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Providence Medford Medical Center

Community Health Needs Assessment

2016

Medford, Oregon

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PROVIDENCE
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Community Health Needs Assessment Executive Summary

Providence Medford Medical Center

Creating healthier communities, together

As health care continues to evolve and systems of care become more complex, Providence is responding with dedication to its Mission and a core strategy to *create healthier communities, together*. Partnering with many community organizations, we are committed to addressing the most pressing health needs in our community. In southern Oregon, Providence proudly serves the community anchored by Providence Medford Medical Center. Our 168-bed hospital is situated in Jackson County and provides an array of services including primary care, surgical services, obstetrics and gynecology, diagnostic imaging, pediatrics, intensive care, and emergency care.

Our starting point: Gathering community health data and input

Through a formal community health needs assessment, Providence identified several key areas of need for Jackson County:

- **28 percent of adults suffer from depression**
- **37 percent of survey respondents are overweight or obese**
- **Hypertension continues to be the top reason vulnerable adults come to the Emergency Department**
- **Nearly 43 percent of survey respondents have experienced three or more adverse life events**
- **Approximately one in three people are covered by the Oregon Health Plan (Medicaid)**

These findings are guiding development of collaborative solutions to fulfill unmet needs for some of the most vulnerable groups of people in communities we serve. Our work is also informed by population demographics. Jackson County, home to nearly 186,000 people, is currently 77.5 percent white non-Hispanic, and by 2021 is expected to be about 75 percent white non-Hispanic, with 18 percent growth amongst the Hispanic/Latino population. About 20 percent of the population is age 65 or older, compared to the national average of about 15 percent.

Identifying top health priorities, together

Several information sources were used for this report, including: state and county public health data; hospital utilization data; a community health survey; key stakeholder interviews; and community listening sessions.

Providence top priority health needs for 2016-2018

Access to care
Behavioral health
Chronic conditions
Social determinants of health and well-being

Community health measures in 2016

Prioritized need	Measures for 2016
Access to care	▪ 35 percent of survey respondents said cost is a major barrier in accessing needed medical services ▪ Nearly 25 percent of the population is enrolled in Medicare ▪ Dental conditions are the most common reason uninsured adults visit the Emergency Department
Behavioral health	▪ 28 percent of adults suffer from depression ▪ Access to timely, affordable and local substance use treatment ▪ Over 42 percent of survey respondents have experienced three or more adverse life events
Chronic conditions	▪ Nearly 30 percent of adults are obese ▪ Hypertension and diabetes are the top two reasons vulnerable adults use the Emergency Department ▪ Access to healthy, affordable food
Social determinants of health and well-being	▪ Homelessness/affordable housing were top needs identified; there is currently a 1 percent rental vacancy rate ▪ Many families struggle with a lack of living wage jobs and access to affordable child care

Measuring our success: Results from our 2013 CHNA

This report also evaluates results from our most recent CHNA in 2013. Identified prioritized needs were: access to preventive and primary care; mental health and substance use treatment services; chronic conditions prevention and management; and oral health. Providence responded by making investments of time, resources and funding to programs that were most likely to have an impact on these needs. This summary includes just a few highlights from across Jackson County.

Name	Type of program	Outcomes	Our support
Project Access NOW	Patient support program	650 individuals served in Jackson County since 2015	Funding, co-development of referral platform
St. Vincent de Paul	Urban Rest Stop; Medical Teams Intl mobile dental vans	Over 11,000 clients served with shower and laundry services; 14 dental van days w/ 168 clients	Grant funding and coordination
Rogue Community Health	Community health worker/Latino outreach	Over 7,000 patient touches (310 home visits), and 796 individuals enrolled in health insurance	Grant funding

This assessment helps and guides our community benefit investments, not only for our own programs but also for many nonprofit partners. Please join us in making our communities healthier.

Assessment Overview

This document serves as an interim Community Health Needs Assessment for Providence's Southern Oregon Service Area. In partnership with the Jefferson Regional Health Alliance, a shared Community Heath Assessment will be recommended to participating members in Spring 2017. It is not expected that key findings included here will change, though additional information may come to light and focus areas adjusted accordingly.

Prioritized Need #1 – Access to care

Including primary care, dental care, and culturally-responsive services.

Data Point	Previous CHNA	Current CHNA
Population to primary care provider	1,077:1	1,110:1
Insurance coverage (percent uninsured)	16 percent	4.3 percent
Unmet needs due to worry about cost	Not available	34.9 percent
Dental conditions (Emergency Department Visits)	740 visits	572 visits

Prioritized Need #2 – Behavioral health

Including mental health and substance use services and trauma/adverse experience prevention.

Data Point	Previous CHNA	Current CHNA
Adults with depression	Not available	27.9 percent
Access to mental health providers	552:1	370:1
Suicidal ideation among 11th grade students	14.4 percent	17.5 percent
Trauma/adverse life event prevalence	Not assessed	64.5 percent

Prioritized Need #3– Chronic conditions

Including diabetes, hypertension, obesity, and other life-course illnesses.

Data Point	Previous CHNA	Current CHNA
Hypertension in adults	29.0 percent	27.4 percent
Obesity in adults	20.7 percent	22.3 percent
Diabetes in adults	7.8 percent	8.3 percent

Prioritized Need #4– Social determinants of health and well-being

Including affordable housing, healthy food access, living wage jobs, and transportation

Data Point	Previous CHNA	Current CHNA
Fewer than two servings of fruit per day	Not assessed	45.7 percent
Fewer than two servings of vegetables per day	Not assessed	33.5 percent
Median household income	$44,142	$44,086

Acknowledgements
Summary of community input

We express our sincere gratitude to participants who provided feedback during the community health needs assessment and for our subsequent health implementation plan. Many attendees may have participated more than once in various meetings and community presentations.

This section describes how the hospital took into account input from persons who represent the broad interests of the community. It summarizes in general terms input provided, including how and over what time period such input was provided.

Summary of CORE Community Health Survey

Providence's Community Health Division contracted with the Center for Outcomes Research and Education (CORE) to conduct a Community Health Survey as part of this CHNA. Jackson County Public Health provided feedback and requested additional questions added, as well as purchased additional surveys in Jackson County. The survey was mailed to 1,125 households in Jackson County based on a random sample of residential addresses. The survey included questions relating to health behaviors, health care access, barriers to care, social cohesion, and others. 234 surveys were returned, a 24 percent response rate. Based upon the self-reported demographics of respondents, a sample weight was applied to make responses representative of the county based on age distribution. A complete report of CORE's findings is included in Appendix I, with many of the findings from the survey highlighted in the following section.

The survey was also administered to 146 individuals who were accessing services at Jackson County Public Health in May and June 2016. Based upon the specific population sampled, these surveys were not weighted and results are reported separately.

Summary of key stakeholder interviews

Representatives from Providence met with leaders across Jackson County to conduct structured interviews in September and October 2016. These representatives included business owners, school representatives, social service agency leaders, and elected officials. These individuals were able to speak on behalf of the population they serve through their professional career and provide additional perspective on the most pressing needs of the community. A list of participants and the question guide are included in Appendix II.

Summary of community listening sessions

Over the course of the fall, Providence and ACCESS hosted community listening sessions. The purpose of these conversations was to provide an opportunity to hear directly from some of the most marginalized members of the county. These sessions were informal and assessed for key themes. There was no transcription, recording, or statistical qualitative analysis conducted. The key themes from these sessions are highlighted in the Key Findings section of this report. A copy of the discussion guide is attached in Appendix III.

Summary of written comments

None received.

Introduction

Creating healthier communities, together

As health care continues to evolve, Providence is responding with dedication to its Mission and a desire to *create healthier communities, together*. Partnering with others of goodwill, we conduct a formal community health needs assessment to learn about the greatest needs and assets in our community, especially considering members of medically underserved, low-income, and minority populations.

This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners, toward improving the health of entire populations. Through strategic programs and donations, health education, charity care, medical research and more, Providence Health & Services provided $848 million in community benefit across Alaska, California, Montana, Oregon and Washington during 2014.

Serving Jackson County

During 2015, our region provided $417 million in community benefit in response to unmet needs and to improve the health and well-being of those we serve in Oregon. In the Southern Oregon Service Area, which includes Jackson County, we provided $61.3 million.

Providence Medford Medical Center is a full-service, 168-bed, acute care, not-for-profit community hospital. Services offered include emergency services, stroke care, cardiac and vascular care, birth center, total joint replacement and spine health programs, robotic surgery, pain management services, and one of the most comprehensive rehabilitation programs in the region.

Providence also operates 18 medical clinics with more than 100 providers serving southern Oregon through Providence Medical Group,

Our Partners in the Community Health Needs Assessment

Jefferson Regional Health Alliance

The Jefferson Regional Health Alliance (JRHA) is a partnership of hospital, public health, and social service organizations. The partners have signed a Memorandum of Understanding with the intent to share findings from various Community Health Needs Assessment processes and the goal of having a shared set of priorities for the Southern Oregon region. The JRHA region includes both Jackson and Josephine counties in Oregon. Providence has included as much information as available at this time to meet publication requirements, and intends to continue working with JRHA to produce a shared regional assessment of needs through March 2017. At that point, the findings of the collaborative assessment will be adopted and partners will begin the shared process of community health improvement planning.

About us

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's combined scope of services includes 34 hospitals, 475 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started nearly 160 years ago when they answered a call for help from a new pioneer community in the West.

Our Mission

As people of Providence, we reveal God’s love for all, especially the poor and vulnerable, through our compassionate service.

Our Values

Respect, Compassion, Justice, Excellence, Stewardship

Our Vision

Simplify health for everyone

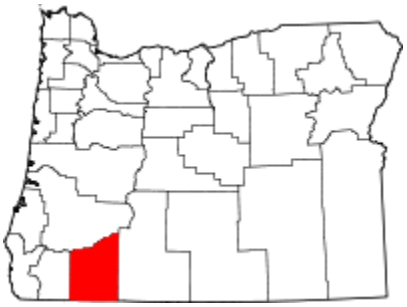
Our Promise

Together, we answer the call of every person we serve: Know me, Care for me, Ease my way. ®

Description of community

This section provides a definition of the community served by the hospital, and how it was determined. It also includes a description of the medically underserved, low-income and minority populations.

Providence Medford Medical Center serves primarily Jackson County in southern Oregon. The service area is defined based upon where our patients come from, market share, and surrounding geographies.

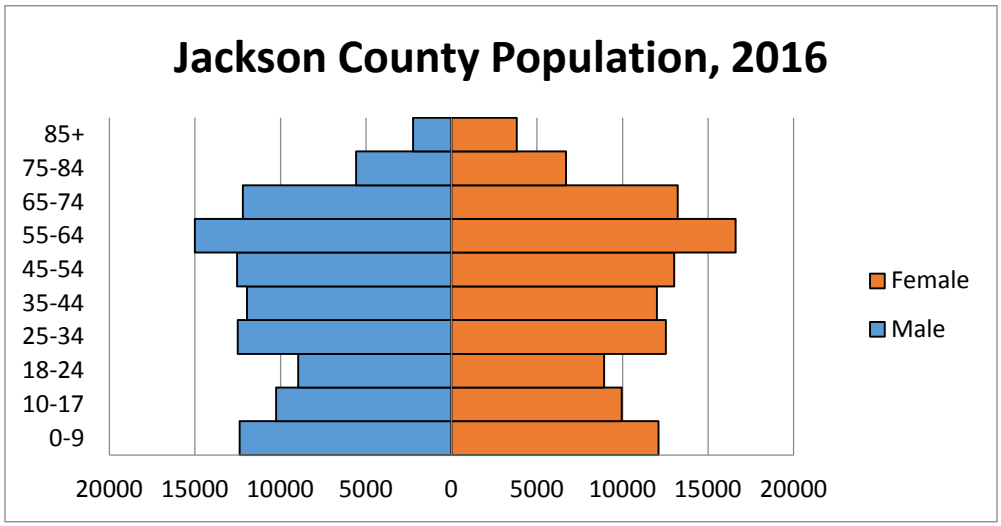


Community profile

Providence Medford Medical Center primarily serves Jackson County in southern Oregon. An area that includes the Rogue Valley, Jackson County and surrounding area is known for its agriculture, Rogue River, and the annual Shakespeare Festival in Ashland.

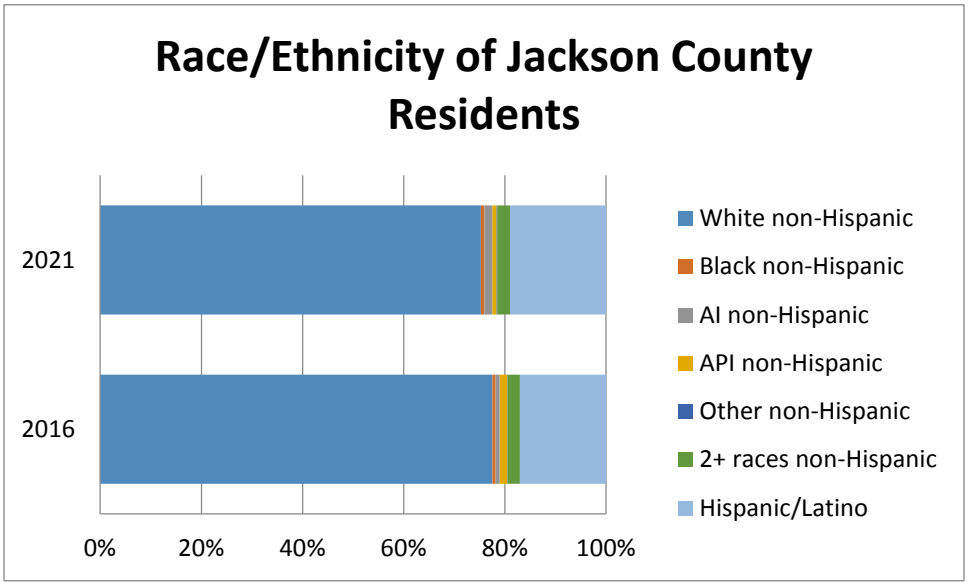
Population and age demographics

The population of Jackson County has a near-normal distribution. The ratio of males to females is 1:1 through the age of 55, when females begin making up a greater proportion of the total population. Due to life expectancy, females often outnumber males at older ages, but the trend starts slightly earlier in Southern Oregon than normal. Just over 20 percent of the population is 65 or older, a greater proportion than elsewhere in the country, where the average is 15 percent.



Ethnicity

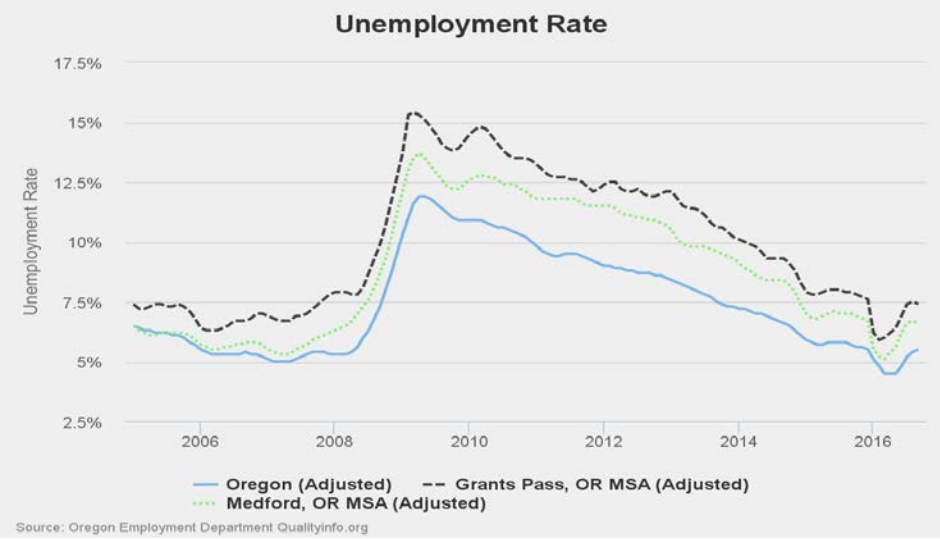
The vast majority of residents (77.5 percent) identify are White non-Hispanic. The second largest population group in Jackson County is individuals who identify as Hispanic/Latino, making up 17 percent of the population. The Hispanic/Latino population is expected to make up 19 percent of the total population by 2021, with the White non-Hispanic population slightly decreasing to approximately 75 percent of the total population.



Income levels and housing

As of 2016, Jackson County is home to approximately 213,000 residents. The area's median household income is $44,086 and the per capita income was below $25,000, slightly lower than the State of Oregon as a whole ($49,260 and $26,171, respectively). The current rental market has less than 1 percent vacancy.

The vast majority of jobs in the Rogue Valley area are in trade, transportation, and utilities. These industries paid just over $792,000,000 into the region in 2015 wages. Education and health services being the second most common category for jobs, providing nearly $910,000,000 in 2015 wages in Jackson and Josephine counties.



Process, participants and health indicators

This section provides a description of the processes and methods used to conduct the assessment; this section describes data and other information used in the assessment, the methods of collecting and analyzing the information, and any parties with whom we collaborated or contracted with for assistance. This section also provides a summary of how we solicited and took into account input received from persons who represent the broad interests of the community. This description includes the process and criteria used in identifying the health needs as significant.

Assessment process

Every three years, Providence conducts a community health needs assessment (CHNA). The CHNA is an evaluation of key health indicators in Jackson County. The assessment includes information from survey responses, key stakeholders, community listening sessions, hospital utilization, public health data, and other public data sets.

The Providence Mission reaches out beyond the walls of care settings to touch lives in the places where relief, comfort and care are needed. One important way we do this is through community benefit spending. Providence programs and funding not only enhance the health and well-being of our patients, but the whole community. Providence is committed to supporting broader determinants of health beyond clinical care. Providence's community benefit connects families with preventive care to keep them healthy, fills gaps in community services and provides opportunities that bring hope in difficult times.

When the Sisters of Providence began our tradition of caring nearly 160 years ago, their ministry greatly depended on partnering with others in the community who were committed to doing good. Today, we collaborate with social service and government agencies, charitable foundations, community organizations, universities and many other partners to identify the greatest needs and create solutions together.

Data collection

Primary Data (new)

This is information that was collected specifically for the purposes of this assessment.

Hospital Utilization Data

In order to help assess major barriers to care, the hospital looked at a list of diagnostic codes called "Ambulatory Care Sensitive Conditions" (ACSCs). These are conditions that should not require a hospital visit with improved access to primary care. Providence looked at all qualified diagnosed conditions for uninsured (self-pay) and Medicaid individuals using the Emergency Department between April 1, 2014 and March 31, 2015. These individuals had to have an address in Jackson County. This information is not generalizable to the full population as it is a specific sub-population with a specific set of diagnostic codes recorded, but it does provide important perspective into some of the conditions that could benefit from public service campaigns, partnership with Public Health, or other prevention activities.

Community Health Survey

Providence's Community Health Division contracted with the Center for Outcomes Research and Education (CORE) to conduct a Community Health Survey as part of this CHNA. Jackson County Public Health provided feedback and requested additional questions added, as well as purchased additional surveys in Jackson County. The survey was mailed to 1,125 households in Jackson County based on a random sample of residential addresses and included questions relating to health behaviors, health care access, barriers to care, social cohesion, and others. 234 surveys

were returned, a 24 percent response rate. Based upon the self-reported demographics of respondents, a sample weight was applied to make responses representative of the county based on age distribution. A complete report of CORE's findings is included in Appendix I, with many of the findings from the survey highlighted in the following section.

The survey was also administered to 146 individuals who were accessing services at Jackson County Public Health in May and June 2016. Based upon the specific population sampled, these surveys were not weighted and results are reported separately.

Key Stakeholder Interviews

Mary Stoneman, a contractor for Providence, met with leaders across Jackson County to conduct structured interviews in September and October 2016. These representatives included business owners, school representatives, social service agency leaders, and elected officials. These individuals were able to speak on behalf of the population they serve through their professional career and provide additional perspective on the most pressing needs of the community. A list of participants and the question guide are included in Appendix II.

Community Listening Sessions

Over the course of the fall, Providence and ACCESS hosted a community listening session. The purpose of the conversation was to provide an opportunity to hear directly from some of the most marginalized members of the county. These sessions were informal and assessed for key themes. There was no transcription, recording, or statistical qualitative analysis conducted. Participants received a $25 gift card in appreciation for their time. The key themes from these sessions are highlighted in the Key Findings section of this report. A copy of the discussion guide is attached in Appendix III.

Secondary Data (existing)

Secondary data is information that has already been collected and analyzed by others for reasons other than this needs assessment. Sources of secondary data include Jackson County Public Health data and information, information from the Coordinated Care Organizations' most recent Community Health Assessment, and other public data sources such as the Annie E. Casey Foundation Kids COUNT, Rogue Valley Metropolitan Planning Organizations, and Southern Oregon Health Equity Coalition. A key resource for secondary data was the Jackson County Oregon Gap Analysis by Total Care Solutions, which was focused on mental and behavioral health services in the county.

Identification of significant health needs

The previous section notes the various forms of information that were taken into account during this assessment. As much as possible, qualitative and quantitative data were treated equally. We saw the opportunities to use interviews and listening sessions to validate the quantitative data, as well as help point us to other information we might like to explore. All topics that were presented in the key stakeholder interviews and community listening session were considered significant health needs. For quantitative data, significant health needs were those that had worsened over time, are worse than the state or national average, or have a disproportionate impact on those who are low-income, persons of color, or otherwise marginalized.

