UMPQUA HEALTH ALLIANCE

Douglas County, Oregon
2023 Community Health Assessment

Contents

Land Acknowledgement

We want to respectfully acknowledge the Cow Creek Band of Umpqua Tribe of Indians ("Tribe" or "Cow Creek"), who have stewarded these lands since time immemorial.

We want to further acknowledge the Tribe's deep cultural and spiritual connection to these lands in addition to its entire interest and ancestral areas, which includes more than six million acres located within the Rogue and Umpqua River Watersheds. These lands and the vibrant resources within them have been important since time immemorial and will continue to be a vibrant part of Tribe's cultural identity for generations to come.

We recognize the preexisting and continued sovereignty of the Tribe and thank them for continuing to share their Indigenous knowledge and perspective on how we might work together to manage and care for these shared resources sustainably, with mutually beneficial outcomes.

We commit to engaging in a respectful, meaningful, and successful partnership as we explore shared stewardship of these lands.

Acknowledgements

The Board, leadership, and staff of Umpqua Health Alliance are grateful to the partners and stakeholders who devoted their leadership, dedication, professional expertise, and time to achieve this milestone for Douglas County.

A special thank you to:

- The UHA Community Advisory Council and Steering Committee Members for dedicating their time and expertise to advising the Community Health Assessment.
- Community partners who helped organize focus groups, including Creating Community Resilience, Umpqua Valley BIPOC Group, Phoenix School of Roseburg, Umpqua Heart, and Cow Creek Band of Umpqua Tribe of Indians.
- Bevin Ankrom, Juliete Palenshus, Danita Tracy-Carter, Jacqueline McCall, and Cady Lyon who helped to facilitate the community member focus groups.
- Community members who spent time sharing their experiences through the community survey and focus groups.

Health Assessment Planning Leads

Kathryn Hart, Community Engagement Manager, Umpqua Health Alliance

Kat Cooper, Community Engagement Coordinator, Umpqua Health Alliance

Community Advisory Council (CAC)

Community Advisory Councils (CACs) are a key component of the unique Oregon Coordinated Care Organization (CCO) model. CACs are governing bodies that include at least 51 percent Medicaid consumers and other stakeholder community members. They provide member voice and authority in our plan and are charged with:

- Ensuring CCO members receive the highest quality patient care and service possible
- Giving voice to member satisfaction and experience
- Participating in the development of the Community Health Assessment and Community Health Improvement Plan
- Administering innovation investments informed by the Community Health Improvement Plan
- Providing oversight for initiatives designed to increase health equity

Steering Committee

Thank you to the individuals and cross-sector partners serving on the Steering Committee. Your time, resources, and expert counsel guided this process. The Steering Committee convened monthly meetings, and we are grateful for their commitment and leadership in the community engagement and data review, which were fundamental to the success and completion of this report.

UHA Steering Committee Members

While not every entity invited to participate in the CHA Steering Committee had capacity to join in this process, we acknowledge and appreciate the input and guidance given at any level. In addition to the listed CHA Steering Committee Members, we also want to thank the Coquille Indian Tribe and the Confederated Tribes of Coos, Lower Umpqua and Siuslaw Indians who were not able to participate in this process but whose ancestral lands partially lie within Umpqua Health Alliance service area.

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Juliete Palenshus
Thrive Umpqua
Jessica Hand
Thrive Umpqua
Chelsea McLaughlin
UCAN Head Start
Brenda Tibbetts
UCAN Head Start
Juliet Rutter
Umpqua Valley Rainbow Collective

Research and Design Partners

The Community Health Assessment was conducted in partnership with Health Management Associates (HMA), an independent, national research and consulting firm specializing in publicly funded healthcare and human services policy, programs, financing, and evaluation. HMA's mission is to improve the health and well-being of individuals and communities by making publicly funded healthcare, and the social services that support it, more accessible, equitable, and effective.

Dear Community Members,

For years, we have embraced the belief that true health and well-being extend far beyond the doctor's office to the spaces in our community in which we live, work, and play. It is with great pride that I present the Umpqua Health Alliance's 2023 Community Health Assessment (CHA). This comprehensive assessment is more than a report; it represents a collective journey towards understanding and enhancing the health of Douglas County.

Our collaboration with Health Management Associates, the CHA Steering Team, and the Community Advisory Council (CAC) has been instrumental in bringing this assessment to fruition. By incorporating the perspectives of Douglas County residents through focus groups, listening sessions, and surveys, we have ensured that our approach is deeply rooted in the community's lived experiences and insights.

The CHA offers a comprehensive analysis, blending both qualitative and quantitative data, including vital population health statistics for Oregon and Douglas County. As you delve into this report, you'll find it not only informative but also reflective of our diverse community. Our goal is for the CHA to be a catalyst for positive change, ensuring that everyone in our community has access to the essential services and supports they need to thrive.

We invite you to explore the CHA and join us in our ongoing efforts to build a healthier, more resilient community, and we thank you for your commitment to this important work.

Together, we are shaping a healthier, more equitable future for Douglas County, and we look forward to continuing this transformative journey with you.

Sincerely,

Brent Eichman, MBA, CHFP
Chief Executive Officer
Umpqua Health Alliance

About Umpqua Health Alliance

Umpqua Health is deeply rooted in Douglas County, and we are proud to call the Umpqua Valley our home. Our integrated network of skilled local providers delivers high-quality healthcare to Douglas County residents. Umpqua Health also collaborates closely with community partners to evaluate ongoing healthcare needs and issues while collaborating on local solutions.

Our subsidiary, the Umpqua Health Alliance (UHA), is one of 16 coordinated care organizations (CCOs) in Oregon that has served members of the Oregon Health Plan (OHP) since 2012. UHA connects more than 40,000 Douglas County OHP members to physical, behavioral, oral health care through an integrated network of providers. UHA is managed through a locally based board of directors and Community Advisory Council (CAC) that ensures local healthcare needs are met.

Umpqua Health also operates the Umpqua Health–Newton Creek Clinic, a certified rural health clinic in Douglas County that offers integrated whole-person care, including pediatric and adult primary care, urgent care, as well as behavioral health services. Local governance and oversight are at the center of the coordinated care model and the heart of the original vision of Gov. John Kitzhaber, MD, because people who live locally know how to best care for our communities.

Improving Community Health

The 2019 UHA Community Health Improvement Plan (CHP) provided a roadmap for our investments in programs, services, and partnerships with community benefit organizations to improve community health. Following the 2019 CHP, UHA has invested annually in four key focus areas:

- Social Determinants of Health
- Behavioral Health and Addictions
- Families and Children
- Healthy Lifestyles

Social Determinants of Health

To improve the economic and social circumstances that profoundly impact the health status of individuals and communities across Douglas County, UHA supported programs and services that:

- Made healthy, nutritious food affordable and accessible
- Improved access to and the safety of community venues for physical activity
- Built infrastructure to expand access to childcare services
- Supported individuals and families experiencing homelessness

Behavioral Health and Addiction

Access to mental health and addiction treatment services across the lifespan is critical for a healthy community. To improve the behavioral health status of community members, Umpqua Health supported programs and services that are designed to:

- Better understand youth vaping in Douglas County
- Increase access to free suicide prevention training for individuals and organizations across the county
- Provide necessities and services to people with substance use disorder (SUD) who are working to achieve sobriety in a safe environment through the Adapt Sobering Center

Families and Children

Helping families and children live longer, healthier lives with lower rates of chronic disease and a higher quality of life requires investments in a range of programs and services. Umpqua Health continues supporting programs that meet basic needs and strive to support families and children in developing healthy habits. UHA supported programs and services that:

- Mitigate childhood adverse experiences
- Improve the number of children who are breastfed
- Reduce reports of child abuse and neglect
- Serve children in foster care

Healthy Lifestyles

Umpqua Health's vision to affect health upstream and eliminate health disparities is the foundation for supporting programs and services that create equal opportunities for Douglas County residents to lead a healthy lifestyle where they live, work, and play. Throughout 2022 and 2023 Umpqua Health supported several healthy lifestyle initiatives that:

- Improving the percentage of children engaging in well-child visits
- Reducing the prevalence of smoking
- Reducing adult obesity rates
- Increasing access to preventive dental or oral health services for children

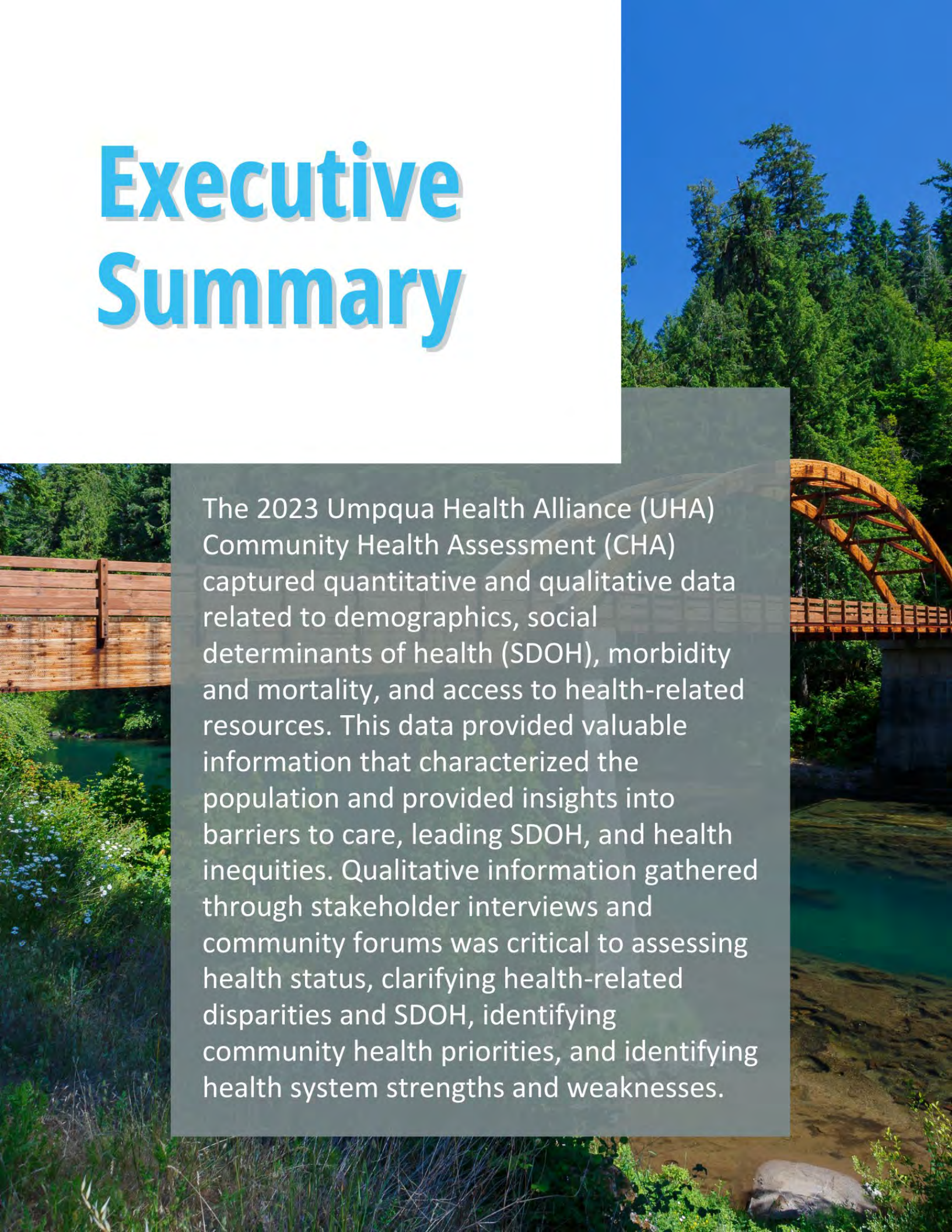
Example Investments to Improve Community Health

Here are example investments that align with one or more of the priority areas:

- The Healthy Kids Outreach program, which provides oral health education to youth in 20 schools across the county
- Protect Our Children, which provides books to children that teach about body safety and autonomy to prevent child sexual abuse
- Food Hero at the Farmers' Market program, which provides meal kits at local farmer's markets that encourage youth to try healthy fruits and vegetables
- Healthy Lifestyles, a program through the Boys and Girls Club of Umpqua Valley that provides opportunities for families to bond while engaging in healthy lifestyle activities like gardening.
- The Douglas County 2023 Pride Fest, an event to celebrate members of the LGBTQIA2S+ population and their allies. Additionally, UHA provides resources to the Umpqua Valley Rainbow Collective for community building and support systems for LGBTQIA2S+ community members.
- The Umpqua Grown Guide, a publication that showcases area farmers and food producers and is offered free of charge.
- The Yoncalla School and Community Playground Wellness Path, in partnership with the Yoncalla School District. The trail is part of the playscape project and will include planned exercise and mindfulness stations throughout to encourage students and community members to focus on their well-being.
- Community Gardening with Neighborworks Umpqua. The partnership provided residents in low-income housing supplies and support for porch gardens and community gardens with in-ground and raised garden beds.

A detailed description of Umpqua Health's community investments and their impacts are available in the June 30, 2023 CHP Progress Report.

Executive Summary



The 2023 Umpqua Health Alliance (UHA) Community Health Assessment (CHA) captured quantitative and qualitative data related to demographics, social determinants of health (SDOH), morbidity and mortality, and access to health-related resources. This data provided valuable information that characterized the population and provided insights into barriers to care, leading SDOH, and health inequities. Qualitative information gathered through stakeholder interviews and community forums was critical to assessing health status, clarifying health-related disparities and SDOH, identifying community health priorities, and identifying health system strengths and weaknesses.

Executive Summary

The data examined for this assessment included:

- Population characteristics such as age, gender identity, race, ethnicity, sexual orientation, language, and disability to characterize community composition, needs, and health status
- Social, economic, and environmental factors that drive health status and health equity, such as income, education, housing, and mobility
- Health outcome data, such as the occurrence of chronic disease and mortality, to characterize disease burden and health inequities, to identify target populations and health-related priorities

This 2023 CHA highlights five-year health trends in Douglas County and illustrates various health and social data indicators. The CHA process includes data collected through the following methods:

- A countywide Community Themes and Strengths Assessment (CTSA) survey
- Priority population focus groups
- Community leader share back meetings, including with the CHA Steering Committee and Umpqua Innovation Conference
- Secondary data collection, review, and analysis

UHA and our partners are deeply connected to the communities that are facing unique health challenges. Completing this assessment is not just a regulatory requirement, but also an opportunity to genuinely improve the health and well-being of the people we serve.

This report is intended to drive discussion at the community level by residents, all sectors, networks, and partnerships committed to taking action to address key healthcare issues. The report also will inform the update of the UHA Douglas County Community Health Implementation Plan (CHP).

The following pages share that evidence. It will be an important part of the CHP process for Umpqua Health, partners, and community members to prioritize the issues, develop shared goals and long-term measures of change, and select the strategies to change the course of the issues identified for the betterment of Douglas County residents most impacted.

There has been a lot of investment and community work since the 2019 CHP, and there are great strengths and signs of improvement in Douglas County.

Health status may be improving for people who identify as women in Douglas County. The rate of people who identify as women in Douglas County self-reporting poor health status was

CSTA survey respondents in Douglas County feel a strong sense of social and community connectedness.

81% of respondents strongly agreed/agreed that "every person and group has the opportunity to contribute to improve the quality of life in my neighborhood."

81% of respondents strongly agreed/agreed that "there are networks of support for me and my family during times of stress and need."

76% of respondents strongly agreed/agreed that "All residents in my neighborhood feel that they – individually and together – can make the neighborhood a better place to live."

90% of respondents strongly agreed/agreed that their neighborhood was a good place to raise children and that they were satisfied with the quality of life in their neighborhood.

significantly [1] lower in 2018–2021 at 17.5 percent than in 2010–2013 when the rate was 28.2 percent, which suggests that people who identify as women in Douglas County feel better today than they did nearly 10 years ago. [2]

Economic stability may be increasing for young adults ages 18 to 39 years. In 2017-2021, the highest unemployment rate in Douglas County was among young adults (18-39 years) at 7.1 percent. However, since 2012-2016, the rate had improved the fastest among this age group, decreasing from 14.7% in 2012-2016. [3]

Food insecurity rates improved between 2017 to 2021, decreasing from 14.2 percent in 2017 to 12.0 percent in 2021. Child food insecurity rates also improved from 22.8 percent in 2017 (4,800 children) to 16.8 percent (3,630 children) in 2021. The percent of people and children who were considered eligible for the federal nutrition programs also increased during this time, suggesting both increased poverty and increased access to food benefits. [4]

Access to health care is improving. In Douglas County, 6.2 percent of the people are uninsured (6,844 people), and in Oregon, it was similar at 6.7 percent. The uninsured rates in both Oregon and Douglas County had significantly improved between 2012–2016 and 2017–2021, decreasing from 9.7 percent and 10.4 percent, respectively. [5]

In 2018–2021, 71.9 percent of Douglas County adults (18+ years) had a routine checkup in the past year. In Oregon, the rate was 69.9 percent. Routine checkups were becoming increasingly common in both Douglas County and Oregon. In Douglas County, the rate significantly increased 16.6 percentage points from 56.7 percent of adults in 2010–2013 to 71.9 percent of adults in 2018–2021. [6]

Health Improvement Priorities

Challenges still exist. Since the last CHP, there have been many forces of change that have either exacerbated existing challenges or brought new ones. These include the COVID-19 pandemic, changing White House administration, environmental events including wildfires and extreme heat, and social justice movements. This CHA identified evidence that suggests it is important to continue focus on the four priority areas identified in UHA's 2019 CHP.

- Social Determinants of Health
- Behavioral Health
- Families and Children
- Healthy Lifestyles

The following pages share that evidence. It will be an important part of the CHP process for UHA, partners, and community members to prioritize the issues, develop shared goals and long-term measures of change, and select the strategies to change the course of the issues identified for the betterment of Douglas County residents most impacted.

[1] The word "significant" is used to indicate a finding that was found to be statistically significant. See page 31 of the Methodology to learn more about how significance was determined.

[2] Oregon Behavioral Health Risk Surveillance System (BRFSS), 2020

[3] American Community Survey, 5-Year Estimate, Tables B23025, B23001, and C23002

[4] Feeding America, retrieved on October 24, 2023.

[5] American Community Survey, Five-year estimates 2017-2020, Tables B27001/C27001.

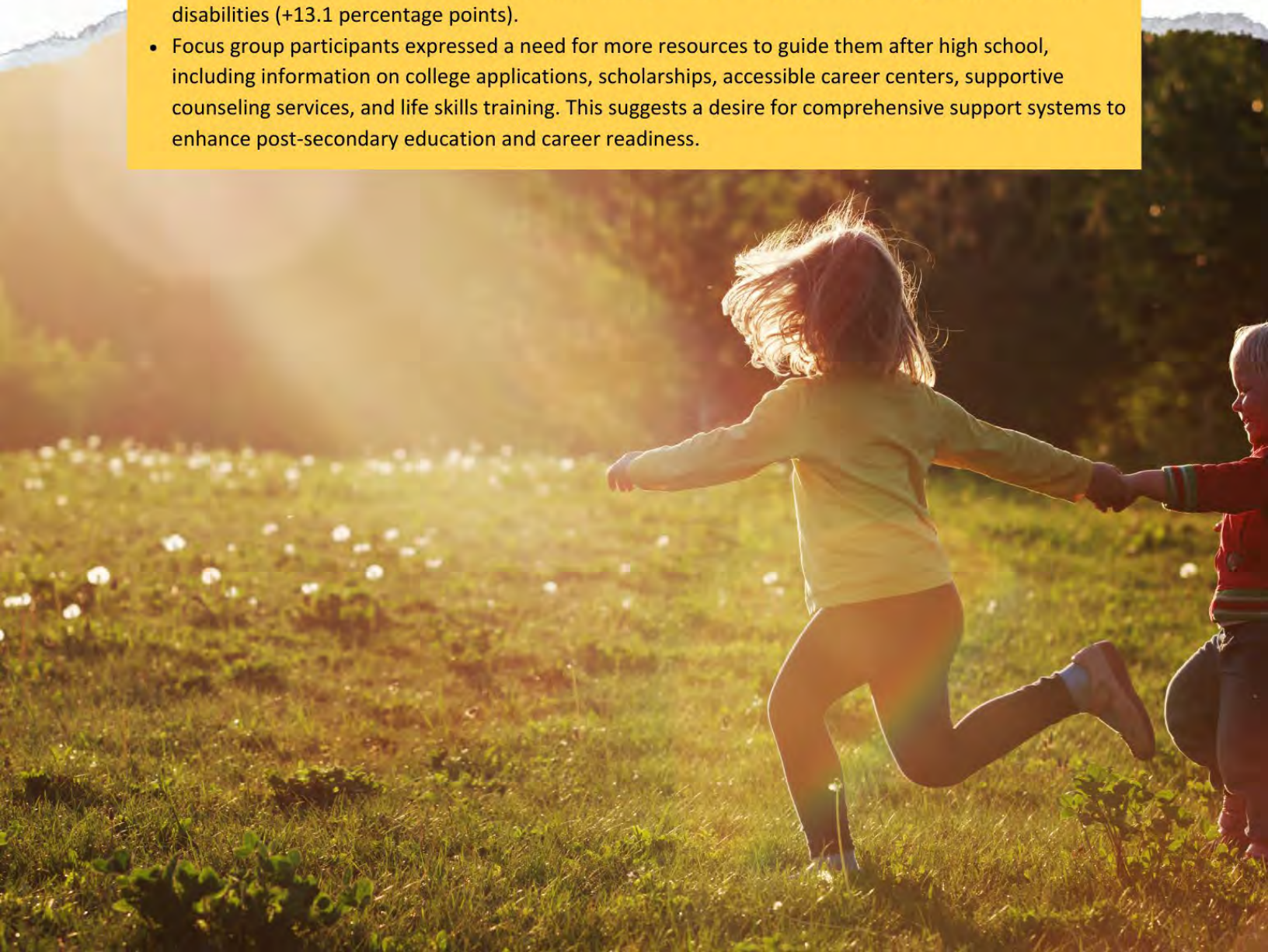
[6] BRFSS via the Oregon Public Health Assessment Tool

Priority Area #1: Social Determinants of Health

The 2023 CHA identified the priority health issues of economic stability, educational access and quality, and housing, supported by the following evidence:

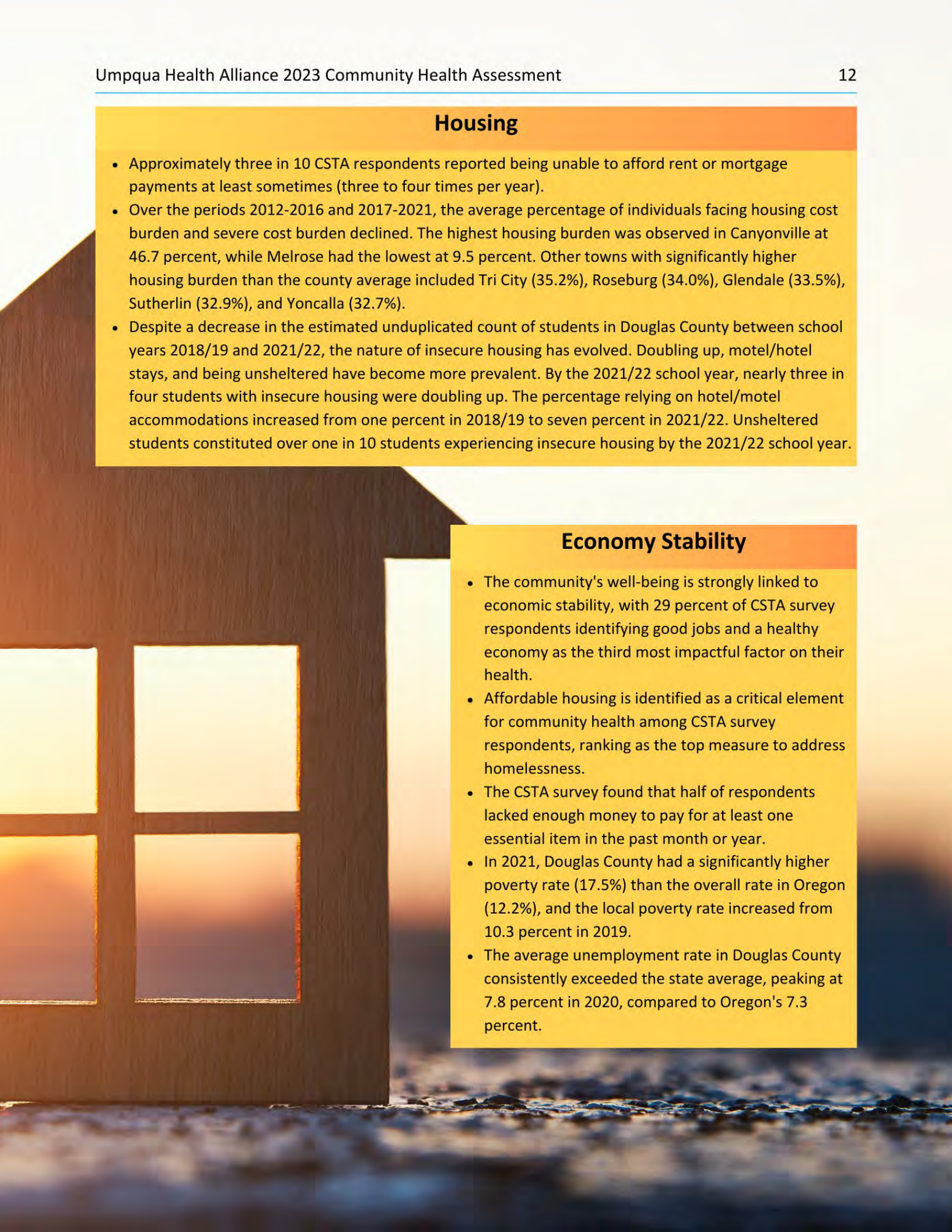
Education Access and Quality

- In the school year 2021-2022, 41.7 percent of kindergarten through grade 12 students in Douglas County were chronically absent, a rate significantly higher than the 36.1 percent in Oregon. This marked an increase from approximately 22 percent in the years preceding the COVID-19 pandemic.
- The four-year graduation rate for ninth-grade cohort students in 2021/22 was 74.3 percent, lower than the state average of 81.3 percent. Although Douglas County's graduation rate has consistently been below Oregon's over the past four years, it has improved from 68.3 percent to 74.3 percent since the school year 2018/19.
- Students facing housing insecurity, in foster care, and with disabilities had notably lower graduation rates in Douglas County—52.3 percent, 40.0 percent, and 56.9 percent, respectively. Despite this, students experiencing housing insecurity showed significant improvement in graduation rates, increasing by 12.8 percentage points between 2018/19 and 2021/22, second only to students with disabilities (+13.1 percentage points).
- Focus group participants expressed a need for more resources to guide them after high school, including information on college applications, scholarships, accessible career centers, supportive counseling services, and life skills training. This suggests a desire for comprehensive support systems to enhance post-secondary education and career readiness.



