 5+ Servings of Fruit or Vegetables per Day</td>
<td>36.0</td>
<td>vs. OR: 27.4, vs. US: 30.2, vs. HP2020: 42.3</td>
</tr>
<tr>
<td>% 7+ Sugar-Sweetened Drinks in Past Week</td>
<td>20.7</td>
<td>vs. OR: 30.2</td>
</tr>
<tr>
<td>% &quot;Very/Somewhat&quot; Difficult to Buy Fresh Produce</td>
<td>15.5</td>
<td>vs. OR: 21.9, vs. US: 27.3</td>
</tr>
<tr>
<td>Population With Low Food Access (Percent)</td>
<td>18.8</td>
<td>vs. OR: 18.4, vs. US: 23.6</td>
</tr>
<tr>
<td>% Food Insecure</td>
<td>21.8</td>
<td>vs. OR: 25.9</td>
</tr>
<tr>
<td>% Healthy Weight (BMI 18.5-24.9)</td>
<td>27.9</td>
<td>vs. OR: 35.9, vs. US: 32.9, vs. HP2020: 33.3</td>
</tr>
<tr>
<td>% Overweight (BMI 25+)</td>
<td>69.6</td>
<td>vs. OR: 61.7, vs. US: 65.2</td>
</tr>
<tr>
<td>% Obese (BMI 30+)</td>
<td>36.9</td>
<td>vs. OR: 27.9, vs. US: 33.4, vs. HP2020: 30.5</td>
</tr>
</tbody>
</table>

**Legend:**
- ☀️ better
- ☁️ similar
- 🌪️ worse
### Nutrition, Physical Activity & Weight (continued)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Medical Advice on Weight in Past Year</td>
<td>21.3</td>
<td><img src="image" alt="20.4" /> <img src="image" alt="22.2" /></td>
</tr>
<tr>
<td>% [Overweights] Counseled About Weight in Past Year</td>
<td>26.1</td>
<td><img src="image" alt="27.1" /> <img src="image" alt="29.0" /></td>
</tr>
<tr>
<td>% [Obese Adults] Counseled About Weight in Past Year</td>
<td>41.1</td>
<td><img src="image" alt="40.8" /> <img src="image" alt="44.0" /></td>
</tr>
<tr>
<td>% [Overweights] Trying to Lose Weight Both Diet/Exercise</td>
<td>29.0</td>
<td><img src="image" alt="57.0" /> <img src="image" alt="31.0" /></td>
</tr>
<tr>
<td>% No Leisure-Time Physical Activity</td>
<td>21.2</td>
<td><img src="image" alt="16.5" /> <img src="image" alt="32.6" /> <img src="image" alt="21.9" /></td>
</tr>
<tr>
<td>% Meeting Physical Activity Guidelines</td>
<td>21.2</td>
<td><img src="image" alt="24.8" /> <img src="image" alt="23.6" /> <img src="image" alt="20.1" /></td>
</tr>
<tr>
<td>Recreation/Fitness Facilities per 100,000</td>
<td>9.7</td>
<td><img src="image" alt="10.6" /> <img src="image" alt="9.7" /></td>
</tr>
</tbody>
</table>

### Oral Health

<table>
<thead>
<tr>
<th>Metric</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>% [Age 18+] Dental Visit in Past Year</td>
<td>64.4</td>
<td><img src="image" alt="65.7" /> <img src="image" alt="49.0" /> <img src="image" alt="50.6" /></td>
</tr>
<tr>
<td>% Have Dental Insurance</td>
<td>63.1</td>
<td><img src="image" alt="66.5" /> <img src="image" alt="50.5" /></td>
</tr>
</tbody>
</table>

### Respiratory Diseases

<table>
<thead>
<tr>
<th>Metric</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLRD (Age-Adjusted Death Rate)</td>
<td>51.8</td>
<td><img src="image" alt="41.8" /> <img src="image" alt="41.4" /></td>
</tr>
<tr>
<td>Pneumonia/Influenza (Age-Adjusted Death Rate)</td>
<td>11.3</td>
<td><img src="image" alt="9.2" /> <img src="image" alt="15.1" /></td>
</tr>
<tr>
<td>Respiratory Diseases (continued)</td>
<td>Josephine County</td>
<td>Josephine County vs. Benchmarks</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>% COPD (Lung Disease)</td>
<td>12.5</td>
<td>☀️</td>
</tr>
<tr>
<td>% Adults Asthma (Ever Diagnosed)</td>
<td>17.2</td>
<td>🌤️</td>
</tr>
<tr>
<td>% [Child 0-17] Currently Has Asthma</td>
<td>6.3</td>
<td>☁️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexually Transmitted Diseases</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>vs. OR</th>
<th>vs. US</th>
<th>vs. HP2020</th>
<th>TRENDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea Incidence per 100,000</td>
<td>88.8</td>
<td>☀️</td>
<td>59.0</td>
<td>110.7</td>
<td></td>
<td>❄️</td>
</tr>
<tr>
<td>Chlamydia Incidence per 100,000</td>
<td>265.3</td>
<td>☀️</td>
<td>394.3</td>
<td>456.1</td>
<td></td>
<td>❄️</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Abuse</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>vs. OR</th>
<th>vs. US</th>
<th>vs. HP2020</th>
<th>TRENDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cirrhosis/Liver Disease (Age-Adjusted Death Rate)</td>
<td>13.2</td>
<td>☁️</td>
<td>12.0</td>
<td>10.2</td>
<td>8.2</td>
<td>☁️</td>
</tr>
<tr>
<td>% Current Drinker</td>
<td>55.1</td>
<td>☁️</td>
<td>59.0</td>
<td>59.7</td>
<td></td>
<td>☁️</td>
</tr>
<tr>
<td>% Excessive Drinker</td>
<td>19.7</td>
<td>☁️</td>
<td>22.2</td>
<td>25.4</td>
<td></td>
<td>☁️</td>
</tr>
<tr>
<td>% Drinking &amp; Driving in Past Month</td>
<td>2.6</td>
<td>☁️</td>
<td>4.1</td>
<td></td>
<td></td>
<td>☁️</td>
</tr>
<tr>
<td>Drug-Induced Deaths (Age-Adjusted Death Rate)</td>
<td>17.5</td>
<td>☁️</td>
<td>14.1</td>
<td>14.6</td>
<td>11.3</td>
<td>☁️</td>
</tr>
<tr>
<td>% Illicit Drug Use in Past Month</td>
<td>3.9</td>
<td>☁️</td>
<td>3.0</td>
<td>7.1</td>
<td>3.3</td>
<td>☁️</td>
</tr>
<tr>
<td>Substance Abuse (continued)</td>
<td>Josephine County</td>
<td>Josephine County vs. Benchmarks</td>
<td>TREND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------</td>
<td>--------------------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Ever Sought Help for Alcohol or Drug Problem</td>
<td>6.1</td>
<td>4.1</td>
<td>6.8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Life Negatively Affected by Substance Abuse</td>
<td>49.0</td>
<td>32.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tobacco Use</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Current Smoker</td>
<td>18.9</td>
<td>17.0</td>
<td>19.7</td>
</tr>
<tr>
<td>% Someone Smokes at Home</td>
<td>13.0</td>
<td>10.2</td>
<td>16.7</td>
</tr>
<tr>
<td>% [Nonsmokers] Someone Smokes in the Home</td>
<td>5.9</td>
<td>3.9</td>
<td>9.7</td>
</tr>
<tr>
<td>% [Household With Children] Someone Smokes in the Home</td>
<td>12.5</td>
<td>10.2</td>
<td>20.5</td>
</tr>
<tr>
<td>% Use Smokeless Tobacco</td>
<td>3.5</td>
<td>3.6</td>
<td>5.2</td>
</tr>
<tr>
<td>% Currently Use Electronic Cigarettes</td>
<td>6.5</td>
<td>3.8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision</th>
<th>Josephine County</th>
<th>Josephine County vs. Benchmarks</th>
<th>TREND</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Blindness/Trouble Seeing</td>
<td>11.7</td>
<td>3.8</td>
<td>7.0</td>
</tr>
</tbody>
</table>
Summary of Key Informant Perceptions

In the Online Key Informant Survey, community stakeholders were asked to rate the degree to which each of 20 health issues is a problem in their own community, using a scale of “major problem,” “moderate problem,” “minor problem,” or “no problem at all.” The following chart summarizes their responses; these findings also are outlined throughout this report, along with the qualitative input describing reasons for their concerns. (Note that these ratings alone do not establish priorities for this assessment; rather, they are one of several data inputs considered for the prioritization process described earlier.)
Data Charts &
Key Informant Input

The following sections present data from multiple sources, including the random-sample PRC Community Health Survey, public health and other existing data sets (secondary data), as well as qualitative input from the Online Key Informant Survey. Data indicators from these sources are intermingled and organized by health topic. To better understand the source data for specific indicators, please refer to the footnotes accompanying each chart.
Community Characteristics

Population Characteristics

Land Area, Population Size & Density

Data from the US Census Bureau reveal the following statistics for our community relative to size, population, and density.

### Total Population
(Estimated Population, 2010-2014)

<table>
<thead>
<tr>
<th></th>
<th>Total Population</th>
<th>Total Land Area (Square Miles)</th>
<th>Population Density (Per Square Mile)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>83,021</td>
<td>1,639.66</td>
<td>50.63</td>
</tr>
<tr>
<td>Oregon</td>
<td>3,900,343</td>
<td>95,988.34</td>
<td>40.63</td>
</tr>
<tr>
<td>United States</td>
<td>314,107,083</td>
<td>3,531,932.26</td>
<td>88.93</td>
</tr>
</tbody>
</table>

Sources:
- US Census Bureau American Community Survey 5-2013 estimates.

Age

It is important to understand the age distribution of the population, as different age groups have unique health needs that should be considered separately from others along the age spectrum.

### Total Population by Age Groups, Percent
(2010-2014)

<table>
<thead>
<tr>
<th></th>
<th>Age 0-17</th>
<th>Age 18-64</th>
<th>Age 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>19.9%</td>
<td>23.4%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Oregon</td>
<td>14.9%</td>
<td>23.5%</td>
<td>62.8%</td>
</tr>
<tr>
<td>United States</td>
<td>13.8%</td>
<td>62.8%</td>
<td>23.5%</td>
</tr>
</tbody>
</table>

Sources:
- US Census Bureau American Community Survey 5-2013 estimates.
Race & Ethnicity

The following charts illustrate the racial and ethnic makeup of our community. Note that ethnicity (Hispanic or Latino) can be of any race.

Total Population by Race Alone, Percent
(2010-2014)

<table>
<thead>
<tr>
<th>Race</th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>93.4%</td>
<td>85.1%</td>
<td>73.8%</td>
</tr>
<tr>
<td>Black</td>
<td>0.3%</td>
<td>1.8%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Some Other Race</td>
<td>2.9%</td>
<td>9.2%</td>
<td>10.7%</td>
</tr>
<tr>
<td>Multiple Races</td>
<td>3.4%</td>
<td>3.9%</td>
<td>2.9%</td>
</tr>
</tbody>
</table>


Hispanic Population
(2010-2014)

<table>
<thead>
<tr>
<th>Race</th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>6.7%</td>
<td>12.2%</td>
<td>16.9%</td>
</tr>
</tbody>
</table>


Notes: Origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person’s parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be of any race.
Social Determinants of Health

About Social Determinants

Health starts in our homes, schools, workplaces, neighborhoods, and communities. We know that taking care of ourselves by eating well and staying active, not smoking, getting the recommended immunizations and screening tests, and seeing a doctor when we are sick all influence our health. Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be.

- Healthy People 2020 (www.healthypeople.gov)

Poverty

The following chart outlines the proportion of our population below the federal poverty threshold, as well as below 200% of the federal poverty level, in comparison to state and national proportions.

Population in Poverty

(Populations Living Below 100% and Below 200% of the Poverty Level; 2010-2014)

<table>
<thead>
<tr>
<th>Source</th>
<th>&lt;100% of Poverty</th>
<th>&lt;200% of Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>19.7%</td>
<td>47.4%</td>
</tr>
<tr>
<td>Oregon</td>
<td>16.7%</td>
<td>37.0%</td>
</tr>
<tr>
<td>US</td>
<td>15.6%</td>
<td>34.5%</td>
</tr>
</tbody>
</table>

38,908 individuals

Sources:
- US Census Bureau American Community Survey 5-2013 estimates.

Notes:
- Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to access including health services, healthy food, and other necessities that contribute to poor health status.
**Education**

Education levels are reflected in the proportion of our population without a high school diploma:

**Population With No High School Diploma**
(Population Age 25+ Without a High School Diploma or Equivalent, 2010-2014)

<table>
<thead>
<tr>
<th></th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% to 20%</td>
<td>11.3%</td>
<td>10.5%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Calculation based on 6,850 individuals</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- This indicator is relevant because educational attainment is linked to positive health outcomes.
Food Insecurity

“Now I am going to read two statements that people have made about their food situation. Please tell me whether each statement was often true, sometimes true, or never true for you in the past 12 months. The first statement is: “I worried about whether our food would run out before we got money to buy more.” Was this statement: often true, sometimes true, or never true?”

“The next statement is: “The food that we bought just did not last, and we did not have money to get more.” Was this statement: often true, sometimes true, or never true?”

In the following chart, food insecurity includes those who responded affirmatively to either of these questions.
General Health Status

Overall Health Status

Self-Reported Health Status
The initial inquiry of the PRC Community Health Survey asked respondents the following:

“Would you say that in general your health is: excellent, very good, good, fair, or poor?”

Self-Reported Health Status
(Josephine County, 2016)

<table>
<thead>
<tr>
<th>Health Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>11.7%</td>
</tr>
<tr>
<td>Very Good</td>
<td>34.3%</td>
</tr>
<tr>
<td>Good</td>
<td>33.0%</td>
</tr>
<tr>
<td>Fair</td>
<td>17.8%</td>
</tr>
<tr>
<td>Poor</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
Notes: Asked of all respondents.

The following charts further detail “fair/poor” overall health responses in Josephine County in comparison to benchmark data, as well as by basic demographic characteristics (namely by sex, age groupings, income [based on poverty status], and race/ethnicity).

Experience “Fair” or “Poor” Overall Health

<table>
<thead>
<tr>
<th>Year</th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>21.0%</td>
<td>15.6%</td>
<td>18.3%</td>
</tr>
<tr>
<td>2014</td>
<td>25.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>20.6%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Experience “Fair” or “Poor” Overall Health
(Josephine County, 2016)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Overall Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>Women</td>
</tr>
<tr>
<td>18 to 44</td>
<td>23.2%</td>
</tr>
<tr>
<td>45 to 64</td>
<td>25.8%</td>
</tr>
<tr>
<td>65+</td>
<td>20.8%</td>
</tr>
<tr>
<td>Low Income</td>
<td>24.9%</td>
</tr>
<tr>
<td>Mid/High Income</td>
<td>20.8%</td>
</tr>
<tr>
<td>Josephine County</td>
<td>21.0%</td>
</tr>
</tbody>
</table>

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 5]

Notes: Asked of all respondents.

Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.

Activity Limitations

About Disability & Health

An individual can get a disabling impairment or chronic condition at any point in life. Compared with people without disabilities, people with disabilities are more likely to:

- Experience difficulties or delays in getting the health care they need.
- Not have had an annual dental visit.
- Not have had a mammogram in past 2 years.
- Not have had a Pap test within the past 3 years.
- Not engage in fitness activities.
- Use tobacco.
- Be overweight or obese.
- Have high blood pressure.
- Experience symptoms of psychological distress.
- Receive less social-emotional support.
- Have lower employment rates.

There are many social and physical factors that influence the health of people with disabilities. The following three areas for public health action have been identified, using the International Classification of Functioning, Disability, and Health (ICF) and the three World Health Organization (WHO) principles of action for addressing health determinants.

- **Improve the conditions of daily life** by: encouraging communities to be accessible so all can live, move through, and interact with their environment; encouraging community living; and removing barriers in the environment using both physical universal design concepts and operational policy shifts.
- **Address the inequitable distribution of resources among people with disabilities and those without disabilities** by increasing: appropriate health care for people with disabilities; education and work opportunities; social participation; and access to needed technologies and assistive supports.
- **Expand the knowledge base and raise awareness about determinants of health for people with disabilities** by increasing: the inclusion of people with disabilities in public health data collection efforts across the lifespan; the inclusion of people with disabilities in health promotion activities; and the expansion of disability and health training opportunities for public health and health care professionals.

- Healthy People 2020 (www.healthypeople.gov)
“Are you limited in any way in any activities because of physical, mental, or emotional problems?”

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Limited in Activities in Some Way
Due to a Physical, Mental or Emotional Problem
(Josephine County, 2016)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 128]

Notes:
- Asked of all respondents.
- Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
Mental Health

About Mental Health & Mental Disorders

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with challenges. Mental health is essential to personal well-being, family and interpersonal relationships, and the ability to contribute to community or society. Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning. Mental disorders contribute to a host of problems that may include disability, pain, or death. Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are among the most common causes of disability. The resulting disease burden of mental illness is among the highest of all diseases.

Mental health and physical health are closely connected. Mental health plays a major role in people's ability to maintain good physical health. Mental illnesses, such as depression and anxiety, affect people’s ability to participate in health-promoting behaviors. In turn, problems with physical health, such as chronic diseases, can have a serious impact on mental health and decrease a person’s ability to participate in treatment and recovery.