Health indicators and trends

The findings below are listed in alphabetical order; there is no prioritization based upon the way that they are listed. Based upon the information from the various sources of information described above, there are four major categories of unmet health need:

Access to care—primary care, dental care, and culturally responsive care

Behavioral health—including access to mental health and substance use treatment services, as well as adverse experience and trauma prevention

Chronic conditions—such as asthma, cancer, diabetes, obesity, and hypertension

Social determinants of health and well-being—including affordable housing, healthy food access, living wage jobs, and transportation

Access to care

This is a general category that includes access to many types of care based upon what we heard and learned through the Needs Assessment process.

Primary Care

Access to primary care has improved due to the expansion of Medicaid/OHP, and access to primary care providers per person is in line with the State average (1,110:1). Approximately one-third of the population are OHP members, and nearly one-quarter are on Medicare. According to County Health Rankings, 25 percent of the adult population and 6 percent of children remain uninsured. However, a February 2015 study by Oregon Health & Science University (OHSU), *The Impact of the Affordable Care Act on Insurance Coverage in Oregon*, estimates that the uninsured rate in Jackson County is only 4.3 percent. This discrepancy may be due in part to a high number of non-citizen residents. Nearly 30 percent of individuals who responded to the Community Health Survey through Jackson County Public Health were uninsured, including nearly 45 percent of respondents who identified as Hispanic/Latino.

Medicare beneficiaries that responded to the mail survey were significantly more likely to get all of the care they needed compared to privately insured, Medicaid, and remaining uninsured. For most respondents (34.9 percent), the primary barrier was cost. This barrier was consistent for surveys administered through Jackson County Public Health.

Of the hand-fielded survey respondents, 20.5 percent reported not having a usual source of care. Hispanic/Latino survey respondents were less likely to have a place for care when it is not an emergency, and were also less likely to have a personal doctor. Individuals at or below 200 percent Federal Poverty Guideline (FPG) were significantly less likely to have a personal doctor than those at or above 201 percent FPG.

2016 Federal Poverty Guidelines			
Household Size	100% FPG	200% FPG	201% FPG
1	$ 11,880	$ 23,760	$ 23,879
4	$ 24,300	$ 48,600	$ 48,843

Dental Care

There is very little public health data available regarding oral health needs, but dental conditions remain one of the top reasons adults are accessing the Emergency Department, and the top reason for uninsured adults using the Emergency Department of the diagnosed conditions assessed. Nearly 20 percent of mail survey respondents reported having to go without needed dental care in the past

year due to cost concerns (36 percent who identified as Medicaid or uninsured), and 33 percent of locally administered survey respondents. A 2015 study conducted by Oregon Health & Science University found that dental caries (cavities) is the top chronic condition for children in the state and one of the most common causes of school absence. Additionally, participants in the key stakeholder interviews noted that timely access to dental care, particularly for OHP clients, continues to be a challenge.

Culturally responsive care

There is a continued need for culturally competent care within Southern Oregon, including training in trauma-informed care and implicit bias. This finding was highlighted through key stakeholder interviews and the Southern Oregon Health Equity Coalition's report. While these disparities reflect specific areas of need discussed throughout this assessment, stakeholders and listening session participants reported a relatively small number of Spanish-speaking providers in the community.

The Southern Oregon Health Equity Coalition (SOHealth-E) noted disparities related to poverty rates, access to health insurance, mental health, oral health, weight and physical activity, and teen pregnancy rates among the Latino community. Based upon information from the Oregon Healthy Teens survey among 8th and 11th grade students, many indicators were higher among Jackson County Latino youth than they were compared to Jackson County non-Hispanic White and statewide averages. These youth were more likely than their non-Latino counterparts to have used alcohol in the past 30 days, changed schools in the past year, report having been harassed at school, and report suicide attempts in the past year.

A lack of cultural competence was also recognized through Total Care Solutions' mental health gap analysis, which noted that for both mental health services and substance use services, consumers were substantially less likely to feel their provider was sensitive to the consumer's cultural background than providers thought they were.

Behavioral health

Mental Health Services

While access to care is an issue for mental health services, this is called out specifically due to the magnitude of the challenge and level of information available. Some key results from the Community Health Survey are included in the table below regarding diagnosed health conditions:

Diagnosed Condition	Mailed Survey	Locally Administered
Depression	18.1 %	40.1 %
PTSD	6.5 %	21.9 %
Anxiety	19.3 %	38.7 %
At least one behavioral health condition	25.5 %	52.6 %

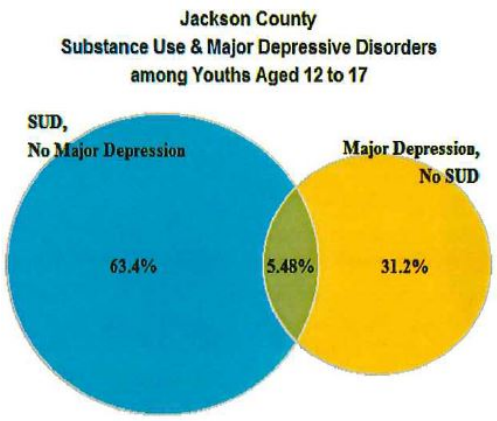
The Community Health Survey identified 10.7 percent of respondents currently experiencing symptoms of depression and 9.9 percent experiencing anxiety. The prevalence of anxiety symptoms varied significantly based on income, with nearly 30 percent of individuals below 200 percent FPG currently experiencing symptoms compared to 5.2 percent of individuals at or above 201 percent FPG. For respondents through Jackson County Public Health programs, 24.6 percent of respondents were experiencing symptoms of anxiety and 15.7 percent were experiencing depression, both of which were significantly higher for individuals living at or below 200 percent FPG.

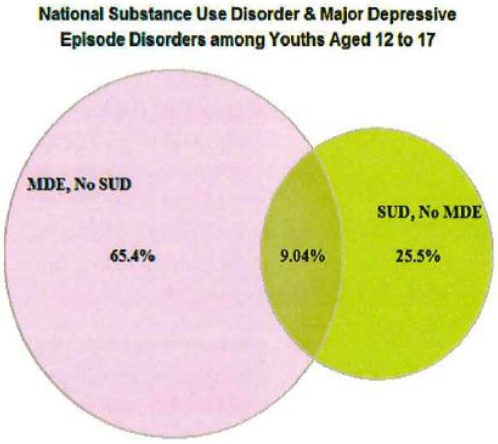
For mail survey respondents, 6.7 percent reported needing care but not getting all the care they needed, with 30 percent reporting both cost and time to get an appointment as the major access barriers.

The Total Care Solutions gap analysis identified 250 mental health providers serving the County, including 155 qualified mental health professionals, 74 qualified mental health associates, and 9 peer support specialists. Key stakeholders expressed specific need for children's mental health services, as there are few pediatric mental health providers.

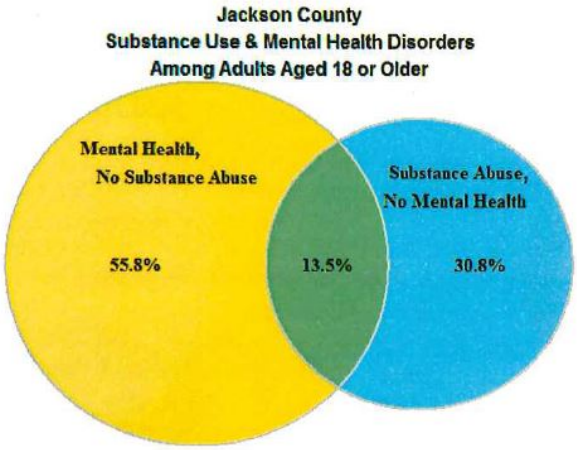
Substance use services

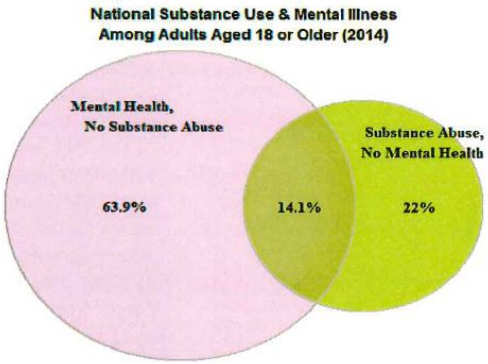
The following graphs are from Total Care Solutions' "Jackson County Oregon Gap Analysis Executive Report" and demonstrate the cross over between mental health and substance use in adults, and major depression with substance use disorders in youth aged 12-17. These challenges are frequently co-occurring, as highlighted by the shared circles in the middle of the diagrams.





Jackson County youth are far more likely to have substance use disorders without major depression than corresponding national trends.





Adults in Jackson County are also more likely to have substance use disorders without a mental health disorder than corresponding national trends.

Adverse Life Experiences and Trauma

The Community Health Survey was one of the first tools to be able to provide information on the prevalence of trauma exposure in Jackson County. Adverse experiences and exposure to trauma at any point in the life-course, particularly childhood, are known to impact health outcomes, educational attainment, chronic conditions, and likelihood of substance use. Some of the responses are highlighted in the table below, with full response information included in Appendix I.

Adverse Experience	Mailed Survey	Locally Administered
Life-changing illness or injury	45.4 %	42.8 %
Lived with someone with mental illness or substance abuse	33.1 %	43.5 %
Witnessed or experienced violence	27.8 %	47.1 %
At least one traumatic event	64.5 %	71.7 %
3 or more traumatic events	26.7 %	42.8 %

Chronic conditions

Chronic conditions is a broad category of need that is influenced by environment and individual health behaviors.

Asthma

Asthma continues to be one of the top reasons for children to access the emergency department. Adults in Jackson County have asthma at approximately the same rate as the state average of 10.3 percent per Oregon Behavioral Risk Factor Surveillance Survey (BRFSS). Of course, substandard housing and environmental factors can aggravate asthma in children and adults, directly connecting these challenges to those of social determinants of health and well-being as discussed in a later section.

Cancer

Cancer is more common in Jackson County than it is elsewhere in the state, with approximately 10.6 percent of the population having some form of cancer (BRFSS). The age-adjusted rate across Oregon is 8.5 percent. This higher rate is likely influenced by health behaviors, environmental factors, and the relative high proportion of elderly adults in the area.

Diabetes

Diabetes, particularly Type II diabetes, remains one of the top preventable reasons individuals are accessing care at the emergency department. The Oregon Behavioral Risk Factor Surveillance Survey (BRFSS) found that between 2010 and 2013, 8.3 percent of Jackson County residents had diabetes. In Oregon, the age-adjusted average is 8.2 percent. 10.2 percent of mail survey respondents reported that they had been diagnosed with diabetes, with the highest diagnosis rate amongst Medicare beneficiaries. For those who answered the survey through Jackson County Public Health, nearly 15 percent reported having been diagnosed with diabetes.

Obesity

Over half of all mail respondents were either overweight or obese (22.8 percent obese), as were two-thirds of hand-fielded survey respondents (37 percent obese). However, BRFSS data shows that Jackson County has below-average rates of obesity for the state. Although Jackson County is below the state average in proportion of the population that is obese, due to the burden of disease and complications that can be attributed to obesity it is important that this trend line continue downwards. State and national data suggest disparities based on income and ethnicity, and we assume the same is true in Jackson County despite not having local data available. This issue also emerged during key stakeholder groups, with particular attention towards preventing obesity in children and adolescents.

Hypertension (high blood pressure)

Based upon the hospital utilization information reviewed, hypertension was the most frequent reason Medicaid, uninsured, or dual eligible adults came to the emergency department, with many people

presenting more than once during the study period. 27.1 percent of mail survey respondents reported having been told by a doctor that they had high blood pressure, with the highest rates among Medicare beneficiaries and White non-Hispanic populations.

For those who answered the survey through Jackson County Public Health programs, 21.9 percent reported having been diagnosed with hypertension. This was highest among the White non-Hispanic population, and disproportionately impacted low-income populations and seniors: 26.4 percent of those at or below 200 percent FPG and 55.6 percent of those on Medicare.

Social determinants of health and well-being

This is a broad category that looks at the environment and other factors that help keep people well. The social determinants of health is a model for looking at opportunities for health and wellness wherever people live, work, learn, and play. These issues are generally referred to as “upstream” solutions, in that they help keep people well and can help prevent chronic illnesses.

Affordable housing

The primary issue raised in the key stakeholder interviews and listening session was availability of safe, affordable housing. Interviewees mentioned a 1 percent rental vacancy rate in the Medford area, which creates challenges for individuals at all income levels. Over 9 percent of mail survey respondents reported having housing but were worried about losing it, and 5 percent reported not having stable housing. For hand-fielded survey respondents, 15.6 percent reported having housing but being worried about losing it, and nearly one-third of respondents said they did not have stable housing. This was particularly true for individuals and families at or below 200 percent FPG.

Healthy food access

Survey respondents and listening session participants indicated that healthy food access remains a challenge for many households in Southern Oregon. 45.7 percent of mail survey respondents reported having fewer than two servings of fruit per day and one-third reported having fewer than two servings of vegetables per day. Nearly 30 percent of respondents had fast food two or more times per week. Key stakeholders that participated in interviews noted that food affordability was particularly challenging in rural areas.

Hand-fielded survey respondents had these experiences more commonly than their mail-respondent counterparts. Nearly 60 percent of these survey respondents reported having fewer than two servings of fruit per day, and over 51 percent reported having fewer than two servings of vegetables. About one in four respondents reported having fast food two or more times per week, which was most common amongst White non-Hispanic respondents. Additionally, nearly 32 percent of hand-fielded survey respondents reported having to go without food in the past year in order to “make ends meet.”

Living wage jobs

This topic includes challenges related to affordable child care for working families, high school graduation, and access to vocational training.

One of the challenges that became apparent was a lack of access to living wage jobs for people who wanted to work. While people felt that there were some jobs available, very few of them paid an hourly rate that covered the costs of basic needs, and even fewer that carry benefits. In the Jackson County Jobs Report in October 2016, the unemployment rate was 6.6 percent and there were approximately 86,000 non-farm jobs. The State of Oregon Employment Department notes that the shortage of workers qualified to work in manufacturing jobs may be a more important factor than technology or outsourcing in the current job market.

Listening session participants explained that even if they could get a job, finding affordable child care was a major barrier. Key stakeholders also recognized affordable childcare as a major need for OHP members. This challenge was also echoed by individuals who were looking to go back to school or complete vocational training as they were not eligible for employment-related day care benefits.

Transportation

Transportation was another common basic need that survey respondents cited as having to go without in order to “make ends meet.” 34 percent of hand-fielded survey respondents noted having to go without transportation, including 35 percent of those under 200 percent FPG and 75 percent of Medicare beneficiaries. For mail survey respondents, 27.4 percent of those under 200 percent FPG and 19 percent of individuals in the Medicaid/uninsured/dual eligible category reported having to go without transportation.

The Rogue Valley Metropolitan Planning Organization (RVMPO) conducted a transportation assessment in 2016 for traditionally underserved populations, including low-income, minority, and senior populations. Based upon current infrastructure and public transit routes, they identified opportunities for improved transit in Ashland, Talent, Phoenix, SE Medford, SW Medford, Central and West Medford, Central Point and North Medford, White City, and Eagle Point. Major concerns expressed included cost, timing of transportation, lack of overlapping routes, and more weekend services.

Key geographies of concern for low-income populations include Ashland, Medford, and White City. Medford and White City were also identified as key areas of concern for minority populations. For senior populations, areas of concern were Talent, Phoenix, and SE Medford.

Identified priority health needs

This section describes the significant priority health needs that were identified during the CHNA. This section also describes the process and criteria used to prioritize the needs. Potential resources in the community to address the significant health needs are also described in the section.

Prioritization process and criteria

Based upon the various sources of information in this assessment, items that were corroborated by two or more sources were identified as priority health needs. These needs were then grouped into four actionable categories, which will guide our efforts in developing the Community Health Improvement Plan. Due to the nature of initial identification of needs, this prioritization included worsening trends, values worse than state averages, and a disproportionate impact on communities of color, low-income, or otherwise marginalized groups.

Additional prioritization regarding feasibility, effectiveness of interventions, and ability to partner with community organizations will be applied during CHIP development.

Priority health issues and baseline data

Priority Health Issue	Rationale/contributing factors
1. Access to care	20.5 percent of survey respondents do not have a usual place of care 20 percent of mail survey respondents went without needed dental care, as did 33 percent of hand-fielded survey respondents Few Spanish speaking providers available in community
2. Behavioral health	25 percent of mail survey respondents have a diagnosed behavioral health condition, as do 53 percent of hand-fielded survey respondents Persistent need for medication assisted treatment There is broad exposure to adverse life events, including 43 percent of survey respondents who experienced 3 or more adverse events
3. Chronic conditions	1,204 adults visited the Emergency Department 1,974 times in a 12-month period with hypertension 640 adults visited the Emergency Department 1,182 times in a 12-month period with Type II Diabetes
4. Social determinants of health and well-being	Median household income in Jackson County is $5,000 below Oregon's median household income There is less than 1% rental vacancy rate Healthy food access remains a challenge, particularly in rural parts of the county

Addressing identifed needs

This section describes how Providence will develop and adopt an implementation strategy (i.e. community health improvement plan) to address the prioritized community needs.

Plan development

Providence will consider the prioritized health needs identified through this community health needs assessment and develop a strategy to address each need. Strategies will be documented in a community health improvement plan (CHIP). The CHIP will describe how Providence plans to address the health needs. If Providence does not intend to address a need, the CHIP will explain why[1].

The CHIP will describe the actions Providence intends to take to address the health need and the anticipated impact of these actions. Providence will also identify the resources the hospital plans to commit to address the health need. Because partnership is important to addressing health needs, the CHIP will describe any planned collaboration between Providence and other facilities or organizations in addressing the health need.

The improvement plan will be approved by the Providence Community Ministry Board by May 15, 2017. When approved, the CHIP will be attached to this community health needs assessment report in Appendix V.

Providence prioritized needs

Once the collaborative CHNA is completed for JRHA, Providence will work with partners to identify opportunities to leverage and combine resources to meet the identified needs. While there are many sub-categories listed above, Providence will address at least one need in each of the major areas identified:

Providence prioritized needs
1. **Access to care** 2. **Behavioral health** 3. **Chronic conditions** 4. **Social determinants of health and well-being**

[1]Reasons may include resource constraints, other facilities or organizations in the community addressing the need, a relative lack of expertise or competency to address the need, the need being a relatively low priority, and/or a lack of identified effective interventions to address the need.

Evaluation of impact from 2014-2016 Community Health Improvement Plan

This section evaluates the impact of actions that were taken to address the significant health needs identified in the prior community health needs assessment and associated implementation strategy (i.e. community health improvement plan).

Following the prior CHNA, Providence collaborated with community partners to develop a community health improvement plan (CHIP) to address the needs identified below. The top health issues for the 2014-2016 CHNA/CHIP were:

1. Access to preventive and primary care
2. Mental health and substance use treatment services
3. Chronic conditions prevention and management
4. Oral health

The culture of Providence supports caregivers being engaged in their communities in variety of ways. The following is an overview evaluating some of the CHIP efforts and their impact on the identified needs.

Prioritized Need #1: Access to preventive and primary care

Data Point	Previous CHNA	Current CHNA
Population to primary care provider	1,077:1	1,110:1
Insurance coverage (uninsured)	16 percent	4.3 percent
Unmet needs due to worry about cost*	17.3 percent	34.9 percent

**Surveys were weighted differently; these results are not directly comparable.*

Providence has invested in its Medical Group to increase provider access in Southern Oregon, including access to specialty services. Providence was an active supporter of insurance enrollment efforts through Medicaid expansion and continues its commitment to serve the poor and vulnerable by offering fully-discounted care for families at or below 300 percent FPG, access to financial counselors, and certified insurance enrollment assisters. Providence has located a low-cost express care clinic on-site as an alternative to more expensive emergency department services.

In partnership with community organizations, Providence continues to expand access to primary care services. La Clinica and Rogue Community Health operate federally-qualified health centers in southern Oregon and receive financial and in-kind imaging assistance from Providence. In the past three years, both organizations have been able to increase their breadth of programs offered as well as number of individuals served.

Prioritized Need #2: Mental health and substance use services

Data Point	Previous CHNA	Current CHNA
Adults with depression	Not available	27.9 percent
Access to mental health providers	552:1	370:1
Suicidal ideation among 11th grade students	14.4 percent	17.5 percent

Providence continues to support internal efforts to include integrated behaviorists in primary care,

currently serving two clinic locations. Other efforts include funding partnerships with Addictions Recovery Center to support the medically supervised detox program that serves over 250 individuals each year, On Track for a Latina youth suicide prevention effort in partnership with Life ART that reached100 youth with intensive programming and anti-bullying education to over 2,000 students, and job training and assistance through Compass House, which provided 48 mentally-ill adults with supportive services.

Prioritized Need #3: Chronic conditions prevention and management

Data Point	Previous CHNA	Current CHNA
Hypertension in adults	29.0 percent	27.4 percent
Obesity in adults	20.7 percent	22.3 percent
Diabetes in adults	7.8 percent	8.3 percent

Providence Medical Group has invested in increased efforts to prevent, manage, and support patients with chronic conditions who are accessing primary care services. These efforts include increased screening, tracking, and referral to services for those who are at-risk or have been diagnosed. Providence has also increased access to local cancer care services, seeking to serve more patients in their community rather than traveling for treatment.

Again, Providence has partnered with other organizations that provide chronic disease prevention and management programs. One of these is Rogue Community Health, which has been operating an Integrated Health & Wellness program, providing home visits and community health worker outreach. The community health workers have provided over 7,000 patient touches, including 310 home visits and enrolling 796 individuals in health insurance. Nearly 30 percent of participants have successfully reduced uncontrolled blood sugar levels. Other funded partners include local YMCA programs for senior health and wellness, as well as ACCESS and St Vincent de Paul to improve healthy food access.