Housing

- Approximately three in 10 CSTA respondents reported being unable to afford rent or mortgage payments at least sometimes (three to four times per year).
- Over the periods 2012-2016 and 2017-2021, the average percentage of individuals facing housing cost burden and severe cost burden declined. The highest housing burden was observed in Canyonville at 46.7 percent, while Melrose had the lowest at 9.5 percent. Other towns with significantly higher housing burden than the county average included Tri City (35.2%), Roseburg (34.0%), Glendale (33.5%), Sutherlin (32.9%), and Yoncalla (32.7%).
- Despite a decrease in the estimated unduplicated count of students in Douglas County between school years 2018/19 and 2021/22, the nature of insecure housing has evolved. Doubling up, motel/hotel stays, and being unsheltered have become more prevalent. By the 2021/22 school year, nearly three in four students with insecure housing were doubling up. The percentage relying on hotel/motel accommodations increased from one percent in 2018/19 to seven percent in 2021/22. Unsheltered students constituted over one in 10 students experiencing insecure housing by the 2021/22 school year.



Economy Stability

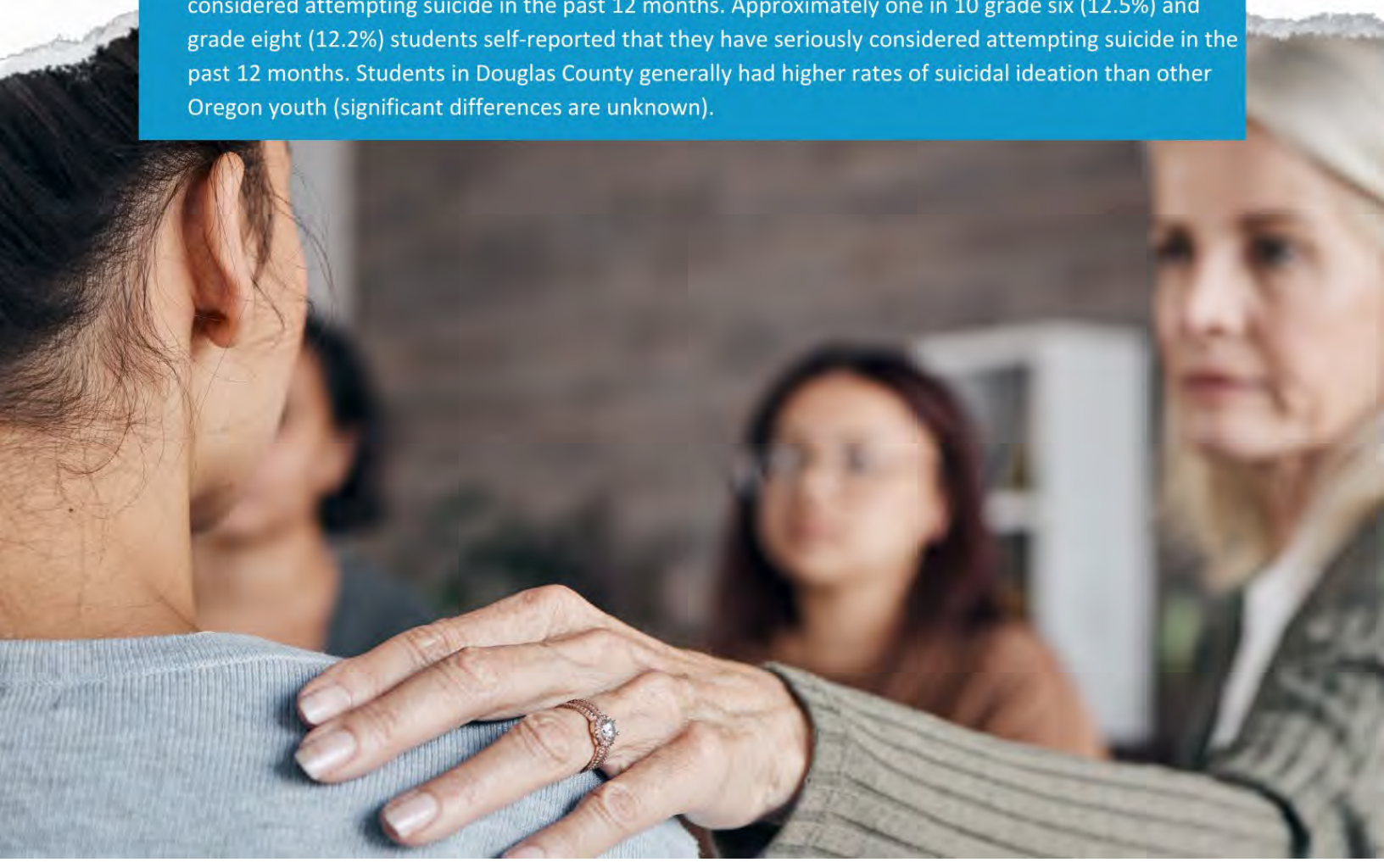
- The community's well-being is strongly linked to economic stability, with 29 percent of CSTA survey respondents identifying good jobs and a healthy economy as the third most impactful factor on their health.
- Affordable housing is identified as a critical element for community health among CSTA survey respondents, ranking as the top measure to address homelessness.
- The CSTA survey found that half of respondents lacked enough money to pay for at least one essential item in the past month or year.
- In 2021, Douglas County had a significantly higher poverty rate (17.5%) than the overall rate in Oregon (12.2%), and the local poverty rate increased from 10.3 percent in 2019.
- The average unemployment rate in Douglas County consistently exceeded the state average, peaking at 7.8 percent in 2020, compared to Oregon's 7.3 percent.

Priority Area #2: Behavioral Health

The health issues and concerns for mental health and substance use disorder continued as an elevated health priority issue in the 2023 CHA, supported by the following evidence:

Mental Health

- Access to mental health services is a primary concern for CSTA survey respondents, who highlighted challenges such as limited availability, long wait times, and difficulties finding providers who accept specific insurance plans. Timely access to care was emphasized as crucial.
- In 2020, residents of Douglas County reported an average of 4.9 mentally unhealthy days in the previous 30 days, compared to 3.9 days for people elsewhere in Oregon.
- Nearly three in 10 adults in Douglas County self-reported being diagnosed with depression.
- According to Oregon Student Health Survey results, students in Douglas County had higher rates of depression than other Oregon students. In Douglas County the prevalence of students saying they felt sad or hopeless almost every day for two weeks or more in a row in 2022 and that they stopped doing some usual activities, increased to nearly half of the 11th grade students (42.7%), compared with 20.8 percent of the grade six students.
- The suicide rate in Douglas County was significantly higher than in Oregon in both 2019 and 2021. In 2021, the suicide rate in Douglas County was 31.5 deaths per 100,000 people, compared to 19.6 deaths per 100,000 people in Oregon. Although the suicide rate increased in both areas between 2016 and 2021, the change was not considered significant.
- In 2022, approximately one in five 11th graders (20.7%) self-reported that they had seriously considered attempting suicide in the past 12 months. Approximately one in 10 grade six (12.5%) and grade eight (12.2%) students self-reported that they have seriously considered attempting suicide in the past 12 months. Students in Douglas County generally had higher rates of suicidal ideation than other Oregon youth (significant differences are unknown).



Substance Use Disorder

- The CSTA survey identified addiction, particularly to methamphetamine, other stimulants, opioids, and alcohol misuse, as the top three contributors to health deterioration in the community. In Douglas County, it is estimated that one in five individuals aged 12 and older (18.2%) have a substance use disorder, totaling 17,691 people.
- In terms of criminal offenses involving drugs, Douglas County reported a slightly higher percentage (6.0%) than Oregon (4.7%). Amphetamines/methamphetamines were the most prevalent drugs in both areas, with Douglas County having a higher involvement rate (71.8% compared to 57.5% in Oregon). Heroin and marijuana were the second and third most common drugs in reported offenses in Douglas County (16.5% and 11.6%, respectively).
- Binge drinking rates in Douglas County among adults aged 18 and older were 15.0 percent in 2018-2021, similar to the Oregon rate of 18.0 percent. This prevalence remained relatively stable from 2010-2013 to 2018-2021.
- Drug-induced death rates increased in Douglas County between 2016 and 2021, from 16.7 deaths to 38.4 deaths per 100,000 people. Douglas County and Oregon have similar substance use-related death rates in 2021; however, in Oregon, alcohol and drug-induced deaths increased significantly in 2016 to 2021.

Priority Area #3: Families and Children

The health issues and concerns for families and children continued as an elevated health priority issue in the 2023 CHA, adding adult connectedness among youth, bullying, and teen birth to the list of priority issues, supported by the following evidence:

Adversity, Trauma, and Toxic Stress

In Oregon, as of 2016, the most reported types of Adverse Childhood Experiences (ACEs) among adults aged 18 years or older were household substance abuse (37.1%), emotional abuse (36.2%), and parental separation/divorce (33.2%). More current data are available for Douglas County describing the percent of adults who had four or more ACEs. In 2018-2021, in Douglas County, the percent of adults with four or more ACEs was significantly higher at 36.0 percent compared to Oregon at 24.0 percent.

Racism, Discrimination, and Health Equity

- Survey respondents were more likely to say they sometimes/often felt that some racial/ethnic groups, such as African Americans, Latinos, and Asians, are discriminated against (59%) than report that they themselves had personally experienced discrimination because of their race, ethnicity, or skin color (26%); however, approximately seven in 10 survey respondents (69%) who identified as a person of color reported that they sometimes or often felt they had been personally discriminated against because of their race/ethnicity or skin color—higher than among survey respondents who did not identify as a person of color (15.0%).
- The most common situation where CSTA respondents said they experienced racism and/or discrimination was on the street or in a public setting (45%), followed by at work (36%) and getting services in stores or restaurants (36%).
- The predominant reason why CSTA respondents believe they experienced discrimination in this situation was race (47%), followed by gender (36%), and ancestry or national origin (31%).
- More than half (58%) of people who have been treated unfairly accept it as a fact of life, with the remainder of the CSTA survey respondents (42%) reporting that they "tried to do something about it." Moreover, among the people who reporting unfair treatment, more than two in three CSTA survey respondents said they talked to other people about it and one in three reporting they kept it to themselves.

Adult Connectedness Among Youth

- The Oregon Student Health Survey assesses students in grades 6, 8, and 11 on whether they feel they have at least one teacher or another adult in their school who genuinely cares about them. Between 2020 and 2022, the percentage of students reporting such connections decreased in both Douglas County and Oregon across all grades.
- In Douglas County in 2022, the rates for sixth, eighth, and 11th graders reporting these beliefs were 41.0 percent, 37.5 percent, and 32.6 percent, respectively. All these rates dropped from their respective values in 2020 (48.0%, 41.4%, and 39.7%).
- Both in Douglas County and Oregon, the likelihood of having at least one caring teacher or adult in their school tends to decrease as students progress from grade six to grade 11. In 2022, 41.0 percent of Douglas County sixth graders reported feeling strongly connected, compared to 32.6 percent of 11th graders. Similar trends were observed in Oregon.

Bullying

- The Oregon Student Health Survey asks students in grades 6, 8, and 11 whether they have experienced bullying. In 2022, approximately one in three eighth and 11th grade students in Oregon reported having been bullied in the past 30 days, 35.1 percent, and 33.9 percent, respectively. Notably, Douglas County exhibited higher bullying rates than other students in Oregon (25.5% of eighth graders and 15.6% of 11th graders).
- The data revealed an increase in bullying during 2020–2022 in both Douglas County and the rest of Oregon. Specifically, within Douglas County, the most significant increase in school-related bullying incidents occurred among grade 11 students, with a substantial 12.6 percentage point rise from 21.3 percent in 2020. In Oregon as a whole, the most substantial increase in bullying incidents was among eighth graders, with a 12.2 percentage point increase from 13.3 percent in 2020.

Teen Birth

Douglas County had a significantly higher teen birth rate compared to Oregon. In 2019-2021, among teens ages 18–19, the teen birth rate was 37.1 births per 1,000 people in Douglas County compared to 20.4 births per 1,000 people in Oregon. Teen birth rate was significantly decreasing for both Douglas County and Oregon, specifically among young people ages 18–19. In Douglas County, the teen birth rate among teens ages 18–19 decreased from 66.0 births per 1,000 people in 2015 – 2017 to 37.1 births per 1,000 people.

Priority Area #4: Healthy Lifestyles

The 2023 CHA identified the priority health issues access to health care, food access and security, and health behaviors, including physical activity, nutrition, obesity, and tobacco use, supported by the following evidence:

Access to Health Care

Access to healthcare providers was recognized as the second most influential factor in improving health. About one in three CSTA survey respondents (35%) reported no barriers to healthcare access. Among those who experienced barriers (65%), high out-of-pocket costs (56%), limited appointment availability (44%), and a lack of needed services in their area (33%) were the most commonly cited challenges.

Health Status

- Between 2018 and 2021, nearly one in five adults (17.8%) in Douglas County, aged 18 and older, self-reported their health status as fair or poor. This rate was higher than the statewide rate of 15.9%.
- In 2020, residents of Douglas County had a significantly higher average of Poor Physical Health Days compared to residents of Oregon overall. The average was 3.5 days in Douglas County, while it was 2.9 days in Oregon. Although the average number of days of poor physical health declined between 2019 and 2020 in both Douglas County and Oregon, it remained significantly higher in Douglas County (4.5 days) compared to Oregon (3.9 days).

Tobacco Use

- Adults (18+ years) living in Douglas County had higher rates of tobacco use compared to Oregon. In 2018-2021, nearly one in three adults (18+ years, 28.4%) was a tobacco user compared to one in four adults (18+ years, 24.3%) in Oregon.
- Past 30-day electronic cigarette use rates in Douglas County students were nearly twice as high as Oregon. In 2022, nearly one in five (19.9%) Grade 11 students reported past 30-day electronic cigarette use, compared to one in 10 (10.8%) Grade 11 students in Oregon.
- The rate of tobacco related deaths per 100,000 people was higher in Douglas County than in Oregon. In 2018-2021, this rate was 215.0 deaths per 100,000 people compared to 147.0 deaths per 100,000 people in Oregon. This rate has been consistently higher in Douglas County compared to Oregon since 2006-2009.

Food Access and Security

- CSTA survey respondent and focus group participant concerns about community health were centered around the availability of affordable, healthy, and nutritious food.
- The food insecurity rate in Douglas County was 12.0 percent in 2021, affecting 13,300 people. Child food insecurity was higher at 16.8 percent.
- In 2022, 65.5 percent of students in Douglas County were eligible for free and reduced-priced meals, exceeding the Oregon state average of 55.1 percent. The percentage of students eligible for free and reduced-priced meals varied across districts, ranging from 50.5 percent in Camas Valley School District to 83.5 percent in Reedsport School District.
- WIC[1] enrollment among births significantly decreased between 2017 and 2021, and WIC enrollment among pregnant mothers was higher than in Oregon. In 2019–2021, the WIC enrollment rate among births was 46.0 percent of births (1,418 births), lower than in 2015–2017 when more than half (56.7%, 1,825) of births were to WIC enrollees. Specifically, WIC enrollment starting to drop in 2018.
- Douglas County residents were more likely to lack adequate access to food compared to other people in Oregon. Approximately 42.5 percent of residents faced limited access to food, defined solely by distance. In 2019, 6.7 percent of residents (7,102) lived in a food desert, characterized by low income and being further than one mile (urban) or 20 miles (rural) from a supermarket. In certain Douglas County cities and towns, twice as many residents lived in food deserts, including Sutherlin (15.9%), Roseburg (15.8%), and Tri-City (15.4%). Myrtle Creek (11.6%), Dillard (10.4%), and Winston (10.3%) had one in 10 residents living in food deserts.

Nutrition

- In terms of soda consumption, the percentage of adults (18+ years) in Douglas County reporting the consumption of seven or more non-diet sodas per week was significantly higher at 26.5 percent in 2018-2021, compared to Oregon's rate of 15.7 percent. This higher rate in Douglas County has been consistent since 2014-2017 and nearly doubled from 2010-2013. In contrast, Oregon's rate remained stable between 2010-2013 and 2018-2021, with females consistently having lower soda consumption compared to males.
- Among youth, a measure of healthy eating is the consumption of five or more servings of fruits and vegetables per day. Although significance is not specified, the percentage of students in Grades 6, 8, and 11 in Douglas County who achieved this was lower compared to statewide rates.

Obesity

- Obesity rates among adults (18+ years) in Douglas County were significantly higher compared to adults in Oregon. In 2018-2021, 37.0 percent of adults in Douglas County were considered obese (BMI ≥ 30), compared to the statewide rate of 30.0 percent. When including the percentage of adults considered overweight (BMI 25 to 29.9), approximately seven in 10 adults (71.7%) in Douglas County were overweight or obese in 2018-2021. This rate was significantly higher compared to the statewide rate of 64.4 percent.

[1] The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, healthcare referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, as well as infants and children up to age five who are found to be at nutritional risk.

Health Outcomes

Health outcomes represent the physical and mental well-being of residents within Douglas County. By looking at measures indicating the length and quality of life, the CHA provides information needed to understand how well health improvement programs in Douglas County are working or whether new or different health improvement programs are needed. Priority health outcomes identified in Douglas County include:

Mortality

- The average life expectancy for Douglas County residents has been significantly lower compared with other Oregonians since 2011 and has been on the decline. In 2021, the average life expectancy was 72.7 years in Douglas County, lower than 77.3 years in Oregon.
- Race and ethnicity disparities affect life expectancy. Black/African American and White, non-Hispanic (NH), Douglas County residents have lower life expectancies at 70.7 year and 73.8 years, respectively. Hispanic and White NH residents had significantly lower life expectancy in 2020–2021 than in 2018–2019.
- In 2021, cancer, heart disease, and COVID-19 were the top three causes of death for Douglas County and Oregon residents. In 2021, deaths rates for the following causes were significantly higher in Douglas County than in Oregon: Cancer (197.7 deaths per 100,000), heart disease (192.5 deaths per 100,000), COVID-19 (140.1 deaths per 100,000), accidents (923.0 deaths per 100,000, intentional self-harm (suicide, 31.5 deaths per 100,000), and Alzheimer's disease (28.0 deaths per 100,000).
- Douglas County had significantly higher rates of accidental deaths than other parts of Oregon. In Douglas County, the significant increase in accidental injury deaths between 2016 and 2021 was because of significant increases for the following injury types: Motor vehicle-related: 10.7 in 2016 to 35.7 per 100,000 in 2021 (37 deaths), Poisoning: 16.1 in 2016 to 28.1 per 100,000 in 2021 (30 deaths); Downing/submersion: 1.6 in 2016 to 6.6 per 100,000 in 2021 (7 deaths).

Morbidity

- The percentage of adults ages 18 and older in Douglas County who have one or more chronic conditions, including arthritis, diabetes, asthma, heart disease/stroke, cancer, depression, and/or chronic obstructive pulmonary disease, was notably higher than the statewide rate in Oregon. From 2018 to 2021, 58.9 percent of adults in Douglas County had at least one chronic condition.
- Nearly three in 10 (29.4%) Douglas County adults self-report having been diagnosed with depression, followed by arthritis (28.0%), and asthma (12.8%).
- Food and waterborne diseases were the most common communicable disease in Douglas County, including campylobacteriosi and Salmonellosis. Between 2013-2015 and 2018-2020, these two diseases significantly increased. In 2018-2020, there were 33.9 cases per 100,000 people of Campylobacteriosis (114 cases), an increase from a rate of 19.1 cases per 100,000 people in 2013-2015. In 2018-2020, there were 21.5 cases per 100,000 people of Salmonellosis (70 cases), an increase from a rate of 9.6 cases per 100,000 people in 2013-2015. The rate of both Campylobacteriosis, Salmonellosis, and Cryptosporidiosis were significantly higher in Douglas County compared to Oregon in 2018-2020.

Introduction

For Umpqua Health Alliance (UHA), as the Coordinated Care Organization (CCO) serving the majority of Douglas County, completing the Community Health Assessment (CHA) serves several essential functions The Oregon Health Authority (OHA) requires its CCOs to conduct regular community health assessments as a part of its accreditation or certification process. [7] The assessment process must meaningfully and systematically engage representatives of local and tribal governments, community partners and stakeholders, and critical populations to assess the community's health needs.

The Commitment Behind the Community Health Assessment

Data are collected, analyzed, and reported, with lines drawn to show the connection between an individual, a community, and a data point. The content of this CHA strives to tell the stories of people and communities in Douglas County and allow the reader to step into another person's shoes.

Assessing the community's health using a systematic process that helps organizations, healthcare providers, and public health agencies better understand the health needs and challenges of the communities they serve. This CHA supports our collective understanding and ability to act to improve community health for all by providing essential data and insights that:

- Reveal disparities in health outcomes
- Identifies areas where the quality of care or services provided can be improved
- Inform strategic planning, including setting priorities, defining goals, and developing strategies to address the community's health needs
- Inform resource allocation to the most needed areas, such as budget, staff, services, and facilities
- Serves as a baseline to measure the impact of Umpqua Health's efforts and those of the community
- Serves as a community resource that provides data crucial in securing financial support from grantors, philanthropic organizations, and government agencies, which often require evidence of community needs as a prerequisite for funding

"The [data presentation] cuts a lot deeper than I thought it was going to cut. It really was enlightening. But it was all pertinent and just the vastness of all of the information. Thank you for caring enough to find all of the data. It's just informative; everybody should know."

Focus Group Participant with Behavioral Health Need

UHA and our partners are deeply connected to the communities that are facing unique health challenges. Completing this assessment is not just a regulatory requirement, but also an opportunity to genuinely improve the health and well-being of the people we serve.

[7] Oregon Administrative Rule (410-141-3730) and CCO Contract Requirements

Methodology

The purpose of the CHA is to be more responsive to the health needs and experiences of the people and communities in Douglas County through systematic, comprehensive data collection, analysis, and reporting. The CHA answers the following questions:

- What are the most critical health issues in the community?
- What are the unhealthiest behaviors in the community?
- What are the most essential factors for community and personal health?

UHA approached these questions by investigating the needs of community members using a framework derived from the Mobilizing for Action through Planning and Partnerships (MAPP) process. This process did not rely on any single source of information, but rather considered multiple data sources in the analysis before arriving at findings. The CHA used a numbers-based (quantitative) and narrative-based (qualitative) approach.

The Numbers Approach. Quantitative data are measurable and express a certain quantity, amount, or range. It is used to quantify a problem or determine how many, how often, or how much. Data are generated through a systematic, verifiable, replicable process and, in and of itself, is not subject to interpretation. Quantitative data are used in public health to show comparisons and may involve counting people, behaviors, conditions, or other discrete events. It also may be used to identify health trends by looking at how a particular indicator has changed over time, helping us to understand the changing needs of community to appropriate plan and priority ways to approach disease prevention and health promotion. **Much of the secondary data collected through the numbers approach informed the Community Status Assessment.**

The Narrative Approach. Primary qualitative data can include almost any non-numerical data. It is data that can be observed but not measured and is subjective rather than objective. Qualitative data can be collected through various means, including opinion-based surveys, meetings, focus group discussions, and key informant interviews. Qualitative data are used in public health to offer context, additional detail, and interpretation of quantitative data. It also can help explain trends seen in the data. **Much of the primary data collected through the narrative approach informed the Community Context Assessment.**

Using these approaches, the CHA process includes data collected through the following methods:

- A countywide Community Themes and Strengths Assessment (CTSA) survey
- Priority Population Focus Groups
- Community leader share back meetings, including with the CHA Steering Committee and Umpqua Innovation Conference
- Secondary data collection, review, and analysis

Findings from the data collection and analysis will guide the CHP, a long-term, systematic effort to address priority issues that affect community health and its implementation. The CHA will guide how resources are expended to ensure efforts are focused on the most pressing community health and social care needs.