The existing model for understanding mental health and mental disorders emphasizes the interaction of social, environmental, and genetic factors throughout the lifespan. In behavioral health, researchers identify: risk factors, which predispose individuals to mental illness; and protective factors, which protect them from developing mental disorders. Researchers now know that the prevention of mental, emotional, and behavioral (MEB) disorders is inherently interdisciplinary and draws on a variety of different strategies. Over the past 20 years, research on the prevention of mental disorders has progressed. The major areas of progress include evidence that:

- MEB disorders are common and begin early in life.
- The greatest opportunity for prevention is among young people.
- There are multyear effects of multiple preventive interventions on reducing substance abuse, conduct disorder, antisocial behavior, aggression, and child maltreatment.
- The incidence of depression among pregnant women and adolescents can be reduced.
- School-based violence prevention can reduce the base rate of aggressive problems in an average school by 25 to 33%.
- There are potential indicated preventive interventions for schizophrenia.
- Improving family functioning and positive parenting can have positive outcomes on mental health and can reduce poverty-related risk.
- School-based preventive interventions aimed at improving social and emotional outcomes can also improve academic outcomes.
- Interventions targeting families dealing with adversities, such as parental depression or divorce, can be effective in reducing risk for depression in children and increasing effective parenting.
- Some preventive interventions have benefits that exceed costs, with the available evidence strongest for early childhood interventions.
- Implementation is complex, and it is important that interventions be relevant to the target audiences.
- In addition to advancements in the prevention of mental disorders, there continues to be steady progress in treating mental disorders as new drugs and stronger evidence-based outcomes become available.

- Healthy People 2020 (www.healthypeople.gov)
Self-Reported Mental Health Status

“Now thinking about your mental health, which includes stress, depression and problems with emotions, would you say that, in general, your mental health is: excellent, very good, good, fair, or poor?”

Self-Reported Mental Health Status
(Josephine County, 2016)

Sources:  2016 PRC Community Health Survey, Professional Research Consultants, Inc.  [Item 116]
Notes:  Asked of all respondents.

Experience “Fair” or “Poor” Mental Health

Sources:  2016 PRC Community Health Survey, Professional Research Consultants, Inc.  [Item 116]
2015 PRC National Health Survey, Professional Research Consultants, Inc.
Notes:  Asked of all respondents.
Experience “Fair” or “Poor” Mental Health  
(Josephine County, 2016)

Sources:  2016 PRC Community Health Survey, Professional Research Consultants, Inc.  
[Item 116]  
Notes:  Asked of all respondents.  
Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.  “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Depression

Diagnosed Depression: “Has a doctor or other healthcare provider ever told you that you have a depressive disorder, including depression, major depression, dysthymia, or minor depression?”

Have Been Diagnosed With a Depressive Disorder

Sources:  2016 PRC Community Health Survey, Professional Research Consultants, Inc.  [Item 119]  
2015 PRC National Health Survey, Professional Research Consultants, Inc.  
Notes:  Asked of all respondents.  
Depressive disorders include depression, major depression, dysthymia, or minor depression.
Symptoms of Chronic Depression: “Have you had two years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes?”

Have Experienced Symptoms of Chronic Depression
(Josephine County, 2016)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.

<table>
<thead>
<tr>
<th>Income Category</th>
<th>Men</th>
<th>Women</th>
<th>18 to 44</th>
<th>45 to 64</th>
<th>65+</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>Josephine County</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24.9%</td>
<td>37.4%</td>
<td>35.9%</td>
<td>30.9%</td>
<td>25.8%</td>
<td>34.6%</td>
<td>28.1%</td>
<td>31.4%</td>
</tr>
</tbody>
</table>

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 117]
- Chronic depression includes periods of two or more years during which the respondent felt depressed or sad on most days, even if (s)he felt okay sometimes.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Suicide

The following chart outlines the most current age-adjusted mortality rates attributed to suicide in our population. (Refer to “Leading Causes of Death” for an explanation of the use of age-adjusting for these rates.)

**Suicide: Age-Adjusted Mortality**
*(2012-2014 Annual Average Deaths per 100,000 Population)*

**Healthy People 2020 Target = 10.2 or Lower**

<table>
<thead>
<tr>
<th></th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td>23.4</td>
<td>17.7</td>
<td>12.7</td>
</tr>
</tbody>
</table>

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2016.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Mental Health Treatment

“Have you ever sought help from a professional for a mental or emotional problem?”

“Are you now taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem?”

**Mental Health Treatment**

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 120-121]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Reflects the total sample of respondents.
“Was there a time in the past 12 months when you needed mental health services but were not able to get them?”

Unable to Get Mental Health Services When Needed in the Past Year
(Josephine County, 2016)

Key Informant Input: Mental Health
The following chart outlines key informants’ perceptions of the severity of Mental Health as a problem in the community:

Perceptions of Mental Health as a Problem in the Community
(Key Informants, 2016)

Challenges
Among those rating this issue as a “major problem,” the following represent what key informants see as the main challenges for persons with mental illness:

Access to Care/Services

We do not have sufficient facilities to address this issue and end up pushing them through the courts or through the Emergency Departments. There is a critical need for more housing and facilities to address this issue. - Community Leader
There is a lack of facilities to house those in crisis. We need transitional housing facilities to help those with mental health issues, as well as those needing rehab services. Unfortunately they are put back on the street. - Community Leader

Access to care. Co-morbidity with substance abuse is common. People with mental health issues make up the majority of the local homeless population. - Public Health Representative

Access help for mental health issues. - Community Leader

Lack of services. - Community Leader

Access and diagnosis. - Community Leader

Data on access and quality. - Other Health Provider

### Access to Providers

**Limited mental health personnel and services.** - Social Services Provider

**Access to providers, and so many don't have an ability to pay for needed care.** - Community Leader

**Poor access to primary services, particularly for Medicaid and Medicare patients.** - Physician

**Finding a provider. Having the money to pay a provider.** - Community Leader

**Lack of private practitioners to take care of the community and Medicaid patients.** - Other Health Provider

### Diagnosis/Treatment

**Diagnosis is the biggest problem we face with students and their parents.** Often viewed as a negative thing, many families are unwilling to consider there may be mental health issues in the family. - Community Leader

**Often times, mental health issues go undiagnosed.** In the school system, we can see a lot of parents that have these issues. It is a difficult conversation from the school perspective to suggest an adult has it. - Community Leader

**Although support services exist, it seems that the number of people with mental health issues is growing faster than the support services can keep up with, leaving needs for housing, employment, and guidance.** - Social Services Provider

### Children/Youth

**Simply getting adequate help.** We have a grave shortage of adolescent psychiatrists. We lack options for serious emotionally disturbed adolescents/youth in our community. What little help that is available for our children is a mental health counselor. - Community Leader

**Emergency Rooms not suited to accommodate youth in mental health crises.** Emergency rooms also not referring to local resources who are actually equipped to handle youth in mental health emergencies. - Other Health Provider

### Health Education

**Understanding how what has happened to them has effected where they are now, and what they can do about it to make changes that have meaning for them in their lives.** - Other Health Provider

**There is a lack of understanding within the community regarding the ongoing mental health challenges that many in our community are facing.** There also appear to be mostly short-term treatment options, if the person can access them. - Social Services Provider

### Housing

**There are so few resources with regard to the scope of mental illness in the community.** Many are treated through the criminal justice system. Many of the homeless population suffer from mental illness they may not know about. - Community Leader

**Insufficient foster care, short term residential facilities and transitional housing.** - Social Services Provider

### Affordable Care/Services

**Low income, high rates of substance abuse and a high percentage of transient population with untreated mental health issues.** Lack of essential diagnostic and preventive care services, lack of community support services, limited public funding. - Community Leader

### Denial/Stigma

We have community resources available. The issue I see is parents' unwillingness to participate in mental health services for their children and/or family. They want the counselor to fix the child, but are not willing to do their part to change practice. - Community Leader
Death, Disease & Chronic Conditions

Leading Causes of Death

Distribution of Deaths by Cause

Cancers and cardiovascular disease (heart disease and stroke) are leading causes of death in the community.

![Pie chart showing leading causes of death](chart.png)

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- CLRD is chronic lower respiratory disease.

Age-Adjusted Death Rates for Selected Causes

In order to compare mortality in the region with other localities (in this case, the state and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2020 targets.

The following chart outlines annual average age-adjusted death rates per 100,000 population for selected causes of death in the county. (For infant mortality data, see also Birth Outcomes & Risks in the Births section of this report.)
### Age-Adjusted Death Rates for Selected Causes
(2012-2014 Deaths per 100,000 Population)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
<th>HP2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant Neoplasms (Cancers)</td>
<td>189.9</td>
<td>163.9</td>
<td>163.6</td>
<td>161.4</td>
</tr>
<tr>
<td>Diseases of the Heart</td>
<td>139.3</td>
<td>132.5</td>
<td>169.1</td>
<td>156.9*</td>
</tr>
<tr>
<td>Unintentional Injuries</td>
<td>57.6</td>
<td>40.3</td>
<td>39.7</td>
<td>36.4</td>
</tr>
<tr>
<td>Chronic Lower Respiratory Disease (CLRD)</td>
<td>51.8</td>
<td>41.8</td>
<td>41.4</td>
<td>n/a</td>
</tr>
<tr>
<td>Cerebrovascular Disease (Stroke)</td>
<td>44.9</td>
<td>37.4</td>
<td>36.5</td>
<td>34.8</td>
</tr>
<tr>
<td>Intentional Self-Harm (Suicide)</td>
<td>25.4</td>
<td>17.7</td>
<td>12.7</td>
<td>10.2</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>22.5</td>
<td>23.4</td>
<td>21.1</td>
<td>20.5*</td>
</tr>
<tr>
<td>Alzheimer's Disease</td>
<td>21.9</td>
<td>27.9</td>
<td>24.2</td>
<td>n/a</td>
</tr>
<tr>
<td>Motor Vehicle Deaths</td>
<td>18.7</td>
<td>8.3</td>
<td>10.6</td>
<td>12.4</td>
</tr>
<tr>
<td>Drug-Induced</td>
<td>17.5</td>
<td>14.1</td>
<td>14.6</td>
<td>11.3</td>
</tr>
<tr>
<td>Firearm-Related</td>
<td>17.3</td>
<td>11.2</td>
<td>10.4</td>
<td>9.3</td>
</tr>
<tr>
<td>Cirrhosis/Liver Disease</td>
<td>13.2</td>
<td>12.0</td>
<td>10.2</td>
<td>8.2</td>
</tr>
<tr>
<td>Pneumonia/Influenza</td>
<td>11.3</td>
<td>9.2</td>
<td>15.1</td>
<td>n/a</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>8.0</td>
<td>7.1</td>
<td>13.2</td>
<td>n/a</td>
</tr>
<tr>
<td>Homicide/Legal Intervention</td>
<td>3.7</td>
<td>2.7</td>
<td>5.6</td>
<td>5.5</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>1.2</td>
<td>1.2</td>
<td>3.0</td>
<td>3.3</td>
</tr>
</tbody>
</table>

**Sources:**
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2016.

**Note:**
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population and coded using ICD-10 codes.
- *The Healthy People 2020 Heart Disease target is adjusted to account for all diseases of the heart; the Diabetes target is adjusted to reflect only diabetes mellitus-coded deaths.
Cardiovascular Disease

About Heart Disease & Stroke

Heart disease is the leading cause of death in the United States, with stroke following as the third leading cause. Together, heart disease and stroke are among the most widespread and costly health problems facing the nation today, accounting for more than $500 billion in healthcare expenditures and related expenses in 2010 alone. Fortunately, they are also among the most preventable.

The leading modifiable (controllable) risk factors for heart disease and stroke are:

- High blood pressure
- High cholesterol
- Cigarette smoking
- Diabetes
- Poor diet and physical inactivity
- Overweight and obesity

The risk of Americans developing and dying from cardiovascular disease would be substantially reduced if major improvements were made across the US population in diet and physical activity, control of high blood pressure and cholesterol, smoking cessation, and appropriate aspirin use.

The burden of cardiovascular disease is disproportionately distributed across the population. There are significant disparities in the following based on gender, age, race/ethnicity, geographic area, and socioeconomic status:

- Prevalence of risk factors
- Access to treatment
- Appropriate and timely treatment
- Treatment outcomes
- Mortality

Disease does not occur in isolation, and cardiovascular disease is no exception. Cardiovascular health is significantly influenced by the physical, social, and political environment, including: maternal and child health; access to educational opportunities; availability of healthy foods, physical education, and extracurricular activities in schools; opportunities for physical activity, including access to safe and walkable communities; access to healthy foods; quality of working conditions and worksite health; availability of community support and resources; and access to affordable, quality healthcare.

- Healthy People 2020 (www.healthypeople.gov)
Age-Adjusted Heart Disease & Stroke Deaths

The greatest share of cardiovascular deaths is attributed to heart disease. The following charts outline age-adjusted mortality rates for heart disease and for stroke in our community.

Heart Disease: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 156.9 or Lower (Adjusted)

![Heart Disease Mortality Chart]

Stroke: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 34.8 or Lower

![Stroke Mortality Chart]
Prevalence of Heart Disease & Stroke

“Has a doctor, nurse, or other health professional ever told you that you had: a heart attack, also called a myocardial infarction; or angina or coronary heart disease?” (Heart disease prevalence here is a calculated prevalence that includes those responding affirmatively to either.)

“Has a doctor, nurse, or other health professional ever told you that you had a stroke?”

### Prevalence of Heart Disease

**Sources:**
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 146]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of all respondents.
- Includes diagnoses of heart attack, angina or coronary heart disease.

### Prevalence of Stroke

**Sources:**
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 35]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of all respondents.
**Cardiovascular Risk Factors**

**About Cardiovascular Risk**

Controlling risk factors for heart disease and stroke remains a challenge. High blood pressure and cholesterol are still major contributors to the national epidemic of cardiovascular disease. High blood pressure affects approximately 1 in 3 adults in the United States, and more than half of Americans with high blood pressure do not have it under control. High sodium intake is a known risk factor for high blood pressure and heart disease, yet about 90% of American adults exceed their recommendation for sodium intake.

- **Healthy People 2020** (www.healthypeople.gov)

**High Blood Pressure & Cholesterol Prevalence**

“Have you ever been told by a doctor, nurse, or other health care professional that you had high blood pressure?”

“Blood cholesterol is a fatty substance found in the blood. Have you ever been told by a doctor, nurse, or other health care professional that your blood cholesterol is high?”

---

**Prevalence of High Blood Pressure**

*Healthy People 2020 Target = 26.9% or Lower*

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**Sources:**
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 43, 147]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of all respondents.
### Prevalence of High Blood Cholesterol

**Healthy People 2020 Target = 13.5% or Lower**

<table>
<thead>
<tr>
<th>Year</th>
<th>Josephine County</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>35.7%</td>
<td>33.5%</td>
</tr>
<tr>
<td>2014</td>
<td>31.4%</td>
<td>42.7%</td>
</tr>
<tr>
<td>2016</td>
<td>35.7%</td>
<td>35.7%</td>
</tr>
</tbody>
</table>

84.9% of adults are taking action to help control their levels (such as medication, diet, and/or exercise).

Sources:  
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 46, 148]  
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.  

Notes:  
- Asked of all respondents.

---

**About Cardiovascular Risk**

Individual level risk factors which put people at increased risk for cardiovascular diseases include:

- High Blood Pressure
- High Blood Cholesterol
- Tobacco Use
- Physical Inactivity
- Poor Nutrition
- Overweight/Obesity
- Diabetes
  - National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Three health-related behaviors contribute markedly to cardiovascular disease:

**Poor nutrition.** People who are overweight have a higher risk for cardiovascular disease. Almost 60% of adults are overweight or obese. To maintain a proper body weight, experts recommend a well-balanced diet which is low in fat and high in fiber, accompanied by regular exercise.

**Lack of physical activity.** People who are not physically active have twice the risk for heart disease of those who are active. More than half of adults do not achieve recommended levels of physical activity.

**Tobacco use.** Smokers have twice the risk for heart attack of nonsmokers. Nearly one-fifth of all deaths from cardiovascular disease, or about 190,000 deaths a year nationally, are smoking-related. Every day, more than 3,000 young people become daily smokers in the US.

Modifying these behaviors is critical both for preventing and for controlling cardiovascular disease. Other steps that adults who have cardiovascular disease should take to reduce their risk of death and disability include adhering to treatment for high blood pressure and cholesterol, using aspirin as appropriate, and learning the symptoms of heart attack and stroke.

- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention
Total Cardiovascular Risk

The following chart reflects the percentage of adults in the Josephine County who report one or more of the following: being overweight; smoking cigarettes; being physically inactive; or having high blood pressure or cholesterol. See also Nutrition, Physical Activity, Weight Status, and Tobacco Use in the Modifiable Health Risks section of this report.

Present One or More Cardiovascular Risks or Behaviors
(Josephine County, 2016)

Key Informant Input: Heart Disease & Stroke

The following chart outlines key informants’ perceptions of the severity of Heart Disease & Stroke as a problem in the community:

Perceptions of Heart Disease and Stroke as a Problem in the Community
(Key Informants, 2016)
Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Prevalence/Incidence

The number of people who have had heart attacks and strokes at a relatively young age. - Community Leader
Poor diet, inactivity, elderly population, high stress levels. - Social Services Provider
Statistics indicate they are a major problem. - Other Health Provider
I don’t have data, but I imagine it is an issue. - Other Health Provider
Poor eating habits. - Community Leader

Aging Population

At-risk population, high percentage of elderly. Lack of affordable diagnostic and preventive care services. Critical care patients are transferred to Medford using advance life support EMS resources, stripping the community of emergent response resources. - Community Leader
Demographics figure in. We have an older population. I recently had to see a cardiologist and was surprised at how many other patients there were. Also, one often has to go to Medford to see a cardiologist and have certain treatments. - Community Leader
Cancer

About Cancer

Continued advances in cancer research, detection, and treatment have resulted in a decline in both incidence and death rates for all cancers. Among people who develop cancer, more than half will be alive in five years. Yet, cancer remains a leading cause of death in the United States, second only to heart disease.

Many cancers are preventable by reducing risk factors such as: use of tobacco products; physical inactivity and poor nutrition; obesity; and ultraviolet light exposure. Other cancers can be prevented by getting vaccinated against human papillomavirus and hepatitis B virus. In the past decade, overweight and obesity have emerged as new risk factors for developing certain cancers, including colorectal, breast, uterine corpus (endometrial), and kidney cancers. The impact of the current weight trends on cancer incidence will not be fully known for several decades. Continued focus on preventing weight gain will lead to lower rates of cancer and many chronic diseases.