Prioritized Need #4: Oral health

Data Point	Previous CHNA	Current CHNA
Dental conditions (Emergency Department Visits)	740 visits	572 visits
Medical Teams Intl Dental Van	9.3 visits/van	9.3 visits/van

Providence is not a dental services provider, but has engaged in provider training regarding oral health challenges and supported local partners to expand their dental care programs. These partners include St. Vincent de Paul and Medical Teams International mobile dental program, which has provided dental care and relief to about 65 patients each year in Jackson County. Providence supported La Clinica to expand its dental health programs, and in 2016 committed funding to support Rogue Community Health's dental outreach efforts in the upper Rogue Valley.

Resources potentially available to address the significant needs identified through the CHNA

This section inventories community partners that are addressing the identified needs in the CHNA. This table begins to outline our strategy of creating healthier communities together.

Providence and partners cannot address the significant community health needs independently. Improving community health requires collaboration across community stakeholders. Below outlines a list of community resources potentially available to address identified community needs.

While this assessment is focused on finding and prioritizing needs within the community, it is important to also recognize the strengths, assets, and resources. In each of the listening sessions and interviews, participants were asked to share what they know is already working, programs they are proud to have in their community, and partnerships they think should be developed further. This list is not exhaustive and will be added to throughout the Community Health Improvement Planning process.

Organization or Program	Description	Associated Community Need
ACCESS	Local Community Action organization	Social determinants
Addictions Recovery Center	Residential, outpatient, sobering services, and supervised medical detox programs	Behavioral health
Compass House	Building dignity and community for adults with mental health issues	Behavioral health, Social determinants
Jackson County Health and Human Services	Public health, mental health programs, disability, and veterans programs	Access to care, Behavioral health, Social determinants
Kids Unlimited	Extended day curriculum for full-time and after school students	Social determinants
La Clinica	Federally-qualified health center	Access to care, Behavioral health
Rogue Community Health	Federally-qualified health center	Access to care, Behavioral health
Rogue Valley Metropolitan Planning Organization	Local transportation planning organization, including preferential services for underserved populations	Social determinants of health and well-being
St. Vincent de Paul	Programs include mobile dental services, meals, and urban rest stop program	Social determinants of health and well-being
United Way of Jackson County	Education, income, health, and transportation programs, including “Big Idea” schools to increase high school graduation	Social determinants of health and well-being
YMCA	Access to local activity and recreation programs, including chronic conditions prevention	Chronic conditions, Social determinants

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PROVIDENCE
Health & Services

16 December 2016

Providence's Southern Oregon Service Area Advisory Council has reviewed and approved the findings of the 2016 Community Health Needs Assessment.

Signed:

Cindy Mayo
Chief Executive, Providence Medford Medical Center

Joel Gilbertson
Senior Vice President, Community Partnerships, Providence Health & Services

Appendices

Appendix I – CORE Community Health Survey

COMMUNITY HEALTH SURVEY 2016: SOUTHERN OREGON SERVICE AREA

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EXECUTIVE SUMMARY (continued)

The mail survey revealed disparities in health status, access to care, and social determinants. The hand-fielded survey data includes a greater proportion of responses from individuals in the Hispanic/Latino/Other category, those in the Medicaid/Other/Uninsured category, and low-income respondents. With these additional responses from priority populations, the hand-fielded survey data revealed even greater disparities than the mail survey data. Some of the more significant disparities are reported below.

DISPARITIES—MAILED SURVEY		DISPARITIES—HAND-FIELDED
Medicare respondents reported a higher prevalence of diabetes, high blood pressure, and high cholesterol than other groups and were more likely to have at least one physical health condition. Respondents with lower income reported higher rates of anxiety symptoms than those with incomes above 200% FPL. Low-income respondents were also more likely to be obese.	HEALTH STATUS	39.8% of low-income respondents report fair or poor health, compared to 14.3% of those with incomes above 200% FPL. Non-Hispanic whites were more likely to report a chronic disease diagnosis than those in the Hispanic/Latino/Other category; disease prevalence was also higher among low-income respondents and Medicare respondents.
Respondents with Medicare and private health insurance were more likely to have a personal doctor than those in the Medicaid/Other/Uninsured category. Medicare respondents had lower rates of unmet health care needs.	ACCESS TO CARE	Those in the Hispanic/Latino/Other category were less likely to have a usual place of care and less likely to have a personal provider. Low-income respondents were less likely to have a personal provider. Those in the Hispanic/Latino/Other category were less likely to need care. Non-Hispanic whites were more likely to report unmet need for behavioral health care.
Low-income respondents and those in the Medicaid/Other/Uninsured were more likely to report going without basic needs. Non-Hispanic whites were more likely to report adverse life experiences than those in the Hispanic/Latino/Other category.	SOCIAL DETERMINANTS	Low-income respondents were more likely to report going without basic needs. They were also less likely to have secure housing and less likely to have sufficient social support. Non-Hispanic whites were more likely to report adverse life experiences than those in the Hispanic/Latino/Other category.

RECOMMENDATIONS

Several community needs appear to cross all populations. The lack of a primary care provider could be addressed by increasing the number of providers and doing community engagement work to enroll people in medical homes. Housing insecurity could be addressed by increasing availability of low-income housing and providing protections to tenants. Trauma-informed care continues to be of necessity across the community.

Low-income communities, however, need special support. Improving access to behavioral health care could have a significant impact among low-income populations. Support meeting basic needs could also have an impact — special outreach may be required within the Hispanic/Latino community. Transportation solutions are important for low-income groups. Community-based wellness programming, geared towards increasing physical activity and improving access to healthy foods, could improve health across the community but could be of particular aid in low-income areas.

METHODS

This report summarizes results from a *community health survey*. The purpose of this survey was to assess health status and health needs throughout the community, including needs related to the social determinants of health. The survey was conducted by CORE in May—June 2016.

SURVEY DESIGN AND SAMPLE

The Community Health Division worked with CORE to design a base survey consisting of 36 questions. The team also created a list of 91 optional survey questions. Southern Oregon Service Area leadership, including Jackson County Public Health, Asante, and other members of the Jefferson Regional Health Alliance, selected an additional 21 questions to add to the survey. The added questions collected information about reasons for not having insurance, drug use, child emergency room use, neighborhood safety and traumatic events. Most survey items were selected from nationally validated tools; a copy of the survey is available in the appendix.

Spanish translation was performed by a certified translator. Surveys and invitation letters underwent plain-language review.

MAIL SURVEY. We used address-based sampling to capture a representative group of households in the community. Beginning with a list of all deliverable residential addresses in the community, we randomly selected 1,125 households to receive the survey. Because the survey used a random sample of households in the Southern Oregon Service Area, mail survey results should be broadly representative of health care needs for those who have addresses. We referred to Census data from 2010-2014 to identify zip codes where at least 10% of households reported that Spanish was spoken at home. Addresses within these zip codes received surveys in both English and Spanish. Of the 212 Spanish-language surveys mailed, none (0) were returned.

MULTI-STAGE MAIL SURVEY PROCESS

1 INITIAL AUTO CALL

For participants with valid phone numbers, we sent an automated phone message asking participants to look for the survey in the mail and call us with any questions.

2 INITIAL SURVEY

An initial survey was sent with a letter explaining the purpose of the study, the survey and a postage-paid return envelope and a $5 cash compensation. Areas with a high enough Spanish population also received a Spanish letter and survey.

3 SECOND AUTO CALL

A second automated phone message was sent to participants who did not return the initial survey and had a valid phone number informing them we did not receive their survey and we were sending a second one.

4 SECOND SURVEY

A second survey was sent to participants that did return the initial survey. Fielding closed on July 1st, 2016.

HAND-FIELDED SURVEYS. Hand-fielding of surveys was conducted through outreach in public health clinics, WIC program offices, and a nurse home visit program. The majority of surveys collected were through the public health clinic and WIC program, where clients were asked to participate in the survey when they checked into the clinic, and completed the survey while waiting in the lobby. There were 146 hand-fielded surveys completed, 32 of which were in Spanish.

EXECUTIVE SUMMARY

PROJECT OVERVIEW

This report gives an overview of results from the Southern Oregon Service Area community health survey. The Center for Outcomes Research and Education (CORE) fielded the surveys in May and June 2016. We sent the survey to a random sample of 1,125 households in the Southern Oregon Service Area; 264 surveys were returned, giving a response rate of 23.5%. An additional 146 hand-fielded surveys were collected. The survey was designed to assess community needs within five key domains of interest: Health Status, Access to Care, Social Determinants of Health, Trauma, and Health Behaviors.

KEY FINDINGS—MAILED SURVEY		KEY FINDINGS—HAND-FIELDED
14.4% of respondents report that they are in "fair" or "poor" health. Nearly half of all mail survey respondents (49.2%) report having a chronic physical condition. High blood pressure, high cholesterol, and asthma were the most commonly reported physical conditions. 25.5% reported at least one mental health condition. 31% are overweight and 22.8% are obese.	HEALTH STATUS	30.5% of respondents report that they are in "fair" or "poor" health. 44.5% of hand-fielded survey respondents report having a chronic physical condition. 52.6% report having a behavioral health condition. Depression (40.1%) and anxiety (38.7%) were the most common chronic conditions. 29.7% are overweight and 36.9% are obese.
6.3% of mailed survey respondents did not have health insurance. 80.1% had needed some kind of care in the last 12 months, and 18.4% had not gotten all the care they needed. 90.6% have a usual source of care, but 20.0% do not have a personal provider. Cost, inability to get an appointment quickly, and not having a regular provider were the most commonly cited barriers to care.	ACCESS TO CARE	26.7% of hand-fielded survey respondents did not have insurance. 69.1% had needed some kind of care in the last 12 months, and 17.3% had not gotten all the care they needed. 20.5% do not have a usual source of care, and 39.7% of respondents do not have a personal doctor. Cost, inability to get an appointment quickly, not having a provider, and transportation were common barriers to care.
10.9% of survey respondents indicated that they went without a social determinants-related need in the past 12 months. 14.1% report housing instability. 64.5% have experienced a traumatic event, and 26.7% have experienced three or more such events. 20.3% report not having someone to confide in or talk to about problems.	SOCIAL DETERMINANTS	46.2% of hand-fielded survey respondents indicated that they went without a social determinants-related need in the past 12 months. 46.8% report housing instability. 71.7% have experienced a traumatic event, and 42.8% have experienced three or more such events. 39.1% report not having someone to confide in or talk to about problems.

UNDERSTANDING MAIL VS. HAND-FIELDED RESULTS

The two surveys represent different populations. Mail survey respondents tend to be older, are less likely to be low-income, and more likely to be non-Hispanic and white than the general population. For that reason, the survey was hand-fielded among priority populations— including Spanish-speaking groups and low-income individuals. A side-by-side comparison of the two surveys is useful because they offer complementary pictures of two populations that overlap within the Southern Oregon Service area.

The hand-fielded survey depicts a population with lower income, greater difficulty meeting basic needs, a greater burden of behavioral health challenges, and greater challenges with access to care.

RESPONDENT DEMOGRAPHICS

The table below gives the un-weighted distribution of respondents to both the mail survey and the hand-fielded survey. Tables depicting respondent demographics continue on the next page.

RESPONDENT DEMOGRAPHICS	MAIL SURVEY		HAND-FIELDED SURVEY	
	%	NUMBER OF SURVEYS	%	NUMBER OF SURVEYS
GENDER				
Male	43.9%	116	20.5%	30
Female	54.9%	145	65.1%	95
Transgender	0.4%	1	1.4%	2
Did not answer	0.8%	2	13.0%	19
AGE				
18 to 39 years	10.6%	28	45.9%	67
40 to 64 years	40.2%	106	38.4%	56
65 to 79 years	34.8%	92	3.4%	5
80+ years	12.9%	34	0.0%	0
Did not answer	1.5%	4	12.3%	18
RACE & ETHNICITY				
White, non-Hispanic	89.0%	235	51.4%	75
Hispanic/Latino	3.8%	10	32.8%	44
Black or African-American	0.8%	2	0.9%	1
Asian	0%	0	0.9%	1
Native Hawaiian or Other Pacific Islander	2.0%	5	8.0%	9
American Indian or Alaska Native	0%	0	0.9%	1
Don't know/Not sure	0.4%	1	0%	0
PREFERRED LANGUAGE				
English	97.0%	256	65.1%	95
Other	0.8%	2	17.1%	25
Did not answer	2.3%	6	17.8%	26

RACE/ETHNICITY CALCULATIONS. Respondents could choose multiple races; categories are not exclusive. For ethnicity, respondents could choose Hispanic/Latino or not Hispanic/Latino. Results will not sum to 100%.

RESPONDENT DEMOGRAPHICS

The table below, continued from the previous page, provides the un-weighted distribution of respondents to both the mail survey and the hand-fielded survey .

RESPONDENT DEMOGRAPHICS	MAIL SURVEY		HAND-FIELDED SURVEY	
	%	NUMBER OF SURVEYS	%	NUMBER OF SURVEYS
HOUSEHOLD INCOME				
100% FPL or lower	12.1%	32	39.7%	58
101% to 200% FPL	9.5%	25	24.7%	36
201% FPL or higher	65.9%	174	19.9%	29
Did not answer	12.5%	33	15.8%	23
EDUCATION				
Less than high school	4.5%	12	19.9%	29
High school diploma or GED	34.5%	91	43.2%	63
Vocational or two year degree	23.9%	63	17.1%	25
4-year college degree or more	35.6%	94	7.5%	11
Did not answer	1.5%	4	12.3%	18
EMPLOYMENT STATUS				
Less than 20 hours per week	6.8%	18	6.8%	10
More than 20 hours per week	35.2%	93	33.6%	49
Retired	48.9%	129	1.4%	2
Unemployed	7.2%	19	45.2%	66
Did not answer	1.9%	5	13.0%	19

DIFFERENCES IN MAIL SURVEY AND HAND-FIELDED SURVEY POPULATIONS

The two sets of survey respondents are different in complementary ways. Respondents to the mail survey were more likely to be white, over the age of 65, retired, earn a higher income, and speak English at home. The hand-fielded survey respondents were more likely than mail survey respondents to be younger than 40 years old, be Hispanic, have less than college-level education, be unemployed, earn a lower income, and to speak a language other than English in the home.

METHODS

WEIGHTING OF RESULTS—MAIL SURVEY

Respondents to the mail survey tended to be older and less likely to be Hispanic, compared to the overall population (table below).

MAIL SURVEY RESPONDENTS

DEMOGRAPHICS	MAIL SURVEY RESPONDENTS	CENSUS ESTIMATE	DIFFERENCE		DEMOGRAPHICS	MAIL SURVEY RESPONDENTS	CENSUS ESTIMATE	DIFFERENCE
RACE & ETHNICITY (respondents could check both White and Hispanic)					**AGE**			
White	92.1%	92.1%	0%		18 to 39 years	10.6%	30.9%	-20.3%
Hispanic	3.8%	10.1%	-6.3%		40 to 64 years	40.2%	41.2%	-1.0%
					65 to 79 years	34.8%	19.9%	+14.9%
					80+ years	12.9%	8.0%	+4.9%

The age distribution of respondents is of particular concern for estimating prevalence of chronic health conditions in the population; to account for this, results presented for findings from the mail survey are adjusted using post-stratification weighting that allows for estimates to be representative of the population's true age distribution. We did not weight results based on race, ethnicity, or any factor other than age. All data tables for the mail surveys display the *weighted* percentages as well as the *actual* number of responses from which these percentages were computed.

HAND-FIELDED SURVEY RESPONDENTS COMPARED TO CENSUS DEMOGRAPHICS

Results for hand-fielded survey results could not be weighted, since the sample was not random. Therefore, data tables for the hand-fielded survey results present the *actual* number of responses received as well as the *actual* percentage of respondents who indicated each response. It should be noted, however, that respondents to the hand-fielded surveys were disproportionately younger, less likely to be white, and more likely to be Hispanic compared to census estimates**.**

HAND-FIELDED SURVEY RESPONDENTS

DEMOGRAPHICS	HF SURVEY RESPONDENTS	CENSUS ESTIMATE	DIFFERENCE		DEMOGRAPHICS	HF SURVEY RESPONDENTS	CENSUS ESTIMATE	DIFFERENCE
RACE & ETHNICITY (respondents could check both White and Hispanic)					**AGE**			
White	65.1%	92.1%	-27.0%		18 to 39 years	45.9%	30.9%	+15.0%
Hispanic	30.1%	10.1%	+20.0%		40 to 64 years	38.4%	41.2%	+2.8%
					65 to 79 years	3.4%	19.9%	-16.5%
					80+ years	0.0%	8.0%	-8.0%

ANALYSIS

We entered all data in tabular form and analyzed it with a statistical software package (SAS). To test for statistically significant differences between subgroups in our data, we used two-tailed chi-square tests of association, with a p-value of .10 or less flagged as "statistically significant." Where the chi square test was invalid due to small expected values, cells are shaded gray.

METHODS

REPRESENTATION OF FINDINGS—MAIL SURVEY

For each survey question, we report the total weighted percentage of respondents who indicated a particular answer. We then report item response rates by race/ethnicity, income, and insurance.

Because few respondents identified as Native American, Black or African-American, Native Hawaiian or Other Pacific Islander, or Asian, we were not able to break down results further than Non-Hispanic White and Hispanic/Latino/Other. For similar reasons, we combine several types of respondents — including dual-eligible and those with military insurance— into the "Medicaid/Other/Uninsured" category, and we present results broken down by income in two categories. For the purposes of this report, "low-income" is defined as at or below 200% of the Federal Poverty Level based on household size and self-reported income.

For each subpopulation, we report the actual number of survey respondents in that category who responded to each question. Not all respondents answered every question; for that reason, the *n* for a subpopulation varies by question.

COVERAGE BY COUNTY OR ZIP CODE

The following zip codes were eligible for inclusion in the sample for the mail survey:

COUNTY	ZIP CODE	COUNTY	ZIP CODE
Josephine County	97497	Josephine County	97531
Jackson County	97501	Josephine County	97532
Jackson County	97502	Josephine County	97534
Jackson County	97503	Jackson County	97535
Jackson County	97504	Jackson County	97536
Jackson County	97520	Jackson County	97537
Jackson County	97522	Josephine County	97538
Josephine County	97523	Jackson County	97539
Jackson County	97524	Jackson County	97540
Jackson County	97525	Jackson County	97541
Josephine County	97526	Josephine County	97543
Josephine County	97527	Josephine County	97544
Jackson County	97530		

MAILED SURVEY RESULTS: HEALTH STATUS

OVERALL HEALTH & DISEASE PREVALENCE

OVERALL HEALTH: About 14.4% of respondents rated their overall health as "Fair" or "Poor" (as opposed to Good, Very Good, or Excellent).

Q17: Self-Reported Overall Health (Fair or Poor vs Good, Very Good, or Excellent)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=232	Hispanic/ Latino Other n=17	200% FPL or lower n=56	201% FPL or higher n=172	Private n=79	Medicare n=110	Medicaid/ Other/ Uninsured n=65
Percent Fair or Poor	14.4%	14.3%	17.8%	28.1%	10.2%	9.3%	17.6%	20.3%

CHRONIC DISEASE: Nearly half (49.2%) of respondents report having been diagnosed with a chronic physical health condition, and 25.5% report a chronic behavioral health condition. The most common chronic conditions reported by the Southern Oregon Service Area population are high blood pressure (27.1%) and high cholesterol (23.0%). We found significant differences by insurance type for a number of chronic conditions. Non-Hispanic whites were more likely (30.0%) to report high blood pressure than those in the Hispanic/Latino/Other category (12.1%) Low-income respondents were more likely (27.9%) than those with incomes above 200% FPL (10.4%) to report both a physical and a mental health condition. All prevalence estimates are age-adjusted.

Q18. Have you ever been told by a doctor or other health professional that you have any of the following? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=233	Hispanic/ Latino Other n=17	200% FPL or lower n=57	201% FPL or higher n=172	Private n=79	Medicare n=111	Medicaid/ Other/ Uninsured n=65
High Blood Pressure	27.1%	**30.0%**	**12.1%**	28.0%	25.3%	**17.7%**	**61.4%**	**15.5%**
High Cholesterol	23.0%	25.2%	10.5%	24.0%	21.2%	**11.1%**	**57.4%**	**16.1%**
Anxiety	19.3%	18.6%	28.2%	29.4%	18.6%	24.7%	11.7%	19.4%
Depression	18.1%	17.2%	28.2%	32.7%	16.0%	23.9%	13.0%	15.9%
Asthma	15.8%	13.5%	32.0%	14.1%	17.1%	16.0%	14.4%	17.3%
Diabetes	10.2%	11.3%	5.3%	13.6%	8.8%	**8.8%**	**18.1%**	**6.9%**
Another mental health condition	6.6%	5.4%	14.5%	**25.7%**	**2.0%**	6.1%	2.0%	11.1%
PTSD	6.5%	4.7%	18.0%	17.3%	3.3%	**1.8%**	**7.7%**	**11.7%**
At least 1 physical condition	49.2%	50.4%	43.3%	49.1%	48.7%	**41.1%**	**79.9%**	**40.4%**
At least 1 mental health condition	25.5%	25.4%	31.6%	40.5%	23.6%	28.2%	20.6%	27.0%
At Least 1 mental health condition AND physical chronic condition	13.7%	13.2%	18.0%	**27.9%**	**10.4%**	**8.4%**	**19.6%**	**16.9%**

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MAILED SURVEY RESULTS: HEALTH STATUS

ANXIETY AND DEPRESSION SYMPTOMS

The survey included a short series of questions designed to assess whether a respondent might currently be experiencing symptoms of anxiety or depression (as opposed to having received a diagnosis of depression). We found that 9.9%% of respondents reported currently experiencing symptoms of anxiety, and 10.7% reported active symptoms of depression. Rates of symptoms of anxiety varied significantly by income.