Language

Inclusive language is the words and phrases used to avoid biases, slang, and expressions that discriminate against groups of people based on race, gender, socioeconomic status, and ability. When used, you can resonate with more audiences by speaking and writing in ways that everyone understands and makes everyone feel welcome.

Race, Ethnicity, and Sexual Orientation

Race is a social construct to classify people based on their physical appearance. Ethnicity, on the other hand, is a broader concept associated with a particular country or region and refers to a person's cultural identity, language, religion, customs, and traditions. Sexual orientation is a complex and multifaceted concept encompassing patterns of emotional, romantic, and sexual attraction to others that plays a significant role in shaping an individual's identity and experiences. These concepts are further discussed in the Community Themes and Strengths Assessment (CSTA) section regarding the demographics of CSTA survey respondents.

Sex and Gender

While often used interchangeably, sex and gender are two distinct concepts. Sex is based on biological attributes of males and females (e.g., chromosomes, anatomy, and hormones), while gender is a social construction whereby a society or culture assigns certain tendencies or behaviors to the concepts of masculinity and femininity. Terms such as "transgender," "non-binary," and "gender nonconforming" all refer to gender, not sex. This assessment relies on the terminology use by the data source. For example, when referring to gender among American Community Survey data, it is capturing current sex as there are no questions about gender, sexual orientation, or sex at birth. Respondents are asked to respond either "male" or "female" based on how they currently identify their sex.

Birthing Person

A birthing person is someone who gives birth, regardless of their gender identity, which may be female, male, nonbinary, or other. Gender-neutral terms like pregnant patients, pregnant people, birth parent, or other wording as applicable (e.g., pregnant teens), present an inclusive alternative. The assessment uses the gender-neutral term birthing person when referring to data on pre- and post-natal care, infant and child health.

Social Determinants of Health

The shift in language from "Social Determinants of Health" to "Social Drivers of Health" reflects an evolving perspective on the factors that influence an individual's health and well-being. The term "Social Drivers of Health" places a stronger emphasis on the active role individuals play in shaping their health outcomes. It suggests that individuals can actively drive their health by making choices and decisions based on their social and environmental circumstances.

The term "Social Determinants of Health" is associated with a more deterministic view, implying that one's health is solely determined by external factors. This perspective can sometimes overlook the agency and choices individuals make in response to their social circumstances. Social Drivers promotes empowerment, reduces determinism, and underscores the complex interplay of social and environmental factors in health outcomes. It reflects an evolving understanding of health and aims to encourage a holistic and less stigmatizing approach to addressing health disparities. This CHA continues to use Social Determinants of Health to align with the Oregon Health Authority and the agency's language.

High School Push Out

The implicit message in the dropout narrative is an assumption that youth who "drop out" are not willing to work hard, are unmotivated, and hence, that investing in these students returning to school will not yield improved outcomes. Low-income, immigrant, English language learners, single parent, rural household, youth of color, LGBTQIA2S+, and youth with disabilities are disproportionately represented in the population of students who drop out or do not graduate.

The term *pushout* refers to students who leave school before graduating due to people or factors inside school, such as disrespectful treatment from teachers and other personnel, violence among students, arbitrary school rules, and the insurmountable presence of high stakes testing. Dropout implies that leaving school was the students' intention/decision, while pushout implies that it was the result of the actions of others, and indicative of other societal root causes. [8]

Community Strength and Themes Assessment Survey

According to MAPP 2.0, telling the community story "emphasizes the need for a complete, accurate, and timely understanding of community health across all sub-populations within the community." [9] Telling the story happens by gathering input from community members with a broad range of views to understand the variances in health outcomes and identify the root causes of those disparities.

The CSTA represents the core of the community's input and its perspectives on the health problems and needs of the population. In CHAs, the CTSA survey is not designed to gather statistically valid information from community members. Rather, it is a form of assessment in which community members are asked to identify what they see as the most critical issues facing their community. In this case, we asked community members to identify the issues that matter most to them and anonymously share their opinions about community health issues and the quality of life in Douglas County. The results are the foundation for focus group discussions that take a deep dive into the identified health-related issues from the community's perspective and ultimately inform the health improvement planning process and create strategies to address the issues.

The Steering Committee worked with UHA to determine survey questions and to distribute the survey using both electronic and paper options, in both Spanish and English. Additionally, marketing and communication materials, including flyers and social media posts, were developed to support Steering Committee members and other community partners to distribute the survey.

The marketing materials, survey link, and a paper survey were distributed via several means by various partners and stakeholders including:

- Routine communications with the steering committee
- Community meetings
- Tribal partners
- Community events (e.g., Pride event)
- Outreach in domestic violence shelters and to houseless communities
- Priority population focus groups
- UHA social media platforms

[8] Burbach, Jessica Hopson, "Pushing Back on School Pushout: Youth at an Alternative School Advocate for Educational Change Through Youth Participatory Action Research" (2018). Dissertations and Theses. Paper 4385. https://doi.org/10.15760/etd.6269

[9] Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 Handbook, The National Association of County and City Health Officials (NACCHO), 2022.

Respondent Privacy and Compensation

Among the 300 survey respondents who answered the question identifying how they learned about the survey, 33 percent said they became aware of the survey through social media, 27 percent through their workplace, and 11 percent through email.

People who have been historically disenfranchised and oppressed may not trust the healthcare system and may be concerned that the results will be used in a way that they disagree with. The survey introduction communicated that respondents' personal information would be kept confidential and used solely to improve community health, assuring respondents of their privacy. Also, respondents were informed that a third party was administering the survey and that all survey data would remain anonymous to UHA and its partners.

Lastly, to compensate respondents for their time and to increase response rates, each person who opened and completed the survey was guaranteed a $10 VISA gift card. Respondents also entered a lottery to be one of 10 respondents randomly selected to win a $100 VISA gift. Overall, 352 individuals responded to the survey. Of the 352 respondents, 144 provided their email address to receive a gift card.

Assessment Limitations: Survey Data and Malicious Actors

The quality of the data collected through the CTSA survey is critical to the CHA and CHP process. UHA provided monetary incentives to increase community member participation in the survey. Unfortunately, malevolent actors frequently target community surveys offering monetary incentives by using bots to take multiple surveys and collect the incentive. A bot is an automated software application that performs repetitive tasks over a network. Bots typically run independent from a human and are sometimes used with malicious intent. Bots can interact with websites and scan through content, following specific instructions to imitate human behavior, but they are faster and more accurate.

Malicious actors from across the United States and from countries around the world targeted the CTSA survey. The issue was first detected when a Steering Committee member questioned survey respondents' demographic data presented during their June meeting. Shortly after that, the survey response rate rose from 600 to more than 10,000. Upon HMA’s review of IP addresses, it became clear that survey responses must be closely monitored, and the data must be reviewed and scrubbed to ensure valid, reliable responses. The agreed-upon process for validating which data to include in this CHA was to review IP addresses. Survey response data included in this assessment come from responses with unique IP address located within Douglas County and multiple responses from an IP address located in a public facility such as a library or health center with publicly accessible devices.

CTSA Response Data

Demographic questions were included in the survey to allow for an examination of the survey responses by priority populations. It is important to understand if and how health priorities and experiences vary depending on the perspective used to answer the CSTA survey. The priority populations used for survey analysis are listed in **Figure 1. CSTA Priority** .

It is important to remember the intersectionality of identities when interpreting the survey results. Survey respondents can be representative of more than one priority population. When that occurs, a survey respondent's perspective is captured in both self-identified priority population groups.

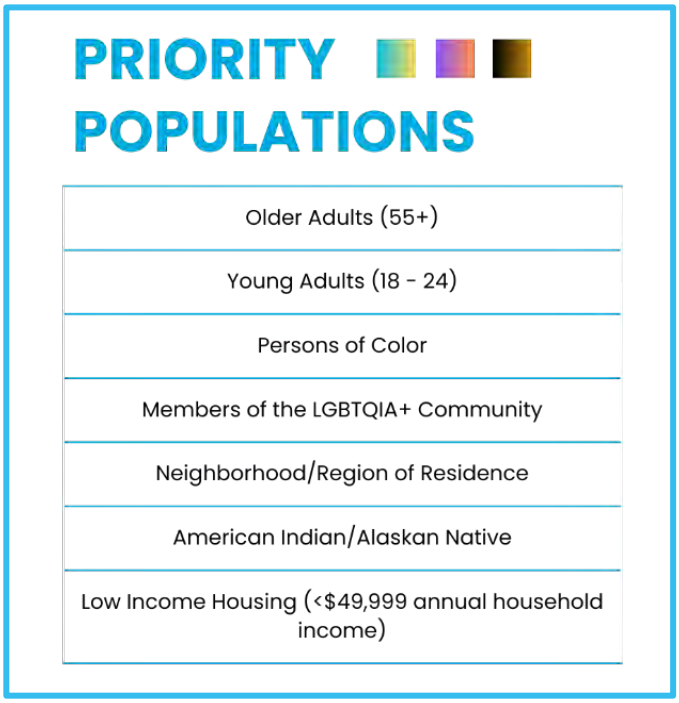


Figure 1. CSTA Priority Populations

Lastly, though 352 individuals responded to the survey, it is important to note that participants were not required to answer every question. For this reason, each question has a unique denominator (denoted as n). Any differences noted in this report between priority populations represent differences that have been determined to be significant. The statistically significant difference between any two groups was determined for survey-derived indicators based on a 10 percent variation from the comparative group. An example of this approach is provided in the Table 1.

Table 1. Determining Statistical Significance of Factors Covered in the Survey

Survey Question	**Please review the factors and behaviors that make a community unhealthy. What three things do you think are the most damaging to the health of your community?**			
	Percent of Respondents Who Selected the Factor or Behavior			
Factor or Behavior	Older Adults (55+ years old) (n=63)	Younger Adults (18–34 years) (n=113)	Percentage Point Difference	Significant (yes or no)
Mental Health Problems	62%	27%	35	Yes
Bullying and Cyberbullying	9%	16%	-7	No

Note: Percentages do not add up to 100 percent as respondents could select more than one answer.

Persons of Color

Race is a social construct to classify people based on their physical appearance but, the construct has no scientific basis Throughout history and in contemporary times, the notion of race has been used as a justification for discrimination and oppression against individuals of diverse backgrounds. Historical examples include the use of race to justify the enslavement and segregation of Native Americans, Black or African Americans, Japanese, and others in the United States. Unfortunately, racism continues to be ingrained in societal laws, policies, and practices, negatively impacting the lives of individuals from

diverse backgrounds. Ethnicity, on the other hand, is a broader concept associated with a particular country or region and refers to a person's cultural identity, language, religion, customs, and traditions.

How race and ethnicity are defined and measured can vary. For example, the US Census Bureau defines race differently than the National Institutes of Health. It is important to remember that race and ethnicity are not mutually exclusive. People can belong to multiple racial and ethnic groups. For example, a person can be Black and African American or Hispanic and Native American. The premise for this survey was that people should be asked to identify their race and ethnicity in a way that is comfortable for them. Asking a person if they identify as a person of color is one way a person who may be considered White by the US Census standards can self-identify. Among all survey respondents, 22 percent (n=67) said they identify as a person of color. Among respondents who identified as a person of color, 63 percent were Black/African American, followed by White (25%).

Table 2. CTSA Respondents Who Identified as a Person of Color

Race/Ethnicity	Percent (#) respondents by race/ethnicity who also selected they identify as a person of color	Percent who identified as a person of color
Middle Eastern	100% (n=1)	1%
Black and African American	95% (n=42)	63%
Native Hawaiian and Pacific Islander	67% (n=1)	3%
Asian	50% (n=1)	1%
Other	33% (n=1)	1%
Hispanic and Latino(a)	20% (n=1)	0%
I prefer not to say	17% (n=2)	0%
White	8% (n=17)	25%
American Indian and Alaska Native	9% (n=1)	1%
Multi-Racial	33% (n=3)	4%
	Total	**100%**

Sexual Identity

By explicitly asking about identity among LGBTQIA2S+ [10] respondents, the survey acknowledged and included people from this community. Identifying LGBTQIA2S+ community members sent a message that their experiences and perspectives are valued and relevant to the assessment. The principle for this question is that people have a right to identify their sexual orientation in a way that is comfortable for them, and asking a person if they identify as a member of the LGBTQIA2S+ community is one way a person can self-identify.

Among survey respondents, 18 percent (n=54) identified as a member of the LGBTQIA2S+ community. All respondents who selected Gay or Queer also considered themselves as part of the LGBTQIA2S+ community, followed by 63 percent of Lesbian and 55 percent of Bisexual survey respondents.

[10] For the purposes of this report LGBTQIA stands for Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual. 2S stands for two spirit, and the + represents all the other identities not encompassed in the acronym.

Table 3. CTSA Respondents Who Identified as a Member of the LGBTQIA2S+ Community

Sexual Orientation	Percent (#) respondents who ***also*** selected they are part of the LGBTQIA2S+ community (n=325)	Percent (#) respondents who identified as part of the LGBTQIA2S+ community
Questioning	0%	0%
Pan Sexual	50% (n=1)	4%
Queer	100% (n=2)	6%
Lesbian	63% (n=5)	9%
Prefer not to say	0%	0%
Gay	100% (n=14)	26%
Asexual	20% (n=3)	6%
Bisexual	55% (n=12)	24%
Straight or heterosexual	6% (n=15)	28%
	Total	**100%**

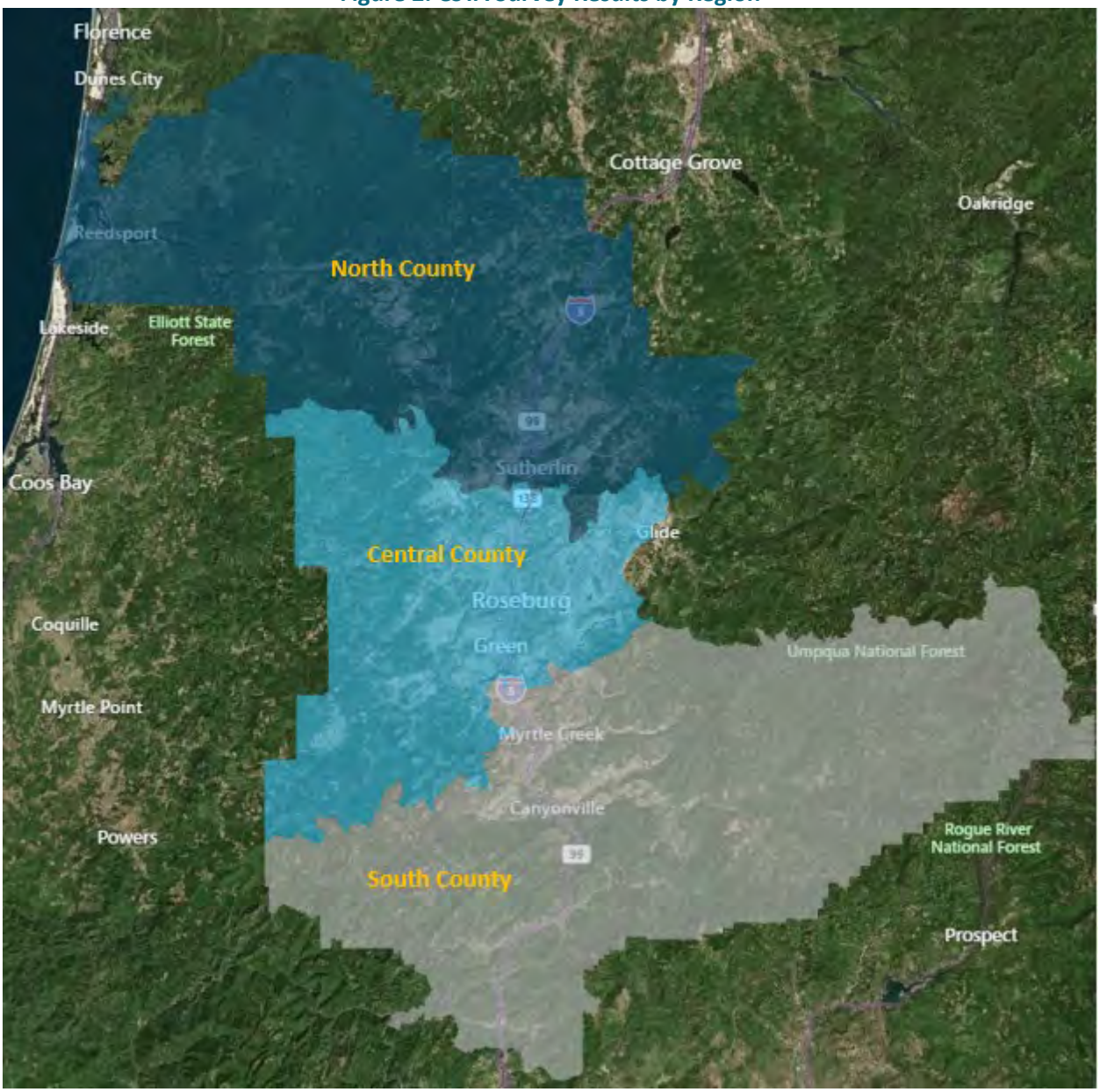
Neighborhood / Region of Residence

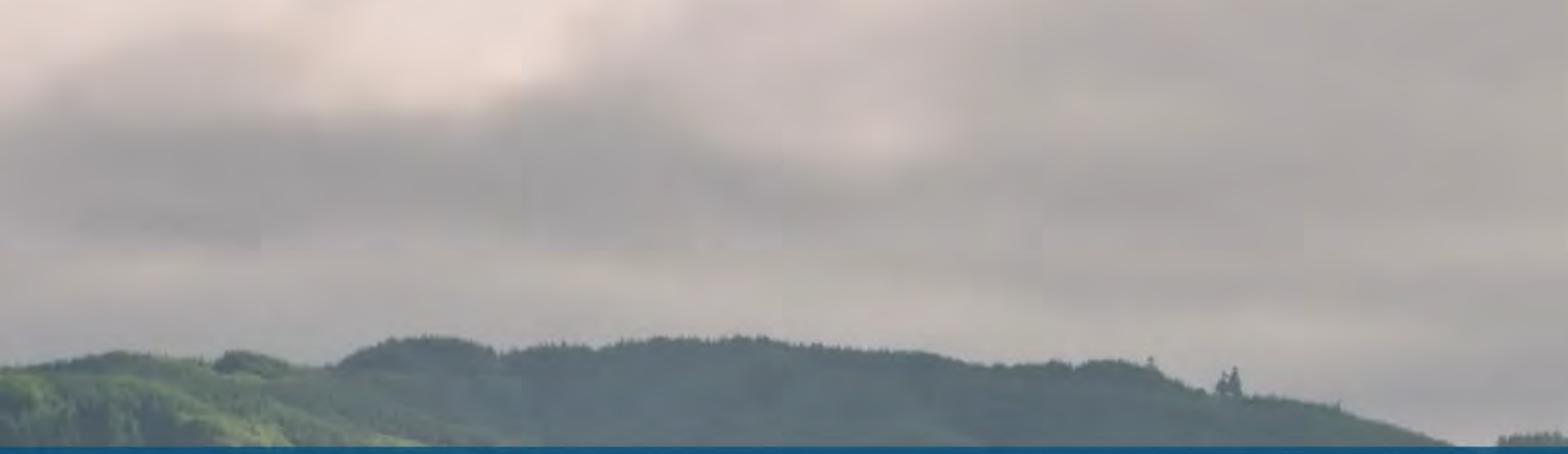
CSTA survey respondents were asked to choose their neighborhood where they live. This assessment created three regions – North, Central, and South County – for the purpose of analyzing the survey results to compare results at a geographic level. The three regions are illustrated in Figure 2. As shown in Table 2, more than half, 53 percent, of CSTA survey respondents lived in a city/town in Central County, including the cities/towns of Dillard, Glide, Green, Lookingglass, Melrose, Roseburg, Roseburg North, and Winston. This representation was slightly less than the census for Central County, which estimates that 61% of adults 18+ years live in Central County. One in four CSTA survey respondents (25%) lived in North County, which was similar to the census, which estimates 24 percent of adults 18+ years living North County. Lastly, 22 percent of CSTA respondents lived in South County, which was higher than the census which estimates 16 percent of adults 18+ years living South County.

Table 4. CSTA Survey Respondents by Neighborhood/Region of Residence

	Adults 18+ Years		CSTA Survey Respondents		
	Number	Percent	Number	Percent	Cities/Towns Represented
North County	14,038	24%	80	25%	Drain, Elkton, Fair Oaks, Gardiner, Oakland, Reedsport, Sutherin., Winchester Bay Yoncalla
Central County	35,635	61%	170	53%	Dillard, Glide, Green, Lookingglass, Melrose, Roseburg, Roseburg North, Winston
South County	9,146	16%	69	22%	Glendale, Myrtle Creek, Riddle, Tri-City
Total	58,818		319		

Figure 2. CSTA Survey Results by Region





2023 CTSA SURVEY RESPONDENT DEMOGRAPHICS

People from 23 communities across Douglas County responded to the survey.

22% Identified as a person of color

19% Older adults (55+ years)

18% Identified as LGBTQIA2S+

35% Young adults (18-24 years)

32% Reported an income less than $50,000

58% Identified as women

Community Member Focus Groups

Focus groups are a valuable tool for collecting qualitative data. They provide a way to gain in-depth insights into people's thoughts, feelings, and experiences. Focus groups allow people to interact with each other and the facilitator who can guide the conversation to glean more nuanced insights that cannot be derived from surveys or questionnaires. Focus groups also provide an opportunity to understand people's motivations and decision-making processes and explore the factors influencing their behavior.

The objectives for the priority population focus groups were to:

- Introduce the community engagement data collection process, Umpqua Health, and Health Management Associates to community members
- Provide a high-level overview of the CHA and CHP processes
- Explain the importance of defining community health by lifting community experiences and voices and understanding the factors that affect community health
- Identify strategies that support, improve, and maintain community health

The priority populations represented in the focus groups were Black, Indigenous, People of Color (BIPOC); families with child welfare involvement; young adults ages 16-24 years; people with behavioral health needs or lived experience with mental and/or substance use disorders; tribal; and people who are unhoused. Participants were provided a $50 gift card for their time and food and drinks.

Each priority population focus group was intended to convene for 90 minutes. The agenda was structured to maximize discussion regarding the community health data presented to the group. However, to accommodate participant availability if a meeting was less than 90 minutes, the data presentation was abbreviated to preserve the amount of discussion time.

A detailed facilitated guide was provided to the UHA staff who organized and facilitated the focus groups (see Appendix C). The primary questions for discussion were:

- Did anything in the data surprise you?
- In what ways, if at all, are the top three health concerns or needs different in your community compared with what was found in the data? You may use a story to share or explain these concerns or needs.
- How do you or your community holistically take care of yourself/itself (social, physical, and mental health)? This can be in or outside of a medical setting.
- What specific supports and resources, such as jobs, food, housing, etc., do your or members of your communities most need?
- Where or to whom do you or members in your community go when you need help navigating health care or finding information?
- What do service providers need to understand about you or your community when it comes to investing in communities' health and wellness?
- What health issues do you think your community can change for the better? Why or why not?

Leveraging community partners in the recruitment of community members resulted in six focus groups that engaged 44 participants. Participants in each focus group were asked to voluntarily complete a demographic form, which 43 people completed. The purpose of the demographic form was to align the focus group findings with the CTSA data for a more comprehensive understanding of community members' lived experience. The demographics of the focus group participants are listed below:

- Nearly one in five participants (19%) identified as a member of the LGBTQIA2S+ community.
- Nearly half (42%) self-identified as a person of color.
- Young adults (ages 16–24) represented 17 percent of the focus group participants, with older adults (55+ years) representing another 16 percent.
- Focus group participants were largely residents of Central County region (67%), including cities/towns of Roseburg, Green, Lookingglass, Dillard, and Melrose.

Community Leader Meetings

Community leaders play an integral role in shaping the health and well-being of their communities. They catalyze change and mobilize individuals and organizations to address common challenges and work toward shared goals. To aid in identifying and addressing community needs, the CHA Steering Committee, including both members of the Umpqua Health Community Advisory Council and other stakeholders, were engaged monthly in the CHA process. The August 2023 Steering Committee was given the same community health data presentation as the focus groups. Following the presentation was a facilitated discussion where committee members reflected on the following questions:

- Did anything in the data surprise you?
- What health issues do you think your organization can change for the better?
- What are the challenges with improving some of these health issues/concerns?
- What are the opportunities with improving some of these health issues/concerns?
- Is there anything missing from the data?

Members of the HMA team also shared the community and health data at UHA's Annual Innovation Conference on October 3, 2023. Participants in this conference included community leaders and partners working collaboratively to impact social determinants of health and improve well-being in the Douglas County community. A post-event survey was distributed to all participants, asking them to share questions or comments about the data presentation, express their interest in participating in the CHP process, and answer questions that would begin to inform the Partner Assessment.

Data Collection and Analysis: Understanding Community Status

According to MAPP 2.0, community status is informed by a community-driven quantitative data assessment, or the numbers approach. It helps communities move upstream and identify inequities beyond health behaviors and outcomes, including their association with social determinants (or drivers) of health (SDOH) and systems of power, privilege, and oppression. Questions relevant to community status include:

- What does the status of your community look like, including key health, socioeconomic, environmental, and quality-of-life outcomes?
- What populations are experiencing inequities across health, socioeconomic, environmental, and quality-of-life outcomes?
- How do systems influence outcomes?