Screening is effective in identifying some types of cancers (see US Preventive Services Task Force [USPSTF] recommendations), including:

- Breast cancer (using mammography)
- Cervical cancer (using Pap tests)
- Colorectal cancer (using fecal occult blood testing, sigmoidoscopy, or colonoscopy)

Age-Adjusted Cancer Deaths

The following chart illustrates age-adjusted cancer mortality (all types) in Josephine County.

Cancer: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 161.4 or Lower

*Sources:*

*Notes:*
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
Cancer Incidence

Incidence rates (or case rates) reflect the number of newly diagnosed cases in a given population in a given year, regardless of outcome. They usually are expressed as cases per 100,000 population per year. These rates are also age-adjusted.

Cancer Incidence Rates by Site

(Annual Average Age-Adjusted Incidence per 100,000 Population, 2008-2012)


Notes: This indicator reports the age adjusted incidence rate (cases per 100,000 population per 2013) of cancers, adjusted to 2000 U.S. standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older). This indicator is relevant because cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.

Cancer Risk

About Cancer Risk

Reducing the nation’s cancer burden requires reducing the prevalence of behavioral and environmental factors that increase cancer risk.

- All cancers caused by cigarette smoking could be prevented. At least one-third of cancer deaths that occur in the United States are due to cigarette smoking.
- According to the American Cancer Society, about one-third of cancer deaths that occur in the United States each year are due to nutrition and physical activity factors, including obesity.
- National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Cancer Screenings

The American Cancer Society recommends that both men and women get a cancer-related checkup during a regular doctor’s checkup. It should include examination for cancers of the thyroid, testicles, ovaries, lymph nodes, oral cavity, and skin, as well as health counseling about tobacco, sun exposure, diet and nutrition, risk factors, sexual practices, and environmental and occupational exposures.

Screening levels in the community were measured in the PRC Community Health Survey relative to: female breast cancer (mammography); cervical cancer (Pap smear testing); and colorectal cancer (sigmoidoscopy and fecal occult blood testing).
Female Breast Cancer Screening

About Screening for Breast Cancer

The US Preventive Services Task Force (USPSTF) recommends screening mammography, with or without clinical breast examination (CBE), every 1-2 years for women age 40 and older.

Rationale: The USPSTF found fair evidence that mammography screening every 12-33 months significantly reduces mortality from breast cancer. Evidence is strongest for women age 50-69, the age group generally included in screening trials. For women age 40-49, the evidence that screening mammography reduces mortality from breast cancer is weaker, and the absolute benefit of mammography is smaller, than it is for older women. Most, but not all, studies indicate a mortality benefit for women undergoing mammography at ages 40-49, but the delay in observed benefit in women younger than 50 makes it difficult to determine the incremental benefit of beginning screening at age 40 rather than at age 50.

The absolute benefit is smaller because the incidence of breast cancer is lower among women in their 40s than it is among older women. The USPSTF concluded that the evidence is also generalizable to women age 70 and older (who face a higher absolute risk for breast cancer) if their life expectancy is not compromised by comorbid disease. The absolute probability of benefits of regular mammography increase along a continuum with age, whereas the likelihood of harms from screening (false-positive results and unnecessary anxiety, biopsies, and cost) diminish from ages 40-70. The balance of benefits and potential harms, therefore, grows more favorable as women age. The precise age at which the potential benefits of mammography justify the possible harms is a subjective choice. The USPSTF did not find sufficient evidence to specify the optimal screening interval for women age 40-49.

Breast Cancer Screening: “A mammogram is an x-ray of each breast to look for cancer. How long has it been since you had your last mammogram?” (Calculated here among women age 50 to 74 who indicate screening within the past 2 years.)

Have Had a Mammogram in the Past Two Years
(Among Women Age 50-74)
Healthy People 2020 Target = 81.1% or Higher

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>69.1%</td>
<td>72.2%</td>
</tr>
<tr>
<td>Oregon</td>
<td>77.0%</td>
<td></td>
</tr>
<tr>
<td>US</td>
<td>80.3%</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- Reflects female respondents 50-74.
- Note that the 2014 sample size is too small to be shown here.
About Screening for Cervical Cancer

The US Preventive Services Task Force (USPSTF) strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.

Rationale: The USPSTF found good evidence from multiple observational studies that screening with cervical cytology (Pap smears) reduces incidence of and mortality from cervical cancer. Direct evidence to determine the optimal starting and stopping age and interval for screening is limited. Indirect evidence suggests most of the benefit can be obtained by beginning screening within 3 years of onset of sexual activity or age 21 (whichever comes first) and screening at least every 3 years. The USPSTF concludes that the benefits of screening substantially outweigh potential harms.

The USPSTF recommends against routinely screening women older than age 65 for cervical cancer if they have had adequate recent screening with normal Pap smears and are not otherwise at high risk for cervical cancer.

Rationale: The USPSTF found limited evidence to determine the benefits of continued screening in women older than 65. The yield of screening is low in previously screened women older than 65 due to the declining incidence of high-grade cervical lesions after middle age. There is fair evidence that screening women older than 65 is associated with an increased risk for potential harms, including false-positive results and invasive procedures. The USPSTF concludes that the potential harms of screening are likely to exceed benefits among older women who have had normal results previously and who are not otherwise at high risk for cervical cancer.

The USPSTF recommends against routine Pap smear screening in women who have had a total hysterectomy for benign disease.

Rationale: The USPSTF found fair evidence that the yield of cytologic screening is very low in women after hysterectomy and poor evidence that screening to detect vaginal cancer improves health outcomes. The USPSTF concludes that potential harms of continued screening after hysterectomy are likely to exceed benefits.


Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.
Cervical Cancer Screening: “A Pap test is a test for cancer of the cervix. How long has it been since you had your last Pap test?” (Calculated here among women age 21 to 65 who indicate screening within the past 3 years.)

Have Had a Pap Smear in the Past Three Years
(Among Women Age 21-65)
Healthy People 2020 Target = 93.0% or Higher

<table>
<thead>
<tr>
<th>Year</th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>65.0%</td>
<td>82.9%</td>
<td>84.8%</td>
</tr>
<tr>
<td>2016</td>
<td>71.7%</td>
<td>65.0%</td>
<td></td>
</tr>
</tbody>
</table>

Sources:
- 2014 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 152]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects female respondents age 21 to 65.
- Note that the 2014 sample size is too small to be shown here.

Colorectal Cancer Screenings

About Screening for Colorectal Cancer

The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years.

The evidence is convincing that screening for colorectal cancer with fecal occult blood testing, sigmoidoscopy, or colonoscopy detects early-stage cancer and adenomatous polyps. There is convincing evidence that screening with any of the three recommended tests (fecal occult blood testing, sigmoidoscopy, colonoscopy) reduces colorectal cancer mortality in adults age 50 to 75 years. Follow-up of positive screening test results requires colonoscopy regardless of the screening test used.


Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.
Colorectal Cancer Screening: “Sigmoidoscopy and colonoscopy are exams in which a tube is inserted in the rectum to view the colon for signs of cancer or other health problems. How long has it been since your last sigmoidoscopy or colonoscopy?” and “A blood stool test is a test that may use a special kit at home to determine whether the stool contains blood. How long has it been since you had your last blood stool test?”

(Calculated here among both sexes age 50 to 75 who indicated fecal occult blood testing within the past year and/or sigmoidoscopy/colonoscopy [lower endoscopy] within the past 10 years.)

Key Informant Input: Cancer
The following chart outlines key informants’ perceptions of the severity of Cancer as a problem in the community:

Perceptions of Cancer as a Problem in the Community
(Key Informants, 2016)

<table>
<thead>
<tr>
<th>Problem Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>9.5%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>71.4%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>14.3%</td>
</tr>
<tr>
<td>No Problem At All</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Top Concerns
Among those rating this issue as a “major problem,” reasons related to the following:

**Aging Population**

- Demographic: higher incidence in the elderly population. Lack of affordable specialty care resources, lack of affordable diagnostic and preventive care services, lack of end stage services. Heavy reliance on emergency services for end stage care. - Community Leader
- I think it’s the demographics of our community; a disproportionate number of seniors make this a major problem here. It is rare that I talk with any senior who hasn’t had or isn’t having a bout with some kind of cancer. - Community Leader
- At-risk population, high percentage of elderly. Lack of affordable diagnostic and preventive care services. Critical care patients are transferred to Medford using advance life support EMS resources, stripping the community of emergent response resources. - Community Leader
- Elderly population, many with long prior history of smoking. - Physician

**Prevalence/Incidence**

- I see a lot of people with oxygen tanks. It seems we have a high incidence of asthma in the area. - Community Leader
Respiratory Disease

**About Asthma & COPD**

Asthma and chronic obstructive pulmonary disease (COPD) are significant public health burdens. Specific methods of detection, intervention, and treatment exist that may reduce this burden and promote health.

Asthma is a chronic inflammatory disorder of the airways characterized by episodes of reversible breathing problems due to airway narrowing and obstruction. These episodes can range in severity from mild to life threatening. Symptoms of asthma include wheezing, coughing, chest tightness, and shortness of breath. Daily preventive treatment can prevent symptoms and attacks and enable individuals who have asthma to lead active lives.

COPD is a preventable and treatable disease characterized by airflow limitation that is not fully reversible. The airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lung to noxious particles or gases (typically from exposure to cigarette smoke). Treatment can lessen symptoms and improve quality of life for those with COPD.

The burden of respiratory diseases affects individuals and their families, schools, workplaces, neighborhoods, cities, and states. Because of the cost to the healthcare system, the burden of respiratory diseases also falls on society; it is paid for with higher health insurance rates, lost productivity, and tax dollars. Annual healthcare expenditures for asthma alone are estimated at $20.7 billion.

**Asthma.** The prevalence of asthma has increased since 1980. However, deaths from asthma have decreased since the mid-1990s. The causes of asthma are an active area of research and involve both genetic and environmental factors.

Risk factors for asthma currently being investigated include:

- Having a parent with asthma
- Sensitization to irritants and allergens
- Respiratory infections in childhood
- Overweight

Asthma affects people of every race, sex, and age. However, significant disparities in asthma morbidity and mortality exist, in particular for low-income and minority populations. Populations with higher rates of asthma include: children; women (among adults) and boys (among children); African Americans; Puerto Ricans; people living in the Northeast United States; people living below the Federal poverty level; and employees with certain exposures in the workplace.

While there is not a cure for asthma yet, there are diagnoses and treatment guidelines that are aimed at ensuring that all people with asthma live full and active lives.

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

[NOTE: COPD was changed to chronic lower respiratory disease (CLRD) with the introduction of ICD-10 codes. CLRD is used in vital statistics reporting, but COPD is still widely used and commonly found in surveillance reports.]
Age-Adjusted Respiratory Disease Deaths

Chronic lower respiratory diseases (CLRD) are diseases affecting the lungs; the most deadly of these is chronic obstructive pulmonary disease (COPD), which includes emphysema and chronic bronchitis.

Pneumonia and influenza mortality also is illustrated in the following chart. For prevalence of vaccinations against pneumonia and influenza, see also Immunization & Infectious Diseases in the Infectious Disease section of this report.

CLRD: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2016.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- CLRD is chronic lower respiratory disease.

Pneumonia/Influenza: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2016.

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
Prevalence of Respiratory Diseases

COPD

“Would you please tell me if you have ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema?”

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)

<table>
<thead>
<tr>
<th>Year</th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>12.5%</td>
<td>5.7%</td>
<td>9.5%</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 24]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes those having ever suffered from or been diagnosed with COPD or chronic obstructive pulmonary disease, including bronchitis or emphysema.
- In 2011 data, the term “chronic lung disease” was used, which also included bronchitis or emphysema.
Asthma

**Adults:** “Have you ever been told by a doctor, nurse, or other health professional that you had asthma?”

**Children:** “Has a doctor or other health professional ever told you that this child had asthma?” and “Does this child still have asthma?” (Calculated here as a prevalence of all children who have ever been diagnosed with asthma and who still have asthma [“current asthma”].)

---

**Adult Asthma: Ever Diagnosed**

- Josephine County: 17.2% 16.6% 15.4%
- Oregon: 17.2% 16.6% 15.4%
- US: 17.2% 16.6% 15.4%

**Sources:**
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 36]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of all respondents.

---

**Childhood Asthma: Current Prevalence**

(Among Parents of Children Age 0-17)

- Josephine County: 6.3% 6.5%
- US: 6.5%

**Sources:**
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 157]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of all respondents with children 0 to 17 in the household.
- Includes children who have ever been diagnosed with asthma, and whom are reported to still have asthma.
- Note that the samples from prior years are too small to be shown here.
Key Informant Input: Respiratory Disease

The following chart outlines key informants’ perceptions of the severity of Respiratory Disease as a problem in the community:

### Perceptions of Respiratory Diseases as a Problem in the Community
(Key Informants, 2016)

- **Major Problem**
- **Moderate Problem**
- **Minor Problem**
- **No Problem At All**

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>15.0%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>50.0%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>35.0%</td>
</tr>
</tbody>
</table>

**Sources:** PRC Online Key Informant Survey, Professional Research Consultants, Inc.

**Notes:** Asked of all respondents.

**Top Concerns**

Among those rating this issue as a “major problem,” reasons related to the following:

**Aging Population**

- At-risk population, high percentage of elderly. Lack of affordable diagnostic and preventive care services. Critical care patients are transferred to Medford using advance life support EMS resources, stripping the community of emergent response resources. – Community Leader (Josephine County)
- Elderly population, many with long prior history of smoking. – Physician (Josephine County)

**Prevalence/Incidence**

- I see a lot of people with oxygen tanks. It seems we have a high incidence of asthma in the area. – Community Leader (Josephine County)
Injury & Violence

**About Injury & Violence**

Injuries and violence are widespread in society. Both unintentional injuries and those caused by acts of violence are among the top 15 killers for Americans of all ages. Many people accept them as “accidents,” “acts of fate,” or as “part of life.” However, most events resulting in injury, disability, or death are predictable and preventable.

Injuries are the leading cause of death for Americans ages 1 to 44, and a leading cause of disability for all ages, regardless of sex, race/ethnicity, or socioeconomic status. More than 180,000 people die from injuries each year, and approximately 1 in 10 sustains a nonfatal injury serious enough to be treated in a hospital emergency department.

Beyond their immediate health consequences, injuries and violence have a significant impact on the well-being of Americans by contributing to:

- Premature death
- Disability
- Poor mental health
- High medical costs
- Lost productivity

The effects of injuries and violence extend beyond the injured person or victim of violence to family members, friends, coworkers, employers, and communities.

Numerous factors can affect the risk of unintentional injury and violence, including individual behaviors, physical environment, access to health services (ranging from pre-hospital and acute care to rehabilitation), and social environment (from parental monitoring and supervision of youth to peer group associations, neighborhoods, and communities).

Interventions addressing these social and physical factors have the potential to prevent unintentional injuries and violence. Efforts to prevent unintentional injury may focus on:

- Modifications of the environment
- Improvements in product safety
- Legislation and enforcement
- Education and behavior change
- Technology and engineering

Efforts to prevent violence may focus on:

- Changing social norms about the acceptability of violence
- Improving problem-solving skills (for example, parenting, conflict resolution, coping)
- Changing policies to address the social and economic conditions that often give rise to violence

Healthy People 2020 (www.healthypeople.gov)
Unintentional Injury

Age-Adjusted Unintentional Injury Deaths

The following chart outlines age-adjusted mortality rates for unintentional injury in the county.

![Unintentional Injuries: Age-Adjusted Mortality](chart1)

**Sources:**

**Notes:**
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Deaths for Selected Injury-Related Causes

The following chart outlines age-adjusted mortality rates for drug-induced deaths and motor vehicle crash deaths.

![Select Injury Death Rates](chart2)

**Sources:**

**Notes:**
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- "Drug-induced deaths include both intentional and unintentional drug overdoses."
Firearm-Related Deaths

The following chart outlines the age-adjusted mortality in the county due to firearms.

### Firearms-Related Deaths: Age-Adjusted Mortality

**(2012-2014 Annual Average Deaths per 100,000 Population)**

Healthy People 2020 Target = 9.3 or Lower

![Chart showing age-adjusted mortality due to firearms in Josephine County, Oregon, and US](chart)

Sources:

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Intentional Injury (Violence)

Homicide

Age-adjusted mortality attributed to homicide is shown in the following chart.

### Homicide: Age-Adjusted Mortality

**(2007-2014 Annual Average Deaths per 100,000 Population)**

Healthy People 2020 Target = 5.5 or Lower

![Chart showing age-adjusted mortality due to homicide in Josephine County, Oregon, and US](chart)

Sources:

Notes:
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
Violent Crime

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault. Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime
(Rate per 100,000 Population, 2010-2012)

Sources: Federal Bureau of Investigation, FBI Uniform Crime Reports.

Notes: This indicator reports the rate of violent crime offenses reported by the sheriff’s office or county police department per 100,000 residents. Violent crime includes homicide, rape, robbery, and aggravated assault. This indicator is relevant because it assesses community safety.
Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Violent Crime Experience: “Have you been the victim of a violent crime in your area in the past 5 years?”

Victim of a Violent Crime in the Past Five Years
(Josephine County, 2016)

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. (Item 49)
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.
Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
Intimate Partner Violence: “Now I would like to ask you about different types of violence in relationships with an intimate partner. By an intimate partner, I mean any current or former spouse, boyfriend, or girlfriend. Someone you were dating, or romantically or sexually intimate with, would also be considered an intimate partner. Has an intimate partner ever hit, slapped, pushed, kicked, or hurt you in any way?”

Have Ever Been Hit, Slapped, Pushed, Kicked, or Hurt in Any Way by an Intimate Partner

Sources:  
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 50]  
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:  
- Asked of all respondents.