Q19: Symptoms of Anxiety or Depression (GAD-2 and PHQ-2 Screening Tools).	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=211	Hispanic/ Latino Other n=17	200% FPL or lower n=50	201% FPL or higher n=161	Private n=71	Medicare n=100	Medicaid/ Other/ Uninsured n=60
Current symptoms of depression	10.7%	7.5%	28.2%	17.4%	9.2%	4.3%	4.1%	24.0%
Current symptoms of anxiety	9.9%	7.0%	28.5%	**28.9%**	**5.2%**	8.3%	3.6%	16.8%

OBESITY/BMI

The survey asked respondents to record their height and weight, which allowed us to calculate self-reported Body Mass Index (BMI). We used these data to estimate age-adjusted estimates of overweight and obesity rates, detailed below. We found the overall prevalence of obesity in this regional sample to be slightly lower (22.8%) than the CDC's statewide rate of 29.9%. There was a significant difference in BMI by income.

Q46-47: Body Mass Index (Based on Self Reported Height and Weight)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=230	Hispanic/ Latino Other n=16	200% FPL or lower n=57	201% FPL or higher n=169	Private n=78	Medicare n=110	Medicaid/ Other/ Uninsured n=63
Overweight (BMI 25 to <30)	31.0%	32.6%	25.0%	**13.1%**	**35.5%**	34.4%	38.0%	24.8%
Obese (BMI 30+)	22.8%	23.1%	23.1%	**32.2%**	**21.3%**	21.5%	27.1%	21.5%

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CHRONIC DISEASE AMONG CHILDREN

We also asked respondents about the health of their children. Overall, 28.8% of respondents reported that they had children under 18 years of age (n=32); of those, 10.7% report that at least one of their children had a chronic physical health condition and 21.6% reported a behavioral health condition. The most common physical illness among children was asthma, with 10.7% of respondents who had children under 18 reporting a diagnosis for at least one of their children. The most common mental health diagnosis among children was anxiety; 16.3% of respondents with children reported that at least one of their children had received an anxiety diagnosis.

Q39-40. Have you ever been told by a doctor or other health professional that any of your children have the following? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=29	Hispanic/ Latino/ Other n=2	200% FPL or lower n=12	201% FPL or higher n=19	Private n=14	Medicare n=1	Medicaid/ Other/ Uninsured n=16
Anxiety	16.3%	10.9%	88.5%	33.6%	10.1%	12.9%	*	24.6%
A behavioral health or mental health diagnosis	12.7%	6.9%	88.5%	37.0%	3.8%	1.6%	*	32.1%
Asthma	10.7%	4.8%	88.5%	36.6%	1.3%	0.0%	*	27.1%
Depression	9.9%	3.9%	88.5%	33.6%	1.3%	0.0%	*	27.1%
A developmental delay or learning disability	9.1%	3.0%	88.5%	30.5%	1.3%	0.0%	*	24.8%
PTSD	7.2%	0.9%	88.5%	26.7%	0.0%	0.0%	*	19.6%
Diabetes	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*	0.0%
Another ongoing health condition	1.7%	1.9%	0.0%	6.5%	0.0%	0.0%	*	4.7%
At least 1 physical condition	10.7%	4.8%	88.5%	36.6%	1.3%	0.0%	*	27.1%
At least 1 mental health condition	21.6%	16.7%	88.5%	46.5%	12.7%	12.9%	*	39.1%

***** *We did not report results when five or fewer respondents from a subgroup answered the question.*

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MAILED SURVEY RESULTS: ACCESS TO CARE

INSURANCE COVERAGE

93.5% of respondents reported that they are currently insured. Within the mail survey population, those in the Non-Hispanic White category were more likely to be uninsured than those in the Hispanic/Latino/Other category. Of those who reported that they are not currently insured (n=13), 66.2% indicated that cost was a key barrier, while 29.1% said that they "hadn't had time to deal with it."

Of those reporting their insurance type, 42.2% are privately insured, 22.4% are on Medicare, 22.3% are on Medicaid or are dual-eligible and 3.9% reported having Military or other insurance.

Q1: Do you currently have any kind of health insurance?	TOTAL	RACE/ETHNICITY		INCOME	
		Non-Hispanic White n=235	Hispanic/ Latino/ Other n=17	200% FPL or lower n=57	201% FPL or higher n=174
No	6.3%	**7.5%**	**0.8%**	4.2%	7.7%

Q2: What kind of insurance do you have? (n=264)	
Private Insurance	42.2%
Medicaid/Dual-Eligible	22.3%
Military or Other insurance	3.9%
Medicare	22.4%
Uninsured	6.3%

CONNECTION TO CARE

9.4% of respondents reported that they do not have a place to go for health care when it is not an emergency. One in five (20.0%) respondents reported that they do not have a person that they think of as their personal doctor or health care provider; within the Medicaid/Dual/Uninsured population, that number was closer to one in three (32.5%). Those with incomes above 200% FPL were more likely to report that they did not have a usual source of care and that they did not have a personal doctor.

Q4-Q6: Usual Place of Care, Personal Health Care Provider	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=235	Hispanic/ Latino Other n=17	200% FPL or lower n=57	201% FPL or higher n=174	Private n=80	Medicare n=112	Medicaid/ Other/ Uninsured n=65
Do not have a place for care that is not an emergency	9.4%	6.4%	14.5%	**1.1%**	**9.5%**	6.3%	2.5%	19.4%
Do not have a personal doctor	20.0%	18.7%	14.5%	**5.9%**	**21.8%**	**19.0%**	**4.4%**	**32.5%**

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MAILED SURVEY RESULTS: ACCESS TO CARE

ACCESS TO PHYSICAL HEALTH CARE

Most respondents (80.1%) reported needing some kind of health care in the preceding 12 months. We found evidence of unmet need in the population across all respondents: 18.4% reported needing care but not getting all of the care they needed during the last 12 months. Medicare beneficiaries were less likely (7.7%) to report unmet need than those with private insurance (20.2%) or those in the Medicaid/Other/Uninsured category (23.4%).

Q8: Access to Needed Care in the last 12 months	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=226	Hispanic/ Latino/ Other n=16	200% FPL or lower n=55	201% FPL or higher n=168	Private n=78	Medicare n=108	Medicaid/ Other/ Uninsured n=61
Did not need any kind of health care	19.9%	14.8%	41.8%	13.3%	20.1%	**19.4%**	**13.6%**	**25.7%**
Needed care; got all the care they needed	61.7%	67.2%	39.8%	69.3%	61.7%	**60.4%**	**78.8%**	**50.9%**
Needed care; did not get all the care they needed	18.4%	18.0%	18.5%	17.3%	18.2%	**20.2%**	**7.7%**	**23.4%**

REASONS FOR UNMET NEED

If a respondent indicated that they were not able to access all the care they needed, we asked them to tell us why. The most common reason given was cost (34.9%), although 13.9% reported that they could not get an appointment quickly enough and 13.9% said that they went without needed care because they did not have a regular provider. Those in the Medicaid/Other/Uninsured category were more likely to report that cost was a barrier; they were also more likely to cite not having a provider and not having transportation as barriers. Medicare beneficiaries were unlikely (1.6%) to report not having a regular provider as a barrier. Those with private insurance were less likely to report needing a timely appointment, and more likely to report cost as a barrier.

Q9: The most recent time you went without needed health care, what were the main reasons? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=199	Hispanic/ Latino/ Other n=14	200% FPL or lower n=44	201% FPL or higher n=151	Private n=66	Medicare n=97	Medicaid/ Other/ Uninsured n=55
Cost	34.9%	36.3%	24.7%	36.3%	35.9%	**38.3%**	**10.7%**	**53.0%**
Couldn't get an appointment quickly enough	13.9%	11.9%	30.8%	6.0%	15.3%	**4.1%**	**17.3%**	**17.1%**
Not having a regular provider	13.9%	15.5%	4.2%	23.9%	12.2%	**13.7%**	**1.6%**	**25.4%**
Transportation	4.8%	2.7%	24.7%	21.9%	0.0%	**0.0%**	**0.6%**	**15.2%**

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MAILED SURVEY RESULTS: ACCESS TO MENTAL HEALTH CARE

ACCESS TO MENTAL HEALTH CARE

14.4% of respondents reported needing mental health care in the preceding 12 months. We found evidence of unmet need in the population: 6.7% of all respondents reported needing care but not getting all of the care they needed during the last 12 months.

Q10 & 12: Access to Mental Health Care in the last 12 months	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=232	Hispanic/ Latino/ Other n=17	200% FPL or lower n=57	201% FPL or higher n=172	Private n=79	Medicare n=112	Medicaid/ Other/ Uninsured n=64
Did not need mental health care	85.6%	85.1%	85.5%	70.5%	88.3%	80.8%	93.6%	84.9%
Needed care; got all the care they needed	7.7%	7.1%	13.7%	12.5%	7.1%	8.7%	3.9%	9.9%
Needed care; did not get all the care they needed	6.7%	7.8%	0.8%	16.9%	4.6%	10.5%	2.5%	5.3%

REASONS FOR UNMET MENTAL HEALTH CARE NEED

If a respondent indicated that they were not able to access all the mental health care they needed, we asked them to tell us why. The most common reasons given were inability to get an appointment soon enough (30.8%) and cost (30.3%). Not having a provider and not knowing where to go were also common reasons.

Q13: The most recent time you went without needed mental health care, what were the main reasons? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=33	Hispanic/ Latino/ Other n=2	200% FPL or lower n=12	201% FPL or higher n=22	Private n=14	Medicare n=7	Medicaid/ Other/ Uninsured n=14
Couldn't get appointments quickly enough	30.8%	21.9%	*	45.1%	23.3%	28.3%	0.0%	41.9%
Cost	30.3%	34.1%	*	40.0%	25.5%	25.1%	33.9%	37.1%
Didn't have a regular provider	18.1%	20.0%	*	5.8%	25.9%	9.5%	0%	33.7%
Didn't know where to go	17.8%	20.5%	*	8.3%	24.0%	25.1%	23.3%	7.7%
Offices aren't open when I could go	2.3%	1.8%	*	1.9%	2.6%	0.0%	18.4%	1.7%

***** *We did not report results when five or fewer respondents from a subgroup answered the question.*

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MAILED SURVEY RESULTS: ACCESS TO SUBSTANCE ABUSE CARE

ACCESS TO SUBSTANCE ABUSE TREATMENT

Only two respondents (0.5%) reported needing substance use care in the preceding 12 months, of whom both reported not receiving all the care they needed.

Q14-15: Access to Substance Abuse Treatment in the last 12 months	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=234	Hispanic/ Latino/ Other n=17	200% FPL or lower n=57	201% FPL or higher n=173	Private n=80	Medicare n=112	Medicaid/ Other/ Uninsured n=64
Did not need drug or alcohol abuse treatment	99.5%	99.4%	100%	98.8%	99.6%	99.4%	100%	99.2%
Needed treatment; got all the care they needed	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Needed treatment; did not get all the care they needed	0.5%	0.6%	0.0%	1.2%	0.4%	0.6%	0.0%	0.8%

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MAILED SURVEY RESULTS: SOCIAL DETERMINANTS OF HEALTH

BASIC NEEDS

We asked respondents to tell us whether they recently had difficulty meeting basic needs. 10.9% of respondents reported that they had to go without one of the "social determinants" items listed (food, utilities, transportation, clothing, housing) and 21.5% had an unmet health need.

The most common unmet needs were dental care (19.9% of respondents went without) and medical care (7.9% of respondents went without). Low-income respondents were significantly more likely (33.8%) to have gone without one of the social determinants items than those with incomes above 200% FPL (5.2%).

Rates of unmet health needs varied significantly by insurance type. Those in the Medicaid/Other/Uninsured category were significantly more likely to have gone without dental care; 35.9% had gone without needed dental care in the past year, compared to only 14.6% of those with private insurance. They were also more likely to have gone without needed medical care.

Non-Hispanic whites were more likely (8.7%) to have gone without needed medical care than those in the Hispanic/Latino/Other category (0.8%)

Q42: In the past 12 months, have you or someone in your household had to go without any of the following when it was really needed because you were having trouble making ends meet?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=233	Hispanic/ Latino/ Other n=17	200% FPL or lower n=56	201% FPL or higher n=173	Private n=79	Medicare n=111	Medicaid/ Other/ Uninsured n=65
SOCIAL DETERMINANTS								
Transportation	6.8%	5.1%	16.2%	**27.4%**	**1.1%**	**0.6%**	**1.6%**	**19.0%**
Food	4.0%	1.9%	15.3%	7.3%	3.0%	0.0%	0.0%	12.4%
Utilities	3.3%	1.6%	14.5%	3.2%	3.7%	1.9%	0.0%	7.6%
Clothing	1.6%	1.9%	0.8%	4.2%	1.1%	1.9%	0.0%	2.6%
Stable Housing or Shelter	0.4%	0.3%	0.8%	0.6%	0.4%	0.6%	0.0%	0.3%
Child Care	0.1%	0.0%	0.8%	0.6%	0.0%	0.0%	0.0%	0.3%
One or more social determinants	10.9%	7.9%	29.9%	**33.8%**	**5.2%**	**3.1%**	**1.6%**	**28.6%**
HEALTH NEEDS								
Dental Care	19.9%	20.8%	14.5%	26.1%	20.1%	**14.6%**	**8.6%**	**35.9%**
Medical Care	7.9%	**8.7%**	**0.8%**	5.0%	9.2%	**5.6%**	**1.5%**	**16.2%**
Medicine	3.1%	3.1%	0.8%	4.3%	2.6%	1.8%	0.0%	7.3%
One or more health needs	21.5%	22.8%	14.5%	28.7%	21.7%	**17.2%**	**8.6%**	**37.5%**

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MAILED SURVEY RESULTS: SOCIAL DETERMINANTS OF HEALTH

HOUSING STABILITY

14.1% of respondents reported housing instability (5.0% of respondents reported no stable housing and 9.1% reported being worried about losing their current housing).

Q41: Housing Insecurity	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=232	Hispanic/ Latino/ Other n=17	200% FPL or lower n=57	201% FPL or higher n=171	Private n=78	Medicare n=111	Medicaid/ Other/ Uninsured n=65
Have secure housing	85.9%	83.8%	97.5%	69.3%	90.4%	91.3%	91.1%	74.1%
Have housing, but worried about	9.1%	10.6%	0.0%	11.8%	8.3%	6.9%	7.5%	14.0%
Do not have stable housing	5.0%	5.6%	2.5%	18.9%	1.3%	1.9%	1.4%	11.9%

SOCIAL SUPPORT

We asked participants a series of questions designed to measure the extent to which they had adequate social support. These questions are drawn from the Social Support Index (SSI). About one in five (18.8%) said they did not have someone to get together with for relaxation, and 20.3% said they did not have someone to confide in or talk to about their problems. We did observe significant variation in some indicators of social support by subgroup; one of the more dominant patterns indicated that those with private insurance had more social support than Medicare beneficiaries or those in the Medicaid/Other/Uninsured category.

Q43: % reporting that they would have someone to do the following "some of the time" or "none of the time" (higher percentages indicate lower social support)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=230	Hispanic/ Latino/ Other n=17	200% FPL or lower n=56	201% FPL or higher 172	Private n=78	Medicare n=107	Medicaid/ Other/ Uninsured n=65
Love and make them feel wanted	11.0%	11.3%	4.3%	12.1%	9.9%	**7.1%**	**17.9%**	**10.3%**
Give good advice about a crisis	12.1%	12.1%	5.9%	**21.3%**	**9.1%**	**6.4%**	**21.7%**	**12.1%**
Get together with for relaxation	18.8%	**20.4%**	**4.3%**	31.9%	15.6%	**7.8%**	**19.6%**	**32.5%**
Confide in or talk about problems	20.3%	19.7%	18.0%	31.0%	17.9%	11.5%	19.3%	32.4%

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MAILED SURVEY RESULTS: TRAUMA

ADVERSE LIFE EXPERIENCES

Adverse life experiences have been associated with poor health outcomes. Therefore, we asked participants to tell us the extent to which they experienced hardship, difficulty, or traumatic events. Nearly two out of three (64.5%) of respondents report experiencing at least one traumatic event; 26.7% have experienced three or more. The most common adverse life experiences reported were a life-changing illness or injury (45.4%), living with someone with mental illness or substance abuse (33.1%), and witnessing or experiencing violence (26.9% of respondents).

The proportion of respondents who had experienced three or more traumatic events was higher among non-Hispanic whites (30.5%) than among those in the Hispanic/Latino/Other category (7.5%). Non-Hispanic whites were more likely to report experiencing all types of traumatic events listed than those in the Hispanic/Latino/Other category; some of these differences were statistically significant. Reports of sexual abuse varied by income.

Q20. To what extent have you experienced hardship, difficulty or traumatic events in your life?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=222	Hispanic/ Latino/ Other n=17	200% FPL or lower n=54	201% FPL or higher n=168	Private n=75	Medicare n=105	Medicaid/ Other/ Uninsured n=63
Life-changing illness or injury	45.4%	**51.1%**	**21.4%**	40.4%	48.1%	44.5%	47.2%	41.6%
Lived with someone with mental illness or substance abuse	33.1%	35.1%	25.6%	42.3%	32.8%	29.8%	23.9%	45.7%
Witnessed or experienced violence	26.9%	**30.5%**	**7.5%**	32.7%	26.6%	25.4%	25.5%	25.8%
Abuse of any kind	21.4%	**24.6%**	**7.2%**	27.9%	20.9%	22.0%	19.3%	24.1%
Neglect of any kind	15.6%	17.4%	8.0%	26.8%	13.8%	11.3%	12.8%	23.7%
Physically hurt or threatened by an intimate partner	12.9%	**14.4%**	**3.5%**	16.0%	12.5%	12.7%	10.5%	15.9%
Forced to do something sexual that you didn't want to do	5.0%	5.1%	3.7%	**14.4%**	**2.5%**	2.4%	7.8%	7.0%
Other traumatic event	12.2%	13.5%	4.4%	12.1%	11.9%	**1.8%**	**18.1%**	**16.5%**
At least one traumatic event	64.5%	70.0%	41.8%	55.5%	69.4%	55.1%	65.3%	73.5%
3 or more traumatic events	26.7%	**30.6%**	**7.2%**	35.0%	26.2%	24.0%	25.2%	27.9%

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MAILED SURVEY RESULTS: HEALTH & LIFESTYLE BEHAVIORS

DIETARY INDICATORS

Participants were asked several questions aimed at assessing diet, including how often they consumed fruit, vegetables, and soda in a typical day, as well as how often they eat fast food per week. Nearly half (45.7%) get less than two servings of fruit per day, and a third (33.5%) get less than two servings of vegetables per day. 29.2% report eating fast food two or more times per week on average.

Although we observed differences in diet between subgroups, most differences were not statistically significant. The one exception: Medicare respondents were more likely (59.8%) to get less than two servings of fruit per day than those with private insurance (41.7%) or those in the Medicaid/Other/Uninsured category (42.1%) .

Q21-24: Fruit, Vegetable, Soda, and Fast Food Consumption		TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
			Non-Hispanic White	Hispanic/ Latino/ Other	200% FPL or lower	201% FPL or higher	Private	Medicare	Medicaid/ Other/ Uninsured
Less than two servings of fruit per day	N	253	227	16	56	165	76	108	63
	%	45.7%	47.7%	30.2%	42.0%	47.5%	**41.7%**	**59.8%**	**42.1%**
Less than two servings of vegetables per day	N	257	230	17	56	168	78	108	65
	%	33.5%	36.3%	21.8%	27.3%	35.9%	28.0%	45.9%	34.0%
Two or more servings of soda per day	N	261	232	17	56	172	79	111	64
	%	8.4%	5.0%	28.2%	14.6%	6.4%	5.6%	4.1%	16.2%
Fast Food two or more times per week	N	253	224	17	56	165	78	106	64
	%	29.2%	27.2%	43.0%	31.9%	29.8%	23.7%	20.1%	43.4%

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MAILED SURVEY RESULTS: HEALTH & LIFESTYLE BEHAVIORS

PHYSICAL ACTIVITY—LEVEL

Participants were asked several questions aimed at assessing physical activity. A majority (78.6%) of respondents report exercising less than they would like to; however, only 14.8% report being less physically active than other people their age. Medicare beneficiaries were less likely (63.5%) to report that they do not exercise as much as they like, compared with 81.0% of those in the Medicaid/Other/Uninsured category and 83.9% of those with private insurance.

Q25 and Q27: Levels and type of physical activities	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=234	Hispanic/ Latino/ Other n=17	200% FPL or lower n=57	201% FPL or higher n=173	Private n=79	Medicare n=112	Medicaid/ Other/ Uninsured n=65
Less physically active than other people your age	14.8%	13.9%	18.0%	21.0%	12.4%	10.5%	18.1%	19.2%
Exercise less than they would like	78.6%	78.6%	83.0%	81.3%	79.8%	**83.9%**	**63.5%**	**81.0%**

PHYSICAL ACTIVITY—PLACE

Participants were asked where they go to engage in physical activity. 56.1% of respondents report exercising at home; 22.9% use a private gym or studio. 12.7% use public parks, and 8.4% use the YMCA. Low-income respondents were more likely (82.3%) to exercise at home than those with incomes above 200% FPL (50.4%). Those in the Hispanic/Latino/Other category, those with incomes above 200% FPL, and those with private insurance were more likely to use private gyms. Only 1.7% of those in the Hispanic/Latino/Other category exercise in parks, compared with 14.4% of non-Hispanic whites.