Secondary Data Collection

Health factors, behaviors, and outcomes data were reviewed and analyzed to paint the picture of health and well-being in Douglas County. Data sources included:

- The American Community Survey (ACS). These data were used to understand the demographics and socioeconomic status of Douglas County residents.9F 11
- Oregon Public Health Assessment Tool. These data provided insight into health behaviors and outcomes, including mortality and morbidity.
- Robert Wood Johnson Foundation County Health Rankings. CHR is a primary curated data source that includes multiple data sources to inform Community Context and Community Status Assessments.
- Oregon Department of Education. These data identify community member's ability to access high-quality education and the SDOH that affect student in the county.
- Uniform Crime Reporting System. These data illustrate criminal activity in Douglas County, including the types of crimes and who the victims and perpetrators are in proportion to their demographic representation in the county.

Analyzing the Numbers

Secondary data were collected and analyzed to understand year-over-year trends, health disparities between different groups, and to benchmark Douglas County against Oregon in various factors including SDOH, health behaviors, and health outcomes.

The significance of secondary data indicators that provided sampling error (but might be subject to reporting error) was determined based on confidence intervals. Determining significance using confidence intervals is a standard statistical method to assess the reliability and relevance of an estimated difference between two groups. Confidence intervals provide a range of values within which we can reasonably expect the true population parameter (e.g., population mean or difference in means) to fall within a certain confidence level. The width of a confidence interval depends on the size and variability of the data. When two confidence intervals overlap, it is unlikely that a difference in the estimated rate between the comparison groups truly exists in the population. If the confidence intervals do not overlap, it may indicate a likely difference in the two rates. When possible, significant differences between two groups were determined by comparing demographics (e.g., race and ethnicity) or comparing two groups over time (e.g., significant change in trends).

Additionally, when available, multi-year census estimates were used to assess health behaviors and outcomes by demographics. These estimates are valuable in needs assessments because they provide more stable, reliable, and comprehensive data. Multi-year estimates are better for getting dependable data about a group of people because they are less likely to show random ups and downs. When you combine data from several years, you have more information to work with, which is helpful for finding out about smaller groups or specific places and makes the data more accurate.

11 ACS is an ongoing survey of US households and residents that provides a variety of information. It replaces the long-form Census questionnaire and is administered to 1 in 38 US households each year. Responses from multiple years can be aggregated to provide information about very small geographies.

Assessment Limitations

All data and assessments have limitations. In terms of content, this assessment was designed to provide a comprehensive picture of the overall community's health. Although this assessment is quite comprehensive, it cannot measure all possible aspects of health in Douglas County; a significant number of medical conditions are not addressed specifically. Nor does this assessment represent all possible populations of interest, and not all voices are proportionately represented. It must be recognized that these information gaps limit the ability to assess disparities comprehensively and accurately among and between communities or all the community's health needs.

In every assessment, certain population groups, particularly those who are and historically have been marginalized—including communities of color, individuals experiencing homelessness, institutionalized or incarcerated people, and those who only speak a language other than English—are not well represented in secondary data. Population groups including people who are pregnant, LGBTQIA2S+,[10] undocumented and documented immigrants, and members of certain racial and ethnic groups might be unidentifiable or represented in numbers that are sufficient for independent analyses.

Additionally, survey data is inherently prone to respondent bias, is time-consuming, and often does not generate a strong response rate. Additionally, hard-to-reach populations often do not respond to surveys. To mitigate common challenges such as language barriers and cultural differences, the CSTA survey and outreach materials was translated into Spanish and UHA collaborated with trusted community-based organizations to distribute the survey to these communities. In addition to electronic outreach (e.g., social media, email), community members posted flyers in physical locations and conducted 1:1 outreach with paper surveys. Unfortunately, the response rate for the non-English language survey was low, so those responses were combined with the English language responses.

About Douglas County

According to the 2020 US Census, 111,201 people reside in Douglas County. The county, situated in southwestern Oregon, covers 5,134 square miles, making it the fifth-largest county in Oregon and one of two counties that extend from the Pacific Ocean to the Cascade Range. Roseberg is the county seat and the largest city in the county, with a population of around 23,000. [12] In Douglas County, 29.8 percent of the people voted Democrat in the last presidential election, 67.3 percent voted for the Republican Party, and the remaining 2.9 percent voted Independent. [13]

Originally, the region was inhabited by the Umpqua Indians, now known as the Cow Creek Band of Umpqua Tribe of Indians, one of nine federally recognized Indian Tribal Governments in the State of Oregon. Today, the Tribe runs the Seven Feathers Casino and Hotel, named after the seven families who refused forced removal to the Grand Ronde Reservation. According to a 2016 report by ECOnorthwest, the county's economic output was $188 million greater due to the jobs and activities provided by Tribal Government. [14]

Historically, the economy of Douglas County relied on the timber and logging industry. However, like many lumber-dependent areas, the county has faced economic challenges because of fluctuations in the timber market and environmental regulations. The county is known for its picturesque natural beauty, and it is renowned for its outdoor recreational opportunities, offering access to numerous parks, forests, and wilderness areas, making it a popular destination for outdoor enthusiasts. Efforts have been made to diversify the economy, with a focus on healthcare, tourism, manufacturing, and small businesses, including its emerging wine industry. The geology of the region is known for producing high-quality grapes, and several wineries and vineyards have been established in the area.

Demographic Profile

The demographic characteristics of a population are critical to understanding the health risks, challenges, strengths, and opportunities of a region. Aspects, such as race and ethnicity, age, and sex are intricately linked to health outcomes. Socioeconomic factors, such as income and education, are likewise associated with health risk and protective factors and outcomes. Subsequent sections of the CHA discuss the reasons for variation in health outcomes among different demographic groups, including the impacts of structural and systemic barriers and oppression, such as racism, colonialism, ableism, sexism, and other factors that contribute to health disparities.

Population

The demographic profile for this assessment was developed using data from the US Census ACS 2017–2021 five-year estimate. These data are used instead of the 2020 decennial census because the main function of the decennial census is to provide counts of people for the purpose of congressional apportionment. The primary purpose of the ACS is to measure changes in the social and economic characteristics of the population including educational attainment, housing affordability, and jobs.

Sex and Age

According to the ACS 2017–2021 five-year estimate, of the 110,680 people residing in Douglas County, the population is overrepresented by three groups that create unique and significant demands on the area's social service system: senior citizens, people with disabilities, and veterans.

[12] American Community Survey, Table B01001, 5-year estimate, 2017-2021

[13] https://www.bestplaces.net/voting/county/oregon/douglas

[14] https://www.cowcreek-nsn.gov/tribal-story/economic-impact/

Age and sex are fundamental factors to consider when assessing individual and community health status. Men tend to have a shorter life expectancy and more chronic illnesses than women; older individuals typically have more physical and mental health vulnerabilities and are more likely than younger people to rely on immediate community resources for support. When growth in the aging population outpaces that of people ages 18 and younger, it can have several negative consequences. One issue is the economic strain created when more people are retired because fewer people are working and paying taxes. Less tax revenue strains programs like Social Security, Medicaid, and Medicare. Another challenge to the economy is the need for more workers. Workforce shortages make it difficult for businesses to find the staff they need and can also lead to higher wages and prices. Workforce shortages also affect the caregiver industry. Aging adults often rely on family members, paid caregivers, or both. Caregiver shortages put a strain on all caregivers and lead to burnout.

Douglas County has an older population relative to the rest of Oregon. In 2017–2021, 19.5 percent of the county's population was younger than 18 years old age compared with 20.8 percent in the state. Conversely, 25.5 percent of the population was age 65 and older compared with 17.7 percent in the state.

Table 5. Age and Sex

Age & Sex	Douglas County		Oregon
	Percent	Number	Percent
Age			
Children and Youth (Under 18 years)	19.5%	21,635	20.7%
Young Adults (18-39 years)	23.0%	25,475	29.8%
Middle-Aged Adults (40-64 years)	31.9%	35,355	31.8%
Older Adults (65 and older)	25.5%	28,215	17.7%
Sex			
Male	49.6%	54,917	49.8%
Female	50.4%	55,763	50.2%

Source: American Community Survey, 5-Year Estimate, 2017-2021, Table DP05

The median age is rising faster than in many parts of the state, and "the area is experiencing an influx of older residents attracted by low property tax rates." [15] Overall, the median age of Douglas County residents is almost eight years older than residents statewide (46.6 as opposed to 39.6 years of age). [16]

Race and Ethnicity

Understanding race and ethnicity composition can help reveal health disparities, including higher rates of chronic disease, access to healthcare services, premature death, and other factors that affect the health of the community's population. From 2017 to 2021, most people in Douglas County were White, accounting for approximately 96.7 percent of the population—higher than the average for the whole state of Oregon, where about 88.0 percent of people were White. Native Americans and Alaska Native residents represented 4.3 percent of the population, which was slightly higher than the state's population at 3.3 percent. Some other races—Asian, Black or African American, and Native Hawaiian and Other Pacific Islander—had a lower representation in Douglas County than the State of Oregon.

15 2022 Community Needs Assessment produced by the United Community Action Network (UCAN) of Douglas and Josephine County
16 American Community Survey, 5-Year Estimate, 2017-2021, Table DP05.

Table 6. Race

Race	Douglas County		Oregon
	Percent	Number	Percent
White	96.7%	107,018	88.0%
American Indian and Alaska Native	4.3%	4,715	3.3%
Some other race	2.8%	3,069	6.9%
Asian	2.1%	2,335	6.3%
Black or African American	0.9%	1,042	3.1%
Native Hawaiian and Other Pacific Islander	0.4%	444	0.9%

Note: Race alone or in combination with one or more other races. Source: American Community Survey, 5-Year Estimate, 2017-2021, Table DP05

Hispanic or Latino (of any race) represented 6.2 percent of the residents living in Douglas County in 2017–2021 and were primarily Mexican (4.0%).

Table 7. Ethnicity

Ethnicity	Douglas County		Oregon
	Percent	Number	Percent
Not Hispanic or Latino	93.8%	103,871	86.4%
Hispanic or Latino (of any race)	6.2%	6,809	13.6%
Mexican	4.0%	4,449	10.9%
Puerto Rican	0.4%	411	0.4%
Cuban	0.1%	82	0.4%
Other Hispanic or Latino	1.7%	1,867	2.2%

Source: American Community Survey, 5-Year Estimate, 2017-2021, Table DP05

Language Spoken

Limited English Proficiency (LEP) is a term used to describe individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English. In 2017-2021, most residents (ages 5 year or older) in Douglas County spoke only English or 3,993 residents in 2017-2021. The second most common language was Spanish (2.2% or 2,344 residents). Diversity in language spoken is greater in Oregon compared to Douglas County, where 15.3 percent of residents speak a language other than English.

Table 8. Language Spoken

Language Spoken	Douglas County		Oregon
	Percent	Number	Percent
English only	96.2%	101,104	84.7%
Language Other than English	3.8%	3,993	15.3%
Spanish	2.2%	2,344	8.9%
Asian and Pacific Islander languages	0.4%	446	3.2%
Other languages	0.1%	131	2.6%

Source: American Community Survey, 5-Year Estimate, 2017-2021, Table DP02

Disability

The relationship between disability status and community health is complex and multifaceted. People with disabilities often face health disparities due to barriers in accessing healthcare, social isolation, and discrimination. Disability is influenced by and can impact social determinants of health, such as income and education. Accessible healthcare, inclusive communities, mental health and social support, and policy advocacy are crucial for improving the well-being of individuals with disabilities.

In Douglas County, the percent of adults who have one or more conditions used to measure disability - including deafness, blindness, cognitive function problems, mobility problems, difficulties taking care of personal care or errands without assistance – decreased between the years 2014 – 2017 and 2018 – 2021, from 51.1 percent to 34.2 percent.

In 2018 – 2021, adults 55 years or older had the highest proportion of people with a disability at 43.1 percent, followed by adults 18 to 34 years at 34.9 percent and adults 25 to 54 years at 22.2 percent. There was the greatest decrease in disability rates among adults 35 to 54 years, decreasing from 53.6 percent in 2014 – 2017 to 22.2 percent in 2018 – 2021.

Table 9 Disability Status Among Adults in Douglas County

	Percent of Adults (18+ years) who have one or more of these conditions is present: deafness, blindness, cognitive function problems, mobility problems, difficulties taking care of personal care or errands without assistance			
	Douglas County			Oregon
Age Group [1]	2014 - 2017	2018 - 2021	Percentage Point Change (2014 – 2017 to 2018 - 2021)	2018 - 2021
18 to 34 years	37.3	34.9	-2.4	Not applicable
35 to 54 years	53.6	22.2	-31.4	
55+ years	54.9	43.1	-11.8	
Adults (18+ years) [2]	51.1	34.2	-16.9	25.9

[1] Douglas County percents by age group are crude or age-specific weighted by the size of the population they represent in Douglas County, and therefore not comparable to Oregon. [2] Douglas County percent for all adults (18+ years) is age adjusted reflected the percent that would be observed if the population had the same age distribution as a standard and therefore is comparable to Oregon. Source: BRFSS via the Oregon Public Health Assessment Tool

Veteran Status

Veterans often face unique challenges, including physical and mental health issues resulting from their service experiences. These challenges can affect their overall well-being, including physical fitness, mental health, social support, and access to healthcare services. As a result, it is important for society and healthcare systems to recognize and address the specific needs of veterans to ensure their continued health and well-being. It is essential to recognize that veterans' experiences and well-being vary greatly based on factors such as the era in which they served, their specific roles, and the level of support and resources available to them.

A higher portion of Douglas County residents have served in the military than individuals living in other Oregon locations. In 2017−2021, 13.9 percent of Douglas County population or 12,394 people were veterans, higher than in Oregon at 8.0 percent. Nine in 10 (90.9%) were male. Age group 65−74 represents the most veterans (33.6%), followed by 75 years old older (25.6%). Working-age adults (ages 18−64) represent more than two-thirds of the veteran population (40.8%). Veterans are more likely to live in poverty than other residents. Their median income is $35,379, lower than veterans living elsewhere in Oregon at $43,723. Nearly one in 10 (9.6%) veterans live below poverty level.

Table 10. Veteran Status

	Douglas County		Oregon
	Percent	Number	Percent
Veterans	13.9%	12,394	8.0%
Male	90.9%	11,261	91.5%
Female	9.1%	1,133	8.5%
18 to 34 years	6.3%	785	7.7%
35 to 54 years	16.6%	2,053	21.4%
55 to 64 years	17.9%	2,213	17.5%
65 to 74 years	33.6%	4,164	29.1%
75 years and over	25.6%	3,179	24.3%
Median Income		$35,379	$43,723
Income in the past 12 months below poverty level	9.6%	1,185	7.7%

Source: American Community Survey, 5-Year Estimate, 2017-2021, Table S2101.

Families and Households

Douglas County was composed of 45,663 households in 2017–2021. Despite Douglas County's increasing median age, many families with children make their homes in the county. Approximately one in four households (24.0% or 10,948 of Douglas County households) include families with children younger than 18 years old. The average family size is a little less countywide than statewide at 2.9 (compared to 3.0), likely reflecting the higher percentage of older adult families. Nearly half (43.6%), or 19,927, the households in Douglas County included people ages 65 and older, higher than elsewhere in Oregon at 31.8 percent of households.

Table 11. Households and Family Characteristics

Household Characteristics	Douglas County		Oregon
	Percent	Number	Percent
Households with one or more people younger than age 18 years	24.0%	10,948	28.2%
Households with one or more people 65 years and older	43.6%	19,927	31.8%
Average family size	2.9		3.0
Female householder with no spouse/partner present with children younger than 18 years old	3.2%	1,439	4.0%
Total households			45,663

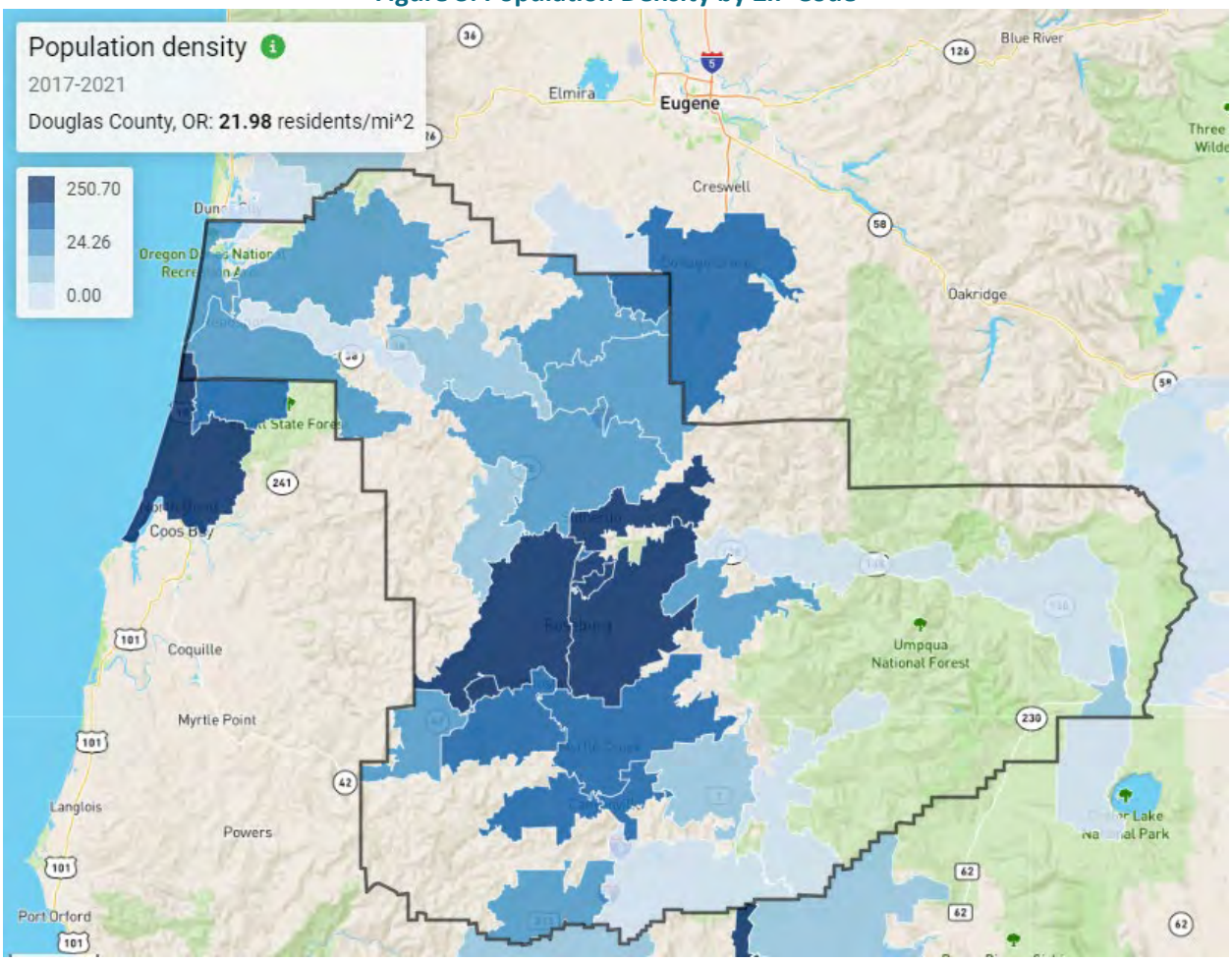
Source: American Community Survey, 5-Year Estimate, 2017-2021, Table DP02

Rurality

Rurality significantly affects community health. Rural areas often face unique healthcare challenges, such as limited access to medical facilities and healthcare professionals, as well as reduced availability of health services. These challenges can result in health disparities, including higher rates of chronic illnesses, limited preventative care, and reduced overall well-being. Addressing the healthcare needs of rural communities is essential to improving the health and quality of life for their residents.

In 2020, 30.4 percent of population of Douglas County was rural versus 19.5 percent of population living elsewhere in Oregon. [17] The population density in Douglas County was 22.0 people per square mile in 2017−2021, compared with 43.8 people per square mile in Oregon.

Figure 3. Population Density by ZIP Code



Source: American Community Survey, 5-year estimate, 2017-2021.

[17] An urban area comprises a densely settled core of census tracts and/or census blocks that meet minimum population density requirements, along with adjacent territory containing non-residential urban land uses, as well as territory with low population density included to link outlying densely settled territory with the densely settled core. To qualify as an urban area, the territory identified according to criteria must encompass at least 2,500 people, at least 1,500 of whom reside outside institutional group quarters like a university or prison. All other areas are designated as rural. Source: US Census Bureau. Urban and Rural. Available at: https://www.census.gov/programs-surveys/geography/guidance/geo-areas/urban-rural.html#:~:text=Rural%20encompasses%20all%20population%2C%20housing,and%2For%20population%20density%20requirements. Accessed November 10, 2023.

Community Context Assessment

As described in the MAPP 2.0 process, the CCA is a qualitative data assessment of the unique insights, expertise, and perspectives of individuals and communities directly affected by social systems to improve how those supports function. One important component of the CCA is the Community Strengths and Assets Survey (CSTA). Results of the CSTA provide important insights about the perspectives and priorities of community members about both their individual health needs and those of their community. In this section of the CHA, the community's perspective and priorities related to key health, socioeconomic, environmental, and quality of life indicators is highlighted by way of the CTSA results. The priorities of key populations also are highlighted and explained in this section. Additional findings from the CCA are provided below, starting on page 129.

Community Health Priorities

The American Planning Association (APA) defines "healthy communities" as places where all individuals have access to a healthy built, social, economic, and natural environment that gives them the opportunity to live up to their fullest potential, regardless of race, ethnicity, gender identity, income, age, abilities, sexual orientation, or other socially defined circumstance. CSTA survey respondents were more likely to report that their overall health was better (89%) than their community's overall health (63%) on a scale of very unhealthy, unhealthy, somewhat healthy, healthy, and very healthy.

Table 12. Health Ratings for Individuals and Their Community

	Very unhealthy	Unhealthy	Somewhat healthy	Healthy	Very healthy
My overall health (n=252)	2%	10%	33%	35%	21%
My community's overall health (n=250)	10%	26%	42%	14%	7%

Source: CSTA Survey, 2023.

The CTSA survey asked respondents questions regarding the health of their community and the experiences affecting their quality of life. Specifically, respondents were asked to identify the following:

What three things are most needed in your community to improve your health? When asked about the three things most needed to improve survey respondents' health, they identified better access to care (including mental health services and health care providers), affordable housing, low crime and safe neighborhoods, and good jobs and a strong economy.

What three things do you think are the most damaging to the health of your community? When asked about the factors most damaging to the health of their community, survey respondents identified behavioral health issues, including both mental illness and misuse of drugs or alcohol, along with homelessness.

What three things do you think are the most damaging to the health of people in your community? When asked about what factors they felt were most damaging to the health of people in their community, survey respondents identified poor eating habits and behavioral health issues, including substance abuse and misuse (e.g., methamphetamines and other stimulants, opioids, and alcohol).

Thinking about your community, what are the top three needs that, if met, would make your community healthier? When asked about their priorities, survey respondents identified affordable housing, education about behavioral health issues, and affordable, healthy, and nutritious food.

Taken together, survey respondents identified health improvement priorities of improving access to care, behavioral health, healthy eating, economic stability, and affordable housing. The dark blue boxes in Figure 3 identify the top three priorities among the CSTA survey respondents.

Figure 3. A Framework for Addressing Key Health Priorities Among CSTA Survey Respondents

Source: CSTA Survey, 2023.

For each of these questions, an analysis was conducted to detect variations in responses from CHA priority populations. For each population, a topic was considered a priority *unique* to the group if the percentage of respondents within the group who selected the topic was 10 or more percentage points higher compared with other respondents. For example, Arts and Cultural Events was selected as a

priority topic for what is needed in the community to improve health for LGBTQIA2S+ survey respondents because the percentage of LGBTQIA2S+ survey respondents who selected Arts and Cultural Events as a priority topic was 10 percentage points higher than non-LGBTQIA2S+ survey respondents.

In Table 13, the positive symbol (+) indicates an area of need in the community to improve their own health that ranked as higher than in other priority communities. Topics with table cells that have tan fill indicates they were one of the top three concerns for the priority population. In summary:

- Affordable housing, though a priority for all survey respondents, was particularly important among survey respondents who were low income (<$49,999 household income) and young adults (18−34 years old).
- Good jobs and a healthy economy ranked higher among older adults compared with young adults.
- Low crime and safe neighborhoods, though a high priority among all respondents, was particularly important among young adults.
- Reliable transportation and safe, stable, and nurturing relationships within the family and community and access to dental care were ranked higher among low-income survey respondents than among respondents with higher incomes.
- Arts and cultural events were ranked as a higher priority among LGBTQIA2S+ respondents relative to non-LGBTQIA2S+ respondents.
- Reliable transportation, access to dental care, and clean water and environment were ranked as a higher priority among Native American/Alaskan Native respondents relative to all respondents.