Neighborhood Safety

“How safe from crime do you consider your neighborhood to be? Would you say: extremely safe, quite safe, slightly safe, or not at all safe?”
Perceive Own Neighborhood as “Slightly” or “Not At All” Safe  
(Josephine County, 2016)

Key Informant Input: Injury & Violence
The following chart outlines key informants’ perceptions of the severity of Injury & Violence as a problem in the community:

Perceptions of Injury and Violence as a Problem in the Community  
(Key Informants, 2016)

Top Concerns
Among those rating this issue as a “major problem,” reasons related to the following:

Domestic Violence and Child Abuse

High rate of child abuse and neglect. High rate of domestic violence. Increased murder rate. - Community Leader
While related to the issues addressed in other questions, crime, domestic violence and child abuse are a significant problem. - Social Services Provider
Child abuse. One in 50 of our children are in foster care. They have and continue to experience trauma of a sort that will impact them throughout their lives. - Social Services Provider
High instances of domestic violence and assault in the community. Lack of criminal justice stability and resources are an extreme factor. - Community Leader

Public Safety
Lack of law enforcement to respond to issues. Domestic violence, due to drug interactions use, including children as victims is a concern, because there are limited resources to respond and limited corrective action. - Social Services Provider
Lack of public safety. - Other Health Provider

Socioeconomic Factors
Rampant drug use, abject and generational poverty stressors, and a severe lack of adequate policing and jail options. We also lack effective inpatient treatment options. - Social Services Provider
Low educational attainment and lack of public safety. - Community Leader

Prevalence/Incidence
With the lack of police officers, the amount of violence is increasing. Also the amount of legal and illegal drugs are also on the rise and has caused issues in this area. - Social Services Provider
Diabetes

About Diabetes
Diabetes mellitus occurs when the body cannot produce or respond appropriately to insulin. Insulin is a hormone that the body needs to absorb and use glucose (sugar) as fuel for the body’s cells. Without a properly functioning insulin signaling system, blood glucose levels become elevated and other metabolic abnormalities occur, leading to the development of serious, disabling complications. Many forms of diabetes exist; the three common types are Type 1, Type 2, and gestational diabetes. Effective therapy can prevent or delay diabetic complications.

Diabetes mellitus:
- Lowers life expectancy by up to 15 years.
- Increases the risk of heart disease by 2 to 4 times.
- Is the leading cause of kidney failure, lower limb amputations, and adult-onset blindness.

The rate of diabetes mellitus continues to increase both in the United States and throughout the world. Due to the steady rise in the number of persons with diabetes mellitus, and possibly earlier onset of type 2 diabetes mellitus, there is growing concern about the possibility that the increase in the number of persons with diabetes mellitus and the complexity of their care might overwhelm existing healthcare systems.

People from minority populations are more frequently affected by type 2 diabetes. Minority groups constitute 25% of all adult patients with diabetes in the US and represent the majority of children and adolescents with type 2 diabetes.

Lifestyle change has been proven effective in preventing or delaying the onset of type 2 diabetes in high-risk individuals.
- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Diabetes Deaths
Age-adjusted diabetes mortality for the area is shown in the following chart.

### Diabetes: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)

<table>
<thead>
<tr>
<th>Area</th>
<th>Age-Adjusted Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine</td>
<td>22.5</td>
</tr>
<tr>
<td>Oregon</td>
<td>23.4</td>
</tr>
<tr>
<td>US</td>
<td>21.1</td>
</tr>
</tbody>
</table>

Healthy People 2020 Target = 20.5 or Lower (Adjusted)

Sources:
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2016.

Notes:
- Deaths are coded using the Tenth Revision of the International Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
- The Healthy People 2020 target for Diabetes is adjusted to account for only diabetes mellitus coded deaths.
Prevalence of Diabetes

“Have you ever been told by a doctor, nurse, or other health professional that you have diabetes? (If female, add: not counting diabetes only occurring during pregnancy?)”

“Have you ever been told by a doctor, nurse, or other health professional that you have pre-diabetes or borderline diabetes? (If female, add: other than during pregnancy?)”

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.

Prevalence of Diabetes

(Josephine County, 2016)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 158]
- Asked of all respondents.
- Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
- Excludes gestational diabetes (occurring only during pregnancy).
Diabetes Testing

Adults who do not have diabetes: “Have you had a test for high blood sugar or diabetes within the past three years?”

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>53.9%</td>
<td>55.1%</td>
</tr>
<tr>
<td>US</td>
<td>61.3%</td>
<td>53.9%</td>
</tr>
</tbody>
</table>

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 39]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of respondents who have not been diagnosed with diabetes.

Key Informant Input: Diabetes

The following chart outlines key informants’ perceptions of the severity of Diabetes as a problem in the community:

Perceptions of Diabetes as a Problem in the Community
(Key Informants, 2016)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>33.3%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>47.6%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>14.3%</td>
</tr>
<tr>
<td>No Problem At All</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Challenges

Among those rating this issue as a “major problem,” the biggest challenges for people with diabetes are seen as:

**Health Education**
- Receiving information and guidance on lifestyle changes that will reduce the symptoms of diabetes. Research is showing the healthy lifestyle can reduce symptoms, but information and guidance is needed to move people in that direction. - Social Services Provider
- Lack of education as to the causes of diabetes, particularly Type 2 in children. - Community Leader

**Nutrition**
- Pervasiveness of high calorie foods. - Social Services Provider
- Poor eating habits. - Community Leader

**Denial/Stigma**
- An unwillingness on many people to address their core issues of cause and management of the disease. Not willing to make the change in diet and exercise to reduce the problem. - Community Leader

**Prevalence/Incidence**
- Seeing more cases in younger populations and not seeking medical attention early or practicing preventative practices. - Community Leader
Alzheimer’s Disease

About Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—to such an extent that it interferes with a person’s daily life. Dementia is not a disease itself, but rather a set of symptoms. Memory loss is a common symptom of dementia, although memory loss by itself does not mean a person has dementia. Alzheimer’s disease is the most common cause of dementia, accounting for the majority of all diagnosed cases.

Alzheimer’s disease is the 6th leading cause of death among adults age 18 years and older. Estimates vary, but experts suggest that up to 5.1 million Americans age 65 years and older have Alzheimer’s disease. These numbers are predicted to more than double by 2050 unless more effective ways to treat and prevent Alzheimer’s disease are found.

Age-Adjusted Alzheimer’s Disease Deaths

Age-adjusted Alzheimer’s disease mortality is outlined in the following chart.

Alzheimer’s Disease: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2016.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
Key Informant Input: Dementias, Including Alzheimer’s Disease

The following chart outlines key informants’ perceptions of the severity of Dementias, Including Alzheimer’s Disease as a problem in the community:

Perceptions of Dementia/Alzheimer’s Disease as a Problem in the Community
(Key Informants, 2016)

<table>
<thead>
<tr>
<th>Perception</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>31.8%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>40.9%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>27.3%</td>
</tr>
<tr>
<td>No Problem At All</td>
<td></td>
</tr>
</tbody>
</table>

Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Aging Population
- Aging population and the lack of providers knowledgeable in caring for people with dementia/Alzheimer’s. - Community Leader
- Large retired population. Limited psychiatric practitioner numbers. - Social Services Provider
- Due to the number of senior citizens in the community, we seem to have more than an average number of individuals who are affected by this disease. - Community Leader
- The number of elderly people I see dealing with this problem and the struggles families have trying to provide care in the gap areas between independent and a permanent care facility. - Community Leader

Prevalence/Incidence
- I don’t have data, but I imagine it is an issue. - Other Health Provider
Kidney Disease

About Kidney Disease

Chronic kidney disease and end-stage renal disease are significant public health problems in the United States and a major source of suffering and poor quality of life for those afflicted. They are responsible for premature death and exact a high economic price from both the private and public sectors. Nearly 25% of the Medicare budget is used to treat people with chronic kidney disease and end-stage renal disease.

Genetic determinants have a large influence on the development and progression of chronic kidney disease. It is not possible to alter a person’s biology and genetic determinants; however, environmental influences and individual behaviors also have a significant influence on the development and progression of chronic kidney disease. As a result, some populations are disproportionately affected. Successful behavior modification is expected to have a positive influence on the disease.

Diabetes is the most common cause of kidney failure. The results of the Diabetes Prevention Program (DPP) funded by the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) show that moderate exercise, a healthier diet, and weight reduction can prevent development of type 2 diabetes in persons at risk.

- Healthy People 2020 (www.healthypeople.gov)

Age-Adjusted Kidney Disease Deaths

Age-adjusted kidney disease mortality is described in the following chart.

Kidney Disease: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)

Sources: CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2016.

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
Prevalence of Kidney Disease

“Would you please tell me if you have ever suffered from or been diagnosed with kidney disease?”

Key Informant Input: Chronic Kidney Disease
The following chart outlines key informants’ perceptions of the severity of Chronic Kidney Disease as a problem in the community:
Potentially Disabling Conditions

Arthritis, Osteoporosis & Chronic Back Conditions

About Arthritis, Osteoporosis & Chronic Back Conditions

There are more than 100 types of arthritis. Arthritis commonly occurs with other chronic conditions, such as diabetes, heart disease, and obesity. Interventions to treat the pain and reduce the functional limitations from arthritis are important, and may also enable people with these other chronic conditions to be more physically active. Arthritis affects 1 in 5 adults and continues to be the most common cause of disability. It costs more than $128 billion per year. All of the human and economic costs are projected to increase over time as the population ages. There are interventions that can reduce arthritis pain and functional limitations, but they remain underused. These include: increased physical activity; self-management education; and weight loss among overweight/obese adults.

Osteoporosis is a disease marked by reduced bone strength leading to an increased risk of fractures (broken bones). In the United States, an estimated 5.3 million people age 50 years and older have osteoporosis. Most of these people are women, but about 0.8 million are men. Just over 34 million more people, including 12 million men, have low bone mass, which puts them at increased risk for developing osteoporosis. Half of all women and as many as 1 in 4 men age 50 years and older will have an osteoporosis-related fracture in their lifetime.

Chronic back pain is common, costly, and potentially disabling. About 80% of Americans experience low back pain in their lifetime. It is estimated that each year:

- 15%-20% of the population develop protracted back pain.
- 2-8% have chronic back pain (pain that lasts more than 3 months).
- 3-4% of the population is temporarily disabled due to back pain.
- 1% of the working-age population is disabled completely and permanently as a result of low back pain.

Americans spend at least $50 billion each year on low back pain. Low back pain is the:

- 2nd leading cause of lost work time (after the common cold).
- 3rd most common reason to undergo a surgical procedure.
- 5th most frequent cause of hospitalization.

Arthritis, osteoporosis, and chronic back conditions all have major effects on quality of life, the ability to work, and basic activities of daily living.

- Healthy People 2020 (www.healthypeople.gov)

“Would you please tell me if you have ever suffered from or been diagnosed with arthritis or rheumatism?” (Reported here among only those here 50+.)

“Would you please tell me if you have ever suffered from or been diagnosed with osteoporosis?” (Reported in the following chart among only those age 50+.)

“Would you please tell me if you have ever suffered from or been diagnosed with sciatica or chronic back pain?” (Reported here among all adults age 18+.)

See also Overall Health Status: Activity Limitations in the General Health Status section of this report.
Prevalence of Potentially Disabling Conditions

**Arthritis/Rheumatism (50+)**
- Josephine County: 44.1%
- US: 32.0%

**Osteoporosis (50+)**
- Josephine County: 12.1%
- US: 8.7%

**Sciatica/Chronic Back Pain (18+)**
- Josephine County: 29.5%
- US: 19.4%

**HP2020 Objective = 5.3% or Lower**

Key Informant Input: Arthritis, Osteoporosis & Chronic Back Conditions
The following chart outlines key informants’ perceptions of the severity of Arthritis, Osteoporosis & Chronic Back Conditions as a problem in the community:

**Perceptions of Arthritis/Osteoporosis/Back Conditions as a Problem in the Community**
(Key Informants, 2016)

- **Major Problem**: 10.0%
- **Moderate Problem**: 60.0%
- **Minor Problem**: 25.0%
- **No Problem At All**: 5.0%

Top Concerns
Among those rating this issue as a “major problem,” reasons related to the following:

**Access to Care/Services**
- I put on free vision clinics, and there are lots of students and poor individuals that use this free service. I also see students in the school that cannot see very well. - Social Services Provider
- No specialty practice in our community for either condition. - Community Leader

**Aging Population**
- Josephine County has a large senior population, with hearing and vision problems being a natural occurrence of an aging population. - Social Services Provider
**Vision & Hearing Impairment**

### About Vision

Vision is an essential part of everyday life, influencing how Americans of all ages learn, communicate, work, play, and interact with the world. Yet millions of Americans live with visual impairment, and many more remain at risk for eye disease and preventable eye injury.

The eyes are an important, but often overlooked, part of overall health. Despite the preventable nature of some vision impairments, many people do not receive recommended screenings and exams. A visit to an eye care professional for a comprehensive dilated eye exam can help to detect common vision problems and eye diseases, including diabetic retinopathy, glaucoma, cataract, and age-related macular degeneration.

These common vision problems often have no early warning signs. If a problem is detected, an eye care professional can prescribe corrective eyewear, medicine, or surgery to minimize vision loss and help a person see his or her best.

Healthy vision can help to ensure a healthy and active lifestyle well into a person’s later years. Educating and engaging families, communities, and the nation is critical to ensuring that people have the information, resources, and tools needed for good eye health.

- Healthy People 2020 (www.healthypeople.gov)

### About Hearing & Other Sensory or Communication Disorders

An impaired ability to communicate with others or maintain good balance can lead many people to feel socially isolated, have unmet health needs, have limited success in school or on the job. Communication and other sensory processes contribute to our overall health and well-being. Protecting these processes is critical, particularly for people whose age, race, ethnicity, gender, occupation, genetic background, or health status places them at increased risk.

Many factors influence the numbers of Americans who are diagnosed and treated for hearing and other sensory or communication disorders, such as social determinants (social and economic standings, age of diagnosis, cost and stigma of wearing a hearing aid, and unhealthy lifestyle choices). In addition, biological causes of hearing loss and other sensory or communication disorders include: genetics; viral or bacterial infections; sensitivity to certain drugs or medications; injury; and aging.

As the nation’s population ages and survival rates for medically fragile infants and for people with severe injuries and acquired diseases improve, the prevalence of sensory and communication disorders is expected to rise.

- Healthy People 2020 (www.healthypeople.gov)
“Would you please tell me if you have ever suffered from or been diagnosed with blindness or trouble seeing, even when wearing glasses?”

“Would you please tell me if you have ever suffered from or been diagnosed with deafness or trouble hearing?”

**Prevalence of Blindness/Deafness**

<table>
<thead>
<tr>
<th></th>
<th>Josephine County</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blindness/Trouble Seeing Even With Glasses</td>
<td>11.7%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Deafness/Trouble Hearing</td>
<td>16.8%</td>
<td>8.6%</td>
</tr>
</tbody>
</table>

*Oregon = 3.8%*

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc.  [Items 25-26]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Reflects the total sample of respondents.

**Key Informant Input: Vision & Hearing**

The following chart outlines key informants’ perceptions of the severity of *Vision & Hearing* as a problem in the community:

**Perceptions of Vision and Hearing as a Problem in the Community**

* (Key Informants, 2016)

<table>
<thead>
<tr>
<th></th>
<th>Major Problem</th>
<th>Moderate Problem</th>
<th>Minor Problem</th>
<th>No Problem At All</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9.1%</td>
<td>36.4%</td>
<td>45.5%</td>
<td>9.1%</td>
</tr>
</tbody>
</table>

Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.
Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Affordable Care/Services

I put on free vision clinics, and there are lots of students and poor individuals that use this free service. I also see students in the school that cannot see very well. – Social Services Provider (Josephine County)

Aging Population

Josephine County has a large senior population, with hearing and vision problems being a natural occurrence of an aging population. – Social Services Provider (Josephine County)
Infectious Disease

About Immunization & Infectious Diseases

The increase in life expectancy during the 20th century is largely due to improvements in child survival; this increase is associated with reductions in infectious disease mortality, due largely to immunization. However, infectious diseases remain a major cause of illness, disability, and death. Immunization recommendations in the United States currently target 17 vaccine-preventable diseases across the lifespan.

People in the US continue to get diseases that are vaccine-preventable. Viral hepatitis, influenza, and tuberculosis (TB) remain among the leading causes of illness and death across the nation and account for substantial spending on the related consequences of infection.

The infectious disease public health infrastructure, which carries out disease surveillance at the national, state, and local levels, is an essential tool in the fight against newly emerging and re-emerging infectious diseases. Other important defenses against infectious diseases include:

- Proper use of vaccines
- Antibiotics
- Screening and testing guidelines
- Scientific improvements in the diagnosis of infectious disease-related health concerns

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule, society:

- Saves 33,000 lives.
- Prevents 14 million cases of disease.
- Reduces direct healthcare costs by $9.9 billion.
- Saves $33.4 billion in indirect costs.

Healthy People 2020 (www.healthypeople.gov)

Key Informant Input: Immunization & Infectious Diseases

The following chart outlines key informants’ perceptions of the severity of Immunization & Infectious Diseases as a problem in the community:

Perceptions of Immunization and Infectious Diseases as a Problem in the Community
(Key Informants, 2016)

<table>
<thead>
<tr>
<th>Major Problem</th>
<th>Moderate Problem</th>
<th>Minor Problem</th>
<th>No Problem At All</th>
</tr>
</thead>
<tbody>
<tr>
<td>19.0%</td>
<td>52.4%</td>
<td>23.8%</td>
<td>4.8%</td>
</tr>
</tbody>
</table>

Sources:
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
Top Concerns
Among those rating this issue as a “major problem,” reasons related to the following:

Child Immunizations

<table>
<thead>
<tr>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very low immunization rate among children for childhood diseases. Low number of seniors who get flu shots, relative to the number of seniors who live in our county. High number of animals determined to be without rabies shots to me is an indicator. - Community Leader</td>
</tr>
<tr>
<td>Parents not immunizing children. - Social Services Provider</td>
</tr>
</tbody>
</table>

Influenza & Pneumonia Vaccination

**About Influenza & Pneumonia**

Acute respiratory infections, including pneumonia and influenza, are the 8th leading cause of death in the nation, accounting for 56,000 deaths annually. Pneumonia mortality in children fell by 97% in the last century, but respiratory infectious diseases continue to be leading causes of pediatric hospitalization and outpatient visits in the US. On average, influenza leads to more than 200,000 hospitalizations and 36,000 deaths each year. The 2009 H1N1 influenza pandemic caused an estimated 270,000 hospitalizations and 12,270 deaths (1,270 of which were of people younger than age 18) between April 2009 and March 2010.