Q26. Where do you exercise or engage in physical activity?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=235	Hispanic/ Latino/ Other n=17	200% FPL or lower n=57	201% FPL or higher n=174	Private n=80	Medicare n=112	Medicaid/ Other/ Uninsured n=65
Home	56.1%	60.9%	41.5%	**82.3%**	**50.4%**	45.8%	63.2%	67.5%
Private gym or studio	22.9%	**17.3%**	**58.5%**	**0.6%**	**30.9%**	**32.9%**	**14.1%**	**11.6%**
Park	12.7%	**14.4%**	**1.7%**	18.8%	11.1%	7.6%	11.0%	21.1%
YMCA	8.4%	10.0%	0.0%	15.1%	7.2%	6.8%	9.0%	11.0%
Public Recreation Center	2.3%	2.8%	0.0%	9.0%	0.6%	0.5%	1.0%	5.6%

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ALCOHOL CONSUMPTION

FREQUENCY. 23.1% of respondents drink alcohol four or more times per week; 16.7% drink three or more alcoholic drinks on the days they do drink. Non-Hispanic whites were more likely (26.3%) to drink four or more times per week than those in the Hispanic/Latino/Other category (1.3%). Those with incomes above 200% FPL were more likely (28.2%) to drink four or more times per week than low-income respondents (6.9%). Medicare beneficiaries were more likely (37.3%) to drink four or more times per week than those in the Medicaid/Other/Uninsured category (28.7%), who in turn were more likely to drink four or more times per week than those with private insurance (14.3%).

Q33-36: Alcohol Consumption	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=157	Hispanic/ Latino/ Other n=9	200% FPL or lower n=31	201% FPL or higher n=130	Private n=62	Medicare n=75	Medicaid/ Other/ Uninsured n=37
Drink alcohol four or more times a week	23.1%	**26.3%**	**1.3%**	**6.9%**	**28.2%**	**14.3%**	**37.3%**	**28.7%**
Drink three or more alcoholic drinks per day	16.7%	15.7%	21.8%	8.8%	18.9%	13.0%	17.2%	23.4%

PROBLEM DRINKING. 98.7% of respondents said that their alcohol use had never led to health, social, legal, or financial problems.

Q37: In the past three months, how often has your alcohol use led to health, social, legal, or financial problems?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=159	Hispanic/ Latino/ Other n=9	200% FPL or lower n=32	201% FPL or higher n=131	Private n=63	Medicare n=75	Medicaid/ Other/ Uninsured n=38
Never	98.7%	98.4%	100.0%	100.0%	98.2%	100.0%	97.1%	97.6%
Once or twice	1.0%	1.3%	0.0%	0.0%	1.4%	0.0%	1.4%	2.4%

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MAILED SURVEY RESULTS: HEALTH & LIFESTYLE BEHAVIORS

SUBSTANCE USE

23.6% of respondents have used marijuana, and 4.9% have used another drug. 71.5% report no drug use at all. Medicare beneficiaries were less likely to report marijuana use than those with private insurance or those in the Medicaid/Other/Uninsured category. Those in the Medicaid/Other/Uninsured category were more likely (12.0%) to have used drugs other than marijuana than Medicare beneficiaries (2.0%) or those with private insurance (1.3%).

Q38: Substance Use	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=228	Hispanic/ Latino/ Other n=15	200% FPL or lower n=54	201% FPL or higher n=169	Private n=77	Medicare n=108	Medicaid/ Other/ Uninsured n=64
Marijuana only	23.6%	23.1%	16.0%	37.1%	19.4%	**28.2%**	**5.9%**	**31.9%**
Any other drug use	4.9%	3.1%	15.9%	1.1%	6.6%	**1.3%**	**2.0%**	**12.0%**

TOBACCO AND NICOTINE USE

We examined current tobacco and nicotine use among respondents. More than one in ten (12.1%) people indicated that they currently smoked at least some days or every day.

Q29: Smoking rates	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=235	Hispanic/ Latino/ Other n=17	200% FPL or lower n=57	201% FPL or higher n=174	Private n=80	Medicare n=112	Medicaid/ Other/ Uninsured n=65
Currently smoke cigarettes or e-cigarettes	12.1%	9.2%	29.2%	19.0%	10.2%	7.9%	7.0%	22.5%

All participants were asked to indicate any tobacco products that they currently use. The most common answers were cigarettes, chewing tobacco, and e-cigarettes. Cigarette use varied significantly by insurance.

Q30: Use of different tobacco products	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=235	Hispanic/ Latino/ Other n=17	200% FPL or lower n=57	201% FPL or higher n=174	Private n=80	Medicare n=112	Medicaid/ Other/ Uninsured n=65
Cigarettes	9.3%	6.1%	27.4%	16.6%	6.6%	**2.4%**	**7.0%**	**20.9%**
Chewing tobacco, snuff or snus	4.0%	4.9%	0.0%	0.6%	5.5%	4.3%	0.6%	6.4%
E-cigarettes or vaping	3.1%	3.4%	1.8%	3.6%	3.3%	4.3%	0.0%	3.8%

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SMOKING CESSATION

Respondents who indicated that they currently use tobacco products (n=53) were asked if they were trying to quit. 17.7% said that they were actively trying to quit using tobacco products. Of those respondents currently trying to quit using tobacco (n=12), the most common methods were the patch (53.3%), nicotine gum, (46.5%), no aids or "cold turkey" (25.6%), and with the help of a doctor (15.1%).

Q31: Actively trying to quit using tobacco products now	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=48	Hispanic/ Latino/ Other n=3	200% FPL or lower n=14	201% FPL or higher n=31	Private n=14	Medicare n=19	Medicaid/ Other/ Uninsured n=20
Yes	17.7%	20.5%	*	21.2%	15.5%	17.9%	15.2%	18.4%

***** *We did not report results when five or fewer respondents from a subgroup answered the question.*

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REPRESENTATION OF FINDINGS—HAND-FIELDED SURVEY

For each survey question, we report the total un-weighted percentage of respondents who indicated a particular answer. We then report item response rates by race/ethnicity, income, and insurance.

Because few respondents identified as Native American, Black or African-American, Native Hawaiian or Other Pacific Islander, or Asian, we were not able to break down results further than Non-Hispanic White and Hispanic/Latino/Other. For similar reasons, we combined several types of respondents — including dual-eligible and those with military insurance— into the "Medicaid/Other/Uninsured" category. Income is broken into two categories. For the purposes of this report, "low-income" is defined as at or below 200% of the Federal Poverty Level (FPL) based on household size and self-reported income.

For each subpopulation, we report the actual number of survey respondents in that category who responded to each question. Not all respondents answered every question; for that reason, the *n* for a subpopulation varies by question.

11.6% of hand-fielded survey respondents did not complete the demographics section of the survey. These respondents are included in the results for the total population.

HAND-FIELDED SURVEY RESULTS: HEALTH STATUS

OVERALL HEALTH & DISEASE PREVALENCE

OVERALL HEALTH: About 30.5% of all respondents rated their overall health as "Fair" or "Poor" (as opposed to Good, Very Good, or Excellent). We saw evidence of statistically significant differences in subjective health by income; low-income respondents were more than twice as likely to report fair or poor health, compared to those with incomes above 200% FPL.

Q17: Self-Reported Overall Health (Fair or Poor vs Good, Very Good, or Excellent)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=75	Hispanic/ Latino/ Other n=52	200% FPL or lower n=93	201% FPL or higher n=28	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=99
Percent Fair or Poor	30.5%	29.3%	36.5%	**39.8%**	**14.3%**	15.8%	33.3%	35.4%

CHRONIC DISEASE: Nearly half (44.5%) of respondents reported having been diagnosed with a chronic physical condition. 52.6% reported a chronic mental health condition. The most common chronic conditions reported in the hand-fielded surveys were depression (40.1%) and anxiety (38.7%). Many statistically significant disparities exist among groups, including higher rates of many chronic conditions within the non-Hispanic white respondents, lower income respondents, and Medicare beneficiaries.

Q18. Have you ever been told by a doctor or other health professional that you have any of the following? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=73	Hispanic/ Latino/ Other n=50	200% FPL or lower n=91	201% FPL or higher n=27	Private n=18	Medicare n=9	Medicaid/ Other/ Uninsured n=96
Depression	40.1%	**53.4%**	**24.0%**	45.1%	33.3%	33.3%	66.7%	38.5%
Anxiety	38.7%	**49.3%**	**30.0%**	**48.4%**	**22.2%**	**22.2%**	**66.7%**	**39.6%**
Asthma	24.1%	**30.1%**	**14.0%**	**26.4%**	**11.1%**	**5.6%**	**66.7%**	**24.0%**
High Blood Pressure	21.9%	**28.8%**	**14.0%**	**26.4%**	**7.4%**	**5.6%**	**55.6%**	**22.9%**
PTSD	21.9%	**30.1%**	**12.0%**	26.4%	18.5%	**5.6%**	**44.4%**	**26.0%**
High Cholesterol	18.2%	23.3%	12.0%	20.9%	11.1%	**11.1%**	**55.6%**	**17.7%**
Diabetes	14.6%	16.4%	14.0%	16.5%	11.1%	11.1%	11.1%	16.7%
Another mental health condition	16.8%	**26.0%**	**6.0%**	18.7%	14.8%	0%	44.4%	17.7%
At least 1 physical condition	44.5%	**53.4%**	**32.0%**	**49.5%**	**25.9%**	**22.2%**	**88.9%**	**45.8%**
At least 1 mental health condition	52.6%	**65.8%**	**40.0%**	**61.5%**	**40.7%**	44.4%	66.7%	53.1%
At Least 1 mental health condition AND physical chronic condition	32.1%	**43.8%**	**20.0%**	**40.7%**	**18.5%**	**16.7%**	**66.7%**	**32.3%**

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HAND-FIELDED SURVEY RESULTS: HEALTH STATUS

ANXIETY AND DEPRESSION SYMPTOMS

The survey included a short series of questions designed to assess whether a respondent might currently be experiencing symptoms of anxiety or depression (as opposed to having received a diagnosis of depression). We found that nearly a quarter (24.6%) of respondents reported currently experiencing symptoms of anxiety, and 15.7% reported active symptoms of depression. There was a statistically significant disparity noted among income levels for both anxiety and depression symptoms, with higher rates of both for low-income respondents.

Q19: Symptoms of Anxiety or Depression (GAD-2 and PHQ-2 Screening Tools).	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=69	Hispanic/ Latino/ Other n=48	200% FPL or lower n=88	201% FPL or higher n=25	Private n=17	Medicare n=9	Medicaid/ Other/ Uninsured n=91
Current symptoms of anxiety	24.6%	23.2%	27.1%	**31.8%**	**8.0%**	0.0%	33.3%	28.6%
Current symptoms of depression	15.7%	16.4%	14.9%	**21.2%**	**4.0%**	0.0%	11.1%	20.5%

OBESITY/BMI

The survey asked respondents to report their height and weight, which allowed us to calculate self-reported Body Mass Index (BMI). We used these data to calculate age-adjusted estimates of overweight and obesity rates, detailed below. We found that nearly 67% of respondents were overweight or obese. The rate of obesity was somewhat higher (36.9%) than the CDC-reported statewide rate (29.9%).

Q46-47: Body Mass Index (Based on Self Reported Height and Weight)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=72	Hispanic/ Latino/ Other n=38	200% FPL or lower n=77	201% FPL or higher n=29	Private n=14	Medicare n=7	Medicaid/ Other/ Uninsured n=78
Overweight (BMI 25-29)	29.7%	27.8%	34.2%	27.3%	34.5%	35.7%	14.3%	30.8%
Obese (BMI 30+)	36.9%	41.7%	28.9%	39.0%	31.0%	28.6%	85.7%	35.9%

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HAND-FIELDED SURVEY RESULTS: CHILDREN'S HEALTH

CHRONIC DISEASE AMONG CHILDREN

We also asked respondents about the health of their children. Overall, 38.7% of respondents reported that they had children under 18 years of age (n=55); of those, 23.5% report that at least one of their children had a chronic physical health condition and 31.4% reported a behavioral health condition. The most common physical illness among children was asthma, with 21.6% of respondents with children under 18 reporting a diagnosis for at least one of their children.

Q40. Have you ever been told by a doctor or other health professional that any of your children have the following? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=18	Hispanic/ Latino/ Other n=29	200% FPL or lower n=37	201% FPL or higher n=8	Private n=6	Medicare n=1	Medicaid/ Other/ Uninsured n=42
A behavioral health or mental health diagnosis	17.6%	27.8%	13.8%	24.3%	0.0%	0.0%	*	19.0%
Asthma	21.6%	22.2%	20.7%	24.3%	12.5%	16.7%	*	21.4%
Depression	13.7%	16.7%	10.3%	13.5%	0.0%	0.0%	*	14.3%
Anxiety	15.7%	11.1%	17.2%	18.9%	0.0%	0.0%	*	16.7%
A developmental delay or learning disability	7.8%	11.1%	6.9%	10.8%	0.0%	0.0%	*	7.1%
PTSD	5.9%	11.1%	3.4%	5.4%	0.0%	0.0%	*	4.8%
Diabetes	2.0%	5.6%	0.0%	0.0%	0.0%	0.0%	*	2.4%
Another ongoing health condition	7.4%	11.5%	5.4%	8.3%	7.7%	5.6%	*	11.1%
At least 1 physical condition	23.5%	27.8%	20.7%	24.3%	12.5%	16.7%	*	23.8%
At least 1 mental health condition	31.4%	44.4%	24.1%	35.1%	12.5%	16.7%	*	33.3%

***** *We did not report results when five or fewer respondents from a subgroup answered the question.*

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HAND-FIELDED SURVEY RESULTS: ACCESS TO CARE

INSURANCE COVERAGE

26.7% of hand-fielded survey respondents were uninsured. Of those who reported that they were not currently insured, 28.2% said that cost was a key barrier. 42.5% were on Medicaid or dual-eligible 13.0%, were privately insured and 6.2% are on Medicare. The difference in uninsurance rates for the two questions is due to fewer respondents answering Q2.

Q1: Do you currently have any kind of health insurance?	TOTAL	RACE/ETHNICITY		INCOME	
		Non-Hispanic White n=75	Hispanic/ Latino/ Other n=54	200% FPL or lower n=94	201% FPL or higher n=29
No	26.7%	**14.7%**	**44.4%**	27.7%	20.7%

Q2: What kind of insurance do you have? (n=132)	
Medicaid/Dual-Eligible	42.5%
Private Insurance	13.0%
Medicare	6.2%
Uninsured	29.5%

CONNECTION TO CARE

20.5% of respondents reported that they do not have a place to go for health care when it is not an emergency. This rate was significantly higher for those within Hispanic/Latino/Other category (33.3%) compared to those in the non-Hispanic White category (8.0%). Nearly four in ten (39.7%) respondents reported that they do not have a person that they think of as their personal doctor or health care provider. This rate was significantly higher among the Hispanic/other population (59.3%) and for low-income respondents (42.6%).

Q4 and Q6: Usual Place of Care, Personal Health Care Provider	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=75	Hispanic/ Latino/ Other n=54	200% FPL or lower n=94	201% FPL or higher n=29	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=104
Do not have a place for care that is not an emergency	20.5%	**8.0%**	**33.3%**	22.3%	10.3%	21.1%	0.0%	24.0%
Do not have a personal doctor	39.7%	**25.3%**	**59.3%**	**42.6%**	**24.1%**	42.1%	0.0%	42.3%

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HAND-FIELDED SURVEY RESULTS: ACCESS TO CARE

ACCESS TO PHYSICAL HEALTH CARE

Most respondents (69.1%) reported needing some kind of health care in the preceding 12 months. Those in the Hispanic/Latino/Other category were less likely to report needing health care compared to those in the non-Hispanic White category. We found evidence of unmet need; 17.3% of hand-fielded survey respondents reported needing care but not getting all of the care they needed.

Q7-8: Access to Needed Care in the last 12 months	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=70	Hispanic/ Latino/ Other n=54	200% FPL or lower n=89	201% FPL or higher n=29	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=98
Did not need any kind of health care	30.9%	**12.9%**	**57.4%**	33.7%	27.6%	10.5%	0%	38.8%
Needed care; got all the care they needed	51.8%	**67.1%**	**27.8%**	46.1%	62.1%	68.4%	77.8%	43.9%
Needed care; did not get all the care they needed	17.3%	20.0%	14.8%	20.2%	10.3%	21.1%	22.2%	17.3%

REASONS FOR UNMET NEED

If a respondent indicated that they were not able to access all the care they needed, we asked them to tell us why. The most common reason selected was cost (29.1%). Additionally, 15.5% reported that they did not have a regular provider, 11.7% said they went without needed care because they could not get an appointment quickly enough, and 11.7% said they needed transportation.

Q9: The most recent time you went without needed health care, what were the main reasons? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=66	Hispanic/ Latino/ Other n=23	200% FPL or lower n=64	201% FPL or higher n=21	Private n=17	Medicare n=9	Medicaid/ Other/ Uninsured n=66
Cost	29.1%	27.3%	30.4%	25.0%	38.1%	29.4%	44.4%	30.3%
Not having a regular provider	15.5%	10.6%	21.7%	18.8%	4.8%	5.9%	0%	21.2%
Needed Transportation	11.7%	12.1%	13.0%	18.8%	0%	5.9%	11.1%	12.1%
Couldn't get an appointment quickly enough	11.7%	12.1%	13.0%	15.6%	4.8%	17.6%	22.2%	9.1%
Not knowing where to go for care	9.7%	12.1%	4.3%	12.5%	4.8%	0%	0%	12.1%

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HAND-FIELDED SURVEY RESULTS: ACCESS TO MENTAL HEALTH CARE

ACCESS TO MENTAL HEALTH CARE

30.8% reported needing mental health care in the preceding 12 months. We found evidence of unmet need in the population: across all hand-fielded survey respondents, 16.1% reported needing mental health care but not getting all of the care they needed during the last 12 months.

Q10-12: Access to Mental Health Care in the last 12 months	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=73	Hispanic/ Latino/ Other n=54	200% FPL or lower n=93	201% FPL or higher n=29	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=101
Did not need mental health care	69.2%	**60.3%**	**81.5%**	64.5%	79.3%	94.7%	22.2%	68.3%
Needed care; got all the care needed	14.7%	**20.5%**	**7.4%**	12.9%	20.7%	5.3%	22.2%	13.9%
Needed care; did not get all the care needed	16.1%	**19.2%**	**11.1%**	22.6%	0.0%	0.0%	55.6%	17.8%

REASONS FOR UNMET NEED

If a respondent indicated that they were not able to access all the care they needed, we asked them to tell us why. The most common reason given was cost. Additionally, 21.3% reported that they did not have a regular provider, 17.0% did not know where to go to get care, and 12.8% said that they went without needed care because they did not have transportation. 10.0% of those in the Hispanic/Latino/Other category said that they needed a culturally-appropriate provider.

Q13: The most recent time you went without needed mental health care, what were the main reasons? *Mark all that apply.*	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=31	Hispanic/ Latino/ Other n=10	200% FPL or lower n=34	201% FPL or higher n=6	Private n=1	Medicare n=7	Medicaid/ Other/ Uninsured n=35
Cost	27.7%	19.4%	40.0%	26.5%	16.7%	*	57.1%	25.7%
Didn't have a regular provider	21.3%	19.4%	10.0%	20.6%	16.7%	*	14.3%	22.9%
Didn't know where to go	17.0%	12.9%	10.0%	17.6%	0%	*	14.3%	20.0%
Needed Transportation	12.8%	9.7%	20.0%	17.6%	0%	*	0.0%	17.1%
Do not have a provider that understands culture, lifestyle, identity or language	6.4%	6.5%	10.0%	5.9%	0%	*	0.0%	8.6%

** We did not report results when five or fewer respondents from a subgroup answered the question.*

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HAND-FIELDED SURVEY RESULTS: ACCESS TO CARE

ACCESS TO SUBSTANCE ABUSE TREATMENT

4.8% of respondents reported needing substance abuse treatment in the preceding 12 months, all of whom were in the Medicaid/ Other/Uninsured category.

Q14-16: Access to Substance Abuse Treatment in the last 12 months	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=75	Hispanic/ Latino/ Other n=53	200% FPL or lower n=93	201% FPL or higher n=29	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=103
Did not need drug or alcohol abuse treatment	95.2%	94.7%	98.1%	95.7%	96.6%	100%	100%	94.2%
Needed treatment; got all the care they needed	2.1%	1.3%	1.9%	2.2%	0.0%	0.0%	0.0%	2.9%
Needed treatment; did not get all the care they needed	2.8%	4.0%	0.0%	2.2%	3.4%	0.0%	0.0%	2.9%

REASONS FOR UNMET NEED

We asked respondents about the reasons they were unable to receive treatment. The reasons given for unmet need were: not having a regular provider, not knowing where to go to get treatment, needing transportation, cost barriers, and not having a culturally-appropriate provider. There were fewer than five respondents for all categories other than Medicaid/Other/Uninsured, so a table is not included for this question.

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HAND-FIELDED SURVEY RESULTS: SOCIAL DETERMINANTS OF HEALTH

BASIC NEEDS

We asked respondents to tell us whether they had recently had difficulty meeting basic needs. 46.2% of respondents reported that they had to go without one of the "social determinants" items listed (food, utilities, transportation, clothing, housing) and 39.5% had an unmet health need.

The most common unmet needs were transportation (34.1% of respondents went without) , dental care (33.3% of respondents went without), an food (31.8% went without).