Table 13. Three Things Most Needed to Improve Health, by Priority Population

Topics	All (n=290)	LGBTQIA+ (n=51)	POC (n=62)	Low Income (n=83)	Older Adults (n=47)	Young Adults (n=89)	AI/AN (n=14)
Access to healthcare providers		+	+	+		+	
Access to mental health services				+	+		
Affordable housing				+		+	
Good jobs and a healthy economy					+		
Low crime and safe neighborhoods						+	
Reliable transportation				+			+
Safe, stable, and nurturing relationships within the family and community				+			
Access to treatment services for substance use or misuse						+	
Fair and equitable treatment of people and groups no matter their race, gender identity, age, or sexual orientation						+	
Access to dental care				+			+
Arts and cultural Events		+					
Clean water and environment							+

+ Priority population ranked as a priority compared with their counterparts. Tan fill indicates a top three priorities for the priority population.
Source: CSTA Survey, 2023.

Regionally, survey respondents indicated the following:

- Affordable housing was a priority for respondents living in most regions (except South County), but it was reported as a need among significantly more survey respondents living in Central County than other regions.
- Fair and equitable treatment of people and groups regardless of race, gender identity, age, or sexual orientation was among the top three needs among respondents who lived in North County. Though not among their top three needs, a significantly higher proportion of respondents living in South County identified fair and equitable treatment of people and groups as a need.

Table 14. Three Things Most Needed in Community to Improve Health, by Region

Topics	All (n=290)	Central County (n=154)	South County (n=68)	North County (n=66)
Access to healthcare providers				
Access to mental health services		+		
Affordable housing		+		
Good jobs and a healthy economy				
Low crime and safe neighborhoods				
Fair and equitable treatment of people and groups no matter their race, gender identity, age, or sexual orientation			+	

+ Region ranked as a priority need compared to all respondents. Tan fill indicates a top priority for the region. Source: CSTA Survey, 2023.

What three things do you think are the most damaging to the health of your community?

Among all survey respondents, mental health problems, drugs or alcohol, and homelessness were the three issues ranked as most damaging to the health of the community. Survey respondents representing priority populations did shed light on some additional issues of concern. In summary:

- Among LGBTQIA2S+ survey respondents, the overuse or inappropriate use of technology and car accidents related to driver behaviors were of top concern compared with non-LGBTQIA2S+ survey respondents.
- Among people of color, community violence, bullying and cyberbullying, car accidents related to driver behaviors, and environmental problems were of top concern compared with survey respondents who did not identify as a person of color.
- Among low-income survey respondents, cancer was a significant concern compared with survey respondents with higher incomes, along with bullying and cyberbullying and overuse or inappropriate use of technology, as well as unaffordable dental care.
- Older adults were aligned with the priority issues among all survey respondents; however, they were more likely to consider these as priority issues compared with young adults.
- Among young adults, community violence and overuse or inappropriate use of technology were among the top three topics selected. Infectious diseases were issues selected among a higher proportion of young adults than all older adults.
- Among AI/AN adults, while their top three priorities were similar to all survey respondents, they did prioritize issues of rape and sexual assault and sex and human trafficking more so than all respondents.

Table 15. Three Things Respondents Think are Most Damaging to the Health of Their Community, by Priority Population

Topics	All (n=289)	LGBTQIA2S+ (n=51)	POC (n=67)	Low Income (n=83)	Older Adults (n=47)	Young Adults (n=89)	AI/AN (n=14)
Mental health problems					+		
Drugs or alcohol					+	+	+
Homelessness					+		+
Community violence			+				
Overuse or inappropriate use of technology		+	+	+		+	
Bullying and cyberbullying			+	+			
Cancer (all types)				+			
Infectious diseases						+	
Car accidents related to driver behaviors		+	+				
Environmental problems			+				
Rape/sexual assault; sex/human trafficking							+
No affordable dental care				+			

+ Priority population ranked as a priority compared to their counterpart. Tan fill indicates a top priority for the priority population. Source: CSTA Survey, 2023.

Regionally, as Table 16 demonstrates:

- The percent of survey respondents living in Central County who prioritized mental health problems, drugs or alcohol and homelessness as the top three things most damaging to the health of their community was significantly higher compared to all survey respondents.
- South County respondents prioritized community violence among its top three things most damaging to the health of their community, along with mental health problems and drugs or alcohol.
- North County identified several things most damaging to their health of their community, including overuse or inappropriate use of technology and environmental problems, along with community violence, mental health problems and drugs or alcohol.

Table 16. Three Things Respondents Believed Are Most Damaging to the Health of Their Community, by Region

Topics	All (n=289)	Central County (n=154)	South County (n=68)	North County (n=64)
Mental health problems		+		
Drugs or alcohol		+		
Homelessness		+		
Community violence			+	
Overuse or inappropriate use of technology				+
Problems related to aging				
Heart disease and high blood pressure				
Environmental problems				+

+ Region ranked as a priority need compared to all respondents. Tan fill indicates a top priority for the region. Source: CSTA Survey, 2023.

What three things do you think are the most damaging to the health of people in your community?

Among all survey respondents, poor eating habits, the misuse of abuse of alcohol, and methamphetamine or other stimulants were the three top-ranked factors causing the most damage to the health of people in their community. Survey respondents representing priority populations shed light on issues of concern within their community. In summary:

- LGBTQIA2S+ respondents prioritized bullying or cyber bullying, unfair treatment because of gender or gender identity, and being overweight compared with all respondents and non-LGBTQIA2S+ respondents.
- Compared with non-LGBTQIA2S+ respondents, LGBTQIA2S+ respondents had a higher proportion of respondents who experienced unfair treatment because of race and ethnicity and sexual orientation. Not following public health recommendations for community safety and unsafe driving behaviors are priorities.
- Survey respondents who identified as BIPOC prioritized bullying or cyber bullying and unfair treatment because of race and ethnicity, along with alcohol misuse or abuse, as the top three issues most damaging to the health of people in their community.
- Low-income respondents ranked the same issues as the most important compared with all respondents; however, they were more likely to also rank untreated mental illnesses, bullying or cyberbullying, unfair treatment due to a personal characteristic, being overweight, and lack of exercise as issues most damaging to the people in their community.
- Older adult respondents ranked the same issues as the most important compared to all respondents; however, they were more likely to also rank being overweight.
- Young adults ranked bullying or cyber bullying, unfair treatment because of sexual orientation, and vaping as priority concerns in their community.
- Native American/Alaska Native respondents agreed with all survey respondents on the top issues but were more likely to rank poor eating habits as a number one issue and ranked untreated mental illness in their top three.

Table 17. Three Things Respondents Believe Are Most Damaging to the Health of People in Their Community, by Priority Population

Topics	All (n=286)	LGBTQIAS+ (n=51)	POC (n=61)	Low Income (n=83)	Older Adults (n=47)	Young Adults (n=89)	AI/AN (n=14)
Poor eating habits					+		+
Alcohol misuse or abuse					+		
Methamphetamine or other stimulants misuse or abuse							
Opioid misuse or abuse (including fentanyl or other synthetic opioids)					+		
Untreated mental illnesses				+			
Bullying or cyber bullying			+	+		+	
Unfair treatment because of gender or gender identity		+		+			
Unfair treatment because of race and ethnicity		+	+	+			

Topics	All (n=286)	LGBTQIAS+ (n=51)	POC (n=61)	Low Income (n=83)	Older Adults (n=47)	Young Adults (n=89)	AI/AN (n=14)
Unfair treatment because of sexual orientation		+		+		+	
Being overweight		+		+	+		
Lack of exercise				+			
Not following public health recommendations for community safety (wearing masks, getting vaccinated, etc.)		+					
Unsafe driving behaviors		+					
Vaping						+	

+ Priority population ranked as a priority compared to their counterpart. Tan fill indicates a top priority for the priority population. Source: CSTA Survey, 2023.

Regionally, as shown in Table 18, survey respondents indicated:

- Survey respondents who reside in Central County ranked the things as most damaging to the health of people in their community similarly to all survey respondents but were more likely to express concern about the use of methamphetamines or other stimulants and untreated mental illness.
- South County survey respondents also ranked as their top three unfair treatment because of gender or gender identity and did so with a higher percentage of respondents who identified unfair treatment because of gender or gender identity than all survey respondents.
- North County survey respondents included bullying or cyber bullying and being overweight in the top three things they considered most damaging to the health of people in their community.

Table 18. Three Thing Respondents Consider Most Damaging to the Health of People in Their Community, by Region

Topics	All (n=286)	Central County (n=154)	South County (n=67)	North County (n=64)
Poor eating habits				
Alcohol misuse or abuse				
Methamphetamine or other stimulants misuse or abuse		+		
Opioid misuse or abuse (including fentanyl or other synthetic opioids)				
Untreated mental illnesses		+		
Bullying or cyber bullying				+
Unfair treatment because of gender or gender identity			+	
Being overweight				

+ Region ranked as a priority need compared to all respondents. Tan fill indicates a top priority for the region. Source: CSTA Survey, 2023.

Thinking about your community, what are the top three needs that, if met, would make your community healthier?

Among all survey respondents, affordable housing; affordable, healthy, and nutritious food; education about behavioral health issues; and programs to prevent substance use or addiction were ranked as the top three needs that, if met, would improve the health of their community. Survey respondents representing priority populations identified additional issues of concern.

- Help managing disease or chronic conditions was considered a top need among LGBTQIA2S+ and people of color.
- People of color placed higher priority on disease prevention services and education than other survey respondents.
- Injury and violence prevention services and education were of higher priority among low-income and young adults.
- Teamwork between healthcare organizations and community organizations to help families meet their needs was more likely to be a priority among Native Americans and Alaska Natives.

Table 19. Top Three Needs That, if Met, Would Make Respondents' Communities Healthier, by Priority Population

Topics	All (n=277)	LGBTQIA2S+ (n=52)	BIPOC (n=67)	Low Income (n=83)	Older Adults (n=47)	Young Adults (n=89)	AI/AN (n=13)
Affordable housing				+			+
Affordable, healthy, and nutritious food				+			+
Education about behavioral health issues							
Programs to prevent substance use or addiction							
Help managing disease or chronic health conditions		+	+				
Emergency preparedness for disasters such as fire, drought, flood, and pandemics		+					
Disease prevention services and education			+				
Injury and violence prevention services and education				+		+	
Teamwork between healthcare organizations and community organizations to help families meet their needs							+

+ Priority population ranked as a priority compared to their counterpart. Tan fill indicates a top priority for the priority population. Source: CSTA Survey, 2023.

Table 20 reflects regional differences in survey respondent priorities

- Central County survey respondents prioritized affordable housing most.
- South County respondents prioritized high quality, culturally responsive healthcare services, along with affordable housing and education about behavioral health issues.
- North County survey respondents prioritized programs to prevent substance use or addiction more so than other CSTA survey respondents living elsewhere in Douglas County.

Table 20. Top Three Needs That, if Met, Would Make Respondents' Communities Healthier, by Region

Topics	All (n=280)	Central County (n=148)	South County (n=67)	North County (n=63)
Affordable housing		+		
Affordable, healthy, and nutritious food				
Education about behavioral health issues				
Programs to prevent substance use or addiction				+
High quality, culturally responsive healthcare services				

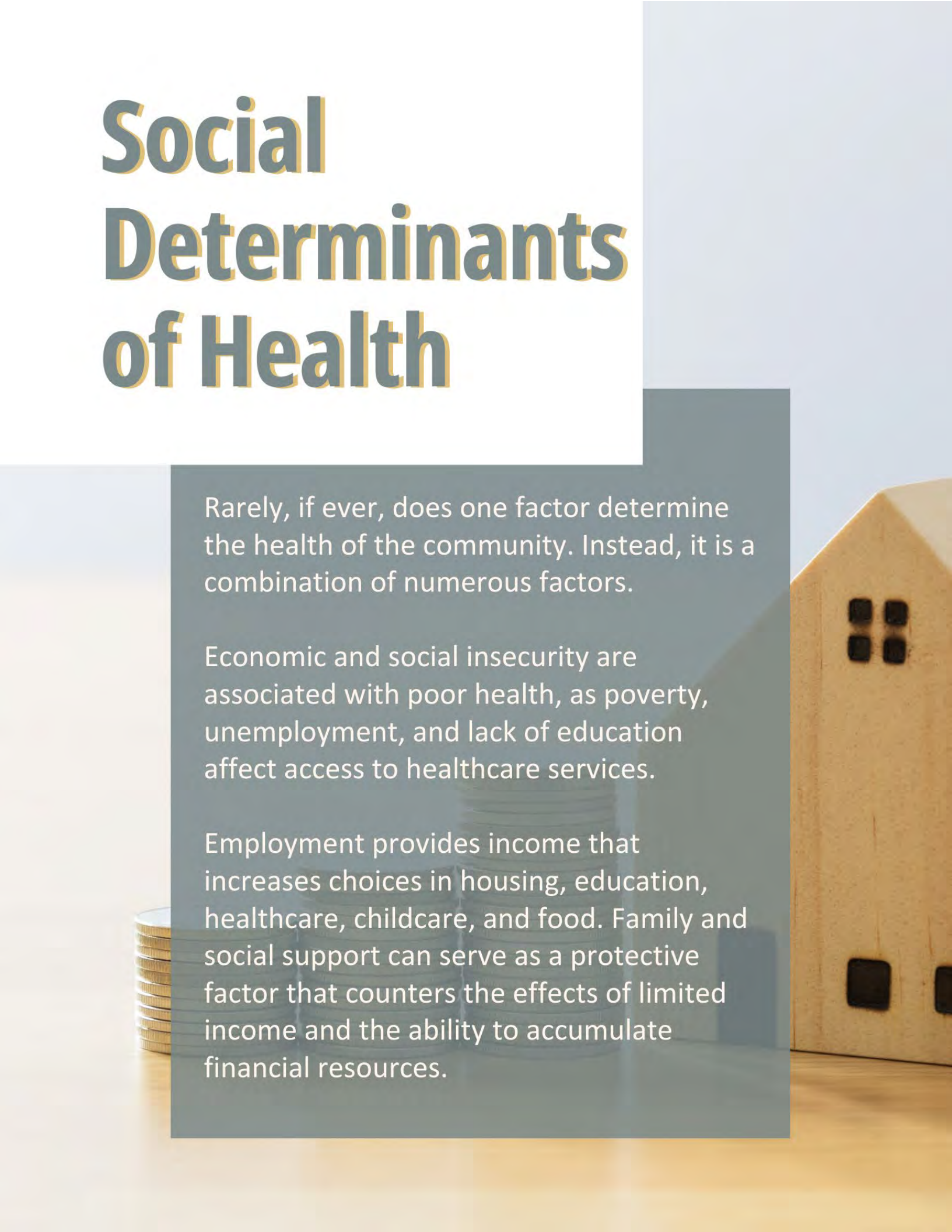
+ Region ranked as a priority need compared to all respondents. Tan fill indicates a top priority for the region. Source: CSTA Survey, 2023.

Social Determinants of Health

Rarely, if ever, does one factor determine the health of the community. Instead, it is a combination of numerous factors.

Economic and social insecurity are associated with poor health, as poverty, unemployment, and lack of education affect access to healthcare services.

Employment provides income that increases choices in housing, education, healthcare, childcare, and food. Family and social support can serve as a protective factor that counters the effects of limited income and the ability to accumulate financial resources.



Community Status Assessment

The Community Status Assessment uses quantitative data to describe the community, including SDOH, health factors and health outcomes present in Douglas County, and where these elements intersect and influence one another.

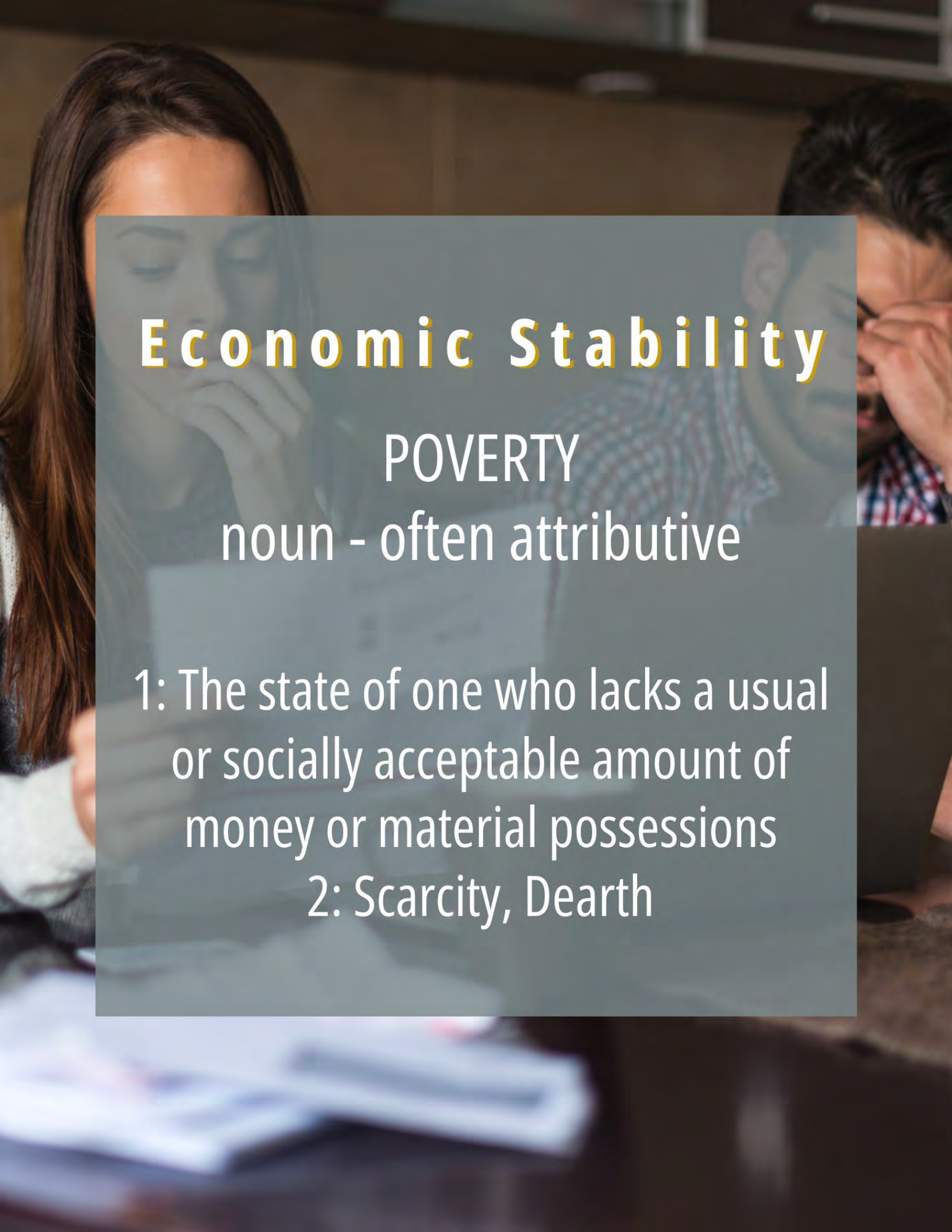
Social Determinants of Health

Rarely does one factor determine the health of a community. Instead, it is a combination of numerous influences. Healthy People 2030 describes five SDOH, including economic stability, access to quality education, access to quality healthcare, neighborhood and built environment, and social and community context. These determinants are defined as "the conditions in which people are born, live, learn, work, play, worship, and age and the wider set of forces and systems shaping the conditions of daily life." [18]

Each determinant independently and in combination influences the health of individuals and their communities. For example, economic and social insecurity are associated with poor health. Poverty, unemployment, and lack of education affect access to healthcare services. Employment provides income that increases choices in housing, education, healthcare, childcare, and food. Family and social support can counter the effects of limited income and the ability to accumulate financial resources.

In the following section, we use the five SDOH as a framework to describe the status of Douglas County as a community using primary data from the CTSA survey and focus groups, as well as secondary data.

18 Centers for Disease Control and Prevention. Economic Stability. Available at: https://www.cdc.gov/prepyourhealth/discussionguides/economicstability.htm#:~:text=SDOH%20are%20grouped%20by%20Healthy,socioeconomic%20status%E2%80%94and%20their%20health.



Economic Stability

POVERTY
noun - often attributive

1: The state of one who lacks a usual or socially acceptable amount of money or material possessions
2: Scarcity, Dearth

Economic Stability

Economic stability means that people have the resources essential to a healthy life. [19] Economic stability is directly tied to people's ability to meet their health needs. People are less likely to live in poverty and more likely to be healthy when they have steady employment. Without sufficient financial resources, individuals may, for example, have inadequate access to health insurance, transportation to get to doctor's appointments, or ability to pay for nutritious food.

CSTA survey respondents were asked to share to what extent they lacked enough money to pay for essential items, such as food, hygiene, housing, or clothing. Half of the CSTA survey respondents (50%, n=245) indicated they lacked enough money to pay for at least one essential item in the past month or year. Medicine/prescriptions or medical supplies were the essential items that CSTA respondents most often identified as unaffordable (35%), followed by gas for a car or other transportation costs (31%) and clothing (30%).

CSTA survey respondents who identified as BIPOC were more likely than other CSTA survey respondents to have had these experiences. Nearly eight in ten (79%) CSTA survey respondents who identified as a person of color indicated they lacked enough money to pay for at least one essential item in the past month or year. This was compared to four in ten (42.0%) of CSTA survey respondent who did not identify as a person of color.

The following indicators related to economic stability are examined in this section:

- Poverty
- Employment
- Transportation
- Access to food and nutrition

Poverty

The federal poverty level is the standard measure of whether individuals or families are poor or unable to meet their basic economic needs. However, poverty as a measure of economic stability has some problems. One issue is that it usually looks only at income and fails to account for important needs like access to education and healthcare and other essential services or supports. Measures of poverty do not consider cost of living and how it varies from place to place. Data used do not capture or describe how people view their own situations. Though this assessment reports poverty rate based on federal measures, to better reflect poverty among Douglas County residents, the assessment also reports on:

- The poverty rate among working residents
- A compositive measure of economic stability known as the hardship index
- Median household income
- Cost of living, including for essential resources such as food, housing, and childcare, are reported in each of the relevant SDOH sections below

Federal Poverty Rate

In 2021, the poverty rate was significantly higher in Douglas County, with 17.5 percent of people living in poverty compared with Oregon at 12.2 percent. The poverty rate in Douglas County also significantly increased to 17.5 percent in 2021 from 10.3 percent in 2019, while it remained relatively stable in Oregon (up to 12.2% in 2021 from 11.4% in 2019).

[19] https://www.networkforphl.org/resources/topics/covid-19-health-equity/economic-stability/

Table 21. Poverty Rate by Year

Year	Douglas County	Oregon
2016	14.8%	13.3%
2017	13.9%	13.2%
2018	14.0%	12.6%
2019	10.3%	11.4%
2020	Not available	Not available
2021	17.5%	12.2%

Source: American Community Survey, 1-year estimate 2016 to 2021, Table B17001.

Working Poor and Sex

The percent of employed Douglas County residents ages 16 and older who were in poverty was comparable to Oregon residents (6.0% and 6.1%, respectively). [20] Female Douglas County residents were significantly more likely to be working and living in poverty (7.7%) than males (4.4%). A similar sex disparity exists among employed residents elsewhere in Oregon.

Table 22. Percent of Currently Employed Douglas County Residents 16 and Older Living in Poverty

	Douglas County	Oregon
Total population	6.0%	6.1%
Females	7.7%	7.1%
Males	4.4%	5.2%

**Significantly higher compared to currently employed males. Source: American Community Survey, 5-year estimate, 2017-2021, Table B17005.*

Household Income

In 2017-2021, the median household income in Douglas County was $52,479; this amount was lower than in households elsewhere in Oregon at $70,084. [21] The median household income estimates are relatively similar across racial and ethnic groups in Douglas County. Median household income increased 11 percent since 2012-2016, when it was $47,404, with only Non-Hispanic White households benefiting from this increase. Non-Hispanic White household median household income in 2012-2016 was $47,624.