- Healthy People 2020 (www.healthypeople.gov)

**Vaccinations**

“The next questions are about some different types of vaccinations. There are two ways to get the flu vaccine: one is a shot in the arm, and the other is a spray, mist, or drop in the nose called FluMist. During the past 12 months, have you had either a flu shot or a flu vaccine that was sprayed in your nose?”

“A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person’s lifetime and is different from the seasonal flu shot. Have you ever had a pneumonia shot?”

Columns in the following chart show these findings among those age 65+. Percentages for “high-risk” adults age 18-64 in Josephine County are also shown; here, “high-risk” includes adults who report having been diagnosed with heart disease, diabetes, or respiratory disease.
Older Adults: Have Had a Flu Vaccination in the Past Year
(Among Adults Age 65+)

Healthy People 2020 Target = 70.0% or Higher

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>US</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>43.6%</td>
<td>58.9%</td>
</tr>
</tbody>
</table>

High-Risk Adults = 24.7%
(HP2020 Goal = 70.0%)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 163-164]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents 65 and older.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
- Note that the 2014 sample is too small to be shown here.

Older Adults: Have Ever Had a Pneumonia Vaccine
(Among Adults Age 65+)

Healthy People 2020 Target = 90.0% or Higher

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>US</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>77.4%</td>
<td>76.3%</td>
</tr>
</tbody>
</table>

High-Risk Adults = 32.1%
(HP2020 Goal = 60.0%)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 165-166]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects respondents 65 and older.
- "High-Risk" includes adults age 18 to 64 who have been diagnosed with heart disease, diabetes or respiratory disease.
- Note that the 2014 sample size is too small to be shown here.
HIV

About Human Immunodeficiency Virus (HIV)

The HIV epidemic in the United States continues to be a major public health crisis. An estimated 1.1 million Americans are living with HIV, and 1 in 5 people with HIV do not know they have it. HIV continues to spread, leading to about 56,000 new HIV infections each year.

HIV is a preventable disease, and effective HIV prevention interventions have been proven to reduce HIV transmission. People who get tested for HIV and learn that they are infected can make significant behavior changes to improve their health and reduce the risk of transmitting HIV to their sex or drug-using partners. More than 50% of new HIV infections occur as a result of the 21% of people who have HIV but do not know it.

In the era of increasingly effective treatments for HIV, people with HIV are living longer, healthier, and more productive lives. Deaths from HIV infection have greatly declined in the United States since the 1990s. As the number of people living with HIV grows, it will be more important than ever to increase national HIV prevention and healthcare programs.

There are gender, race, and ethnicity disparities in new HIV infections:

- Nearly 75% of new HIV infections occur in men.
- More than half occur in gay and bisexual men, regardless of race or ethnicity.
- 45% of new HIV infections occur in African Americans, 35% in whites, and 17% in Hispanics.

Improving access to quality healthcare for populations disproportionately affected by HIV, such as persons of color and gay and bisexual men, is a fundamental public health strategy for HIV prevention. People getting care for HIV can receive:

- Antiretroviral therapy
- Screening and treatment for other diseases (such as sexually transmitted infections)
- HIV prevention interventions
- Mental health services
- Other health services

As the number of people living with HIV increases and more people become aware of their HIV status, prevention strategies that are targeted specifically for HIV-infected people are becoming more important. Prevention work with people living with HIV focuses on:

- Linking to and staying in treatment.
- Increasing the availability of ongoing HIV prevention interventions.
- Providing prevention services for their partners.

Public perception in the US about the seriousness of the HIV epidemic has declined in recent years. There is evidence that risky behaviors may be increasing among uninfected people, especially gay and bisexual men. Ongoing media and social campaigns for the general public and HIV prevention interventions for uninfected persons who engage in risky behaviors are critical.

- Healthy People 2020 (www.healthypeople.gov)
**HIV/AIDS Deaths**

The following chart outlines age-adjusted mortality rates for the area in comparison with state and national rates.

**HIV/AIDS: Age-Adjusted Mortality**
*(2005-2014 Annual Average Deaths per 100,000 Population)*

Healthy People 2020 Target = 3.3 or Lower

<table>
<thead>
<tr>
<th></th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005-2014</td>
<td>1.2</td>
<td>1.2</td>
<td>3.0</td>
</tr>
</tbody>
</table>

**Sources:**
- CDC WONDER Online Query System. Centers for Disease Control and Prevention, Epidemiology Program Office, Division of Public Health Surveillance and Informatics. Data extracted September 2016.

**Notes:**
- Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
- Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

**HIV Prevalence**

The following chart outlines prevalence (current cases, regardless of when they were diagnosed) of HIV per 100,000 population in the county.

**HIV Prevalence**
*(Prevalence Rate of HIV per 100,000 Population, 2013)*

<table>
<thead>
<tr>
<th></th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>80.7</td>
<td>162.3</td>
<td>340.4</td>
</tr>
</tbody>
</table>

**Sources:**
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

**Notes:**
- This indicator is relevant because HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the prevalence of unsafe sex practices.
**Key Informant Input: HIV/AIDS**

The following chart outlines key informants’ perceptions of the severity of HIV/AIDS as a problem in the community:

**Perceptions of HIV/AIDS as a Problem in the Community**
(Key Informants, 2016)

<table>
<thead>
<tr>
<th>Problem Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>25.0%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>70.0%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>5.0%</td>
</tr>
<tr>
<td>No Problem At All</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.*

*Notes: Asked of all respondents.*
Sexually Transmitted Diseases

**About Sexually Transmitted Diseases**

STDs refer to more than 25 infectious organisms that are transmitted primarily through sexual activity. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STDs remain a significant public health problem in the United States. This problem is largely unrecognized by the public, policymakers, and health care professionals. STDs cause many harmful, often irreversible, and costly clinical complications, such as: reproductive health problems; fetal and perinatal health problems; cancer; and facilitation of the sexual transmission of HIV infection.

Because many cases of STDs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to CDC at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STDs in the US. Untreated STDs can lead to serious long-term health consequences, especially for adolescent girls and young women. Several factors contribute to the spread of STDs.

**Biological Factors.** STDs are acquired during unprotected sex with an infected partner. Biological factors that affect the spread of STDs include:

- **Asymptomatic nature of STDs.** The majority of STDs either do not produce any symptoms or signs, or they produce symptoms so mild that they are unnoticed; consequently, many infected persons do not know that they need medical care.
- **Gender disparities.** Women suffer more frequent and more serious STD complications than men do. Among the most serious STD complications are pelvic inflammatory disease, ectopic pregnancy (pregnancy outside of the uterus), infertility, and chronic pelvic pain.
- **Age disparities.** Compared to older adults, sexually active adolescents ages 15 to 19 and young adults ages 20 to 24 are at higher risk for getting STDs.
- **Lag time between infection and complications.** Often, a long interval, sometimes years, occurs between acquiring an STD and recognizing a clinically significant health problem.

**Social, Economic, and Behavioral Factors.** The spread of STDs is directly affected by social, economic, and behavioral factors. Such factors may cause serious obstacles to STD prevention due to their influence on social and sexual networks, access to and provision of care, willingness to seek care, and social norms regarding sex and sexuality. Among certain vulnerable populations, historical experience with segregation and discrimination exacerbates these factors. Social, economic, and behavioral factors that affect the spread of STDs include: racial and ethnic disparities; poverty and marginalization; access to healthcare; substance abuse; sexuality and secrecy (stigma and discomfort discussing sex); and sexual networks (persons “linked” by sequential or concurrent sexual partners).

- Healthy People 2020 (www.healthypeople.gov)

**Chlamydia & Gonorrhea**

**Chlamydia.** Chlamydia is the most commonly reported STD in the United States; most people who have chlamydia are unaware, since the disease often has no symptoms.

**Gonorrhea.** Anyone who is sexually active can get gonorrhea. Gonorrhea can be cured with the right medication; left untreated, however, gonorrhea can cause serious health problems in both women and men.

The following chart outlines local incidence for these STDs.
Chlamydia & Gonorrhea Incidence
(Incidence Rate per 100,000 Population, 2014)

Sources:
- Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.

Notes:
- This indicator is relevant because it is a measure of poor health status and indicates the prevalence of unsafe sex practices.

Hepatitis B

“To be vaccinated against Hepatitis B, a series of three shots must be administered, usually at least one month between shots. Have you completed a Hepatitis B vaccination series?”

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 311]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes a series of three shots, usually administered at least one month between shots.
Key Informant Input: Sexually Transmitted Diseases

The following chart outlines key informants’ perceptions of the severity of Sexually Transmitted Diseases as a problem in the community:

Perceptions of Sexually Transmitted Diseases as a Problem in the Community (Key Informants, 2016)

<table>
<thead>
<tr>
<th>Perception</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>13.0%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>52.2%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>30.4%</td>
</tr>
<tr>
<td>No Problem At All</td>
<td>4.3%</td>
</tr>
</tbody>
</table>

Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

**Health Education**

- Lack of education and access to testing and condoms. A significant portion of our population is resistant to efforts to educate our community, especially our children, to the dangers of STDs. - Social Services Provider

**Prevalence/Incidence**

- Very high rate of STD’s in our county. - Community Leader
Births

About Infant & Child Health

Improving the well-being of mothers, infants, and children is an important public health goal for the US. Their well-being determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. The risk of maternal and infant mortality and pregnancy-related complications can be reduced by increasing access to quality preconception (before pregnancy) and inter-conception (between pregnancies) care. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential. Many factors can affect pregnancy and childbirth, including pre-conception health status, age, access to appropriate healthcare, and poverty.

Infant and child health are similarly influenced by socio-demographic factors, such as family income, but are also linked to the physical and mental health of parents and caregivers. There are racial and ethnic disparities in mortality and morbidity for mothers and children, particularly for African Americans. These differences are likely the result of many factors, including social determinants (such as racial and ethnic disparities in infant mortality; family income; educational attainment among household members; and health insurance coverage) and physical determinants (i.e., the health, nutrition, and behaviors of the mother during pregnancy and early childhood).

- Healthy People 2020 (www.healthypeople.gov)

Birth Outcomes & Risks

Low-Weight Births

Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight. Largely a result of receiving poor or inadequate prenatal care, many low-weight births and the consequent health problems are preventable. Births of low-weight infants are described in the following chart.

Low-Weight Births
(Percent of Live Births, 2006-2012)
Healthy People 2020 Target = 7.8% or Lower


Note: This indicator reports the percentage of total births that are low birth weight (Under 2500g). This indicator is relevant because low birth weight infants are at high risk for health problems. This indicator can also highlight the existence of health disparities.
Infant Mortality

Infant mortality rates reflect deaths of children less than one year old per 1,000 live births. These rates are outlined in the following chart.

**Infant Mortality Rate**

(Annual Average Infant Deaths per 1,000 Live Births, 2012-2014)

Healthy People 2020 Target = 6.0 or Lower

<table>
<thead>
<tr>
<th></th>
<th>Infant Mortality Rate (Annual Average Infant Deaths per 1,000 Live Births, 2012-2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>9.1</td>
</tr>
<tr>
<td>Oregon</td>
<td>5.1</td>
</tr>
<tr>
<td>US</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Sources:  

Notes:  
- Infant deaths include deaths of children under 1 year old.  
- This indicator is relevant because high rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health.

Key Informant Input: Infant & Child Health

The following chart outlines key informants’ perceptions of the severity of Infant & Child Health as a problem in the community:

**Perceptions of Infant and Child Health as a Problem in the Community**

(Key Informants, 2016)

<table>
<thead>
<tr>
<th></th>
<th>Major Problem</th>
<th>Moderate Problem</th>
<th>Minor Problem</th>
<th>No Problem At All</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>29.2%</td>
<td>41.7%</td>
<td>20.8%</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Sources:  
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

Notes:  
- Asked of all respondents.
Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

**Socioeconomic Factors**

I worry that the poverty and substance abuse in our county contributes to a significant amount of children not getting their early childhood needs met. I believe that strong bonds early is critical, along with healthy regular communication. - Community Leader

Low income demographic, high percentage of single parent families, lack of affordable diagnostic and preventive care services. Lack of county funding for minimal essential public health programs, lack of qualified pediatric physicians and services. - Community Leader

Homeless families; ACEs data. - Other Health Provider

Low income and poorly-educated parents. - Community Leader

**Housing**

Number of homeless children living in shared or multi-family dwellings. Lack of food and proper nutrition for these children and their families. Children living with parents with drug and alcohol addictions. - Community Leader

**Low Immunization Levels**

Low level of immunizations for childhood diseases. Childhood obesity and Type 2 diabetes rates are high. - Community Leader

**Neglect**

Parental neglect is the number one health risk we see impacting our CASA kids. Neglect due to drug and alcohol addictions, in particular. - Social Services Provider

**Prevalence/Incidence**

I learn of children's health problems at CCO meetings. - Other Health Provider
Family Planning

Births to Teen Mothers

About Teen Births

The negative outcomes associated with unintended pregnancies are compounded for adolescents. Teen mothers:

- Are less likely to graduate from high school or attain a GED by the time they reach age 30.
- Earn an average of approximately $3,500 less per year, when compared with those who delay childbearing.
- Receive nearly twice as much Federal aid for nearly twice as long.

Similarly, early fatherhood is associated with lower educational attainment and lower income. Children of teen parents are more likely to have lower cognitive attainment and exhibit more behavior problems. Sons of teen mothers are more likely to be incarcerated, and daughters are more likely to become adolescent mothers.

- Healthy People 2020 (www.healthypeople.gov)

The following chart describes local teen births.

Teen Birth Rate

(Births to Women Age 15-19 Per 1,000 Female Population Age 15-19, 2006-2012)

Sources:
- Centers for Disease Control and Prevention, National Vital Statistics System. Accessed using CDC WONDER.

Notes:
- This indicator reports the rate of total births to women under the age of 15-19 per 1,000 female population age 15-19. This indicator is relevant because in many cases, teen parents have unique social, economic, and health support services. Additionally, high rates of teen pregnancy may indicate the prevalence of unsafe sex practices.
Key Informant Input: Family Planning

The following chart outlines key informants’ perceptions of the severity of Family Planning as a problem in the community:

**Perceptions of Family Planning as a Problem in the Community**
(Key Informants, 2016)

<table>
<thead>
<tr>
<th>Problem Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>23.1%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>46.2%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>26.9%</td>
</tr>
<tr>
<td>No Problem At All</td>
<td>3.8%</td>
</tr>
</tbody>
</table>

**Sources:** PRC Online Key Informant Survey, Professional Research Consultants, Inc.

**Notes:** Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

**Unplanned Pregnancies**
- At CASA we are seeing the fallout of unplanned and repeated pregnancies. Women, young and old, who are addicted to meth, heroin or other substances giving birth to children who are born drug-affected and sick, many of whom will bear the burden. - Social Services Provider
- High rate of unplanned pregnancy. Lack of resources to educate and prepare youth in the community for the future and the consequences of being sexually active at a younger age. - Community Leader
- Percent of unplanned pregnancies; contraception measure. - Other Health Provider

**Health Education**
- Organized anti-family planning disinformation campaigns. Low level of education, high level of alcohol and drug use, poor self-control. "Just Say No" is a poor contraceptive. - Social Services Provider
- Lack of social outreach services for youth and young adults. Lack of mental health services. Lack of quality substance abuse treatment programs. Lack of domestic violence prevention and support services. Community struggles to support the high percentage. - Community Leader

**Family Life**
- Families need to spend time working together to build a group that will last, and focus on current and future needs. A lot of needs are for just today, not for the future. The family needs to be healthy in the sense of health and financially. - Social Services Provider

**Unprotected Sex**
- Most people don't use birth control. - Community Leader
Modifiable Health Risks

Actual Causes Of Death

**About Contributors to Mortality**

A 1999 study (an update to a landmark 1993 study), estimated that as many as 40% of premature deaths in the United States are attributed to behavioral factors. This study found that behavior patterns represent the single-most prominent domain of influence over health prospects in the United States. The daily choices we make with respect to diet, physical activity, and sex; the substance abuse and addictions to which we fall prey; our approach to safety; and our coping strategies in confronting stress are all important determinants of health.

The most prominent contributors to mortality in the United States in 2000 were tobacco (an estimated 435,000 deaths), diet and activity patterns (400,000), alcohol (85,000), microbial agents (75,000), toxic agents (55,000), motor vehicles (43,000), firearms (29,000), sexual behavior (20,000), and illicit use of drugs (17,000). Socioeconomic status and access to medical care are also important contributors, but difficult to quantify independent of the other factors cited. Because the studies reviewed used different approaches to derive estimates, the stated numbers should be viewed as first approximations.

These analyses show that smoking remains the leading cause of mortality. However, poor diet and physical inactivity may soon overtake tobacco as the leading cause of death. These findings, along with escalating healthcare costs and aging population, argue persuasively that the need to establish a more preventive orientation in the US healthcare and public health systems has become more urgent.