For most of the basic needs listed, low-income respondents were significantly more likely to have gone without. Medicare respondents were significantly more likely to have gone without dental care; 6 of 8 (75.0%) had gone without needed dental care in the past year compared to only 13.3% of those with private insurance. Medicare beneficiaries and those in the Medicaid/Other/Uninsured category were more likely to have gone without basic needs than those with private insurance. Those in the Hispanic/Latino/Other category were more likely (14.9%) to have gone without child care than those in the Non-Hispanic White category (1.4%).

Q42: In the past 12 months, have you or someone in your household had to go without any of the following when it was really needed because you were having trouble making ends meet?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=73	Hispanic/ Latino/ Other n=47	200% FPL or lower n=89	201% FPL or higher n=28	Private n=15	Medicare n=8	Medicaid/ Other/ Uninsured n=94
SOCIAL DETERMINANTS								
Transportation	34.1%	32.9%	31.9%	**41.6%**	**7.1%**	13.3%	50.0%	37.2%
Food	31.8%	32.9%	27.7%	**39.3%**	**10.7%**	13.3%	37.5%	36.2%
Stable Housing or Shelter	24.0%	21.9%	23.4%	**29.2%**	**3.6%**	6.7%	12.5%	29.8%
Utilities	21.7%	15.1%	25.5%	**24.7%**	**3.6%**	13.3%	37.5%	23.4%
Clothing	21.5%	19.2%	20.8%	24.4%	10.7%	6.3%	25.0%	25.5%
Child Care	8.5%	**1.4%**	**14.9%**	9.0%	0.0%	6.7%	0%	10.6%
One or more social determinants	46.2%	47.9%	41.7%	**56.7%**	**14.3%**	**12.5%**	**62.5%**	**52.1%**
HEALTH NEEDS								
Dental Care	33.3%	31.5%	29.8%	**34.8%**	**17.9%**	**13.3%**	**75.0%**	**34.0%**
Medicine	24.2%	20.5%	19.6%	**26.1%**	**3.6%**	21.4%	50.0%	24.5%
Medical Care	20.9%	15.1%	19.1%	19.1%	7.1%	13.3%	37.5%	22.3%
One or more health needs	39.5%	37.0%	34.0%	**41.6%**	**17.9%**	**20.0%**	**75.0%**	**41.5%**

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HAND-FIELDED SURVEY RESULTS: SOCIAL DETERMINANTS OF HEALTH

HOUSING STABILITY

Housing insecurity was prevalent among the hand-fielded survey population. 31.2% of respondents reported that they do not have secure housing, and 15.6% have housing but are worried about losing it. Housing insecurity was more common among low-income respondents.

Q41: Housing Insecurity	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=65	Hispanic/ Latino/ Other n=36	200% FPL or lower n=70	201% FPL or higher n=28	Private n=15	Medicare n=8	Medicaid/ Other/ Uninsured n=76
Have secure housing	53.2%	52.3%	55.6%	**47.1%**	**71.4%**	80.0%	62.5%	46.1%
Have housing, but worried about	15.6%	15.4%	16.7%	**14.3%**	**21.4%**	13.3%	37.5%	14.5%
Do not have secure/stable housing	31.2%	32.3%	27.8%	**38.6%**	**7.1%**	6.7%	0.0%	39.5%

SOCIAL SUPPORT

We asked participants a series of questions designed to measure the extent to which they had adequate social support. These questions are drawn from the Social Support Index (SSI). The table below illustrates the percentage of those who report low social support. Social support varied significantly by income and insurance.

Q43: % reporting that they would have someone to do the following "some of the time" or "none of the time" (higher percentages indicate lower social support)	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=72	Hispanic/ Latino/ Other n=51	200% FPL or lower n=91	201% FPL or higher n=28	Private n=16	Medicare n=8	Medicaid/ Other/ Uninsured n=92
Love and make you feel wanted	39.1%	36.1%	41.2%	**45.1%**	**25.0%**	**6.3%**	**62.5%**	**45.7%**
Give good advice about a crisis	32.0%	29.2%	33.3%	**38.5%**	**14.3%**	**6.3%**	**50.0%**	**38.0%**
Get together with for relaxation	43.0%	43.1%	41.2%	**50.5%**	**25.0%**	**6.3%**	**62.5%**	**48.9%**
Confide in or talk about problems	39.1%	37.5%	39.2%	**46.2%**	**21.4%**	**12.5%**	**50.0%**	**44.6%**

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HAND-FIELDED SURVEY RESULTS: TRAUMA

ADVERSE LIFE EXPERIENCES

Since adverse life experiences have been associated with poor health outcomes, we asked participants to tell us the extent to which they had experienced hardship, difficulty, or traumatic events. Nearly three of four (71.7%) hand-fielded survey respondents report experiencing at least one traumatic event; 42.8% have experienced three or more.

The three most common adverse life experiences reported were witnessing or experiencing violence (47.1%), living with someone with mental illness of substance abuse (43.5%), and a life-changing illness or injury (42.8%). Trauma histories varied significantly by race/ethnicity and by insurance status, but not by income.

Q20. To what extent have you experienced hardship, difficulty or traumatic events in your life?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=74	Hispanic/ Latino/ Other n=51	200% FPL or lower n=93	201% FPL or higher n=27	Private n=18	Medicare n=9	Medicaid/ Dual/ Uninsured n=98
Witnessed or experienced violence	47.1%	**59.5%**	**33.3%**	53.8%	40.7%	**22.2%**	**66.7%**	**46.9%**
Lived with someone with mental illness or substance abuse	43.5%	**51.4%**	**33.3%**	45.2%	37.0%	**22.2%**	**66.7%**	**44.9%**
Life-changing illness or injury	42.8%	**58.1%**	**23.5%**	46.2%	37.0%	**22.2%**	**66.7%**	**45.9%**
Neglect of any kind	36.2%	**44.6%**	**25.5%**	39.8%	33.3%	**16.7%**	**55.6%**	**39.8%**
Abuse of any kind	35.5%	**44.6%**	**23.5%**	40.9%	29.6%	22.2%	44.4%	35.7%
Physically hurt or threatened by an intimate partner	21.0%	24.3%	13.7%	20.4%	18.5%	16.7%	33.3%	19.4%
Forced to do something sexual that you didn't want to do	19.6%	24.3%	13.7%	22.6%	18.5%	16.7%	33.3%	19.4%
Other traumatic event	15.2%	17.6%	11.8%	16.1%	11.1%	0.0%	33.3%	17.3%
At least one traumatic event	71.7%	**86.5%**	**52.9%**	76.3%	66.7%	61.1%	77.8%	71.4%
3 or more traumatic events	42.8%	**54.1%**	**31.4%**	48.4%	37.0%	**16.7%**	**66.7%**	**43.9%**

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HAND-FIELDED SURVEY RESULTS: HEALTH & LIFESTYLE BEHAVIORS

DIETARY INDICATORS

Participants were asked several questions aimed at assessing diet, including how often they consumed fruit and vegetables in a typical day. More than half (58.2%) of hand-fielded survey respondents gets less than two servings of fruit per day, and 51.1% get less than two servings of vegetables per day.

21.5% of respondents consume two or more servings of soda per day, and 26.4% eat fast food two or more times per week.

Fast food consumption varied significantly by race/ethnicity; 33.3% of those in the Non-Hispanic White category reported consuming fast food two or more times per week, compared to only 14.6% of those in the Hispanic/Latino/Other category.

Q21-24: Fruit, Vegetable, Soda, and Fast Food Consumption		TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
			Non-Hispanic White	Hispanic/ Latino/ Other	200% FPL or lower	201% FPL or higher	Private	Medicare	Medicaid/ Other/ Uninsured
Less than two servings of fruit per day	N	134	72	50	88	29	19	8	95
	%	58.2%	58.3%	56.0%	55.7%	55.2%	42.1%	75.0%	56.8%
Less than two servings of vegetables per day	N	131	67	52	86	28	17	8	94
	%	51.1%	46.3%	55.8%	53.5%	39.3%	41.2%	62.5%	48.9%
Two or more servings of soda per day	N	130	71	49	86	29	93	7	18
	%	21.5%	26.8%	16.3%	24.4%	20.7%	5.6%	14.3%	24.7%
Fast Food two or more times per week	N	129	69	48	85	27	91	8	18
	%	26.4%	**33.3%**	**14.6%**	23.5%	37.0%	38.9%	25.0%	22.0%

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HAND-FIELDED SURVEY RESULTS: HEALTH & LIFESTYLE BEHAVIORS

PHYSICAL ACTIVITY—LEVEL

Participants were asked several questions aimed at assessing physical activity. A majority (68.3%) of respondents report exercising less than they would like to; however, only 28.5% report being less physically active than other people their age.

Q25 and Q27: Levels and type of physical activities	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=74	Hispanic/ Latino/ Other n=54	200% FPL or lower n=92	201% FPL or higher n=29	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=100
Less physically active than other people your age	28.5%	27.0%	29.4%	31.9%	20.7%	26.3%	37.5%	30.9%
Exercise less than they would like	68.3%	71.2%	63.0%	65.2%	75.9%	73.7%	88.9%	65.0%

PHYSICAL ACTIVITY—PLACE

Participants were asked where they go to engage in physical activity. 40.4% of respondents report exercising at home; 23.3% use a park. 10.3% use the YMCA, and 6.8% go to a private gym or studio. Low-income respondents were less likely (38.3%) to exercise at home than those with incomes above 200% FPL (58.6%).

Q26. Where do you exercise or engage in physical activity?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=75	Hispanic/ Latino/ Other n=54	200% FPL or lower n=94	201% FPL or higher n=29	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=104
Home	40.4%	48.0%	35.2%	**38.3%**	**58.6%**	47.4%	33.3%	38.5%
Park	23.3%	21.3%	27.8%	26.6%	20.7%	15.8%	11.1%	26.9%
YMCA	10.3%	14.7%	5.6%	12.8%	6.9%	10.5%	33.3%	9.6%
Private gym or studio	6.8%	6.7%	5.6%	7.4%	3.4%	15.8%	11.1%	5.8%
Public Recreation Center	2.1%	2.7%	1.9%	0.0%	10.3%	0.0%	0.0%	1.0%

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ALCOHOL CONSUMPTION

FREQUENCY. 11.5% of respondents drink alcohol four or more times per week, 24.4% drink three or more alcoholic drinks on the days they do drink.

Q33-36: Alcohol Consumption	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic n=52	Hispanic/ Latino/ Other n=28	200% FPL or lower n=61	201% FPL or higher n=17	Private n=15	Medicare n=5	Medicaid/ Other/ Uninsured n=59
Drink alcohol four or more times a week	11.5%	9.6%	14.3%	13.1%	5.9%	0.0%	*	15.5%
Drink three or more alcoholic drinks per day	24.4%	23.5%	25.0%	26.7%	23.5%	14.3%	*	25.4%

***** *We did not report results when five or fewer respondents from a subgroup answered the question.*

PROBLEM DRINKING. 11.3% of respondents said that their alcohol use had led to health, social, legal, or financial problems. 3.4% said that it led to problems daily or almost daily.

Q37: In the past three months, how often has your alcohol use led to health, social, legal, or financial problems?	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=53	Hispanic/ Latino/ Other n=31	200% FPL or lower n=64	201% FPL or higher n=18	Private n=14	Medicare n=5	Medicaid/ Other/ Uninsured n=61
Never	88.8%	88.7%	90.3%	87.5%	94.4%	100.0%	*	86.9%
Once or twice	3.4%	3.8%	3.2%	4.7%	0.0%	0.0%	*	3.3%
Monthly	1.1%	1.9%	0.0%	0.0%	5.6%	0.0%	*	0.0%
Weekly	3.4%	3.8%	3.2%	3.1%	0.0%	0.0%	*	4.9%
Daily or almost daily	3.4%	1.9%	3.2%	4.7%	0.0%	0.0%	*	4.9%

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HAND-FIELDED SURVEY RESULTS: HEALTH & LIFESTYLE BEHAVIORS

SUBSTANCE USE

29.8% of respondents have used marijuana, and 7.4% have used another drug. 62.8% report no drug use at all. Those in the Hispanic/Latino/Other category were less likely (19.5%) to have used marijuana than non-Hispanic whites (38.9%).

Q38: Substance use	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=72	Hispanic/ Latino/ Other n=41	200% FPL or lower n=83	201% FPL or higher n=26	Private n=14	Medicare n=8	Medicaid/ Other/ Uninsured n=86
Marijuana only	29.8%	**38.9%**	**19.5%**	31.3%	26.9%	28.6%	25.0%	31.4%
Any other drug use	7.4%	4.2%	7.3%	7.2%	3.8%	0.0%	0.0%	9.3%

TOBACCO AND NICOTINE USE

More than one in four (28.7%) people indicated that they currently smoke at least some days or every day. Those in the Hispanic/Latino/Other category were less likely (18.5%) to be current smokers than non-Hispanic whites (36.5%). Smoking rates varied by income.

Q29: Smoking rates	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=74	Hispanic/ Latino/ Other n=54	200% FPL or lower n=93	201% FPL or higher n=29	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=101
Currently smoke cigarettes or e-cigarettes	28.7%	**36.5%**	**18.5%**	**33.3%**	**17.2%**	10.5%	33.3%	30.7%

All participants were asked to indicate any tobacco products that they currently use. The most common answers were cigarettes, e-cigarettes, and chewing tobacco. We found differences by race/ethnicity and by income.

Q30: Use of different tobacco products	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=74	Hispanic/ Latino/ Other n=54	200% FPL or lower n=93	201% FPL or higher n=29	Private n=19	Medicare n=9	Medicaid/ Other/ Uninsured n=101
Cigarettes	23.8%	**29.7%**	**14.8%**	25.8%	17.2%	10.5%	22.2%	24.8%
E-cigarettes or vaping	3.5%	5.4%	1.9%	5.4%	0.0%	0.0%	11.1%	4.0%
Chewing tobacco, snuff or snus	2.1%	4.1%	0.0%	**1.1%**	**6.9%**	5.3%	0.0%	1.0%

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SMOKING CESSATION

Respondents who indicated that they currently use tobacco products (n=101) were asked if they were trying to quit. 18.8% said that they were actively trying to quit using tobacco products. Non-Hispanic whites and those with incomes above 200% FPL were more likely to be trying to quit smoking.

Of those respondents currently trying to quit using tobacco (n=19), 52.6% were using no aid or going "cold turkey," 21.1% were using the patch, and 10.5% said they were relying on support from friends and family.

Q31: Actively trying to quit using tobacco products now	TOTAL	RACE/ETHNICITY		INCOME		INSURANCE		
		Non-Hispanic White n=57	Hispanic/ Latino/ Other n=34	200% FPL or lower n=72	201% FPL or higher n=17	Private n=14	Medicare n=6	Medicaid/ Other/ Uninsured n=72
Yes	18.8%	**28.1%**	**2.9%**	**15.3%**	**29.4%**	16.7%	33.3%	7.1%

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MAIL SURVEY RESULTS: CONCLUSIONS

KEY FINDINGS

HEALTH 14.4% of respondents self-report their overall health as 'Fair' or 'Poor' opposed to 'Good,' 'Very Good,' or 'Excellent.' 49.2% indicated that they had been told by their doctor that they have at least one chronic physical condition. High blood pressure (27.1%) and high cholesterol (23.0%) were the most common physical conditions. Respondents indicating that they had Medicare reported a significantly higher prevalence of diabetes, high blood pressure, and high cholesterol compared to those with other types of health insurance. 25.5% of respondents have been told by a health professional that they have at least one behavioral health condition; the most common behavioral conditions were depression (18.1%) and anxiety (19.3%). Low-income respondents were more likely (28.9%) to report current symptoms of anxiety than those with incomes above 200% FPL (5.2%). 31.0% of respondents were overweight, and 22.8% of respondents were obese.

28.8% of respondents reported that they have children under the age of 18. 21.6% of respondents with children were told by a doctor or health professional that at least one of their children has a behavioral health condition, and 10.7% were told that their child has a physical health condition. Asthma and anxiety were the most frequently reported childhood conditions selected.

ACCESS TO CARE 93.7% of respondents report that they are currently insured, and of those 42.2% are privately insured, 22.4% are insured through Medicare, and 22.3% have Medicaid or dual coverage. 20.0% of survey respondents do not have a personal doctor and 9.4% do not have a regular place for care for non-emergencies. 14.4% of respondents reported a need for mental health care, and 6.7% of all respondents did not get all the mental health care they needed. 19.9% of respondents went without needed dental care in the past year.

SOCIAL DETERMINANTS OF HEALTH 5% of respondents reported not having secure or stable housing and 9.1% reported being worried about losing their current housing. Almost two out of three (64.5%) respondents report experiencing at least one traumatic event; 26.7% have experienced three or more. The proportion of those who report adverse life experiences are disproportionately white (non-Hispanic).

HEALTH BEHAVIORS One out of three (33.5%) respondents reports eating less than two servings of vegetables per day and 45.7% report eating less than two servings of fruit each day. 29.2% indicate that they eat fast food at least twice each week. 12.1% of this survey population currently smokes tobacco, and 23.1% drink alcohol four or more times per week. 23.6% have used marijuana. 78.6% exercise less than they would like. Most (56.1%) exercise at home, although 22.9% use a private gym or studio and 12.7% use the YMCA.

PATTERNS & TRENDS

Results from the mail survey data depict a population in which nearly half (49.2%) have a chronic condition and one in four (25.5%) have a behavioral health condition. The population generally has access to health insurance and a usual source of care. However, one-fifth of respondents do not have a personal doctor, and nearly one-third (32.5%) of those in the Medicaid/Other/Uninsured category do not have a personal doctor. Not having a regular provider led to challenges in access to care; cost was also an important factor in unmet health care need.

Most respondents are able to meet basic needs, although nearly one in three low-income respondents (30.7%) reports housing instability and 27.4% of low-income respondents report transportation challenges. While most respondents reported some level of social support, 31.9% of low-income respondents report that they did not always have someone to get together with for relaxation and 31.0% report that they do not always have someone to confide in or talk to about their problems. On top of these challenges, nearly one in three (27.9%) of low-income respondents report both a behavioral health and a physical diagnosis, compared with just 10.4% of those with incomes above 200% FPL. Thus, while most of the survey population is able to get their needs met, low-income respondents as a group face significant challenges in achieving health and healthy living.

HAND-FIELDED SURVEY RESULTS: CONCLUSIONS

KEY FINDINGS

HEALTH 30.5% of respondents rated their overall health as 'Fair' or 'Poor' as opposed to 'Good,' 'Very good,' or 'Excellent.' A larger proportion of those who reported low income earnings also reported 'Fair' or 'Poor' health (39.8%) compared to those with higher income (14.3%). 44.5% of all respondents reported having at least one diagnosed physical condition. The most commonly reported conditions were asthma (24.1%) and high blood pressure (21.9%). Of those who reported these two common conditions, non-Hispanic white and low income groups were disproportionately affected. Additionally, within this population sample, over half (52.6%) have been told by a doctor that they have a mental health condition. 38.7% report having been diagnosed with anxiety and 40.1% with depression. Chronic conditions were more prevalent among non-Hispanic white respondents and low-income respondents. 38.7% of respondents have children under the age of 18. Of those, 23.5% indicate that at least one of their children has at least one physical condition and 31.4% have a mental health condition.

ACCESS TO CARE While 26.7% of all respondents report being uninsured, more than 44% of Hispanic/Latino/ Other respondents indicated they do not have heath insurance. Only 13% of the survey group had private insurance, and 42.5% were on Medicaid or were dual-eligible. 39.7% of respondents indicated that they do not have a personal doctor, and that number was significantly higher among the Hispanic/Latino/Other population (59.3%). 17.3% did not get all the health care they needed, 16.1% did not receive the mental health care they needed, and 2.8% did not receive the substance abuse care they needed.

SOCIAL DETERMINANTS OF HEALTH Nearly half of all survey respondents reported having an unmet need related to the social determinants of health (46.2%). Those with low income report unmet food, transportation, stable housing, prescription medication, and dental needs more often than their higher income counterparts. Additionally, the privately insured report lower rates of overall unmet needs than those who hold other types of insurance or are uninsured. Self-reported social support among lower income respondents and those without private insurance was significantly lower across all four question domains. 71.7% of all respondents report having experienced at least one traumatic event, and 42.8% have experienced three or more events. The most frequently reported traumatic events were witnessing or experiencing violence (47.1%), living with someone with mental illness or substance abuse (43.5%), and life-changing illness or injury (42.8%).

HEALTH BEHAVIORS Over half of the survey population reported eating less than two servings of fruits and vegetables per day (58.2% and 51.1% respectively). 26.4% indicated that they eat fast food at least two times weekly, and that number was significantly higher among non-Hispanic whites (33.3%). 68.3% indicate that they exercise less than they would like to, though only 28.5% report being less physically active than other people their age. 28.7% of this population smokes tobacco, however, 18.8% are actively trying to quit. Marijuana use was reported more often among non-Hispanic White respondents (38.9%) than others (19.5%).

PATTERNS & TRENDS

The dominant pattern throughout the hand-fielded survey responses was the disparity seen among lower income respondents across all domains. There is a demonstrated need for additional services and programs to assist people with lower income to attain basic needs services such as transportation and stable housing. Programming could also improve social support and reduce the burden of anxiety and depression.

UNDERSTANDING MAIL VS. HAND-FIELDED RESULTS

DIFFERENT POPULATIONS

The mail survey and hand-fielded survey populations differ in important ways. The mail survey was sent to a random sample of addresses, and therefore can be said to be generally representative of those who have stable addresses. Additionally, respondents to mail surveys tend to be disproportionately older than the general population. Although we did send surveys in Spanish and English, relatively few mail surveys were completed in Spanish. 0.8% preferred a language other than English, and 26.9% were on Medicaid.