Table 23. Median Household Income by Race and Ethnicity, Douglas County and Oregon, 2017-2021

Populations	Douglas County		Oregon	
	2012-2016	2017-2021	2012-2016	2017-2021
Total population	$47,404	$ 52,479	$60,050	$ 70,084
Non-Hispanic White	$47,624	$ 53,215	$62,141	$ 71,787
Non-Hispanic Black*	$93,353	$ 41,673	$36,143	$ 50,950
Asian*	$107,718	$ 64,904	$77,437	$ 90,406
Hispanic or Latino	$44,963	$ 47,974	$47,696	$ 59,719
Native American	n/a	$ 42,151		$ 54,231

**Median household income estimates for non-Hispanic Black and Asian Douglas County residents have low level of certainty due to wide confidence interval. Source: American Community Survey, 5-Year Estimates, 2017-2021, Table B19013.*

Income earned among households can come from multiple sources, including employment, social security, retirement, supplemental sources, cash public assistance, and food stamp/SNAP benefit. The percent of households relying on income from these non-employment/labor sources was higher in Douglas County than in Oregon. In 2017−2021, nearly half of households (47.3%) had social security income in Douglas County (32.9% in Oregon), followed by 31.6 percent of households with retirement

20 American Community Survey, 5-year estimate, 2017-2021, Table B17005.

21 American Community Survey, 5-Year Estimates, 2017-2021, Table B19013.

income (23.1% in Oregon), and 17.8% of households with Food Stamp/SNAP benefits in the past 12 months (14.7% in Oregon). Cash public assistance income supported 3.7 percent of households in Douglas County (3.9% in Oregon). [22]

Table 24. Percent of Households by Income Type

Households by Income Types	Douglas County	Oregon	Number of Douglas County Households
With earnings	64.5%	76.2%	29,433
With Social Security	47.3%	32.9%	21,578
With retirement income	31.6%	23.1%	14,431
With Supplemental Security Income	7.7%	4.7%	3,538
With cash public assistance income	3.7%	3.9%	1,671
With food stamp/SNAP benefits in the past 12 months	17.8%	14.7%	8,150

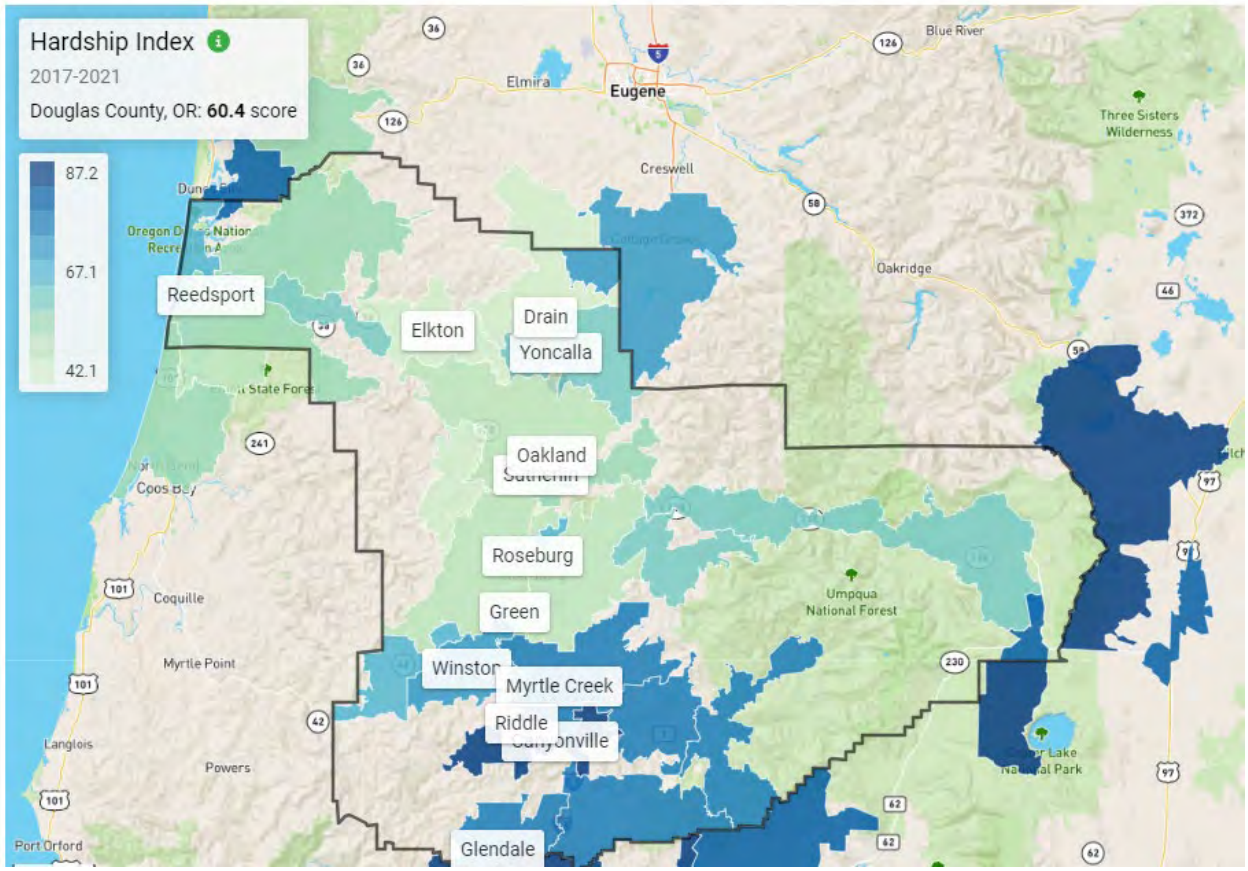
Source: American Community Survey, 5-year estimate 2017-2021, Table DP03

Hardship Index

The hardship index is a composite score reflecting economic challenges in the community (higher values indicate greater hardship). It incorporates unemployment, age dependency, education, per capita income, crowded housing, and poverty into a single score that allows comparison between geographies. It is highly correlated with other measures of economic hardship, such as labor force statistics and poor health outcomes. It begins to take into consideration the influential factors that better define poverty. In Figure 3, the darker the blue, the greater the economic hardship. Douglas County has a higher score at 60.4 than Oregon at 46.6. Communities with the greatest hardship in Douglas County were Riddle (87.2), Canyonville (85.5), and Tri City (83.2).

22 American Community Survey, 5-year estimate 2017-2021, Table DP03

Figure 4. Hardship Index by ZIP Code, 2017–2021



Source: Hardship Index was developed by Developed by Richard P. Nathan and Charles F. Adams, Jr., of the Brookings Institution, 1976. Source: American Community Survey, 2017-2021. Calculated by Metopio

Employment

As mentioned previously, people with steady employment are more likely to be healthy and not in poverty. Approximately half the people ages 16 and older in Douglas County were part of the labor force, which means they have jobs or are actively looking for work in 2017–2021. More specifically, 50.7 percent of this group (46,643 individuals) were part of the labor force. All age groups participated in the labor force at significantly lower rates than their peers living elsewhere in Oregon. Young adults (18–39 years old) had the highest participant rate at 77.1 percent, followed by middle-aged adults (40-64 years old) at 61.8 percent, and older adults (65+ years old) at 12.3 percent.

Table 25. Percent of Residents Who Participated in the Labor Force by Age, 2017–2021

Age	Douglas County	Oregon
Total population	50.8%	62.6%
Young Adults (18-39 years)	73.0%	77.1%
Middle-Aged Adults (40-64 years)	61.8%	72.1%
Adults (18-64 years)	67.8%	75.1%
Seniors (65 and older)	12.3%	17.4%

Source: American Community Survey, 5-year estimates, 2017-2021, Tables B23025, B23001, and C23002. Pulled from Metopio.

Participation in the labor force varies among different racial and ethnic groups in Douglas County. In 2017–2021, non-Hispanic White residents were least likely to be part of the labor force in Douglas County, with 50.1 percent of non-Hispanic White residents participating in the workforce. This number

was also lower than the state of Oregon's overall rate (60.7%). On the other hand, Asian residents in Douglas County were most likely to be part of the labor force, with 66.5 percent of them actively working or seeking employment. Hispanic or Latino residents follow closely, with 59.3 percent of them being part of the labor force.

Table 26. Percent of Residents Who Participated in the Labor Force by Race and Ethnicity, 2017–2021

Race/Ethnicity	Douglas County	Oregon
Total population	50.8%	62.6%
Non-Hispanic White	50.1%	60.7%
Non-Hispanic Black	61.9%	65.6%
Asian	66.5%	65.9%
Hispanic or Latino	59.3%	72.7%
Native American	52.5%	60.4%

Note: Pacific Islander/Native Hawaiian estimate was 4.8%, an unstable. Source: American Community Survey, 5-year estimates, 2017-2021, Tables B23025, B23001, and C23002. Pulled from Metopio.

Measuring the Labor Force

Percent of Labor Force by Occupation and *Percent of Labor Force by Industry Sector* are two ways to categorize and measure the distribution of workers in an economy. The percentage of the labor force by occupation measures the ***proportion of workers employed in each occupation***. The percentage of the labor force by industry sector measures the ***proportion of workers employed in each industry sector***. The two measures are used for different purposes. The percentage of the labor force by occupation is often used to assess the skills and education levels of the workforce. In contrast, the percentage of the labor force by industry sector is often used to assess the economic health of different sectors of the economy.

In Douglas County, there are more people working in jobs related to natural resources, construction, maintenance, production, transportation, and services compared to the rest of the state. Additionally, there are slightly more people working in sales and office jobs in Douglas County than in the state. The number of people working in management, business, science, and arts jobs in Douglas County was much lower than the state average.

Table 27. Percent of Labor Force by Occupation

Occupation	Douglas County	Oregon
Management, business, science, and arts occupations	29.8%	41.0%
Sales and office occupations	22.7%	20.4%
Service occupations	19.8%	17.4%
Production, transportation, and material moving occupations	16.8%	12.3%
Natural resources, construction, and maintenance occupations	11.0%	8.9%

Source: American Community Survey, 5-year estimate 2017-2021, Table DP03

In Oregon, the biggest job providers were in education, healthcare, and social assistance, followed by retail trade and manufacturing. However, in Douglas County, employers in arts, entertainment, recreation, accommodation, and food services (11.2%) and agriculture, forestry, fishing, hunting, and mining (8.3%) were more significant compared to the state of Oregon. On the other hand, the professional, scientific, management, administrative, and waste management services sector was smaller in Douglas County at 8.3 percent than in the rest of Oregon at 11.5 percent.

Table 28. Percent of Labor Force by Industry Sector

Industry	Douglas County	Oregon
Educational services, and health care and social assistance	23.5%	23.4%
Retail trade	12.9%	11.6%
Manufacturing	12.6%	11.0%
Arts, entertainment, and recreation, and accommodation and food services	11.2%	9.4%
Professional, scientific, and management, and administrative and waste management services	8.3%	11.5%
Construction	5.8%	6.6%
Agriculture, forestry, fishing and hunting, and mining	5.6%	2.9%
Public administration	5.0%	4.7%
Transportation and warehousing, and utilities	4.7%	4.6%
Other services, except public administration	3.6%	4.6%
Finance and insurance, and real estate and rental and leasing	3.5%	5.5%
Wholesale trade	2.0%	2.6%
Information	1.1%	1.6%

Source: American Community Survey, 5-year estimate 2017-2021, Table DP03

The average unemployment rate for Douglas County was consistently above the average unemployment rate for Oregon, meaning more people in Douglas County are more likely to be unemployed than people statewide. The highest unemployment rates were in 2020 where Douglas County was at 7.8 percent and Oregon State was at 7.3 percent. Looking at prior years and years following the average unemployment rate was between 4.0 percent to 5.9 percent.

Table 29. Average of Unemployment Rate

Race/Ethnicity	Douglas County	Oregon
2017	5.3%	4.7%
2018	5.2%	4.6%
2019	4.8%	4.3%
2020	7.8%	7.3%
2021	5.9%	5.4%
2022	5.3%	4.6%

Source: Bureau of Labor Statistics, 2017 to 2022

In 2017−2021, the highest unemployment rate in Douglas County was among young adults ages 18−39 (7.1%), a significant decrease from 2012−2016 for this age group (14.7%).

Table 30. Unemployment Rate by Age Group

Age	2012-2016	2017-2021	Percentage Point Change
Total population	10.9%	5.9%	-5.0%
Young adults (18–39 years)	14.7%	7.1%	-7.5%
Middle-aged adults (40–64 years)	7.5%	4.5%	-3.0%
Seniors (65+ years)	3.0%	4.1%	1.1%

Source: American Community Survey, 5-Year Estimate, Tables B23025, B23001, and C23002

Transportation

Having reliable transportation, whether one's own vehicle or public transportation, is crucial to being able to access healthcare and other things that influence health such as healthy foods or work. This is particularly true in Douglas County, which is known for its rural and often remote areas. Public transportation options are limited or non-existent in many parts of the county. Having a vehicle provides essential mobility for daily activities like grocery shopping, commuting, and accessing healthcare. In 2017-2021, one in 20 Douglas County households (5.0%) had no vehicle available to them. [23] There were specific areas like Reedsport (14.0%), Winchester Bay (10.8%), and Roseburg (9.1%) where the number of households without cars was twice as high as the county average.

Table 31. Percent of Occupied Households with No Vehicles, by City or Town

City or Town	Percent
Reedsport	14.0
Winchester Bay	10.8
Roseburg	9.1
Melrose	8.7
Canyonville	8.6
Days Creek	5.2
Tri-City	5.2
Winston	5.0
Green	4.1
Glide	3.9
Glendale	3.4
Myrtle Creek	3.3
Sutherlin	3.1
Yoncalla	3.0
Riddle	2.5
Roseburg North	2.3

Note: It was estimated that all households in the towns of Dillard, Drain, Elkton, Fair Oaks, Gardiner, Lookingglass, and Oakland had a vehicle.
Source: American Community Survey, 5-Year Estimate, 2017-2021, Table B25044.

U-Trans (formerly Umpqua Transit) has provided public transportation, such as fixed box routes and paratransit services for people with disabilities, in the Douglas County communities of Roseburg, Sutherlin, and Myrtle Creek. In 2017, U-Trans significantly expanded these services to include locations such as Oakland and Tenmile. Greyhound Lines provide Roseburg with more distant transportation, and

23 American Community Survey, 5-Year Estimate, 2017-2021, Table B25044

Dial-a-Ride services are available in some parts of Douglas County. These services typically allow residents to schedule rides in advance and are often used by seniors and people with disabilities. Additionally, Oregon Health Plan (OHP) members have access to Non-Emergent Medical Transportation (NEMT) services. These rides are free of charge for OHP members who need help getting to and from a covered or health-related service.

The most common means of transportation to work is by car, truck, or van among Douglas County residents (83.8%). Approximately one in 10 (11.8%) residents work from home and do not commute. Less than 1.0 percent of Douglas County residents rely on public transportation for work. Across all methods of transportation, it takes an average of 20 minutes to get to work in Douglas County, which is lower than the state of Oregon (22.8 minutes).

Table 32. Means of Transportation to Work

Transportation Type	Douglas County	Oregon
Car, truck, or van	83.8%	72.7%
Drove alone	70.5%	64.1%
Carpooled	13.3%	8.6%
Workers per car, truck, or van	1.1%	1.1%
Public transportation (excluding taxicab)	0.1%	2.1%
Walked	3.0%	3.6%
Bicycle	0.0%	1.3%
Taxicab, motorcycle, or other means	1.4%	1.4%
Worked from home	11.8%	19.0%
Mean travel time to work (minutes)	20	22.8

Source 1 American Community Survey, 5-year estimates, 2017-2021, Table S0801.

Nearly all (92.8%) of employed county residents work in Douglas County, which was higher than Oregon (81.2%). [24]

Table 33. Place of Work

Place of Work	Douglas County	Oregon
Worked in state of residence	99.6%	98.1%
Worked in county of residence	92.8%	81.2%

Source: American Community Survey, 5-year estimates, 2017-2021, Table S0801

24 American Community Survey, 5-year estimates, 2017-2021, Table S0801.

Access to Food and Nutrition

Access to food and nutrition is a critical SDOH and a key economic indicator. It signifies an individual's ability to secure nourishing food, which is fundamental to overall well-being. Adequate nutrition is pivotal not only for physical health, but also affects cognitive development and productivity. In the broader context, a population's access to food and nutrition serves as a vital economic indicator, as it reflects the stability and productivity of a society. A well-fed community is more likely to be healthy and capable of contributing to a nation's economic growth and stability, making food security and nutrition essential components of public health and economic well-being.

Free and Reduced Priced Lunch

The Free and Reduced Price Meals (FRPM) program is a federal initiative in the United States aimed at providing nutritional support to students from low-income families. In Oregon, children eligible for FRPM include:

- Children whose household meets income guidelines
- Children whose household receives SNAP (food stamps), TANF (welfare), WIC, or the Food Distribution Program on Indian Reservations (FDPIR)
- Foster children that are under the legal responsibility of a foster care agency or court are eligible for free meals.
- Children who are enrolled in Head Start program
- Children who meet the definition of homeless, runaway, or migrant

In 2022, an average of 55.1 percent of students in Oregon were eligible for free and reduced priced meals. In Douglas County, this rate was higher, at 65.5 percent of students. The percent of students eligible for free and reduced priced meals in Douglas County ranged from a low of 50.5 percent in Camas Valley School District to a high of 83.5 percent in Reedsport School District.

Table 34. Percent of Students Eligible for Free and Reduced Priced Meals in Douglas County, 2022

School Districts	Average of Percent Eligible
Glide SD 12	33.6%
Elkton SD 34	50.4%
Camas Valley SD 21J	50.5%
Oakland SD	53.5%
North Douglas SD 22	61.6%
Sutherlin SD 130	64.2%
Yoncalla SD 32	66.1%
Days Creek SD 15	67.4%
Riddle SD 70	67.5%
Roseburg SD 4	68.2%
Winston-Dillard SD 116	69.1%
Glendale SD 77	73.5%
South Umpqua SD 19	75.0%
Reedsport SD 105	83.5%
Douglas County Average	65.5%

Source: Oregon Department of Education, Free and Reduced Lunch Report 2022.

Food Insecurity

Food insecurity means not always having enough nutritious food to eat. It can happen when people have too little money, cannot find work, are indigent, or cannot easily get to grocery stores. When food is scarce, people skip meals, eat less, or choose unhealthy, cheaper options. As a result, people in these situations develop health issues because they are consuming products that have low nutritional value.

The food insecurity rate in Douglas County was 12.0 percent in 2021 (13,300 people). Among these individuals, 17.0 percent were ineligible for the federal nutrition programs (SNAP). The child (younger than 18 years old) food insecurity was higher (16.8%). Among these children, 16.0 percent were likely ineligible for federal nutrition programs because their incomes exceeded 185 percent of the poverty level).

Table 35. 2021 Food Insecurity in Douglas County, 2021

Demographic Characteristic	Percent Food Insecure	Percent Ineligible for Federal Nutrition Programs
All individuals	12.0%	17.0%
Children (younger than 18 years old)	16.8%	16.0%
Latino/Hispanic	20.0%	Not available
White, Non-Hispanic	11.0%	Not Available

Source: Feeding America, retrieved on October 24, 2023.

Food insecurity rates improved between 2017 to 2021, from 14.2 percent in 2017 to 12.0 percent in 2021. Child food insecurity rates also improved from 22.8 percent in 2017 (4,800 children) to 16.8 percent (3,630 children) in 2021. The percent of people and children who were considered eligible for the federal nutrition programs also increased during this time, suggesting both increased poverty and increased access to food benefits.

Table 36. Food Insecurity Rates

Year	Children			All Ages		
	Percent	Number	Percent Ineligible for Federal Nutrition Programs	Percent	Number	Percent Ineligible for Federal Nutrition Programs
2017	22.8%	4,800	27%	14.2%	15,330	21%
2018	22.6%	4,760	24%	14.7%	15,870	22%
2019	20.8%	4,410	20%	14.0%	15,280	23%
2020	18.8%	4,000	15%	12.5%	13,750	17%
2021	16.8%	3,630	16%	12.0%	13,300	17%

Source: Feeding America, retrieved on October 24, 2023.

Students who responded to the Oregon Health Student Survey were asked whether in the past 30 days they experienced hunger. In both Oregon and Douglas County, approximately 60–70 percent of sixth, eighth, and 11th students reported "never or almost never." Hunger was, however, more common in Douglas County, particularly among 11th graders. The range in the percent of students who reported experiencing hunger at least once in the past month because of a lack of money in Douglas County varied from 15.1 percent among eighth graders to 29 percent among 11th graders. In Oregon, this range was lower and narrower, with a floor of 19.3 percent of eighth grade students and a ceiling of 21.1 percent of students in sixth grade reporting this challenge.

Table 37. Hunger among Students, by Grade

	Percent of Students					
	Douglas County			Oregon		
	Grade 6	Grade 8	Grade 11	Grade 6	Grade 8	Grade 11
Never or almost never	69.9%	71.0%	67.3%	63.3%	70.0%	72.2%
About once a week	12.3%	6.3%	15.8%	10.6%	8.9%	9.9%
2 to 3 times a week	3.1%	8.0%	12.0%	5.2%	5.2%	5.2%
Almost every day	6.1%	0.8%	1.2%	5.3%	5.2%	5.2%
One more or times a week	**21.5%**	**15.1%**	**29.0%**	**21.1%**	**19.3%**	**20.3%**
I am not sure	4.3%	8.6%		6.9%	6.8%	5.5%
I don't know what this question is asking		2.7%		2.3%	1.5%	0.6%
I prefer not to answer	4.3%	2.6%	3.6%	6.4%	4.6%	3.9%

Source. Oregon Student Health Survey, 2022

Food Affordability

The price of a meal in Douglas County went up by 23 percent, to $3.74 in 2021 from $3.03 in 2017. [25] In 2017, the typical household earned $52,958, but by 2021, that income had fallen by 3.4 percent to $51,166. [26]

Focus Group Participants

Participants mentioned that food stamp benefits might not be sufficient to meet their food needs. They emphasized the importance of affordable and accessible food resources to ensure that community members have access to adequate nutrition.

The percent of households in Douglas County receiving SNAP benefits over the past 12 months was 19.2 percent in 2021, higher than elsewhere in Oregon (15.9%). [27] The number of SNAP participants increased in 2019–2021. In Douglas County, it increased from 18.1 percent in 2019, whereas for Oregon, the increase was greater, up from 13.4 percent of households. Five-year estimates (2017–2021) suggests that SNAP enrollment was significantly higher in Douglas County than in Oregon, 17.9 percent and 14.7 percent, respectively.

The percent of households living in poverty not receiving SNAP was nearly half (49.6%) in Douglas County in 2017–2021 and has increased from 32.9 percent in 2012–2016. [28]

Table 38. Percent of Households in Douglas County Receiving/Not Receiving SNAP benefits

Year	Household received Food Stamps/SNAP in the past 12 months:		Household did not receive Food Stamps/SNAP in the past 12 months:	
	Oregon	Douglas County	Oregon	Douglas County
2017	14.5%	18.1%	79.7%	80.6%
2018	14.7%	18.8%	85.2%	79.5%
2019	13.4%	18.1%	86.6%	81.9%
2020	15.0%	18.4%	85.1%	83.3%
2021	16.9%	19.4%	89.3%	81.9%

25 Feeding America, retrieved on October 24, 2023.

26 American Community Survey, 1-Year Estimate, 2017 and 2021, Table B19013.

27 American Community Survey, 1-year estimates, 2021, Tables B22003, B22005, and S2201

28 American Community Survey, 5-year estimates, 2017-2021, Tables B22003.

Proximity to Healthy Foods

The Food Environment Index describes factors that contribute to a healthy food environment, with zero representing the least healthy conditions to 10 representing the healthiest. The County Health Rankings measure of the food environment includes both proximity to healthy foods and cost. In 2020, the food environment index (FEI) in Douglas County was 7.3, lower than elsewhere in Oregon at 8.1, meaning that residents of Douglas County had a worse food environment than the state overall. [29] The median value nationally for counties was 7.6 and most counties fell between 6.8 and 8.2.

Consistent with the FEI described above, Douglas County residents were more likely to lack adequate access to food than other people in Oregon. [30] Nearly half of residents (42.5%) have limited access to food, defined solely by distance. [31] The percentage of residents who experience living in a food desert, defined as being low-income and further than one mile (urban) or 20 miles (rural) from a supermarket, was 6.7 percent (7,102) residents in 2019. In some Douglas County cities and towns, twice as many residents lived in a food desert, including people in Sutherlin (15.9%), Roseburg (15.8%), and Tri-City (15.4%). One in 10 residents of Myrte Creek (11.6%), Dillard (10.4%), and Winston (10.3%) lived in food deserts.

29 USDA Food Environment Atlas; Map the Meal Gap from Feeding America, as in County Health Rankings 2023.

30 The original "Low Access" designation applied to the entire Census tract if >33% of residents, or 500 residents, had low access. This topic is continuous rather than binary to allow for closer examination, but broadly speaking areas with >33% low food access are the ones officially designated as Low Access. This topic measures only physical access to food, and residents cannot necessarily afford that food.

31 USDA, Food Access Research Atlas, 2019 via Metopio. Further than 1/2 mile from the nearest supermarket in an urban area, or further than 10 miles in a rural area.

Access to Quality Education

EDUCATION
noun

1a: The action or process of educating or of being educated;
1b: The knowledge and development resulting from the process of being educated

Education Access and Quality

People with higher levels of education are more likely to live healthier and longer lives; therefore, access to high-quality educational opportunities is an important SDOH.

A 2022 United Community Action Network (UCAN) assessment identified that Douglas County has some of the state's lowest high school graduation rates. [32] Douglas County also experienced a shortage of individuals with bachelor and graduate degrees and struggles to retain talented students who often leave the area to attain higher education, as it lacks four-year degree programs and graduate education options. High unemployment and low median wages discourage college graduates from returning to the area.

Focus Group Participants

Participants express a desire for more resources to guide them after high school, including information on applying to colleges and scholarships. They mention the need for accessible career centers and supportive counseling services.

Participants emphasized the need for improved education and life skills training. They highlighted the importance of catching people before they reach a point where they require extensive services. This includes teaching individuals better coping skills and basic life skills. The participants expressed that current educational systems often lack adequate preparation in these areas. They suggested that high schools could play a significant role in providing this education, especially for those who lack traditional family structures.

The following indicators related to education are examined in this section:

- Preschool enrollment, including childcare and preschool affordability
- Public school enrollment and absenteeism
- Graduation rates
- Educational achievement

Preschool Enrollment

Preschool enrollment serves as a meaningful measure of community health because it reflects a community's commitment to early childhood development, educational readiness, reduced disparities, and the long-term well-being of its residents. It is an investment in the future that can lead to positive social, economic, and health outcomes for the community.