While causes of death are typically described as the diseases or injuries immediately precipitating the end of life, a few important studies have shown that the actual causes of premature death (reflecting underlying risk factors) are often preventable.
Nutrition, Physical Activity & Weight

Nutrition

About Healthful Diet & Healthy Weight

Strong science exists supporting the health benefits of eating a healthful diet and maintaining a healthy body weight. Efforts to change diet and weight should address individual behaviors, as well as the policies and environments that support these behaviors in settings such as schools, worksites, healthcare organizations, and communities.

The goal of promoting healthful diets and healthy weight encompasses increasing household food security and eliminating hunger.

Americans with a healthful diet:

- Consume a variety of nutrient-dense foods within and across the food groups, especially whole grains, fruits, vegetables, low-fat or fat-free milk or milk products, and lean meats and other protein sources.
- Limit the intake of saturated and trans fats, cholesterol, added sugars, sodium (salt), and alcohol.
- Limit caloric intake to meet caloric needs.

Diet and body weight are related to health status. Good nutrition is important to the growth and development of children. A healthful diet also helps Americans reduce their risks for many health conditions, including: overweight and obesity; malnutrition; iron-deficiency anemia; heart disease; high blood pressure; dyslipidemia (poor lipid profiles); type 2 diabetes; osteoporosis; oral disease; constipation; diverticular disease; and some cancers.

Diet reflects the variety of foods and beverages consumed over time and in settings such as worksites, schools, restaurants, and the home. Interventions to support a healthier diet can help ensure that:

- Individuals have the knowledge and skills to make healthier choices.
- Healthier options are available and affordable.

Social Determinants of Diet. Demographic characteristics of those with a more healthful diet vary with the nutrient or food studied. However, most Americans need to improve some aspect of their diet.

Social factors thought to influence diet include:

- Knowledge and attitudes
- Skills
- Social support
- Societal and cultural norms
- Food and agricultural policies
- Food assistance programs
- Economic price systems

Physical Determinants of Diet. Access to and availability of healthier foods can help people follow healthful diets. For example, better access to retail venues that sell healthier options may have a positive impact on a person's diet; these venues may be less available in low-income or rural neighborhoods.

The places where people eat appear to influence their diet. For example, foods eaten away from home often have more calories and are of lower nutritional quality than foods prepared at home.

Marketing also influences people’s—particularly children’s—food choices.

- Healthy People 2020 (www.healthypeople.gov)
Daily Recommendation of Fruits/Vegetables

To measure fruit and vegetable consumption, survey respondents were asked multiple questions, specifically about the foods and drinks they consumed on the day prior to the interview.

“Now I would like you to think about the foods you ate or drank yesterday. Include all the foods you ate, both at home and away from home. How many servings of fruit or fruit juices did you have yesterday?”

“How many servings of vegetables did you have yesterday?”

The questions above are used to calculate daily fruit/vegetable consumption for respondents. The proportion reporting having 5 or more servings per day is shown here.

![Graph showing the percentage of respondents consuming five or more servings of fruits/vegetables per day in Josephine County, 2016.](image)

**Consume Five or More Servings of Fruits/Vegetables Per Day**

(Josephine County, 2016)

<table>
<thead>
<tr>
<th>Category</th>
<th>Men</th>
<th>Women</th>
<th>18 to 44</th>
<th>45 to 64</th>
<th>65+</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>Josephine County</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>34.8%</td>
<td>37.0%</td>
<td>33.9%</td>
<td>33.7%</td>
<td>40.9%</td>
<td>30.3%</td>
<td>42.9%</td>
<td>36.0%</td>
<td>27.4%</td>
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</tbody>
</table>

**Sources:**
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 168]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of all respondents.
- Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
- For this issue, respondents were asked to recall their food intake on the previous day.
Access to Fresh Produce

“How difficult is it for you to buy fresh produce like fruits and vegetables at a price you can afford — would you say: very difficult, somewhat difficult, not too difficult, or not at all difficult?”

Find It “Very” or “Somewhat” Difficult to Buy Affordable Fresh Produce
(Josephine County, 2016)

A food desert is defined as a low-income area where a significant number or share of residents is far from a supermarket, where “far” is more than 1 mile in urban areas and more than 10 miles in rural areas. This related chart is based on US Department of Agriculture data.

Population With Low Food Access
(Percent of Population That Is Far From a Supermarket or Large Grocery Store, 2010)

Sources:  

Notes:  
- This indicator reports the percentage of the population living in census tracts designated as food deserts. A food desert is defined as low-income areas where a significant number or share of residents is far from a supermarket, where “far” is more than 1 mile in urban areas and more than 10 miles in rural areas. This indicator is relevant because it highlights populations and geographies facing food insecurity.
Sugar-Sweetened Beverages

“During the past seven, how many servings of sugar-sweetened beverages did you have? Please include beverages such as soda, Kool-Aid, sweetened fruit juice, sports drinks, energy drinks, or sweet tea. Do not include “diet” drinks.”

**Had Seven or More Sugar-Sweetened Beverages in the Past Week**

(Josephine County, 2016)

<table>
<thead>
<tr>
<th>Category</th>
<th>Men</th>
<th>Women</th>
<th>18 to 44</th>
<th>45 to 64</th>
<th>65+</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>Josephine County</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24.0%</td>
<td>17.8%</td>
<td>32.9%</td>
<td>16.9%</td>
<td>14.1%</td>
<td>31.0%</td>
<td>13.9%</td>
<td>20.7%</td>
<td>30.2%</td>
</tr>
</tbody>
</table>

Sources:  
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 212]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:  
- Asked of all respondents.
- Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
- Includes soda, Kool-Aid, sweetened fruit juice, sports drinks, energy drinks, or sweet tea. Does not include “diet” drinks.
Physical Activity

About Physical Activity

Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Among adults, physical activity can lower the risk of: early death; coronary heart disease; stroke; high blood pressure; type 2 diabetes; breast and colon cancer; falls; and depression. Among children and adolescents, physical activity can: improve bone health; improve cardiorespiratory and muscular fitness; decrease levels of body fat; and reduce symptoms of depression. For people who are inactive, even small increases in physical activity are associated with health benefits.

Personal, social, economic, and environmental factors all play a role in physical activity levels among youth, adults, and older adults. Understanding the barriers to and facilitators of physical activity is important to ensure the effectiveness of interventions and other actions to improve levels of physical activity.

Factors positively associated with adult physical activity include: postsecondary education; higher income; enjoyment of exercise; expectation of benefits; belief in ability to exercise (self-efficacy); history of activity in adulthood; social support from peers, family, or spouse; access to and satisfaction with facilities; enjoyable scenery; and safe neighborhoods.

Factors negatively associated with adult physical activity include: advancing age; low income; lack of time; low motivation; rural residency; perception of great effort needed for exercise; overweight or obesity; perception of poor health; and being disabled. Older adults may have additional factors that keep them from being physically active, including lack of social support, lack of transportation to facilities, fear of injury, and cost of programs.

Among children ages 4 to 12, the following factors have a positive association with physical activity: gender (boys); belief in ability to be active (self-efficacy); and parental support.

Among adolescents ages 13 to 18, the following factors have a positive association with physical activity: parental education; gender (boys); personal goals; physical education/school sports; belief in ability to be active (self-efficacy); and support of friends and family.

Environmental influences positively associated with physical activity among children and adolescents include:

- Presence of sidewalks
- Having a destination/walking to a particular place
- Access to public transportation
- Low traffic density
- Access to neighborhood or school play area and/or recreational equipment

People with disabilities may be less likely to participate in physical activity due to physical, emotional, and psychological barriers. Barriers may include the inaccessibility of facilities and the lack of staff trained in working with people with disabilities.

- Healthy People 2020 (www.healthypeople.gov)
Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one’s line of work.

“During the past month, other than your regular job, did you participate in any physical activities or exercises, such as running, calisthenics, golf, gardening, or walking for exercise?”

No Leisure-Time Physical Activity in the Past Month

Healthy People 2020 Target = 32.6% or Lower

Recommended Levels of Physical Activity

Adults should do 2 hours and 30 minutes a week of moderate-intensity (such as walking), or 1 hour and 15 minutes (75 minutes) a week of vigorous-intensity aerobic physical activity (such as jogging), or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. The guidelines also recommend that adults do muscle-strengthening activities, such as push-ups, sit-ups, or activities using resistance bands or weights. These activities should involve all major muscle groups and be done on two or more days per week.

The report finds that nationwide nearly 50 percent of adults are getting the recommended amounts of aerobic activity and about 30 percent are engaging in the recommended muscle-strengthening activity.

Meeting Physical Activity Recommendations

To measure physical activity frequency, duration and intensity, respondents were asked:

“During the past month, what type of physical activity or exercise did you spend the most time doing?”

“And during the past month, how many times per week or per month did you take part in this activity?”

“And when you took part in this activity, for how many minutes or hours did you usually keep at it?”

Respondents could answer the above series for up to two types of physical activity. The specific activities identified (e.g., jogging, basketball, treadmill, etc.) determined the intensity values assigned to that respondent when calculating total aerobic physical activity hours/minutes.

Respondents were also asked about strengthening exercises:

“During the past month, how many times per week or per month did you do physical activities or exercises to strengthen your muscles? Do not count aerobic activities like walking, running, or bicycling. Please include activities using your own body weight, such as yoga, sit-ups, or push-ups, and those using weight machines, free weights, or elastic bands.”

“Meeting physical activity recommendations” includes adequate levels of both aerobic and strengthening activity:

- Aerobic activity is at least 150 minutes per week of light to moderate activity, 75 minutes per week of vigorous physical activity, or an equivalent combination of both;
- Strengthening activity is at least 2 sessions per week of exercise designed to strengthen muscles.

Meets Physical Activity Recommendations
(Josephine County, 2016)
Healthy People 2020 Target = 20.1% or Higher

Sources:
2016 PRC Community Health Survey, Professional Research Consultants, Inc. (Item 174)
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
- Meeting both guidelines is defined as the number of persons age 18+ who report light or moderate aerobic activity for at least 150 minutes per week or who report vigorous physical activity 75 minutes per week or an equivalent combination of moderate and vigorous-intensity activity and report doing physical activities specifically designed to strengthen muscles at least twice per week.
Weight Status

About Overweight & Obesity

Because weight is influenced by energy (calories) consumed and expended, interventions to improve weight can support changes in diet or physical activity. They can help change individuals' knowledge and skills, reduce exposure to foods low in nutritional value and high in calories, or increase opportunities for physical activity. Interventions can help prevent unhealthy weight gain or facilitate weight loss among obese people. They can be delivered in multiple settings, including healthcare settings, worksites, or schools.

The social and physical factors affecting diet and physical activity (see Physical Activity topic area) may also have an impact on weight. Obesity is a problem throughout the population. However, among adults, the prevalence is highest for middle-aged people and for non-Hispanic black and Mexican American women. Among children and adolescents, the prevalence of obesity is highest among older and Mexican American children and non-Hispanic black girls. The association of income with obesity varies by age, gender, and race/ethnicity.

- Healthy People 2020 (www.healthypeople.gov)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m²). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared (inches²)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m² and obesity as a BMI ≥30 kg/m². The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m². The increase in mortality, however, tends to be modest until a BMI of 30 kg/m² is reached. For persons with a BMI ≥30 kg/m², mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m².


### Classification of Overweight and Obesity by BMI

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI (kg/m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underweight</td>
<td>&lt;18.5</td>
</tr>
<tr>
<td>Healthy Weight</td>
<td>18.5 – 24.9</td>
</tr>
<tr>
<td>Overweight, not Obese</td>
<td>25.0 – 29.9</td>
</tr>
<tr>
<td>Obese</td>
<td>≥30.0</td>
</tr>
</tbody>
</table>


Adult Weight Status

“About how much do you weigh without shoes?”

“About how tall are you without shoes?”

“Are you now trying to lose weight?”

Reported height and weight were used to calculate a Body Mass Index or BMI value (described above) for each respondent. This calculation allows us to examine the proportion of the population who is at a healthy weight, or who is overweight or obese (see table above).
Prevalence of Total Overweight (Overweight or Obese)
(Percent of Adults With a Body Mass Index of 25.0 or Higher)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 176, 218]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.

Prevalence of Obesity
(Percent of Adults With a Body Mass Index of 30.0 or Higher)
Healthy People 2020 Target = 30.5% or Lower

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Based on reported heights and weights, asked of all respondents.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.
Prevalence of Obesity
(Percent of Adults With a BMI of 30.0 or Higher; Josephine County, 2016)
Healthy People 2020 Target = 30.5% or Lower

![Chart showing prevalence of obesity by gender, age group, and income level.]

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 176]

Notes:
- Based on reported heights and weights, asked of all respondents.
- Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size.
- “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
- The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0, regardless of gender.

Key Informant Input: Nutrition, Physical Activity & Weight

The following chart outlines key informants’ perceptions of the severity of Nutrition, Physical Activity & Weight as a problem in the community:

![Chart showing perceptions of nutrition, physical activity, and weight as a problem in the community.]

Sources: PRC Online Key Informant Survey, Professional Research Consultants, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Obesity
- Reducing obesity. - Other Health Provider
- Obesity in the community is a problem. - Other Health Provider
- Obesity, inactivity and poor food choices are big problems in Josephine County. - Social Services Provider
- Weight is up in our area, and also the amount of coffee drinks is not helping the situation. - Social Services Provider
Motivation to Change

*It isn’t a priority for very many people, as they don’t see the connection. Lack of education and understanding of the connection between diet and nutrition, physical activity and their weight.* - Community Leader

*The value placed on healthy living is not there. Many students have very little exercise outside of PE. Additionally, many students are not making healthy decisions about nutrition. Both of these are difficult for students when poor modeling takes place.* - Community Leader

Built Environment

*Inactivity, poor dietary choices, easy access to high caloric foods, limited walking paths and bike paths. Basic community layout does not lend itself to healthy choice being the default. Too much TV and screen time.* - Social Services Provider

Nutrition

*Poor eating habits.* - Community Leader
## Substance Abuse

### About Substance Abuse

Substance abuse has a major impact on individuals, families, and communities. The effects of substance abuse are cumulative, significantly contributing to costly social, physical, mental, and public health problems. These problems include:

- Teenage pregnancy
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Other sexually transmitted diseases (STDs)
- Domestic violence
- Child abuse
- Motor vehicle crashes
- Physical fights
- Crime
- Homicide
- Suicide

Substance abuse refers to a set of related conditions associated with the consumption of mind- and behavior-altering substances that have negative behavioral and health outcomes. Social attitudes and political and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues. In addition to the considerable health implications, substance abuse has been a flash-point in the criminal justice system and a major focal point in discussions about social values: people argue over whether substance abuse is a disease with genetic and biological foundations or a matter of personal choice.

Advances in research have led to the development of evidence-based strategies to effectively address substance abuse. Improvements in brain-imaging technologies and the development of medications that assist in treatment have gradually shifted the research community’s perspective on substance abuse. There is now a deeper understanding of substance abuse as a disorder that develops in adolescence and, for some individuals, will develop into a chronic illness that will require lifelong monitoring and care.

Improved evaluation of community-level prevention has enhanced researchers’ understanding of environmental and social factors that contribute to the initiation and abuse of alcohol and illicit drugs, leading to a more sophisticated understanding of how to implement evidence-based strategies in specific social and cultural settings.

A stronger emphasis on evaluation has expanded evidence-based practices for drug and alcohol treatment. Improvements have focused on the development of better clinical interventions through research and increasing the skills and qualifications of treatment providers.

- Healthy People 2020 (www.healthypeople.gov)
Related Age-Adjusted Mortality

Cirrhosis/Liver Disease. Heavy alcohol use contributes to a significant share of liver disease, including cirrhosis. The following chart outlines age-adjusted mortality for cirrhosis/liver disease in the county.

Drug-Induced Deaths. Drug-induced deaths include both intentional and unintentional drug overdoses. The following chart outlines local age-adjusted mortality for drug-induced deaths.

Cirrhosis/Liver Disease: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 8.2 or Lower

Drug-Induced Deaths: Age-Adjusted Mortality
(2012-2014 Annual Average Deaths per 100,000 Population)
Healthy People 2020 Target = 11.3 or Lower
Alcohol Use

**Excessive Drinkers.** Excessive drinking reflects the number of adults (age 18+) who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women), or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.

“During the past 30 days, on how many days did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?”

“On the day(s) when you drank, about how many drinks did you have on the average?”

“Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 (if male)/4 (if female) or more drinks on an occasion?”

![Graph showing excessive drinkers by gender, age, and income level.](image)

**Healthy People 2020 Target = 25.4% or Lower**

**Sources:**
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 189]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of all respondents.
- Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
- Excessive drinking reflects the number of persons aged 18 Years and over who drank more than two drinks per day on average (for men) or more than one drink per day on average (for women) or who drank 5 or more drinks during a single occasion (for men) or 4 or more drinks during a single occasion (for women) during the past 30 days.
Drinking & Driving. As a self-reported measure – and because this indicator reflects potentially illegal behavior – it is reasonable to expect that it might be underreported, and that the actual incidence of drinking and driving in the community is likely higher.

“During the past 30 days, how many times have you driven when you’ve had perhaps too much to drink?”

Illicit Drug Use

“During the past 30 days, have you used an illegal drug or taken a prescription drug that was not prescribed to you?”
Alcohol & Drug Treatment

“Have you ever sought professional help for an alcohol or drug-related problem?”

Have Ever Sought Professional Help for an Alcohol/Drug-Related Problem

<table>
<thead>
<tr>
<th></th>
<th>Josephine County</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>6.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td>2014</td>
<td>9.8%</td>
<td>4.1%</td>
</tr>
<tr>
<td>2016</td>
<td>6.1%</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 68]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.

Personal Impact of Substance Abuse

“To what degree has your life been negatively affected by your own or someone else’s substance abuse issues, including alcohol, prescription, and other drugs? Would you say: a great deal, somewhat, a little, or not at all?”