In contrast, the hand-fielded survey population looks different. Although the sample was not random, respondents were recruited generally in safety-net and social service settings. Respondents were younger and more likely to be low-income; they were also less likely to be non-Hispanic whites. 17.1% said that they preferred a language other than English, and 47.0% were on Medicaid.

Merging data from the two surveys into a single dataset would offer a survey sample that was not representative, and it would compromise the generalizability of the random address-based sample. And yet, a mail survey still faces non-response bias. Those who don't respond to mail surveys are often younger, have lower incomes, and prefer languages other than English. This is the very population that responded to the hand-fielded survey.

Therefore, the two surveys are useful side-by-side because they offer complementary pictures of two populations that overlap within the Southern Oregon Service Area.

The **mail survey population** —broadly, those with stable addresses— faces some important community needs. Many struggle with high blood pressure and high cholesterol, some of them could use support with a healthy diet, some are housing insecure, and some may need social support.

The **hand-fielded survey population**— broadly, those supported by the safety net— face behavioral health challenges to a much greater degree. Many struggle with anxiety and depression. A greater percentage of them are uninsured and struggle to get access to the care they need. Many face housing insecurity or food insecurity, and social support is also a need.

The mail survey data revealed differences among subpopulations, but in many cases the subgroup sizes were too small to confirm that those differences were statistically significant. Fortunately, the hand-fielded survey population includes a greater number of low-income respondents, those in the Hispanic/Latino/Other category, and those in the Medicaid/Other/Uninsured category. For that reason, we were able to find more statistically significant differences by race/ethnicity and income using the hand-fielded survey data, and more significant differences by insurance in the mail survey. In many cases, the disparities confirm trends that were suggested by the mail survey data.

COMMUNITY HEALTH SURVEY

INSTRUCTIONS: For each question, please fill in the circle that best represents your answer. Your results are completely private, and you can skip any question you do not want to answer. When you are finished, place the survey in the postage-paid envelope we have provided and drop it in the mail. If you have questions about this survey, please read the included letter or call us at 1-877-215-0686.

PART 1 YOUR HEALTH CARE

These questions help us understand your health and health care.

1 Do you currently have any kind of health insurance?

◯ Yes ◯ No → **(Skip to Question 3)**

2 What kind of health insurance do you have? *Mark all that apply.*

- ◯ Medicaid/Oregon Health Plan (OHP)
- ◯ Medicare
- ◯ VA, TRICARE or other military health care
- ◯ Private coverage through an employer or family member's employer
- ◯ A private plan I pay for myself
- ◯ Other (tell us): _____
- ◯ I don't have any insurance now
- ◯ I don't know

3 If you **don't** currently have any kind of health insurance, what are the main reasons why? *Mark all that apply.*

- ◯ It costs too much
- ◯ I don't think I need insurance
- ◯ I am waiting to get coverage through a job
- ◯ Signing up is too confusing
- ◯ I haven't had time to deal with it
- ◯ Other (tell us): _____

4 Do you have a place to go for health care when it is not an emergency?

◯ Yes ◯ No → **(Skip to Question 6)**

5 Where do you usually go to receive health care when it is not an emergency? *Mark only one.*

- ◯ A private doctor's office or clinic
- ◯ A public health clinic or community health center
- ◯ A tribal health clinic
- ◯ A VA facility
- ◯ A hospital-based clinic
- ◯ A hospital emergency room
- ◯ An urgent care clinic
- ◯ Other (tell us): _____
- ◯ I don't have a usual place

6 Do you have **one person** you think of as your personal doctor or health care provider?

◯ Yes ◯ No

7 Was there a time in the **last 12 months** when you needed any type of health care?

◯ Yes ◯ No → **(Skip to Question 10)**

8 If you needed health care in the **last 12 months**, did you get **all** the care you needed?

- ◯ I got **all** the care I needed
- ◯ I got **some but not all** needed care
- ◯ I got **no care at all**
- ◯ I don't know

9 The **most recent time** you went without needed health care, what were the main reasons? *Mark all that apply.*

- ◯ Cost
- ◯ Not having a regular provider
- ◯ Not knowing where to go
- ◯ Couldn't get appointments quickly enough
- ◯ Offices aren't open when I can go
- ◯ Needed childcare
- ◯ Needed transportation
- ◯ Not having a provider that understands my culture or speaks my language
- ◯ Other reasons (tell us): _____

10 In the **last 12 months** have you needed treatment or counseling for a **mental health condition or personal problem**?

◯ Yes ◯ No → **(Skip to Question 14)**

11 If you did receive treatment or counseling for a mental health condition or personal problem in the **last 12 months**, where did you mostly go to get care? *Mark only one.*

- ◯ My primary care doctor's office
- ◯ A county clinic
- ◯ Hospital emergency room
- ◯ Other (tell us): _____

12 In the **last 12 months**, when you needed treatment or counseling for a mental health condition or personal problem did you get **all** the care you needed?

- ◯ I got **all** the care I needed
- ◯ I got **some but not all** needed care
- ◯ I got **no care at all**
- ◯ I don't know

13 The **most recent time** you went without needed mental health care, what were the main reasons? *Mark all that apply.*

- ◯ Cost
- ◯ Not having a regular provider
- ◯ Not knowing where to go
- ◯ Couldn't get appointments quickly enough
- ◯ Offices aren't open when I can go
- ◯ Needed childcare
- ◯ Needed transportation
- ◯ Not having a provider that understands my culture or speaks my language
- ◯ Other reasons (tell us): _____

14 In the **last 12 months** have you needed treatment or counseling for your use of alcohol or any drug, not counting cigarettes?

- ◯ Yes
- ◯ No → **(Skip to Question 17)**

15 In the **last 12 months**, when you needed treatment or counseling for your use of alcohol or drugs, did you get **all** the care you needed?

- ◯ I got **all** the care I needed
- ◯ I got **some but not all** needed care
- ◯ I got **no care at all**
- ◯ I don't know

16 The **most recent time** you went without needed drug or alcohol abuse treatment, what were the main reasons? *Mark all that apply.*

- ◯ Cost
- ◯ Not having a regular provider
- ◯ Not knowing where to go
- ◯ Couldn't get appointments quickly enough
- ◯ Offices aren't open when I can go
- ◯ Needed childcare
- ◯ Needed transportation
- ◯ Not having a provider that understands my culture or speaks my language
- ◯ Other reasons (tell us): _____

PART 2 YOUR HEALTH & LIFESTYLE

These questions give us a picture of your overall health.

17 In general, would you say your health is:

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor

18 Have you **ever** been told by a doctor or other health professional that you have any of the following?

	Yes	No
Diabetes or sugar diabetes	◯	◯
Asthma	◯	◯
High blood pressure	◯	◯
High cholesterol	◯	◯
Depression	◯	◯
Post-traumatic stress disorder	◯	◯
Anxiety	◯	◯
Another mental health condition	◯	◯

19 During the **past 2 weeks**, about how often have you been bothered by the following problems:

	Not at all	Several days	Over half the days	Nearly every day
Little interest or pleasure in doing things	◯	◯	◯	◯
Feeling down, depressed or hopeless	◯	◯	◯	◯
Feeling nervous, anxious or on edge	◯	◯	◯	◯
Not being able to stop or control worrying	◯	◯	◯	◯

20 To what extent have you experienced hardship, difficulty or traumatic events in your life?

	Not at all	Some	A lot
Life changing illness or injury	◯	◯	◯
Neglect of any kind	◯	◯	◯
Lived with someone with mental illness or substance abuse	◯	◯	◯
Witnessed or experienced violence	◯	◯	◯
Forced to do something sexual that you didn't want to do	◯	◯	◯
Physically hurt or threatened by an intimate partner	◯	◯	◯
Abuse of any kind	◯	◯	◯
Other traumatic event (tell us):_____	◯	◯	◯

21 During a **typical** day, how many servings of fruit do you usually eat? *A serving is one piece of fruit or about a cup of cut-up fruit. Don't count juices.*

↳ _____ servings per day

22 During a **typical** day, how many servings of vegetables do you usually eat? *A serving is about a cup of vegetables like green beans, salad or potatoes. Don't include fried foods like french fries.*

↳ _____ servings per day

23 During a **typical** day, how many servings of soda, such as Coke or 7-Up, do you usually drink? *A serving is about one can. Don't count diet drinks.*

↳ _____ servings per day

24 During a **typical** week, about how many times do you eat fast food

↳ _____ times per week

25 Do you exercise as much as you would like?

- ◯ Yes
- ◯ No

26 Where do you go to exercise or engage in physical activity?

- ◯ YMCA
- ◯ Park
- ◯ Public recreation center
- ◯ Private gym or studio
- ◯ Home
- ◯ Other (tell us): _____

27 Compared to other people your age, would you say you are…

- ◯ More physically active
- ◯ Less physically active
- ◯ About the same

28 Have you smoked at least 100 cigarettes in your entire life?

- ◯ Yes
- ◯ No

29 Do you **currently** smoke cigarettes or e-cigarettes?

- ◯ Every day
- ◯ Some days
- ◯ Not at all

30 Do you now use any of the following tobacco products? *Mark all that apply.*

- ◯ Cigarettes
- ◯ Cigars
- ◯ E-Cigarettes
- ◯ Vaping
- ◯ Nicotine
- ◯ Chewing tobacco, snuff or snus
- ◯ I do not use any of the above products → **(Skip to Question 33)**

31 Are you actively trying to quit using tobacco products **now**?

- ◯ Yes
- ◯ No → **(Skip to Question 33)**

32 If you are actively trying to quit using tobacco, which methods are you using? *Mark all that apply.*

- ◯ Patch
- ◯ Quitline
- ◯ Nicotine gum
- ◯ Prescription (Chantix, etc.)
- ◯ Support group or program
- ◯ Support from friends or family
- ◯ Support from my doctor
- ◯ I'm quitting by myself / going "cold turkey"

33 How often did you have a drink containing alcohol in the **past year**?

- ◯ Never → **(Skip to Question 38)**
- ◯ Monthly or less
- ◯ 2-4 times a month
- ◯ 2-3 times a week
- ◯ 4 or more times a week

34 How many days per week do you drink alcohol?

- ◯ 0 to 1
- ◯ 2 to 3
- ◯ 4 to 5
- ◯ 6 to 7

35 On the days when you did drink alcohol, how many drinks did you usually have **per day**? *A 'drink' is one beer, one glass of wine or one shot of liquor.*

- ◯ 1 or 2
- ◯ 3 or 4
- ◯ 5 or 6
- ◯ 7 to 9
- ◯ 10 or more

36 How often did you have six or more drinks containing alcohol in the **past year**?

- ○ Never
- ○ Less than monthly
- ○ Monthly
- ○ Weekly
- ○ Daily or almost daily

37 In the **past 3 months**, how often has your alcohol use led to health, social, legal or financial problems?

- ○ Never
- ○ Once or twice
- ○ Monthly
- ○ Weekly
- ○ Daily or almost daily

38 In the **last 12 months**, have you or anyone in your household used any of the following? *Mark all that apply.*

- ○ Marijuana, pot, grass, hash or hash oil
- ○ Opioids not as prescribed (oxycodone, heroin, morphine, methadone, codeine, etc.)
- ○ Cocaine (coke, crack, etc.)
- ○ Amphetamine-type stimulants (meth, speed, diet pills, ecstasy, etc.)
- ○ Any other street drug
- ○ I did not use any of these in the last 12 months

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

- ○ Yes
- ○ No → **(Skip to Question 41)**

40 Have you **ever** been told by a doctor or other health care professional that any of your children have any of the following?

	Yes	No
Diabetes or sugar diabetes	○	○
Asthma	○	○
A behavioral or mental health diagnosis (such as depression, anxiety or ADHD).	○	○
A developmental delay or learning disability (such as Autism or Dyslexia)	○	○
Depression	○	○
Post-traumatic stress disorder	○	○
Anxiety	○	○
Another ongoing health condition	○	○

(tell us): _____

PART 3 YOUR HOUSEHOLD FINANCES

These questions help us understand finances for you and your family.

41 Which of the following best describes your housing situation today? *Mark all that apply.*

- ○ I have housing of my own, and I'm NOT worried about losing it
- ○ I have housing of my own, but I AM worried about losing it
- ○ I'm staying in a hotel
- ○ I'm staying with friends or family
- ○ I'm staying in a shelter, in a car or on the street
- ○ Other (tell us): _____

42 In the past 12 months, have you or someone in your household had to **go without** any of the following when it was really needed because you were having trouble making ends meet?

	Yes	No
Food	○	○
Utilities	○	○
Transportation	○	○
Clothing	○	○
Stable Housing or Shelter	○	○
Medical Care	○	○
Medicine	○	○
Child Care	○	○
Dental Care	○	○

PART 4 ABOUT YOU & YOUR FAMILY

These questions help us understand more about you, your living situation and your family.

43 How often do you think you would have someone available to do each of the following?

	None of the time	Some of the time	Most of the time	All of the time
Love you and make you feel wanted?	○	○	○	○
Give you good advice about a crisis?	○	○	○	○
Get together with for relaxation?	○	○	○	○
Confide in or talk to about your problems?	○	○	○	○
Help you if you were confined to a bed?	○	○	○	○

44 Are you male, female or transgender?

○ Male ○ Female ○ Transgender

45 What year were you born? 19____

46 What is your height?

↳ _____ Feet _____ Inches

47 About how much do you currently weigh?

↳ _____ pounds

48 Are you Hispanic or Latino?

○ Yes
○ No

49 Which one or more of the following would you say is your race? *Mark all that apply.*

○ White
○ Black or African-American
○ Asian
○ Native Hawaiian or Other Pacific Islander
○ American Indian or Alaska Native
○ Don't know / Not sure
○ Prefer not to answer

50 What language do you speak best? *Mark only one.*

○ English
○ Spanish
○ Vietnamese
○ Russian
○ Other (tell us): _____

51 What is the highest level of education you have completed? *Mark only one.*

○ Less than high school
○ High school diploma or GED
○ Vocational training or 2-year degree
○ A 4-year college degree
○ An advanced or graduate degree

52 Are you currently employed or self-employed?

○ Yes, employed by someone else
○ Yes, self-employed
○ Not currently employed
○ Retired

53 About how many hours per week, on average, do you work at your current job(s)? *Your best estimate is fine.*

○ I don't currently work
○ Less than 20 hours per week
○ 20-39 hours per week
○ 40 or more hours per week

54 Have you or a member of your family with whom you reside: *(Mark only one)*

○ Moved in the last 12 months to another area (established a temporary home) in order to work primarily in agriculture?
○ Stayed in the area for the last 12 months in order to work primarily in agriculture?
○ Does not apply to me

55 What is your gross household income (before taxes and deductions are taken out) for last year (2015)? *Your best estimate is fine.*

○ $0
○ $1 to $10,000
○ $10,001 to $20,000
○ $20,001 to $30,000
○ $30,001 to $40,000
○ $40,001 to $50,000
○ $50,001 to $60,000
○ $60,001 to $70,000
○ $70,001 to $80,000
○ $80,001 to $90,000
○ $90,001 to $100,000
○ $100,001 or more

56 Altogether, how many people currently live in your home? *Count adults and children under 18.*

↳ Me, plus ___ other adults and ___ children.

57 What is your zip code? _____

58 We may ask some participants to participate in listening sessions or other research (and be compensated for their time). If your household is selected again, are you interested?

○ No
○ Yes → *Is there a good phone number to reach you? (include area code):*

_____

and/or E-mail:

_____

STOP HERE

Thank you very much for taking time to complete this survey. Please place the survey in the postage-paid envelope and mail it.

Contact us at 1-877-215-0686 or core@providence.org with any questions.

03/31/16

Appendix II – Key Stakeholder Interviews

Key Community Stakeholder Interview	Hospital Representatives
Date and Time Of Interview **Location**	*(please list all attendees)*
Key Community Stakeholder Names/Titles *(please list all attendees)*	
Organization Name	
Address	
Phone(s)/Email	
How would you describe your organization's role within the community?	
How would you describe the geographic area your organization serves?	
Please identify and discuss specific unmet health needs in your community for the persons you serve:	
Can you prioritize these issues? What are your top concerns?	
Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health needs cited above. We have a particular concern for those that are low income, vulnerable or are experiencing health inequities.	
What existing community health initiatives or programs in your community are helpful in addressing the health needs of the persons you serve, especially with identifying health needs earlier? Can you rank them in terms of effectiveness?	
What other things do you think we should hear about?	
Other comments:	

2016 Jackson County CHNA Key Stakeholders Interviewed:

Cynthia Ackerman, Chief Quality Officer, AllCare Health
Hannah Ancel, Community Engagement Coordinator, Jackson Care Connect
Jackson Baures, Division Manager, Jackson County Public Health Services
Stacy Brubaker, Division Manager, Jackson County Mental Health
Corey Falls, Sheriff, Jackson County
Doug Flow, Chief Executive Officer, AllCare Health
Heidi Hill, Engagement Program Manager, Jackson Care Connect
Socorro Holloway, Council President, St. Vincent de Paul Rogue Valley
Tiffany Lambert, Special Services Director, Eagle Point School District
Dan Peterson, Fire Chief, Jackson County Fire District 3
Tammi Pitzen, Children's Advocacy Center of Jackson County
Tania Tong, Medford School District
Angela Warren, Collaboration Manager, Jefferson Regional Health Alliance
Hank Williams, Mayor, City of Central Point

Appendix III – Community Listening Session Guide

Jackson County Needs Assessment: Listening Session Discussion Guide
(Adapted from Healthy Columbia Willamette Collaborative, 2016)

Preface with purpose of conversation, context of overall flow and topics to be covered, and why their participation is important.

INTRODUCTION

We have a little over an hour to talk, and I'd like to start with a creative activity. I'd like you to start by thinking about your community. People might think of "community" in different ways. Maybe it's family, or maybe it's neighbors, or maybe it's coworkers or friends. For the next 5 minutes, draw a picture that represents **your community**.

Pause, give people ~5 minutes to draw. Facilitator should draw too.

So let's go around in a circle—tell me your name, and tell us something about the community represented in your drawing. We will each have about thirty seconds to share. I'll start.

Facilitator introduces self, models talking about community.

Then everyone goes in a circle, introducing self and saying a few words about their community.

Thank you all for sharing. That leads into what we're going to talk about next: the health of your community. This is going to be an informal discussion. We want to hear about your ideas, experiences and opinions. Everyone's comments are important. They might be similar or very different, but they all should be heard. The goal today is to record everyone's opinions.

CONTEXT

What we were hoping to talk about today is: ***What makes a healthy community?***

That's a difficult question, because it involves two ideas. First, there's ***HEALTH***. What do we mean by health? Do we mean freedom from disease? Having enough to eat? Feeling generally good about life? Being financially healthy?

Then there's the idea of ***COMMUNITY***. What do we mean by community? Are we talking about each one of you, individually? Are we talking about your friends and family? Your neighborhood? Your church? Your racial or ethnic group? Your city or town?

We're not going to define these things for you. We're going to keep it open.

QUESTION 1. VISION . Now take a minute to think about your community—that community that is represented in your drawing. How can you tell when your community is healthy?

Instructions: write ideas on the poster.

QUESTION 2. NEEDS.

So we've talked about what a healthy community looks like. Now let's talk about what's not there or what you need more of.

What's needed? What more could be done to help your community be healthy?

Instructions: write ideas on the poster.

QUESTION 3. STRENGTHS. So you've told us what a healthy community looks like and what the needs are in your community. Let's explore this idea a little more. Communities have certain **resources** that can help them be healthy. It might be programs. It might be a park or a community center. It might be a really great teacher at your local school. It might be a local business or a local organization that helps people be healthy.

My question for you is:

What's working? What are the resources that CURRENTLY help your community to be healthy?

Instructions: write ideas on the poster.

Wrap-Up: Thank participants for coming, describe any next steps. Make sure folks signed in for an appropriate count, and distribute gift cards/incentives as they leave.

Appendix IV – 2017-2019 Community Health Improvement Plan

PROVIDENCE
Medford
Medical Center

Community Health Improvement Plan
2017-2019

Providence Medford Medical Center
Jackson County, Oregon

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2017-2019

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Providence Medford Medical Center
1111 Crater Lake Avenue
Medford, OR 97504

TO OUR COMMUNITY MEMBERS,

It is with great pleasure that we present the findings of our Community Health Needs Assessment and resulting Community Health Improvement Plan. Over 160 years ago, the Sisters of Providence came to the Northwest with the goal of addressing the most pressing needs of the time. Today, through their *Hopes and* Aspirations document, the Sisters call us to "be open to the call of those who suffer by addressing emerging needs with wise and discerning responses". Providence is pleased to partner with many agencies in our communities to address the most pressing health and social determinant needs in each of our service areas. We are uniquely positioned to use our role as a primary, acute, and specialty care provider, insurer, and the largest employer in the state to truly impact the health of our communities.

We are grateful for the partnership of community organizations, survey respondents, listening session participants, interviewees, and many others in the development of these needs assessments and plans. We know that addressing these challenges will require long-term commitment, systemic change, and expertise outside of the health system. Our communities have many strengths, and it is our privilege to support programs and organizations actively addressing these needs, as well as generating momentum to think differently about these services within our own organization.

Finally, let us thank you for your interest in reviewing this plan and engaging in our community health improvement efforts. We believe that this work is central to our strategic vision of creating healthier communities, together.

Sincerely,

Pamela Mariea-Nason, RN, MBA
Executive, Community Health Division
Providence Health & Services – Oregon

Executive summary

Purpose

This Community Health Improvement Plan is based upon the findings of our 2016 Community Health Needs Assessment. This plan is specifically designed to serve the Jackson County area, which is ProvidenceMedford Medical Center's primary service area. Each of these interventions will be prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods.