Preschool enrollment among infants and toddlers (0–4 years old) was 52.0 percent in Douglas County in 2017–2021, slightly higher than the average for Oregon at 42.2 percent of infants and toddlers. [33] The preschool enrollment rate significantly increased in Douglas County from 2012–2016 when it was 33.3 percent of infants and toddlers from birth to four years old. This rate remained stable in Oregon. The rate was reflected Douglas County's rate catching up to the rest of the state.

Table 39. Preschool Enrollment

Year	Douglas County	Oregon
2012-2016	33.3%	43.4%
2017-2021	52.0%	42.2%

Source: American Community Survey, 5-Year estimate, 2017-2021, Table B14003.

[32] United Community Action Network Douglas and Josephine County. 2022 Needs Assessment.

33 American Community Survey, 5-Year estimate, 2017-2021. Table B14003. Includes home school and licensed private preschool, as well as 4-year-olds enrolled in kindergarten (which usually begins at age 5).

Childcare and Preschool Proximity and Affordability

In 2017–2021, 9,288 households in Douglas County had children younger than 18 years old. Among these households, 22.8 percent had children younger than six years of age (2,117 households). Furthermore, among these households, 64 percent had one or both working parents. [34] Therefore, approximately 1,355 households have the potential need for childcare.

In June 2023, the Oregon Child Care Research Partnership through Oregon State University released an early care and education profile for Douglas County, which noted that 2,002 childcare slots are available in the county.

Childcare expenses usually comprise a large portion of a family's budget. In 2022, the percentage of household income required for childcare expenses (for a household with two children as a percent of median household income) was higher in Douglas County (29.0%) than in Oregon (24.2%). [35] The median annual price of toddler care in a childcare center was $10,320, and it is estimated that 41 percent of a minimum wage worker's annual earnings would be needed to pay for a toddler enrolled in these services. [36]

CTSA Survey Respondents

Approximately one in 10 CSTA survey respondent selected quality and affordable childcare as top three needs that, if met, would make their community healthier.

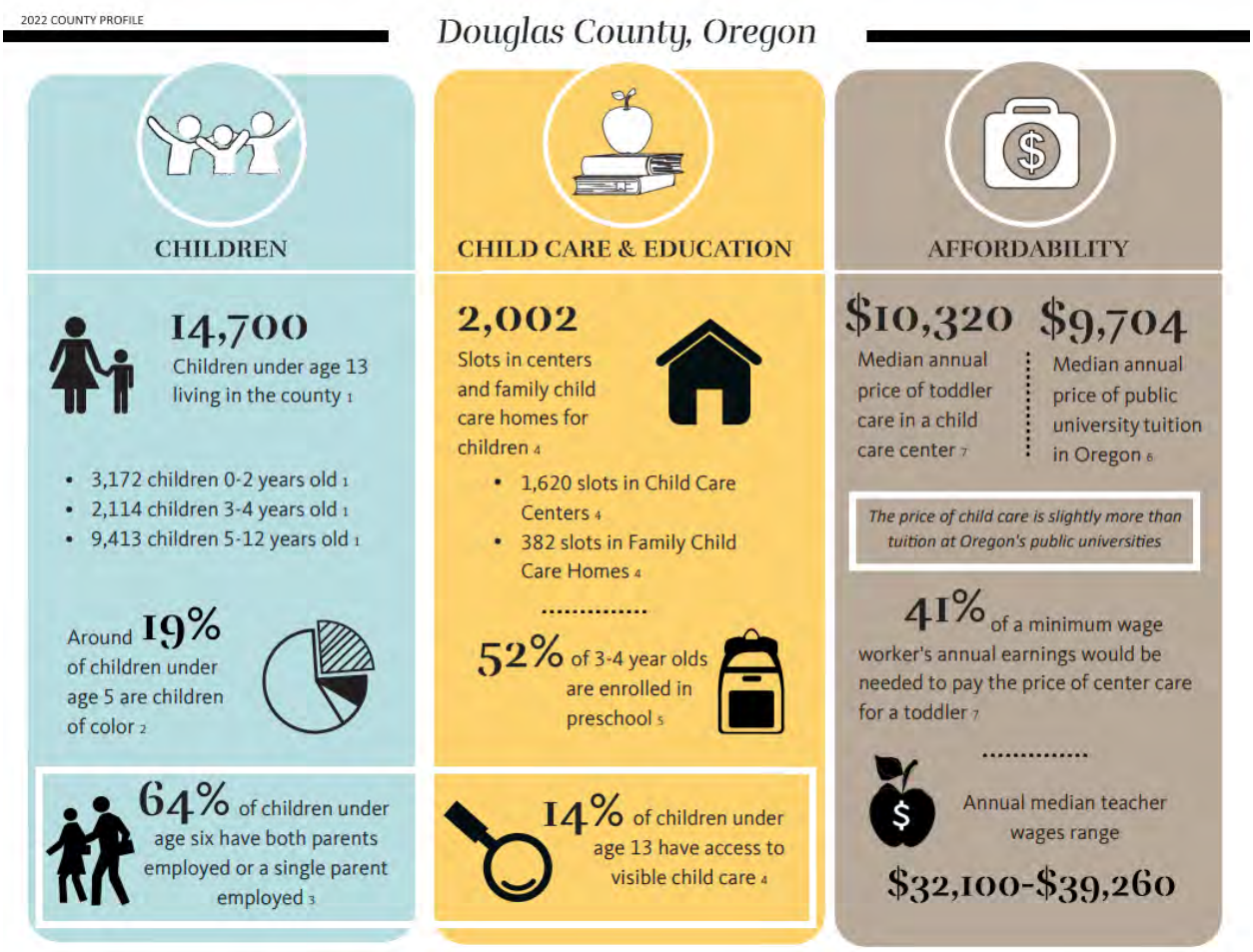
Economic challenges, particularly housing affordability and high childcare costs were major concerns. These issues can impact families' ability to access mental health care, with some individuals having to reduce work hours to care for their children due to the lack of affordable childcare options.

34 Oregon State University, Oregon Child Care Research Partnership June 2023. Retrieved from https://health.oregonstate.edu/sites/health.oregonstate.edu/files/early-learners/pdf/county/douglas/douglas-county-early-learning-profiles-2022.pdf

35 The Living Wage Calculator: Small Area Income and Poverty Estimates, as reported in County Health Rankings 2023. Child care costs as a percentage of median income in a county is not fully representative of the cost burden of child care in a county, as half of the households have a lower income and thus child care would constitute an even higher percentage of their income. Similarly, this measure is not representative of the cost of child care for families with more than two children, or with infant children. Finally, the quality of child care is most important in terms of positive impacts on children's development, and the measure of Child Care Cost Burden does not reflect the quality of available care.

36 As reported in Oregon State University, Oregon Child Care Research Partnership June 2023. Retrieved from https://health.oregonstate.edu/sites/health.oregonstate.edu/files/early-learners/pdf/county/douglas/douglas-county-early-learning-profiles-2022.pdf

Figure 5. Oregon Child Care Research Partnership's Early Care and Education Profile for Douglas County



Source: Oregon State University, Oregon Child Care Research Partnership June 2023. Retrieved from https://health.oregonstate.edu/sites/health.oregonstate.edu/files/early-learners/pdf/county/douglas/douglas-county-early-learning-profiles-2022.pdf

In 2010–2022, Douglas County had fewer childcare centers (5.9 for every 1,000 children younger than age five) than average in Oregon (8.6 for every 1,000 children younger than age five). Douglas County had 33 childcare centers, 54.6 percent of which were daycare centers, followed by Head Start Programs (27.3%) and before/after school programs (18.2%). [37] Nearly half of these centers (45.5%) were in Roseburg.

37 Homeland Infrastructure Foundation-Level Data (HIFLD) Open Data Site. Retrieved on October 24, 2023, from https://hifld-geoplatform.opendata.arcgis.com/datasets/geoplatform::child-care-centers/about

Table 40. Childcare Centers by Type and Location

Childcare Centers	Percent of Childcare Centers
Child Daycare Centers	**54.55%**
Drain	3.03%
Glide	3.03%
Reedsport	6.06%
Riddle	6.06%
Roseburg	30.30%
Sutherlin	6.06%
Child Daycare, Before or After School, Separate from Schools	**18.18%**
Myrtle Creek	6.06%
Oakland	3.03%
Reedsport	3.03%
Roseburg	3.03%
Winston	3.03%
Head Start Programs, Separate from Schools	**27.27%**
Glendale	3.03%
Myrtle Creek	3.03%
Reedsport	3.03%
Roseburg	12.12%
Sutherlin	3.03%
Yoncalla	3.03%
	100.00%

Source: Homeland Infrastructure Foundation-Level Data (HIFLD) Open Data Site. Retrieved on October 24, 2023 from https://hifld-geoplatform.opendata.arcgis.com/datasets/geoplatform::child-care-centers/about

Chronic Absenteeism

School attendance is an influential factor in academic achievement for kindergarten through grade 12 students. Chronic absenteeism is associated with several negative consequences for students, including lower academic achievement and increased risk of dropping out. [38] Students in Douglas County School District had higher rates of chronic absenteeism than students elsewhere in Oregon. Chronic absenteeism in Oregon was defined as a student missing 10 percent or more of the school year for any reason. Chronically absent students typically missed 18 days or more in a school year. Chronic absenteeism considers both excused and unexcused absences.

In school year (SY) 2021−2022, 41.7 percent (5,229) kindergarten through grade 12 students were chronically absent in Douglas County, significantly higher than the 36.1 percent of students in Oregon. It also represents an increase from approximately 22 percent in school years preceding the COVID-19 pandemic starting in SY 2020-21.

38Robert Balfanz and Vaughan Byrnes, "The Importance of Being in School: A Report on Absenteeism in the Nation's Public Schools," (Baltimore: Johns Hopkins University Center for Social Organization of Schools, May 2012). Source: Oregon Department of Education

Table 41. Chronically Absent Students

Year	Douglas County	Number of Douglas County Students	Oregon
2017-2018	22.8%	2,823	20.5%
2018-2019	22.9%	2,910	20.4%
2020-2021	36.9%	4,430	28.1%
2021-2022	41.7%	5,229	36.1%

Source: Oregon Department of Education

Chronic absenteeism, a longstanding educational concern, took on new dimensions during the pandemic. COVID-19 exacerbated chronic absenteeism as lockdowns, health concerns, and digital learning challenges disrupted regular attendance. Remote learning, though necessary for safety, posed barriers for students in households lacking proper technology or a conducive learning environment. As a result, many students struggled to consistently attend virtual classes, leading to the rise in chronic absenteeism rates in Douglas County and throughout Oregon.

Post-COVID-19, schools now work to reengage students who may have fallen behind academically because of disrupted learning routines. Nonetheless, the pandemic's effects on mental health, economic stability, and access to technology have exacerbated chronic absenteeism, particularly in marginalized communities.

- Students experiencing homelessness (insecure housing) had the highest rates in 2021–2022, with 65.5 percent of students experiencing chronic absenteeism.
- More than half (54.4%) of Native American/Alaska Native students in Douglas County were chronically absent in 2021–2022.
- Among the different racial and ethnicity groups, Native American/Alaska Native, Native Hawaiian/Pacific Islander, White, and Hispanic/Latino students all experienced a similar or greater increase in chronic absenteeism from SY 2017/18 to SY 2021/22.
- Among the at-risk student groups, Ever English Learners, migrant students, and students with disabilities all experienced a similar or greater increase in chronic absenteeism between 2017/18 to 2021/22.
- Kindergarten, elementary, and middle school students experienced a greater increase in chronic absenteeism between 2017/18 and 2021/22 than high school students.

Table 42. Percent of Douglas County Students Chronically Absent by Student Group

		2017/18	2018/19	2020/21	2021/22	Percentage point Change (2017/2018 to 2021/22)
	All students	**22.8%**	**22.9%**	**36.9%**	**43.3%**	**+20.4%**
Race and Ethnicity	**Native American/Alaska Native**	**29.0%**	**31.0%**	**39.8%**	**54.4%**	**+25.4%**
	Asian	9.3%	17.1%	19.0%	15.8%	+6.5%
	Black/African American	29.2%	31.0%	58.3%	34.6%	+5.4%
	Multi-racial	26.7%	27.6%	38.2%	42.9%	+16.2%
	Native Hawaiian/Pacific Islander	**33.3%**	**33.3%**	**18.2%**	**54.5%***	**+21.2%**
	White	**22.4%**	**22.2%**	**36.4%**	**42.6%**	**+20.2%**
	Hispanic/Latino	**23.8%**	**24.8%**	**40.4%**	**48.1%**	**+24.3%**
At-Risk Student Groups	Economically Disadvantaged	26.9%	27.5%	37.1%	43.3%	+16.4%
	Ever English Learners	**19.7%**	**22.5%**	**37.2%**	**45.7%**	**+26.0%**
	Foster Care				49.6%	n/a
	Homeless	46.6%	41.5%	49.8%	65.5%	+18.8%
	Migrant	**25.9%**	**13.3%**	**40.0%**	**50.0%**	**+24.1%**
	Military Connected			31.6%	25.0%	n/a
	Students with Disabilities	**27.5%**	**28.0%**	**41.5%**	**50.8%**	**+23.3%**
	Talented and Gifted	10.2%	14.0%	17.3%	23.6%	+13.5%
Grade Level	**Kindergarten**	**22.0%**	**24.2%**	**31.2%**	**47.8%**	**+25.8%**
	Grade 1	**21.5%**	**18.4%**	**28.1%**	**44.9%**	**+23.4%**
	Grade 2	**16.1%**	**19.5%**	**25.8%**	**40.2%**	**+24.1%**
	Grade 3	**17.8%**	**13.2%**	**24.4%**	**40.7%**	**+22.8%**
	Grade 4	16.4%	17.0%	25.6%	36.2%	+19.8%
	Grade 5	**16.3%**	**16.9%**	**22.5%**	**39.8%**	**+23.5%**
	Grade 6	**21.0%**	**20.0%**	**37.5%**	**42.2%**	**+21.3%**
	Grade 7	22.0%	22.0%	41.6%	40.5%	+18.4%

		2017/18	2018/19	2020/21	2021/22	Percentage point Change (2017/2018 to 2021/22)
	Grade 8	25.2%	25.8%	45.7%	44.1%	+18.8%
	Grade 9	25.6%	24.6%	45.1%	41.2%	+15.6%
	Grade 10	29.9%	29.5%	49.7%	45.2%	+15.3%
	Grade 11	30.7%	33.5%	49.9%	48.2%	+17.5%
	Grade 12	37.4%	37.9%	52.7%	51.2%	+13.8%

Note: **Bold** indicates a student group that experienced a greater change in rate between 2017/18 and 2021/22.
Source: Oregon Department of Education

High School Completion

Getting a high school diploma is important for health and well-being as it can lead to better job opportunities and higher income, making it easier to afford essentials, such as healthcare and nutritious food, while reducing financial stress. Education also helps improve critical thinking and decision-making skills, which are essential for a healthy lifestyle. High school can provide a support network for building positive relationships and reduce the risk of loneliness, contributing to better mental and emotional well-being. For high school completion, the assessment looks at two measures: the annual dropout/pushout rate and the four-year cohort graduation rate.

- The four-year cohort graduation rate provides information about a particular group of students followed over the course of high school (i.e., the number and percent of the students who started ninth grade together and graduated within four years).
- The annual dropout/pushout rate provides information about one particular school year and all students enrolled in high school in that year. It is the number and percent of high school students who dropped out or pushed out of school and did not return by October 1 of the following school year.

Four-Year Cohort Graduation Rate

In 2021/22, the percent of ninth-grade cohort students who graduated within four years was 74.3 percent, lower than in Oregon at 81.3 percent. [39] Though the cohort graduation rate has remained lower than Oregon over the last four years, since SY 2018/19, it has grown to 74.3 percent from 68.3 percent (+6.0 percentage points). In Oregon, the change was smaller—81.3 percent from 80.0 percent (+1.3 percentage points).

There is disparity in graduation outcomes among students of different sexes, economic status, race and ethnicities, and ability.

- Students experiencing housing insecurity, in foster care, and with disabilities all had significantly lower graduation rates than other students in Douglas County—52.3 percent, 40.0 percent, and 56.9 percent, respectively.

39 Four-year cohort graduation rate, which is the rate tracks a cohort of students from 9th grade through high school and represents the percentage of the cohort that graduates within four years.

- Females were slightly more likely to graduate than male students, and both had seen a similarly rates of improvement (+6.1 percentage points) in the graduation rate between SY 2018/19 and 2021/22.

As noted previously, slightly more than half (53.2%) of students who experience insecure housing graduated in 2021/22; however, they also experienced one of the greatest rates of improvement in the graduation rate between 2018/19 and 2021/22 (+12.8 percentage points), second only to students with disabilities (+13.1 percentage points).

Table 43. Four-Year Cohort Graduation Rate

	Oregon		Percentage Point Change (2018/19 to 2021/22)	Douglas County		Percentage Point Change (2018/19 to 2021/22)
Student Demographics	2018/19	2021/22	Oregon	2018/19	2021/22	Douglas County
All students	80.0	81.3	+1.3	68.3	74.3	+6.0
Female	83.4	84.2	+0.8	71.1	77.2	+6.1
Male	76.9	78.8	+1.9	66.0	72.0	+6.1
Homeless students	55.4	58.6	+3.1	40.4	53.2	+12.8
Foster care	n/a	48.4	+4.4	n/a	40.0	+6.7
Students with disabilities	63.4	67.5	+4.1	43.8	56.9	+13.1
White	81.3	82.5	+1.2	68.5	74.4	+5.9
Multi-racial	79.9	79.7	-0.2	65.2	72.7	+7.5
Native American/ Alaska Native	67.7	68.9	+1.3	70.0	>95%	n/a
Hispanic/Latino	76.2	78.7	+2.5	65.7	71.1	+5.4

Source: Oregon Department of Education

High School Dropout/Pushout Rate

In 2021, Douglas County had a higher percentage of students who do not graduate (8.3%) than Oregon at 4.1 percent. [40] The dropout/pushout rate was improving in Douglas County in 2017/18 and 2020/21; however, in 2021/22, the rate nearly doubled to 8.3 percent (361 students) from 4.4 percent of high school students (189 students) in 2017/18.

40 Dropouts/pushouts are students who left school between July 1 and June 30 of a given year and did not return to school, graduate, or pass the general educational development (GED) exam by the following October 1. The US Department of Education developed this measure, and it has been reported since 1993.

Table 44. High School Dropout/Pushout Rate

School Year	Douglas County	Oregon	Number of Students in Douglas County Who Dropped Out/Pushed Out
2017/18	6.3%	3.6%	277
2018/19	5.3%	3.3%	231
2019/20	3.4%	2.4%	148
2020/21	4.4%	1.8%	189
2021/22	8.3%	4.1%	361

Source: Oregon Department of Education

In 2021/22, disparities existed among students who were homeless or in foster care, with high school noncompletion rates of 18.5 percent and 17.2 percent respectively, and considerably higher than the 8.3 percent among all students.

Table 45. High School Dropout/Pushout Rate, 2021/22

	Douglas County	Oregon
All students	8.3%	4.1%
Underserved races/ethnicities	8.0%	5.2%
Homeless	18.5%	11.9%
Foster care	17.2%	9.6%
Economically disadvantaged	8.3%	3.9%
Students with disabilities	8.1%	5.5%

Source: Oregon Department of Education

Educational Attainment

The connection between a high school diploma and higher education and better health outcomes is widely recognized. More years of formal education are strongly associated with enhanced job prospects, decreased psychological stress, and healthier lifestyles. [41]

The percentage of adults ages 25 and older with a high school diploma or equivalent was similar in Douglas County to Oregon, at 90.5 percent and 91.5 percent, respectively. [42] This rate increased slightly since 2012-2016, when it was 89.1 percent.

In 2017-2021, non-Hispanic White Douglas County residents had a significantly lower high school graduation rate at 90.9 percent compared to their peers living elsewhere in Oregon at 94.5 percent. Meanwhile, Hispanic or Latino and American Indian/Native American residents were significantly more likely to have higher high school graduation rate at 84.0 percent and 92.5 percent, respectively.

41Egerter S, Braveman P, Sadegh-Nobari T, Grossman-Kahn R, Dekker M. Education Matters for Health. Princeton, NJ: RWJF Commission to Build a Healthier America; 2009. Issue Brief 6.

42 American Community Survey, 5-year estimates, 2017-2021, Table B15002

Table 46. High School Graduation Rates among Residents Ages 25 and Older (including GED and any higher education)

Race/Ethnicity	Douglas County	Oregon
Total population	90.5%	91.5%
Non-Hispanic White*	90.9%	94.5%
Non-Hispanic Black	95.9%	90.3%
Asian	86.5%	88.0%
Hispanic or Latino*	84.0%	69.9%
American Indian/Native American*	92.5%	83.1%

*Significantly different rate in Douglas County compared with Oregon.
Source: American Community Survey, 5-year estimates, 2017-2021, Table B15002.

Adults in Douglas County were less likely than other Oregon adults to have some post-secondary education. More than half (58.5%) of adults in Douglas County have some higher education compared with 69.0 percent in Oregon. [43] It increased slightly from 2012−2016, when it was 56.7 percent. In 2017−2021, non-Hispanic White Douglas County residents were significantly less likely to have any higher education (58.4%) than their peers living elsewhere in Oregon (71.8%).

Table 47. Any Higher Education Rate by Race and Ethnicity

Race/Ethnicity	Douglas County	Oregon
Full population	58.5%	69.0%
Non-Hispanic White*	58.4%	71.8%
Non-Hispanic Black	63.2%	67.4%
Asian	70.9%	74.8%
Hispanic or Latino	53.7%	44.7%
Native American/Alaska Native	48.9%	52.5%

**Significantly different rate in Douglas County compared with Oregon. Source: American Community Survey, 5-year estimates, 2017-2021, Table B15002.*

43 American Community Survey, 5-year estimates, 2017-2021, Table B15002

Neighborhood & Built Environment

NEIGHBORHOOD

noun

1. As in district, an area (as of a city) set apart for some purpose or having some special feature

2. As in town, the people living in a particular area

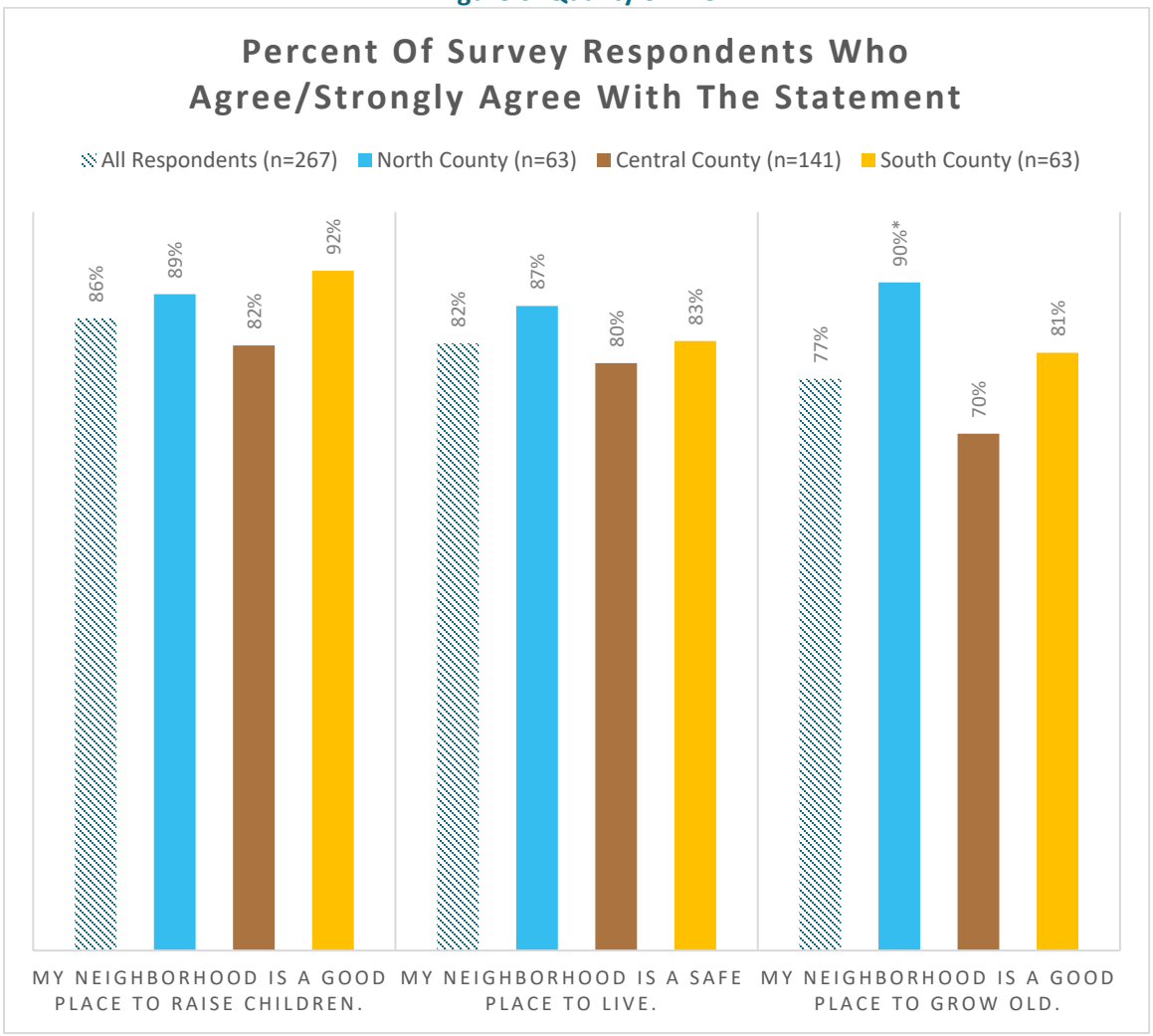
3. As in backyard, an adjoining region or space

Neighborhood and Built Environment

Neighborhood and built environment refer to the places where people are born, live, learn, work, play, worship, and age and have a major impact on health and well-being. [44] A neighborhood's physical, social, economic, and environmental characteristics all play a role in shaping the quality of life for its community members. The interplay of these factors can result in widely varying living conditions and experiences, making the neighborhood an essential determinant of well-being and overall life satisfaction.