Life Has Been Negatively Affected by Substance Abuse (by Self or Someone Else)

(Josephine County, 2016)

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>18 to 44</th>
<th>45 to 64</th>
<th>65+</th>
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<td>18 to 44</td>
<td>44.0%</td>
<td>53.7%</td>
<td>52.7%</td>
<td>55.4%</td>
<td>39.2%</td>
<td>53.9%</td>
<td>49.1%</td>
<td>54.6%</td>
<td>49.1%</td>
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<tr>
<td>45 to 64</td>
<td>44.0%</td>
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<td>50.0%</td>
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<td>65+</td>
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</tr>
<tr>
<td>Low Income</td>
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<tr>
<td>Mid/High Income</td>
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<tr>
<td>Josephine County</td>
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<tr>
<td>US</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 69]
2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes: Asked of all respondents.
Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
Key Informant Input: Substance Abuse

The following chart outlines key informants’ perceptions of the severity of Substance Abuse as a problem in the community:

### Perceptions of Substance Abuse as a Problem in the Community
(Key Informants, 2016)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>75.9%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>20.7%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>3.4%</td>
</tr>
<tr>
<td>No Problem At All</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Sources:** PRC Online Key Informant Survey, Professional Research Consultants, Inc.

**Notes:** Asked of all respondents.

Barriers to Treatment

Among those rating this issue as a “major problem,” the greatest barriers to accessing substance abuse treatment are viewed as:

**Affordable Care/Lack of Funding**
- Lack of funding for these services. - Community Leader
- Lack of affordable or public-based substance abuse treatment programs or resources. Heavy reliance on emergent services providers, law enforcement, EMS, fire and Emergency Room, to provide critical care services. It is costly and strains local resources. - Community Leader
- Cost and visibility of programs. - Community Leader
- The cost of in-house treatment. - Community Leader

**Access to Care/Services**
- Lack of alternatives for treatment. About 200 from our community have to go to Medford for their treatments with methadone or other drugs to try to get them off illegal drugs. - Community Leader
- We have made important progress with the recent opening of a Sobering Center and soon-to-be-open Medically Assisted Treatment Center for narcotic addicts. Barriers are transportation, lack of public awareness as to the magnitude of the problem. - Public Health Representative
- Requiring services for those who need it and/or having those who need services to see the need. - Community Leader

**Denial/Stigma**
- There is a stigma attached to substance abuse treatment, which prevents some people from seeking help. I do not know many resources to help in our community. There is a significant substance abuse issue in our community, so relapse is common. - Community Leader
- Stigma and capacity. - Other Health Provider
- Stigma, denial and effective treatment opportunities. Addiction is still linked to character flaws. There is a high incidence of multi-generational addiction in this county. - Social Services Provider

**Motivation to Change**
- A true desire of the client to quit. - Other Health Provider
- Many patients are unwilling to seek treatment. But if they are willing, they run into payment barriers. Private payers open more doors than no-pay, self-pay and Medicaid. - Physician
- Persons with substance abuse issues often do not seek treatment. - Social Services Provider

**Access to Providers**
Inability to have sufficient, qualified personnel in the community to address the issues. Also, not enough emphasis on trying to develop a comprehensive system to address the addiction. Prevention and education needed to improve our current state. - Community Leader
Access to providers, inability to pay and actually getting people into the programs. - Community Leader

Law Enforcement
Lack of jail space. Juvenile detention space prevents substance abuse criminals from facing consequences and prevents a possible first step in treatment. - Social Services Provider
Lack of law enforcement. - Community Leader

Prevalence/Incidence
The overwhelming number of methamphetamine users. Limited resources available for treatment. - Social Services Provider
Community Health Assessment and court and justice data. - Other Health Provider

Health Education
Engagement of clients in services, education of the community of the problem. Oftentimes addiction is confused with mental health. - Social Services Provider

**Problematic Substances as Identified by Key Informants**

<table>
<thead>
<tr>
<th>Substance</th>
<th>Most Problematic</th>
<th>Second-Most Problematic</th>
<th>Third-Most Problematic</th>
<th>Total Mentions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamines or Other Amphetamines</td>
<td>33.3%</td>
<td>22.2%</td>
<td>33.3%</td>
<td>8</td>
</tr>
<tr>
<td>Alcohol</td>
<td>22.2%</td>
<td>33.3%</td>
<td>22.2%</td>
<td>7</td>
</tr>
<tr>
<td>Heroin or Other Opioids</td>
<td>33.3%</td>
<td>11.1%</td>
<td>22.2%</td>
<td>6</td>
</tr>
<tr>
<td>Over-The-Counter Medications</td>
<td>11.1%</td>
<td>0.0%</td>
<td>11.1%</td>
<td>2</td>
</tr>
<tr>
<td>Prescription Medications</td>
<td>0.0%</td>
<td>22.2%</td>
<td>0.0%</td>
<td>2</td>
</tr>
<tr>
<td>Marijuana</td>
<td>0.0%</td>
<td>11.1%</td>
<td>11.1%</td>
<td>2</td>
</tr>
</tbody>
</table>
Tobacco Use

About Tobacco Use

Tobacco use is the single most preventable cause of death and disease in the United States. Scientific knowledge about the health effects of tobacco use has increased greatly since the first Surgeon General’s report on tobacco was released in 1964.

Tobacco use causes:

- Cancer
- Heart disease
- Lung diseases (including emphysema, bronchitis, and chronic airway obstruction)
- Premature birth, low birth weight, stillbirth, and infant death

There is no risk-free level of exposure to secondhand smoke. Secondhand smoke causes heart disease and lung cancer in adults and a number of health problems in infants and children, including: severe asthma attacks; respiratory infections; ear infections; and sudden infant death syndrome (SIDS).

Smokeless tobacco causes a number of serious oral health problems, including cancer of the mouth and gums, periodontitis, and tooth loss. Cigar use causes cancer of the larynx, mouth, esophagus, and lung.

Healthy People 2020 (www.healthypeople.gov)

Cigarette Smoking

“Do you now smoke cigarettes: every day, some days, or not at all?”

Current Smokers

Healthy People 2020 Target = 12.0% or Lower

<table>
<thead>
<tr>
<th></th>
<th>Josephine County</th>
<th>Oregon</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>18.9%</td>
<td>17.0%</td>
<td>14.0%</td>
</tr>
<tr>
<td>2014</td>
<td>19.7%</td>
<td>21.6%</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>18.9%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Includes regular and occasional smokers (those who smoke cigarettes every day or on some days).
Current Smokers
(Josephine County, 2016)
Healthy People 2020 Target = 12.0% or Lower

Sources: 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 181]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasion smokers (every day and some days).

Smoking Cessation

About Reducing Tobacco Use
Preventing tobacco use and helping tobacco users quit can improve the health and quality of life for Americans of all ages. People who stop smoking greatly reduce their risk of disease and premature death. Benefits are greater for people who stop at earlier ages, but quitting tobacco use is beneficial at any age.

Many factors influence tobacco use, disease, and mortality. Risk factors include race/ethnicity, age, education, and socioeconomic status. Significant disparities in tobacco use exist geographically; such disparities typically result from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco prevention.

- Healthy People 2020 (www.healthypeople.gov)

Secondhand Smoke
“In the past 30 days, has anyone, including yourself, smoked cigarettes, cigars or pipes anywhere in your home on an average of four or more days per week?”

The following chart details these responses among the total sample of respondents, as well as among only households with children (age 0-17).
Use of Vaping Products

“The next questions are about electronic vaping products, such as electronic cigarettes, also known as e-cigarettes. These are battery-operated devices that simulate traditional cigarette smoking, but do not involve the burning of tobacco. The cartridge or liquid “e-juice” used in these devices produces vapor and comes in a variety of flavors. Have you ever used an electronic vaping product, such as an e-cigarette, even just one time in your entire life?”

“Do you now use electronic vaping products, such as e-cigarettes, “every day,” “some days,” or “not at all”?”
Currently Use Electronic Cigarettes  
(Josephine County, 2016)

Sources:  2016 PRC Community Health Survey, Professional Research Consultants, Inc.  [Item 181]

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size.  “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.
- Includes regular and occasion users (every day and some days).

Other Tobacco Use
“Do you currently use chewing tobacco, snuff, or snus every day, some days, or not at all?”

Smokeless Tobacco Users  
Healthy People 2020 Target = 0.3% or Lower

Sources:  2016 PRC Community Health Survey, Professional Research Consultants, Inc.  [Item 58]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Reflects the total sample of respondents.
- Smokeless tobacco includes chewing tobacco or snuff.
Key Informant Input: Tobacco Use

The following chart outlines key informants’ perceptions of the severity of Tobacco Use as a problem in the community:

### Perceptions of Tobacco Use as a Problem in the Community
(Key Informants, 2016)

<table>
<thead>
<tr>
<th>Level of Problem</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major Problem</td>
<td>46.2%</td>
</tr>
<tr>
<td>Moderate Problem</td>
<td>38.5%</td>
</tr>
<tr>
<td>Minor Problem</td>
<td>15.4%</td>
</tr>
<tr>
<td>No Problem At All</td>
<td></td>
</tr>
</tbody>
</table>

**Sources:**
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.
- Asked of all respondents.

**Top Concerns**

Among those rating this issue as a “major problem,” reasons related to the following:

**Prevalence/Incidence**
- There are still lots of smokers. - Other Health Provider
- High rate of tobacco use among young people in the county. - Community Leader
- The number of people I see with cigarettes or purchasing cigarettes. - Community Leader
- High incidence of tobacco and marijuana use at all ages. Lack of preventive or treatment services. - Community Leader

**Comorbidities**
- It is unhealthy. Would like to see more of a campaign to prevent teens from starting. - Community Leader

**Lifestyles**
- Poor health habits. - Community Leader

**Socioeconomic Factors**
- Low education level, easy access to tobacco products, high addictive characteristics of nicotine. - Social Services Provider
Access to Health Services

Lack of Health Insurance Coverage (Age 18 to 64)

Survey respondents were asked a series of questions to determine their healthcare insurance coverage, if any, from either private or government-sponsored sources. Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population), who have no type of insurance coverage for healthcare services – neither private insurance nor government-sponsored plans (e.g., Medicaid).

“Do you have any government-assisted healthcare coverage, such as Medicare, Medicaid (or another state-sponsored program), or VA/military benefits?”

“Do you currently have: health insurance you get through your own or someone else’s employer or union; health insurance you purchase yourself; or, you do not have health insurance and pay for health care entirely on your own?”

Lack of Healthcare Insurance Coverage
(Among Adults Age 18-64)

Healthy People 2020 Target = 0.0% (Universal Coverage)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents under the age of 65.
Lack of Healthcare Insurance Coverage
(Among Adults Age 18-64; Josephine County, 2016)
Healthy People 2020 Target = 0.0% (Universal Coverage)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 190]

Notes:
- Asked of all respondents under the age of 65.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Difficulties Accessing Healthcare

About Access to Healthcare
Access to comprehensive, quality health care services is important for the achievement of health equity and for increasing the quality of a healthy life for everyone. It impacts: overall physical, social, and mental health status; prevention of disease and disability; detection and treatment of health conditions; quality of life; preventable death; and life expectancy.

Access to health services means the timely use of personal health services to achieve the best health outcomes. It requires three distinct steps: 1) Gaining entry into the health care system; 2) Accessing a health care location where needed services are provided; and 3) Finding a health care provider with whom the patient can communicate and trust.

**Healthy People 2020** (www.healthypeople.gov)

Barriers to Healthcare Access
To better understand healthcare access barriers, survey participants were asked whether any of the following barriers to access prevented them from seeing a physician or obtaining a needed prescription in the past year.

“Was there a time in the past 12 months when…

- … you needed medical care, but had **difficulty finding a doctor**?
- … you had difficulty getting an **appointment** to see a doctor?*
- … you needed to see a doctor, but could not because of the **cost**?
- … a **lack of transportation** made it difficult or prevented you from seeing a doctor or making a medical appointment?*
- … you were not able to see a doctor because the **office hours were not convenient**?*
- … you needed a **prescription medicine**, but did not get it because you could not afford it?*

The percentages shown in the following chart reflect the total population, regardless of whether medical care was needed or sought.

### Barriers to Access Have Prevented Medical Care in the Past Year

<table>
<thead>
<tr>
<th>Barriers to Access</th>
<th>Josephine County</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting a Dr Appointment</td>
<td>20.2%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Cost (Prescriptions)</td>
<td>15.1%</td>
<td>9.5%</td>
</tr>
<tr>
<td>Finding a Doctor</td>
<td>13.5%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Cost (Doctor Visit)</td>
<td>11.5%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Inconvenient Office Hours</td>
<td>9.9%</td>
<td>6.4%</td>
</tr>
<tr>
<td>Lack of Transportation</td>
<td>14.4%</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

**Sources:**
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 7-11, 13]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.
- *Asked of all respondents.*
The following charts reflect the composite percentage of the total population experiencing problems accessing healthcare in the past year (indicating one or more of the aforementioned barriers or any other problem not specifically asked), again regardless of whether they needed or sought care.

**Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year**

Sources:  
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc.  
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:  
- Asked of all respondents.
- Represents the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.

**Experienced Difficulties or Delays of Some Kind in Receiving Needed Healthcare in the Past Year (Josephine County, 2016)**

Sources:  
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc.  
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:  
- Represent the percentage of respondents experiencing one or more barriers to accessing healthcare in the past 12 months.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. "Low Income" includes households with incomes up to 200% of the federal poverty level; "Mid/High Income" includes households with incomes at 200% or more of the federal poverty level.
Accessing Healthcare for Children

Surveyed parents were also asked if, within the past year, they experienced any trouble receiving medical care for a randomly-selected child in their household.

“Was there a time in the past 12 months when you needed medical care for this child, but could not get it?”

Had Trouble Obtaining Medical Care for Child in the Past Year
(Among Parents of Children 0-17)

Key Informant Input: Access to Healthcare Services

The following chart outlines key informants’ perceptions of the severity of Access to Healthcare Services as a problem in the community:

Perceptions of Access to Healthcare Services as a Problem in the Community
(Key Informants, 2016)

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 136]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents with children 0 to 17 in the household.
- Note that the 2014 sample is too small to be shown here.
Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Access to Providers

- It is difficult for people new to the community to find a primary care provider who is accepting new patients. The same problem exists for those who have recently graduated from high school or college and are leaving their parents’ health insurance. - Community Leader
- Lack of doctors. Very few doctors are taking new patients, and the only available care for many is a physician’s assistant or a nurse practitioner. - Community Leader
- Poor orthopedic emergency room coverage. Long waits to be established with primary care. Difficult to find medical care for new patients. - Social Services Provider
- Lack of providers and adequate facilities for the demographic. Lack of coordinated care system, from in-home to critical care services. - Community Leader
- PCP Shortage, ED utilization. - Other Health Provider

Affordable Care/Services

- People wrestling with how they fund their health care. People choosing not to get treatment or finding it difficult to get treatment because of not having a primary care physician. - Community Leader
- Limited number of people who have funds for adequate health insurance. - Community Leader
- Ability to pay, travel, distance. - Other Health Provider

Insurance Issues

- I have heard many complaints of people who cannot access services because their health insurance carrier is not accepted by Asante. Also, Medicare patients having to change doctors to receive services, and then having to wait weeks for appointments. - Community Leader
- Many physicians do not take certain insurances. - Social Services Provider

Lack of Services

- At CASA, we deal solely with abused and neglected children and their families who are in the foster care system. There is a serious scarcity of resources for mental, physical and emotional health. Their access is limited to and reliant upon DHS. - Social Services Provider
- Lack of supportive treatment and support services for the various non-emergent health related issues within the community results in the reliance on emergent services providers to be the first point of contact into the health care system for non-emergent. - Community Leader

Housing

- Housing insecurity has a known negative impact on health. - Public Health Representative

Medicare/Oregon Health Plan

- Lack of providers who will take Medicare and OHP patients. - Community Leader
Type of Care Most Difficult to Access

Key informants (who rated this as a “major problem”) were further asked to identify the type of care they perceive as the most difficult to access in the community.

<table>
<thead>
<tr>
<th>Medical Care Difficult to Access as Identified by Key Informants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most Difficult</strong></td>
</tr>
<tr>
<td>---------------------</td>
</tr>
<tr>
<td>Mental Health Care</td>
</tr>
<tr>
<td>Primary Care</td>
</tr>
<tr>
<td>Specialty Care</td>
</tr>
<tr>
<td>Substance Abuse Treatment</td>
</tr>
<tr>
<td>Elder Care</td>
</tr>
<tr>
<td>Dental Care</td>
</tr>
<tr>
<td>Prenatal Care</td>
</tr>
<tr>
<td>Chronic Disease Care</td>
</tr>
</tbody>
</table>
**Primary Care Services**

**About Primary Care**

Improving health care services depends in part on ensuring that people have a usual and ongoing source of care. People with a usual source of care have better health outcomes and fewer disparities and costs. Having a primary care provider (PCP) as the usual source of care is especially important. PCPs can develop meaningful and sustained relationships with patients and provide integrated services while practicing in the context of family and community. Having a usual PCP is associated with:

- Greater patient trust in the provider
- Good patient-provider communication
- Increased likelihood that patients will receive appropriate care

Improving health care services includes increasing access to and use of evidence-based preventive services. Clinical preventive services are services that: prevent illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention); or detect a disease at an earlier, and often more treatable, stage (secondary prevention).

- Healthy People 2020 ([www.healthypeople.gov](http://www.healthypeople.gov))

**Access to Primary Care**

This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

**Access to Primary Care**

(Number of Primary Care Physicians per 100,000 Population, 2013)

![Graph showing access to primary care](image)

**Sources:**
- US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File.
- Retrieved September 2016 from Community Commons at [http://www.chna.org](http://www.chna.org)

**Notes:**
- This indicator is relevant because a shortage of health professionals contributes to access and health status issues.
Specific Source of Ongoing Care

Having a specific source of ongoing care includes having a doctor’s office, clinic, urgent care center, walk-in clinic, health center facility, hospital outpatient clinic, HMO or prepaid group, military/VA clinic, or some other kind of place to go if one is sick or needs advice about his or her health. This resource is crucial to the concept of “patient-centered medical homes” (PCMH).