This plan is intended to serve as a guiding document for community investment, community building and development, and community health efforts through 2019. It will be reviewed and updated annually or as needed to recognize new partners, initiatives, and metrics as they are available. Importantly, this plan is not intended to be an exhaustive inventory of all of Providence's efforts to address these needs. Rather, this document highlights those efforts that are measurable and community-based. This plan should be reviewed in conjunction with our annual Community Benefit report, which will provide additional narrative and will be updated in June of each year.

Summary of prioritized needs

Access to care

- Primary care
- Dental care
- Culturally-responsive care

Behavioral health

- Mental health services (including youth and adolescent suicide)
- Substance use treatment
- Trauma/adverse experience prevention and building resilience

Chronic conditions

- Diabetes
- Hypertension
- Obesity (particularly amongst youth and adolescents)

Social determinants of health and well-being

- Affordable housing
- Healthy food access
- Living wage jobs
- Transportation

Many of these needs will be directly addressed through internal initatives and community partnerships over the next three years. You will find additional information about our specific actions and how we will measure our success in the following sections.

Introduction

CREATING HEALTHIER COMMUNITIES, TOGETHER

As health care continues to evolve, Providence is responding with dedication to its Mission and a core strategy to *create healthier communities, together*. Partnering with others of goodwill, we conduct a formal community health needs assessment to learn about the greatest needs and assets from the perspective of some of the most marginalized groups of people in communities we serve. This assessment helps us develop collaborative solutions to fulfill unmet needs while continuing to strengthen local resources. It guides our community benefit investments, not only for our own programs but also for many partners, toward improving the health of entire populations. Through strategic programs and donations, health education, charity care, medical research and more, Providence Health & Services provided over $1.1 billion in community benefit across Alaska, California, Montana, Oregon and Washington during 2016.

Serving our communities

About us

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. Providence's combined scope of services includes 34 hospitals, 475 physician clinics, senior services, supportive housing and many other health and educational services. The health system and its affiliates employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington – with its system office located in Renton, Washington. Our community health activities are rooted in the charitable work the Sisters of Providence started nearly 160 years ago when they answered a call for help from a new pioneer community in the West.

Mission
As people of Providence, we reveal God's love for all, especially the poor and vulnerable, through our compassionate service.

Vision
Together, we answer the call of every person we serve: Know me, Care for me, Ease my way. ®

Values
Respect, Compassion, Justice, Excellence, Stewardship

Purpose of this plan

In 2016 Providence Medford Medical Center conducted a community health needs assessment. This community health improvement plan is designed to address key health needs identified in that assessment. The prioritized needs were chosen based on community health data and identifiable gaps in available care and services. In the course of our work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration. These are:

Providence prioritized needs
Access to care • Primary care • Dental care • Culturally-responsive care **Behavioral health** • Mental health services • Substance use treatment • Trauma/adverse experience prevention and resilience building **Chronic conditions** • Diabetes • Hypertension • Obesity (particularly youth and adolescents) **Social determinants of health and well-being** • Affordable housing • Healthy food access • Living wage jobs • Transportation

Our overall goal for this plan

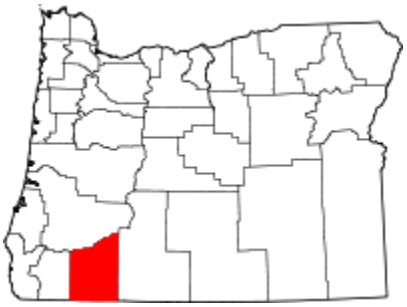
As we work to create healthier communities, together, the goal of this improvement plan is to measurably improve the health of individuals and families living in the areas served by Providence Medford Medical Center and across Jackson County. The plan's target population includes the community as a whole, and specific population groups including minorities, low-income, and other underserved demographics living in high needs areas.

This plan includes components of education, outreach, prevention, and treatment, and features collaboration with other community organizations working in alignment with the Providence Mission to address these identified needs. The plan's implementation will be facilitated by the hospital through the regional Community Health Division, hospital executive leadership, and members of the Service Area Advisory Council.

This plan is intended to serve as a guiding document for community investment, community building and development, and community health efforts through 2019. It will be reviewed and updated annually or as needed to recognize new partners, initiatives, and metrics as they are available. Importantly, this plan is not intended to be an exhaustive inventory of all of Providence's efforts to address these needs. Rather, this document highlights those efforts that are measurable and community-based. This plan should be reviewed in conjunction with our annual Community Benefit report, which will provide additional narrative and will be updated in June of each year.

Community Profile

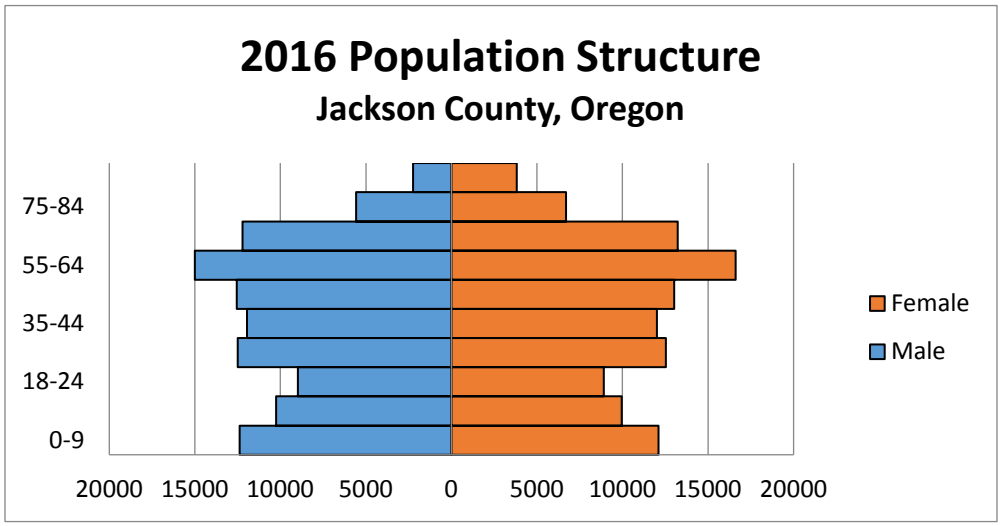
Jackson County, Oregon



Providence Medford Medical Center primarily serves Jackson County in Oregon. Providence has seven additional hospitals in the northern part of the state as well as a medical group.

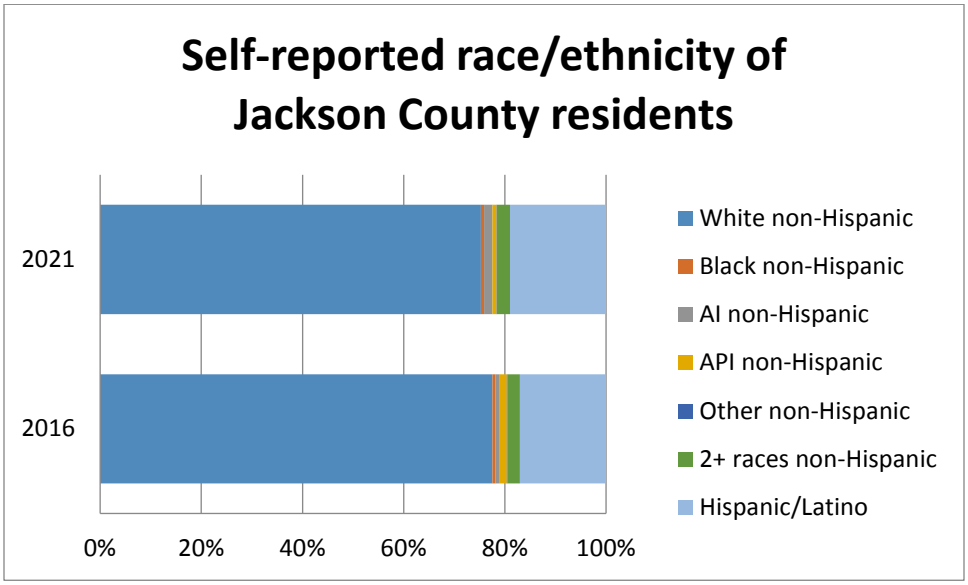
POPULATION AND DEMOGRAPHICS

As of 2016, Jackson County is home to approximately 213,000 residents. The population of Jackson County has a near-normal distribution. The ratio of males to females is 1:1 through the age of 55, when females begin making up a greater proportion of the total population. Due to life expectancy, females often outnumber males at older ages, but the trend starts slightly earlier in Southern Oregon than normal. Just over 20 percent of the population is 65 or older, a greater proportion than elsewhere in the country, where the average is 15 percent.



Ethnicity

The vast majority of residents (77.5 percent) identify are White non-Hispanic. The second largest population group in Jackson County is individuals who identify as Hispanic/Latino, making up 17 percent of the population. The Hispanic/Latino population is expected to make up 19 percent of the total population by 2021, with the White non-Hispanic population slightly decreasing to approximately 75 percent of the total population.



Income and Housing

The area's median household income is $44,086 and the per capita income was below $25,000, slightly lower than the State of Oregon as a whole ($49,260 and $26,171, respectively). The current rental market has less than 1 percent vacancy.

Health and Wellbeing

In Jackson County, 28 percent of adults suffer from depression and over 17 percent of 11th grade students report suicidal ideation. Nearly 33 percent are Oregon Health Plan members and nearly 25 percent are Medicare beneficiaries. Of those surveyed, nearly 46 percent of respondents report having fewer than two servings of fruit per day and over 35 percent report having fewer than two servings of vegetables.

SUMMARY OF PROVIDENCE PRIORITIZED NEEDS AND ASSOCIATED ACTION PLANS

The prioritized needs were chosen based on various community health data and identifiable gaps in available care and services. These health needs were those that had worsened over time, are worse than the state or national average, or have a disproportionate impact on those who are low-income, communities of color, or otherwise marginalized populations. In the course of our work, we determined that emphasis on these needs would have the greatest impact on the community's overall health with significant opportunities for collaboration. These interventions will be prioritized based upon relative needs and opportunities, particularly those that serve identified high needs ZIP codes and neighborhoods including low-income and minority populations.

ACCESS TO CARE

- Timely and consistent access to **primary care** remains a challenge, particularly for those on the Oregon Health Plan (Mediciad) and the remaining uninsured.
- **Dental** conditions are among the top preventable reasons uninsured individuals access the Emergency Department, which is rarely the best point of care for these conditions. This presents opportunity for prevention education and increasing access to preventive services.
- As the population is diversifying, it is increasingly important that community members feel welcome, safe, and respected in healthcare settings. One of the greatest opportunities to improve health amongst low-income and minority communities is to increase access to **culturally-responsive care**.

BEHAVIORAL HEALTH

- **Mental health services** remain a barrier for many community members. There is need to reduce stigma associated with mental health treatment and increase availability of providers and treatment services. This is particularly true amongst youth and adolescents, presenting opportunities to partner with school-based health centers.
- Access to **substance use treatment** continues to be a challenge for many. This includes alcohol and drug addiction services, both residential and outpatient treatment options. Oregon has relatively high rates of death from drug overdose, drug use (heroin, methamphetamines, and narcotics), and binge drinking.
- As we continue to learn about adverse childhood experiences (ACES) and the impacts of trauma on health later in life (i.e. child abuse, neglect, domestic violence, sexual assault, etc), increasing **community resilience** and preventing exposure to these events in the first place has become increasingly important.

CHRONIC CONDITIONS

- **Diabetes** continues to be one of the top reasons uninsured adults seek care in an Emergency Department, though the condition is likely better managed in a primary care setting. This suggests opportunities regarding prevention, education, and nutrition support.
- Similarly, **hypertension** is among the top three diagnosed conditions in uninsured adults using the Emergency Department. The fact that emergency care was required suggests need for primary care, education regarding self-management, medication access, and nutrition support.
- **Obesity** is a public health challenge, for both youth and adults. The current generation of youth may be the first to have a shorter life expectancy than their parents due to complications from obesity and its associated conditions.

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

- **Affordable housing** (or housing accessibility) is a major challenge for low and moderate income families in the area, particularly for those in recovery. Housing and rental prices are increasing faster than the median income, making it difficult for people to stay close enough to their places of employment, care, and children's school. Safe, secure housing has been proven to improve health outcomes.
- A key barrier for many of Oregon's families continues to be **healthy food access**. More than half of the state's students are on free or reduced price lunch, with four school districts in Jackson County serving populations where over 60 percent of the students qualify. Improvements in nutrition can further improve oral health and chronic conditions.
- Economic development and **living-wage jobs** are key opportunities to improve the health and well-being of our communities. Families expressed concern about working full-time or multiple jobs and still not being able to afford healthy food or housing. Adverse experiences and trauma are more likely in low-income households, particularly those in which the parents are stressed about resources. This also speaks to the challenge in Oregon of the "benefits cliff," whereby families lose many of their social service benefits at the same point.
- **Transportation** is a challenge for some populations, particularly for the elderly and those in more rural areas. Many are dependent on others for rides to work, medical appointments, or other basic errands.

ACCESS TO CARE

Goals

- Community members will have improved access to timely, consistent primary care
- Community members will experience more accessible preventive and primary dental care and improved oral health
- Community members will be able to receive healthcare services in a culturally-responsive and welcoming setting

Objectives

- Providence Medical Group will continue to provide care for over 8,500 Oregon Health Plan members
- Support federally-qualified health centers (FQHC) and school-based health centers (SBHC) to extend hours and services to improve primary care access
- Support at least 8 free- or reduced-cost dental clinics per year and reduce Emergency Department visits for dental conditions

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Improve access by providing primary care homes for Oregon Health Plan members in Providence Medical Group	Current CCO enrollment (December 2016): 9,728
Partner with St. Vincent de Paul and Medical Teams International to provide free- or reduced-cost dental services	98 adults received dental care
Partner with Rogue Community Health to support mobile dental outreach, particularly in the Upper Rogue	Number served
Partner with Rogue Community Health to support the Integrated Health & Wellness program, including community health worker visits	1,833 served; 423 enrolled in insurance; 34% reduction in HgA1C levels
Promote enhanced diversity in hiring practices within Providence to better reflect the community being served	Partner with Human Resources to enhance cultural competency in our workforce

Existing partners

Partners listed above are highlighted here to note the specific area their program(s) address. A more complete list of potential partners is provided at the end of this document.

Organization	Primary Care	Dental Care	Culturally-Responsive
All Care	x		
Jackson Care Connect	x		
Medical Teams International		x	
Rogue Community Health	x	x	x
St. Vincent de Paul		x	

BEHAVIORAL HEALTH

Goals

- Community members will have increased access to timely and affordable mental health treatment, including supportive services and therapy
- Stigma associated with mental health and substance use will be reduced
- Youth and teen suicide attempt and completion rates will be reduced
- Community members will have improved access to substance use treatment when needed, including residential or outpatient services as appropriate
- Fewer children will experience abuse, neglect, racism, discrimination, and other adverse experiences that are harmful throughout life and negatively impact health outcomes. Adults with traumatic experiences will be supported in their recovery through resilient communities.

Objectives

- At least three Mental Health First Aid trainings will be provded in a train-the-trainer model
- Implement stigma reduction training and social media campaign through high schools and school-based health centers beginning Fall 2018
- All providers will have access to trauma-informed care training; at least 80% of Emergency Department providers will have received training in trauma-informed care by December 2019

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Partner with Rogue Retreat to establish Hope Village and supportive programs for residents	Number housed; self-sufficiency scores
Partner with NAMI Oregon to support Mental Health First Aid training (train-the-trainer)	Number of trainees certified as trainers
Provide training in trauma-informed care for Emergency Department and other providers	Number of staff trained (ED and other)
Partner with United Way of Jackson County to support ACES/implicit bias training in schools	Number trained; students reached
Provide reduced or no-cost access to the “Persistent Pain” education program	Number served; trainings completed; self-assessment

Existing partners

Partners listed above are highlighted here to note the specific area their program(s) address. A more complete list of potential partners is provided at the end of this document.

Organization	Mental health services	Substance use treatment	Trauma prevention
United Way of Jackson County			x
Rogue Retreat	x	x	
NAMI Oregon	x	x	x

CHRONIC CONDITIONS

Goals

- Community members will have improved access to education and self-management cirriculums for chronic disease in both English and Spanish
- Chronic disease burden will be reduced, particularly within communities of color
- Community members will have increased opportunity for physical acticity and nutritious eating, particularly youth and adolescents

Objectives

- Emergency department utilization for chronic conditions, particularly diabetes and hypertension, will be reduced through increased access to primary care and meeting social determinant needs
- Patients with diagnosed conditions will have access to chronic condition self-management education
- Individuals with diagnosed chronic conditions will have unmet social needs addressed as part of care
- More youth will report adequate physical activity and healthy behaviors due to Providence's Healthier Kids, Together Initiative

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Partner with Kids Unlimited on Health & Wellness program for youth	Participation; behavior change; attendance
Implement 5-2-1-0 messaging in clinics and with community parnters	Clinics providing 5-2-1-0 messaging; health behavior change
Partner with YMCA on Junior Wellness program to increase physical activity and nutrition in youth	Number served; behavior change

Existing partners

Partners listed above are highlighted here to note the specific area their program(s) address. A more complete list of potential partners is provided at the end of this document.

Organization	Diabetes	Hypertension	Obesity
Kids Unlimited	x		x
Rogue Valley YMCA			x
Rogue Community Health	x	x	x

SOCIAL DETERMINANTS OF HEALTH AND WELL-BEING

Goals

- Community members will have improved access to safe, stable housing
- Community members will have increased access to affordable healthy food
- Community members will be able to support themselves and their families on one full-time job (or equivalent)
- Community members, particularly elderly and those in rural communities, will have access to convenient, frequent public transit or ride share services

Objectives

- Provide safe and secure discharge for at least 400 individuals needing short-term social service support annually
- Fewer working families will report having to work multiple jobs to make ends meet
- Fewer elderly adults and community members will recognize transportation as a barrier to receiving needed primary care and safe discharge
- Community members and providers will have increased awareness of available social service resources

Action plan and baseline or proposed measurement

Action plan	2016 baseline or proposed measurement
Explore opportunities to implement Community Resource Desk model in 2018	Project plan developed; resource connection rate
Partner with Project Access NOW to connect eligible clients to Patient Support Program	485 patients supported with social needs for safe discharge
Support the Oregon Business Council's Poverty Reduction Task Force, including policy reform for working families	Legislation that supports working families and eases the "benefits cliff"
Partner with Partners for a Hunger-Free Oregon to support summer meal sites	Number served; enrichment activities
Support 211-info to provide community and provider trainings on local social service resources	Trainings completed; number of attendees

Existing partners

Partners listed above are highlighted here to note the specific area their program(s) address. A more complete list of potential partners is provided at the end of this document.

Organization	Housing	Food	Jobs	Transportation
211-info	x	x		x
Oregon Business Council			x	
Partners for a Hunger-Free Oregon		x		
Project Access NOW	x	x		x
St. Vincent de Paul	x	x	x	x

Healthier Communities Together

As outlined, Providence is working to address each of the identified needs in a variety of ways over the next three years. That said, it is important to note that some of this work will be completed in more indirect ways than others. To address systematic issues, like living wage jobs, Providence will work with a diverse coalition of stakeholders to move this issue forward. Utilizing our relationships with elected officials, business leaders and union representatives – we are well positioned to promote public policy changes that support Oregon families.

Although the built environment was not specifically called out, we recognize that it is an important component of the health and well-being of our communities. Our priority areas and initiatives were selected based on our findings from relevant data, conversations with people living in our community and the opportunities we have to make marked improvements in the coming years. We will seek out opportunities to support local jurisdictions and community organizations focused on access to safe parks, pedestrian and bicycle-friendly transportation, and other components of the built environment that lead to improved health outcomes.

Providence cannot address the significant community health needs independently. Improving community health requires collaboration across community stakeholders. Below outlines a list of community resources potentially available to address identified community needs.

Organization	Associated Community Need(s)*
211-info	SDH
ACCESS	SDH
Addictions Recovery Center	BH
All Care	AC
Ashland Family YMCA	CC
Children's Advocacy Center	BH, SDH
Compass House	BH
Family Nurturing Center	BH
Jackson Care Connect	AC
Jackson County Health & Human Services	AC, BH, CC
Jefferson Regional Health Alliance	Funding/coordinating partner
Kairos	BH
Kids Unlimited	CC, SDH
La Clinica del Valle	AC, BH, CC
Magdalene Home	SDH
Maslow Project	BH
Medical Teams International	AC
Mercy Flights	AC, BH
NAMI Oregon	BH
Oregon Business Council	SDH
Partners for a Hunger-Free Oregon	SDH
Project Access NOW	AC, SDH
Rogue Community Health	AC, BH, CC
Rogue Retreat	BH, SDH
Rogue Valley Council of Governments	BH, SDH

Rogue Valley YMCA	CC
St. Vincent de Paul	SDH
United Way of Jackson County	BH, SDH

*Legend: AC=Access to care, BH=Behavioral health, CC=chronic conditions, SDH=social determinants of health and well-being

PLAN APPROVAL

Cindy Mayo 4/27/2017

Cindy Mayo Date
Chief Executive, Providence Medford Medical Center
Co-Chair, Southern Oregon Service Area Advisory Council
Providence Health & Services – Oregon

Len Hebert Date 5/2/17
Co-Chair
Southern Oregon Service Area Advisory Council
Providence Health & Services – Oregon

Date 5/1/17

Joel Gilbertson
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Providence St. Joseph Health

This plan was adopted on April 24, 2017.

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