“Is there a particular place that you usually go to if you are sick or need advice about your health?”

“What kind of place is it: a medical clinic, an urgent care center/walk-in clinic, a doctor’s office, a hospital emergency room, military or other VA healthcare, or some other place?”

The following chart illustrates the proportion of the Josephine County population with a specific source of ongoing medical care. Note that a hospital emergency room is not considered a specific source of ongoing care in this instance.

### Have a Specific Source of Ongoing Medical Care

**(Josephine County, 2016)**

**Healthy People 2020 Target = 95.0% or Higher**

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>18 to 44</th>
<th>45 to 64</th>
<th>65+</th>
<th>Low Income</th>
<th>Mid/High Income</th>
<th>Josephine County</th>
<th>US</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>71.3%</td>
<td>83.5%</td>
<td>68.4%</td>
<td>81.6%</td>
<td>81.8%</td>
<td>71.0%</td>
<td>82.0%</td>
<td>77.8%</td>
<td>74.0%</td>
</tr>
<tr>
<td>Sources</td>
<td>2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Items 174-176]</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td>2015 PRC National Health Survey, Professional Research Consultants, Inc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>Asked of all respondents.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Income categories reflect respondent’s household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Utilization of Primary Care Services

**Adults:** “A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition. About how long has it been since you last visited a doctor for a routine checkup?”

**Children:** “About how long has it been since this child visited a doctor for a routine checkup or general physical exam, not counting visits for a specific injury, illness, or condition?”

### Have Visited a Physician for a Checkup in the Past Year

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2014</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>72.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>62.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>US</td>
<td>70.5%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sources:** 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 18]

**Notes:** Asked of all respondents.

### Child Has Visited a Physician for a Routine Checkup in the Past Year (Among Parents of Children 0-17)

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Josephine County</td>
<td>91.5%</td>
<td></td>
</tr>
<tr>
<td>US</td>
<td>89.3%</td>
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**Sources:** 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 138]

**Notes:** Asked of all respondents with children 0 to 17 in the household. Note that samples from prior studies are too small to be shown here.
Emergency Room Utilization

“In the past 12 months, how many times have you gone to a hospital emergency room about your own health? This includes ER visits that resulted in a hospital admission.” (Responses here reflect the percentage with two or more visits in the past year.)

“What is the main reason you used the emergency room instead of going to a doctor’s office or clinic?”

**Have Used a Hospital Emergency Room More Than Once in the Past Year**

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<td>Notes</td>
<td>Asked of all respondents.</td>
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**Used the ER because:**
- Emergency Situation = 54.5%
- Weekend/After Hours = 28.1%
- Long Wait for Apt = 13.0%
- Don’t Have a Doctor = 1.8%
- Doctor Recommended = 1.4%
Oral Health

About Oral Health

Oral health is essential to overall health. Good oral health improves a person’s ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions. However, oral diseases, from cavities to oral cancer, cause pain and disability for many Americans. Good self-care, such as brushing with fluoride toothpaste, daily flossing, and professional treatment, is key to good oral health. Health behaviors that can lead to poor oral health include: tobacco use; excessive alcohol use; and poor dietary choices.

The significant improvement in the oral health of Americans over the past 50 years is a public health success story. Most of the gains are a result of effective prevention and treatment efforts. One major success is community water fluoridation, which now benefits about 7 out of 10 Americans who get water through public water systems. However, some Americans do not have access to preventive programs. People who have the least access to preventive services and dental treatment have greater rates of oral diseases. A person’s ability to access oral healthcare is associated with factors such as education level, income, race, and ethnicity.

Barriers that can limit a person’s use of preventive interventions and treatments include: limited access to and availability of dental services; lack of awareness of the need for care; cost; and fear of dental procedures.

There are also social determinants that affect oral health. In general, people with lower levels of education and income, and people from specific racial/ethnic groups, have higher rates of disease. People with disabilities and other health conditions, like diabetes, are more likely to have poor oral health.

Potential strategies to address these issues include:

- Implementing and evaluating activities that have an impact on health behavior.
- Promoting interventions to reduce tooth decay, such as dental sealants and fluoride use.
- Evaluating and improving methods of monitoring oral diseases and conditions.
- Increasing the capacity of State dental health programs to provide preventive oral health services.
- Increasing the number of community health centers with an oral health component.

- Healthy People 2020 (www.healthypeople.gov)
Dental Care

“About how long has it been since you last visited a dentist or a dental clinic for any reason?”

Have Visited a Dentist or Dental Clinic Within the Past Year (Josephine County, 2016)
Healthy People 2020 Target = 49.0% or Higher

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 20]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
- Income categories reflect respondent's household income as a ratio to the federal poverty level (FPL) for their household size. “Low Income” includes households with incomes up to 200% of the federal poverty level; “Mid/High Income” includes households with incomes at 200% or more of the federal poverty level.

Dental Insurance

“Do you currently have any health insurance coverage that pays for at least part of your dental care?”

Have Insurance Coverage That Pays All or Part of Dental Care Costs

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 21]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
Key Informant Input: Oral Health

The following chart outlines key informants’ perceptions of the severity of Oral Health as a problem in the community:

### Perceptions of Oral Health as a Problem in the Community
(Key Informants, 2016)

- **Major Problem:** 20.8%
- **Moderate Problem:** 41.7%
- **Minor Problem:** 33.3%
- **No Problem At All:** 4.2%

**Sources:**
- PRC Online Key Informant Survey, Professional Research Consultants, Inc.

**Notes:**
- Asked of all respondents.

**Top Concerns**

Among those rating this issue as a “major problem,” reasons related to the following:

**Access to Care/Services**

- Provider shortage; reimbursement policy changes. - Other Health Provider
- Low income and no dental insurance. - Community Leader

**Prevalence/Incidence**

- I have observed a lot of children and adults with dental problems, discolored teeth, broken teeth, missing teeth and dentures at a young age. Lack of fluoride in the water and the cost of dental care. - Community Leader
- I imagine it is a problem. - Other Health Provider

**Insurance Issues**

- Access to dental care is hard to get. Not everyone accepts OHP. You usually have to pay up front and deal with your insurance after the fact. - Public Health Representative
Local Resources

Perceptions of Local Healthcare Services

“How would you rate the overall health care services available to you? Would you say: excellent, very good, good, fair, or poor?”

Perceive Local Healthcare Services as “Fair/Poor”

![Bar chart showing the percentage of people who perceive local healthcare services as “fair/poor” in Josephine County and the US from 2011 to 2016.]

Sources:
- 2016 PRC Community Health Survey, Professional Research Consultants, Inc. [Item 6]
- 2015 PRC National Health Survey, Professional Research Consultants, Inc.

Notes:
- Asked of all respondents.
Resources Available to Address the Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

### Access to Healthcare Services
- Asante Physician Partners (APP)
- Asante Health System
- Asante Three Rivers Medical Center
- Choices Counseling
- Doctor's Offices
- Federal Insurance Exchange
- Grants Pass Clinic
- Health Department
- Josephine County Mental Health
- KAIROS
- La Clinica
- Mid-Rogue Independent Physicians Associated
- Options of Southern Oregon
- Oregon Health Plan
- Public Health
- Siskiyou Community Health Center
- Valley Immediate Care
- Women's Health Center

### Diabetes
- AllCare
- Asante Health System
- Asante Three Rivers Medical Center
- CCOs (Coordinated Care Organizations)
- Doctor's Offices
- Health Education
- Hospitals
- OSU Extension Service
- Siskiyou Community Health Center
- SNAP
- State of Oregon
- Urgent Care
- YMCA

### Arthritis, Osteoporosis & Chronic Back Conditions
- Doctor's Offices

### Cancer
- Asante Three Rivers Medical Center
- Doctor's Offices
- Hospice
- Oncology Clinic
- Spears Cancer Center

### Dementias, Including Alzheimer's Disease
- Adult and Senior Living Facilities
- Ashley Manor Care Centers
- Black Oak Adult Foster Care
- Doctor's Offices
- Highland House
- Memory Care Facilities
- Mountain Springs
- Senior Services
- Spring Pointe

### Hearing & Vision
- CCOs (Coordinated Care Organizations)
- Doctor's Offices
- Josephine County Foundation
- Lions Club
- Siskiyou Community Health Center

### Heart Disease & Stroke
- Asante Health System
- Asante Rogue Regional Medical Center
- Asante Three Rivers Medical Center
- Cardiology Clinic - Grants Pass
- Doctor's Offices
- Fitness Centers/Gyms
- Grants Pass Clinic
- Siskiyou Community Health Center
- Southern Oregon Cardiology
**Immunization & Infectious Diseases**
- Siskiyou Community Health Center

**Infant & Child Health**
- Doctor's Offices
- Early Head Start
- Family Nurturing Center
- Grants Pass Clinic
- Health and Human Services
- Health Department
- Hospitals
- Josephine County Public Health
- Options of Southern Oregon
- Public Health
- Siskiyou Community Health Center
- WIC
- Women's Health Center

**Injury & Violence**
- Choices Counseling
- Crime Victim Resources
- District Attorney's Office
- Grants Pass Public Safety
- Hospitals
- Illinois Valley Safe House Alliance
- Josephine County Mental Health
- OnTrack
- Options of Southern Oregon
- Police Department
- Public Safety
- Siskiyou Community Health Center
- UCAN
- Women's Crisis Support Team

**Mental Health**
- AllCare
- Asante Rogue Regional Medical Center
- Asante Three Rivers Medical Center
- Choices Counseling
- Crisis Resolution Center
- Doctor's Offices
- Family Solutions
- Foster Homes
- Gospel Rescue Mission
- Health and Human Services
- Health Department
- Hugo Hills
- Josephine County Mental Health
- Josephine County Public Health
- KAIROS

**Nutrition, Physical Activity & Weight**
- Asante Health System
- CCOs (Coordinated Care Organizations)
- Club Northwest
- Doctor's Offices
- Exercise Programs
- KidZone Community Foundation
- OSU Extension Service
- Parks and Recreation Department
- Public Health
- School System
- Self-Healing Community Initiative
- YMCA

**Oral Health**
- Advantage Dental
- Local Dental Association
- Public Health
- School System

**Respiratory Diseases**
- Asante Three Rivers Medical Center
- Doctor's Offices

**Sexually Transmitted Diseases**
- Planned Parenthood

**Substance Abuse**
- AA/NA
- Adapt Medford
- Asante Three Rivers Medical Center
- CCOs (Coordinated Care Organizations)
- Choices Counseling
- Doctor's Offices
- Genesis
- Josephine County Health Department
- OnTrack
Options of Southern Oregon
Police Department
Public Safety
Self-Healing Community Initiative
Sobering Center
Treatment Centers

Tobacco Use

Adapt Medford
Asante Health System
CCOs (Coordinated Care Organizations)
Choices Counseling
Doctor's Offices
Grants Pass School District #7
Private Insurance
Public Health
Self-Healing Community Initiative
Seventh Day Adventist Smoking Cessation Program
Siskiyou Community Health Center
The Asante Three Rivers Medical Center CHNA amendment does not include the full Implementation Strategy adopted by the Asante Board of Directors in 2017, but rather contains an evaluation of the impact of any actions that were taken since the immediately preceding CHNA.
1. **Access to health care services**
   - New primary care and specialty providers are being recruited for medical clinics in Grants Pass to increase the availability of health care providers in the community.
   - Certified application counselors will be hired to help community members complete health care application forms for insurance coverage through the Oregon Health Plan.
   - The Transitional Care Clinic was recently opened to help patients connect with medical providers for timely follow-up care after they are discharged from the hospital.
   - Access to tele-intensivists is being made available 24/7 for doctors working in the hospital’s intensive care unit treating patients who need an advanced level of care.
   - Our ongoing discounted or free prescription drug program was established to provide medications to patients who are financially unable to secure needed prescriptions upon discharge from the hospital.
   - Social workers connect patients to resources by working with outside agencies to help patients who have little to no means of support (financial, social and emotional) secure essential needs for healing and stability after hospitalization.
   - A sports medicine outreach program is being developed in Grants Pass to provide injury prevention, evaluation, treatment and rehabilitation for student athletic injuries for high schools in outlying areas of the Three Rivers School District at no cost to student athletes or the school district.
   - The Family House provides a low-cost place for patients and families from out of the area and receiving medical treatment at the hospital. More than 900 people are served annually.
   - Annually, several hospital departments provide no-cost education and training required for licensure for college students, including imaging, nursing, dietary, sleep technology, laboratory and other clinical programs.
   - Each year, training and hands-on experience is provided for students in doctor and nurse practitioner licensing programs for the next generation of health care providers who require hospital residencies for licensure.
   - Asante committed a substantial financial contribution to the Rogue Community College Allied Health Program ensuring quality clinical education in the health sciences is available locally and helping to increase the number of trained technicians and medical support personnel in our community.

2. **Mental health & substance abuse**
   - The psychiatric care rooms in the hospital will be painted a more calming color.
   - Licensed clinical social workers are being hired at Asante family practice clinics in Grants Pass to address the need for outpatient mental health needs with a medical home model.
   - Financial support has been pledged to the Grants Pass Sobering Center and a member of the ATRMC executive team serves on its board.

3. **Heart disease and stroke**
   - The hospital received acute stroke ready certification from our accrediting agency to validate enhanced stroke care services at the hospital, such as tele-stroke capabilities.
Asante Three Rivers Medical Center
Asante 2017 Implementation Strategy
Amended May 2019

— As the primary financial sponsor of PulsePoint, a heart attack notification app, Asante has partnered with several community groups to bring this potentially life-saving tool to Josephine County. When a cardiac emergency is in a public place, the location-aware app alerts nearby CPR-trained citizens at the same time a 9-1-1 call is made.

4. **Infant health and family planning**
   — The pediatric unit is being renovated to update technology and services.

5. **Diabetes**
   — Low cost nutritional cooking classes are provided to the public to aid community members in the planning and preparation of healthful meals and snacks.
   — A Diabetes Care Center and Nutrition Services program is planned in Grants Pass to offer medical diagnosis and treatment, support groups and education.
   — Inpatient consultations are being made available for people with diabetes to help them prepare for post-discharge care and nutrition.
   — An endocrinology clinic in Grants Pass provides diabetes care and education.

6. **Nutrition, physical activity and weight**
   — Dietitians provide nutrition education for community members in the demonstration kitchen in the Asante Outpatient Center.
   — Inpatient and outpatient nutrition counselors are retained to help patients learn about how their diet affects their health condition and how to make better food choices.
   — Asante intends to commit annual funding to the Friends of Josephine County Food Bank, leveraging matching donations from the community and providing hundreds of free meals to the underserved in the community.
   — Asante has committed funding and other support to a new Blue Zones Project in Grants Pass, actively supporting and promoting a healthier, more active lifestyle for community members.

7. **Respiratory diseases**
   — Discharged patients with pneumonia and respiratory issues are scheduled to see an Asante pulmonologist to ensure a continuum of care and reduce their chance of being readmitted.
   — An Asante pulmonologist rotates through Asante’s Grants Pass clinic to provide this specialty health service that is under-represented in the community.
   — Telemedicine pulmonary intensivist consultations were implemented for medical providers treating patients in the hospital to give advanced care to patients.
   — The Asante Sleep Center staff provides fittings and troubleshooting for mask PAP therapy equipment, PAP therapy education and sleep hygiene education to nearly 200 community members using these sleeping devices. Improving PAP therapy compliance and PAP therapy adoption should improve the health of patients with obstructive sleep apnea.
8. **Cancer**

- The breast cancer nurse navigator program was introduced in Josephine County to assist patients with pre-screening and qualifying for free mammograms. The nurse navigator also provides emotional support to patients during medical appointments, administers compassion funds, aids with government applications such as SSDI and coordinates referral to community agencies for basic needs.
- 3-D mammography technology was recently installed at the imaging center for enhanced detection of breast cancer.
- The Spears Cancer Center was recently remodeled, and technology was upgraded adding a new linear accelerator for improved detection and treatment of cancer.
- A wig bank was created to provide cancer patients and community members suffering from cancer with wigs at no cost.
- Each year, national breast cancer awareness month activities and education are provided to inform people of the services available for breast cancer treatment and support.
- With financial help from Asante Foundation, Asante provides low and no-cost preventive and diagnostic mammography for underinsured or uninsured community members.
- During National Colon Cancer Awareness Month, Asante providers promoted education and screening to community members.
- Meeting rooms are provided at no cost for community-based education and support groups for community members dealing with cancer and its associated medical conditions.

9. **Disability and health**

- Asante Physician Partners Neurology providers have recently been added to Grants Pass to meet the need for this specialty in Josephine County. Additional neurologists are being sought to meet the growing demand and ensure timely access to care.
- An interdisciplinary ALS clinic is being developed for community members from Southern Oregon and Northern California who are diagnosed with ALS. Clinics address the needs of the people regarding equipment, home safety, medications, communication devices, wheelchairs, adaptive devices, pain management, nutrition and helping with grief and family member education.

10. **Injury and violence prevention**

- The hospital funds specialized training for Sexual Assault Nurse Examiners. These specially trained nurses perform sexual assault exams at no cost to the patient.
- Licensed clinical social workers are being hired at Asante medical clinics in Grants Pass to help victims of abuse.
- Asante partners with the American Red Cross to provide Prepare Out Loud earthquake and disaster preparedness events in Josephine County. These events provide no-cost education about medical preparedness and steps to take to reduce the impact of disasters.
— Asante provides clothing, sleeping gear and cold weather supplies for low-income patients who have inadequate clothing, housing or heat.

— Asante will partner with Kohl’s Cares to provide educational PSAs supporting children’s safety that will be aired on local radio, tv and movie theatre screens.

11. **Tobacco use**

— The Asante tobacco use policy was revised to restrict hospital-inpatient tobacco use to nicotine patches and gum to promote better health. Smoking cessation education is also provided.