Nearly 90 percent of CSTA survey respondents strongly agreed/agreed that their neighborhood was a good place to raise children. Eight in 10 (82%) CSTA survey respondents strongly agreed/agreed that their neighborhood was a safe place to live. Lastly, the fewest respondents (77%) strongly agreed/agreed that their neighborhood was a good place to grow old, except for survey respondents who live North County.

Figure 6. Quality of Life



**Percent of respondents who strongly agreed/agreed with the statement was significantly different from the percent of all respondents. Source: CSTA Survey*

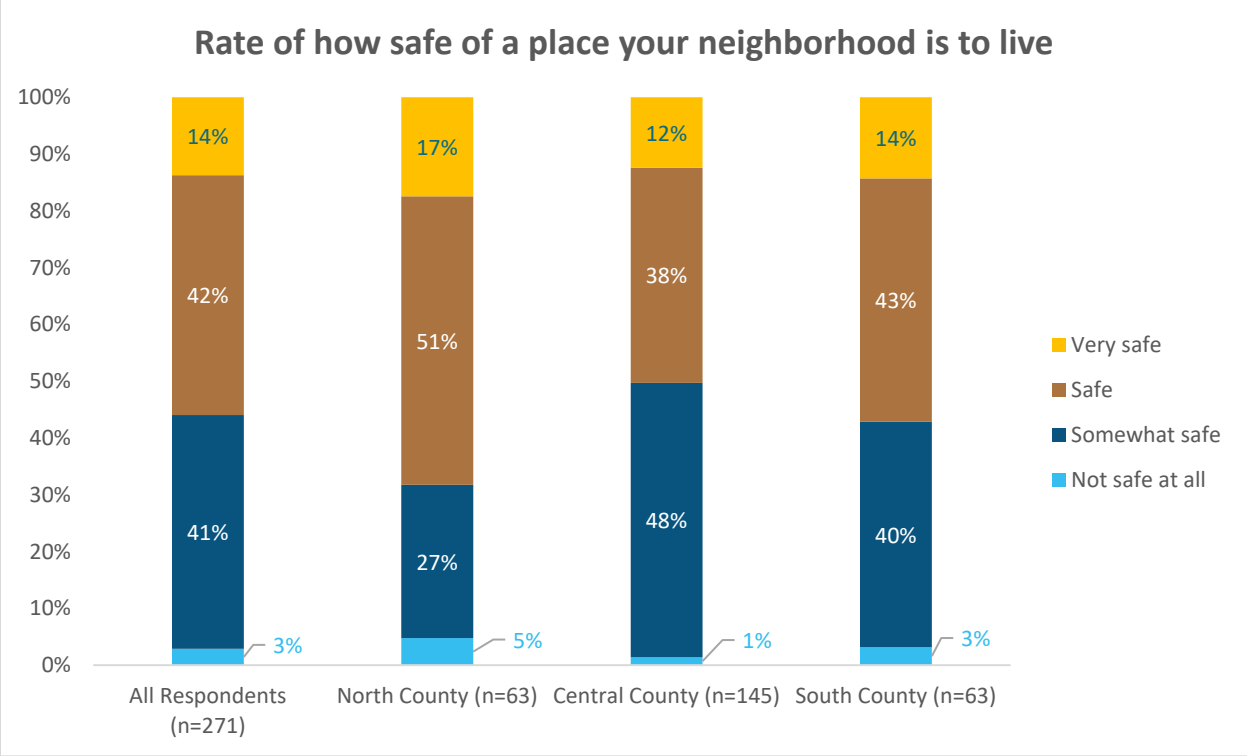
When individuals feel secure in their surroundings, they are more likely to engage in physical activity, social interactions, and outdoor leisure, all of which promote better health. Additionally, a safe

44 https://www.cdc.gov/about/sdoh/index.html

neighborhood is associated with lower crime rates, reducing the risk of injury or trauma, and allowing for a more conducive environment for a healthier, more fulfilling lifestyle. This level of agreement was similar across the four regions within the county.

When asked to rate how safe survey respondents felt their neighborhood was, more than half (56%) rated their neighborhoods as safe or very safe. This rating was similar across the four regions within the county.

Figure 7. Neighborhood Safety



Note: When asked to rate how safe of a place your neighborhood is to live, survey respondents were asked to consider the safety of their home, workplace, schools, playgrounds, parks, and public places, as well as how well neighbors know and trust one another and whether they look out for one another.
Source: CSTA Survey, 2023.

The following indicators related to neighborhood and built environment are examined in this section:

- Housing, including housing security, housing conditions, and housing affordability
- Crime and safety
- Walkability
- Environmental Quality
- Access to broadband internet

Housing

Rental housing conditions, affordability, and stability can affect an individual's physical and mental well-being. Poor housing conditions, such as mold, pests, or inadequate ventilation, can lead to health problems. The financial strain of renting, especially in expensive markets, can limit access to healthcare and nutritious food. Additionally, frequent moves because of renting instability can cause stress and disrupt social connections. Overall, being a renter is closely connected with health and wellness, and the quality of rental housing and the stability it provides can significantly affect an individual's overall health.

The percent of renter occupied housing units in Douglas County was significantly lower than in the rest of the state. In 2017–2021, 29.3 percent of housing units were renter-occupied in Douglas County compared with 36.8 percent elsewhere in Oregon. The percent of renter-occupied housing units had decreased significantly between 2012–2016 and 2017–2021, thereby increasing the proportion of owner-occupied housing units. Non-White race and ethnicities were more likely to be renters in both Oregon and Douglas County.

Table 48. Percent of Renter Occupied Housing Units

	Douglas County			Oregon		
	2012–2016	2017–2021	% Change	2012–2016	2017–2021	% Change
Total population	**32.4%**	**29.3%**	**-3.1%***	**38.6%**	**36.8%**	**-1.8%**
Non-Hispanic White	31.6%	28.4%	-3.2%	35.3%	33.3%	-2.0%*
Non-Hispanic Black	52.4%	58.3%	5.8%	68.7%	63.8%	-4.9%*
Asian	30.3%	42.9%	12.6%	42.0%	36.7%	-5.3%*
Hispanic or Latino	48.3%	42.5%	-5.8%	59.7%	55.2%	-4.6%*
Native American	0.0%	42.2%	n/a	0.0%	51.9%	n/a

**Significantly different change in the percent of renter occupied housing units. Source: American Community Survey, Five-Year Estimates, Table B25003*

Housing Security

Housing insecurity refers to a situation in which individuals or families lack stable, safe, and reliable housing. It typically involves housing that is temporary, inadequate, or poses risks to the well-being of its occupants. Insecure housing can take various forms, including homelessness, substandard or overcrowded living conditions, and frequent changes in housing because of eviction, affordability issues, unstable living arrangements, etc. People experiencing housing insecurity often face challenges related to physical safety, access to basic amenities, and overall housing stability, which can have negative impacts on their physical and mental health, as well as their overall quality of life.

Unhoused

Focus Group Participants

Concerns were raised about the prevalence of homeless youth in the community and a lack of understanding about the reasons behind this issue. Participants discuss efforts to support homeless teens and the need for more comprehensive solutions.

Every year the federal government requires communities to spend time in late January gathering information about people experiencing homelessness, including unsheltered and sheltered individuals. This yearly survey, known as the point-in-time count, is done in collaboration with local and private agencies that collect data by going out in the community and conducting surveys. Once the data are gathered, the Department of Housing and Urban Development reviews survey findings before determining the amount of federal assistance needed to aid in community programs for homeless people.

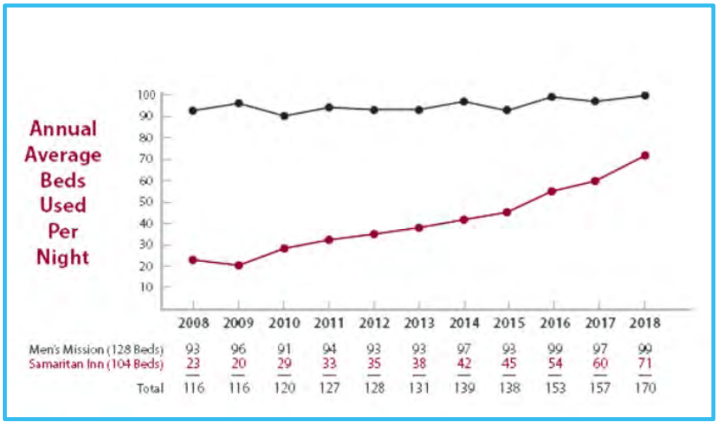
A 2019 housing analysis conducted in Roseburg showed an acute shortage of affordable housing, a situation that could worsen as the population continues to grow. The study showed that more than 2,600 new housing units will need to be built in the next 20 years to accommodate the expected population growth. [45]

45 https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Cooper-UHA-Navigation-Center.pdf

The 2020 point-in-time survey identified 845 people in Douglas County who are experiencing homelessness. Approximately 10 percent of these people were considered chronically homeless.

Since the start of the pandemic, a concerning trend shows more people are experiencing long-term episodes of homelessness, sometimes lasting up to a year. Homeless shelters, even temporary ones, are rather uncommon throughout the state. A study conducted by EndHomelessness.org shows only 36 percent of the communities in Oregon offer or have homeless shelters. Douglas County is one of those communities offering the following:

Figure 8. Annual Average Beds Used per Night, as Reported in UHA 2021 Housing Study



- Roseburg Rescue Mission, a men's shelter: Requirements include passing urinalysis for drug use, weekly chapel attendance, 10:00 pm curfew.
- Roseburg Samaritan Inn, a women's and children's Shelter: Requirements include 6:30 pm curfew, children must be accompanied by a guardian, passing a urinalysis for drug use, drug- and alcohol-free for at least 30 days at intake.

Until June 2022, Douglas County had no low-barrier shelters.

The number of Douglas County School District students who were insecurely housed decreased from an estimated (unduplicated) 702 students in 2019 to 454 students in 2022−2023. Doubling up was the type of insecure housing that was highest among students. The percentage of insecurely housed students who were unaccompanied by a guardian increased between 2019 and 2021.

Table 49. Students Experience Housing Insecurity

	2018-2019	2019-2020	2020-2021	2021-2022
Total Student Enrollment	14,408	14,444	13,385	13,564
Number of Students with Insecure Housing*	702	686	434	454
Percent of Students with Insecure Housing	4.9%	4.7%	3.2%	3.3%
Number of students with Insecure Housing per 1,000 Students	48.7	47.5	32.4	33.5

**The number of students with insecure housing does not represent unduplicated student counts (e.g., students may attend more than one district during a school year). The number of students with insecure housing also is underestimated, as the district totals used in this assessment did not account for student counts in districts with one to five students because of suppression of counts less than five. Source: PK-12 Homeless by Living Situation UHY 21-22.*

Housing insecurity includes four types of housing: [46]

- Doubled-up: Sharing housing with other people, whether relatives or friends, because of loss of housing, economic hardship, domestic violence, or similar reason
- Hotel/motel: Temporary commercial accommodations because of loss of housing, economic hardship, or similar reason

46 Oregon Department of Education (ODE)

- Shelter: Public or private accommodations intended for use by homeless individuals and families
- Unsheltered: Living in cars, trailers, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings not designed as a regular sleeping quarters
- Unaccompanied: A child residing in one of the above homeless living situations, who is unaccompanied by a parent or legal guardian or adults with educational guardianship

Though the estimated unduplicated count of students in Douglas County has decreased between SY 2018/19 and 2021/22, the type of insecure housing has changed and shifted more toward doubling up, motels/hotels, and being unsheltered. By SY 2021/22, nearly three in four students with insecure housing were doubling up. The percent relying on hotels/motels increased from 1 percent in SY 2018/19 to 7 percent in SY 2021/22. Unsheltered students were greater than one in 10 students with insecure housing by SY 2021/22.

Table 50. Students Experiencing Housing Insecurity by Type of Housing

Year	Doubled Up	Motel/ Hotel	Shelter	Unsheltered	Unaccompanied	Estimated Unduplicated Count of Students
2018-19	67%	1%	16%	5%	11%	702
2019-20	71%	3%	13%	8%	6%	686
2020-21	67%	2%	15%	8%	9%	434
2021-22	74%	7%	5%	11%	2%	454

Source: Oregon Department of Education

Healthy Housing

Healthy housing refers to living environments that promote and support good physical and mental health. Such housing is designed and maintained in ways that minimize health hazards, ensuring clean air, safe drinking water, adequate ventilation, and freedom from toxins like mold, lead, and pests. It also includes elements like proper lighting, safety features, and accessibility to support residents' well-being.

In 2015−2019, the percentage of households with at least one of four housing problems—high housing costs, overcrowding, lack of kitchen facilities, or lack of plumbing facilities—in Douglas County was 15.7 percent, lower than in Oregon (18.4%). The percent of households with one or more problems was decreased in the county from 2012−2014 when it was 18.0 percent.

Table 51. Housing Problems

Location	Douglas County	Oregon
2010−2014	18.0%	20.0%
2015−2019	15.7%	18.4%

Source: American Community Survey, 5 Year Estimates, Via County Health Rankings

Affordable Housing

Affordable housing refers to housing that is reasonably priced in relation to income, ensuring that housing costs do not consume a disproportionate share of a person's financial resources. Affordable housing is a crucial determinant of health, as it addresses not only the basic need for shelter, but also plays a pivotal role in reducing stress, promoting physical health, and fostering a sense of belonging within the community.

Approximately three in 10 CSTA respondents indicated they did were unable to afford rent/mortgage at least sometimes (three to four times per year).

Focus Group Participants

Participants in the people of color focus group stress the need for affordable housing as high prices impact physical, mental, and emotional health. Affordable housing is a significant concern, particularly for young adults seeking independent living.

Affordable housing is becoming more difficult to find in Douglas County. As reported in the Economic Stability section of this report, the median household income increased 11 percent from $47,404 in 2012–2016 to $52,479 in 2017–2021. Meanwhile, the median home value increased faster, increasing 17 percent to $224,400 in 2017–2021 from $191,637 in 2012–2016. The median rent increased 5 percent to $899 from $860, respectively.

Table 52. Median Household Income, Home Value and Rent

Year	Median Household Income	Median Home Value	Median Rent
2012–2016	$ 47,404	$ 191,637	$ 860
2017–2021	$ 52,479	$ 224,400	$ 899
Percent Increase	11%	17%	5%

Source: American Community Survey, Table B19013, B25064, and B25077.

Mortgage and rent burden are defined as spending more than 30 percent of household income on mortgage or rent payments, and severe mortgage and rent burden are defined as spending more than 50 percent of household income on those payments. [47] Between 2012–2016 and 2017–2021 the average percent of individuals who were cost burdened and severely cost burdened declined.

Table 53. Housing Cost Burden

	Percent of Households in Douglas County	
	2012–2016	2017–2021
Housing burdened	33.08%	27.80%
Severely housing burdened	15.52%	11.23%
Rent burdened	48.68%	35.75%
Severely rent burdened	25.66%	14.60%

Source: American Community Survey, Five-Year Estimates, Tables B25070/B25091.

The percent of households experiencing housing cost burden ranged from a high of 46.7 percent in Canyonville to a low of 9.5 percent in Melrose. Additional towns with significantly higher housing burden compared to the county overall, included Tri City (35.2%), Roseburg (34.0%), Glendale (33.5%), Sutherlin (32.9%), and Yoncalla (32.7%).

47 https://www.census.gov/library/stories/2022/12/housing-costs-burden.html

The minimum wage in Douglas County was $13.20, less than $14.20 offered elsewhere in Oregon. The federal minimum wage as of November 2023 is $7.25. [48] The housing wage, meaning the hourly wage needed to afford a studio apartment in Douglas County was $15.92. [49]

Table 54. Housing Wage and Annual Income Needed to Afford a House in Douglas County

	Housing Wage	Annual Income Need to Afford
Number of Bedrooms	**$ 13.20 (Minimum Wage)**	**$ 52,479 (Median Household Income)**
Studio Bedroom	$ 15.92	$ 33,120.00
One bedroom	$ 18.10	$ 37,640.00
Two Bedroom	$ 23.83	$ 49,560.00
Three Bedroom	$ 33.87	$ 70,440.00
Four Bedroom	$ 40.23	$ 83,680.00

Source: National Low Income Housing Coalition. Out of Reach. Oregon State Report. Retrieved on October 23, 2023, from https://nlihc.org/oor/state/or

Violence Prevention

Crime and Safety

Crime and neighborhood safety play a crucial role in community health as they have far-reaching effects on the well-being of residents. Safer neighborhoods with lower crime rates tend to promote better mental and physical health outcomes. Reduced exposure to violence and crime-related stressors can lead to lower levels of anxiety and trauma among community members, contributing to improved mental health. Additionally, a safer environment encourages outdoor activities, exercise, and social interactions, which are key components of physical well-being. Moreover, lower crime rates can foster a sense of trust and social cohesion within a community, which in turn can positively influence social support networks and access to resources like healthcare and education. In essence, crime and neighborhood safety are integral to the overall health and vitality of a community, impacting not only physical safety but also mental and social well-being.

- Between 2014-2020, the homicide rate in Douglas County was significantly higher at 5.9 deaths per 100,000 compared to Oregon at 2.98 deaths per 100,000.48F 50
- In 2019, the juvenile arrest rate (delinquency cases per 1,000 juveniles) was lower in Douglas County at 27.0 per 100,000 compared to Oregon at 28.1 per 100,000.49F 51

Between January 1, 2020, and September 30, 2023, a total of 54,392 criminal offenses were reported Douglas County, representing 4.1 percent of all reported offenses in Oregon. [52] In Douglas County, the most reported offense was to property at 31.5, including larceny/theft, vandalism, burglary, motor vehicle theft, and fraud. Other offenses ranked second in Oregon at 29.7 percent of offenses, and this percentage was higher than in Douglas County. The leading type of other offense was Part 3 crimes (e.g., undocumented immigrant, protective custody, detoxification, mental health hold, material witness, warrants, recovered property and vehicles for other agencies, and failure to register as a sex offender), followed by traffic violations. Crimes against society accounted for another 26.8 percent of offenses in Oregon and primarily involved disorderly conduct, drug/narcotic offenses, and driving under the

48 https://www.usa.gov/minimum-wage#:~:text=The%20federal%20minimum%20wage%20is,applies%20to%20covered%20nonexempt%20workers.

49National Low Income Housing Coalition. Out of Reach. Oregon State Report. Retrieved on October 23, 2023, from https://nlihc.org/oor/state/or

50 National Center for Health Statistics - Mortality Files, 2014-2020, as cited in the County Health Rankings.

51 Easy Access to State and County Juvenile Court Case Counts (EZACO), as cited in the County Health Rankings

[52] Oregon Uniform Crime Reporting Data. Retrieved on November 8, 2023.

influence. Offenses against persons, which represented 11.9 percent of reported offenses, included simple assault, aggravated assault, and intimidation.

Table 55. Number and Percent of Reported Offense by Type

	Douglas County		Oregon
	Number	Percent	Percent
Society	14,590	26.8%	23.3%
Person	6,476	11.9%	11.8%
Property	17,154	31.5%	51.5%
Other	16,172	29.7%	13.4%

Source: Oregon Uniform Crime Reporting Data. Retrieved on November 8, 2023.

The extent to which drugs, weapons, or bias were involved in the reported offenses is measured. The percent of cases with reported criminal offenses involving drugs in Douglas County was 6.0 percent, which was slightly higher than in Oregon at 4.7 percent. Amphetamines/methamphetamines were the most prevalent types of drugs involved in both Oregon and Douglas County crimes. In fact, in Douglas County, amphetamines/methamphetamines were involved in 71.8 percent of the cases with reported offenses, which was higher than in Oregon at 57.5 percent. In Douglas County, heroin and marijuana were the second and third most common type of drugs in cases with reported offenses (16.5% and 11.6%, respectively). A similar proportion was reported in Oregon.

One in five reported offenses (20.7%) in Oregon involved a weapon. This percentage was significantly higher than in Douglas County where approximately one in 10 reported offenses (9.6%) involved a weapon.

The percent of offenses that involved bias was reportedly low in both Oregon and Douglas County, at 1.0 percent of less of reported offenses.

Table 56. Number and Percent of Reported Offenses, January 1, 2020, to September 30, 2023

	Douglas County	Oregon
Number of Reported Offenses	54,392	1,314,538
Percent of Offenses Involved Drugs	**6.0% (3,240)**	**4.7% (61,777)**
Amphetamines/Methamphetamines	71.8%	57.5%
Heroin	16.5%	15.9%
Marijuana	11.6%	11.2%
Other Drugs	17.3% [1]	31.9% [1]
Percent of Offenses involving Weapons	**9.6% (n=5,242)**	**20.7%**
Percent of Offenses Involved Bias	**0.5% (n=257)**	**1.0%**

[1]. Other drugs include narcotics, unknown, cocaine (except crack), other hallucinogens, and opium.

Source: Oregon Uniform Crime Reporting Data. Retrieved on November 8, 2023.

Adverse Childhood and Life Experiences

Experiences that can cause trauma or toxic stress include one-time experience such as a car accident, or ongoing events such as abuse, living in poverty, experience of racism, going to jail, or having a family member in jail. These experiences, especially when they happen when a person is young, can have a lifelong effect on health. These experiences are also linked with things such as substance use, suicide, and cancers. [53]

The original ACEs looked at experiences of abuse, neglect, and household dysfunction (household substance abuse or mental illness, parental divorce, incarcerated household member, exposure to domestic violence). Some ACEs scales also include experiences that occur across the lifespan, such as historical trauma, discrimination, community violence or war, being a refugee, school violence and bullying, or poverty, hunger, and homelessness.

In Oregon, as of 2016, the most reported types of ACEs among adults aged 18 years or older were household substance abuse (37.1%), emotional abuse (36.2%), and parental separation/divorce (33.2%). [54] More current data are available for Douglas County describing the percent of adults who had four or more ACEs. In 2018-2021, in Douglas County, the percent of adults with four or more ACEs was significantly higher at 36.0 percent compared to Oregon at 24.0 percent. Adult males were significantly more likely in Douglas County to have had four or more ACEs when compared to the statewide rate for adult males.

Table 57. Adults Who Had Four or More ACEs

Age Adjusted Percentages						
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010-2013	30.7	27.8*	29.4**	22.5*	14.5	18.6
2014-2017	29.5	26.7	28.2	24.9	20.6	22.8
2018-2021	36.5	34.4*	36.0**	27.6*	20.2	24.0
Percentage Point Change 2010-2013 to 2018-2021	+5.8	+6.6	+6.6	+5.1	+5.8^{+}	+5.4^{+}

*Note: Douglas County estimates are available only as a four-year estimate. Oregon rates are only available as one-year estimates. Therefore, an unweighted four-year estimates was created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate between males and female rates. **Significantly different rate in Douglas County compared to Oregon. $^{+}$Significantly increasing trend between 2010-2013 and 2018-2021.Source: BRFSS via the Oregon Public Health Assessment Tool*

[53] Oregon State Population Health Indicators. https://www.oregon.gov/oha/PH/ABOUT/Documents/ship/StrategicIssues/ACE_ALE_Trauma_ToxicStress.pdf

[54] Oregon Behavioral health Risk Factor Surveillance System, 2016.

Walkability

Walkability and community health are closely related. Walkable communities come in various sizes and styles depending upon where they are in the country; whether they are in a city, suburb, or small town; and whether pedestrians can access public transit. It encompasses factors such as the presence of sidewalks, crosswalks, pedestrian-friendly infrastructure, and proximity to essential destinations like schools, parks, grocery stores, and public transportation.

Walkable communities facilitate easy access to stores, workplaces, and various destinations, thereby promoting increased physical activity and contributing to better individual health. These personal advantages collectively lead to broader public health benefits, including decreased rates of obesity and diabetes. [55] Opting for walking, cycling, or public transportation over driving also reduces vehicle emissions, benefiting both human health and the environment by lowering pollution levels. [56]

Focus Group Participants

The proximity of services was noted as a particular challenge. The inconvenience of not having certain services, like the DMV, in town, affects community members' ability to access essential resources, such as driver's licenses. Service providers should understand that accessibility plays a critical role in community members' well-being.

The mention of the limitations related to not having a permanent address, such as difficulties with receiving mail or applying for services like phones, underscores the need for service providers to be flexible and accommodating in their processes.

The fact that Adapt and the DMV used to work out of the library but no longer do suggests that the availability and accessibility of services have changed over time. Service providers should take into account the evolving needs of the community and maintain convenient service locations.

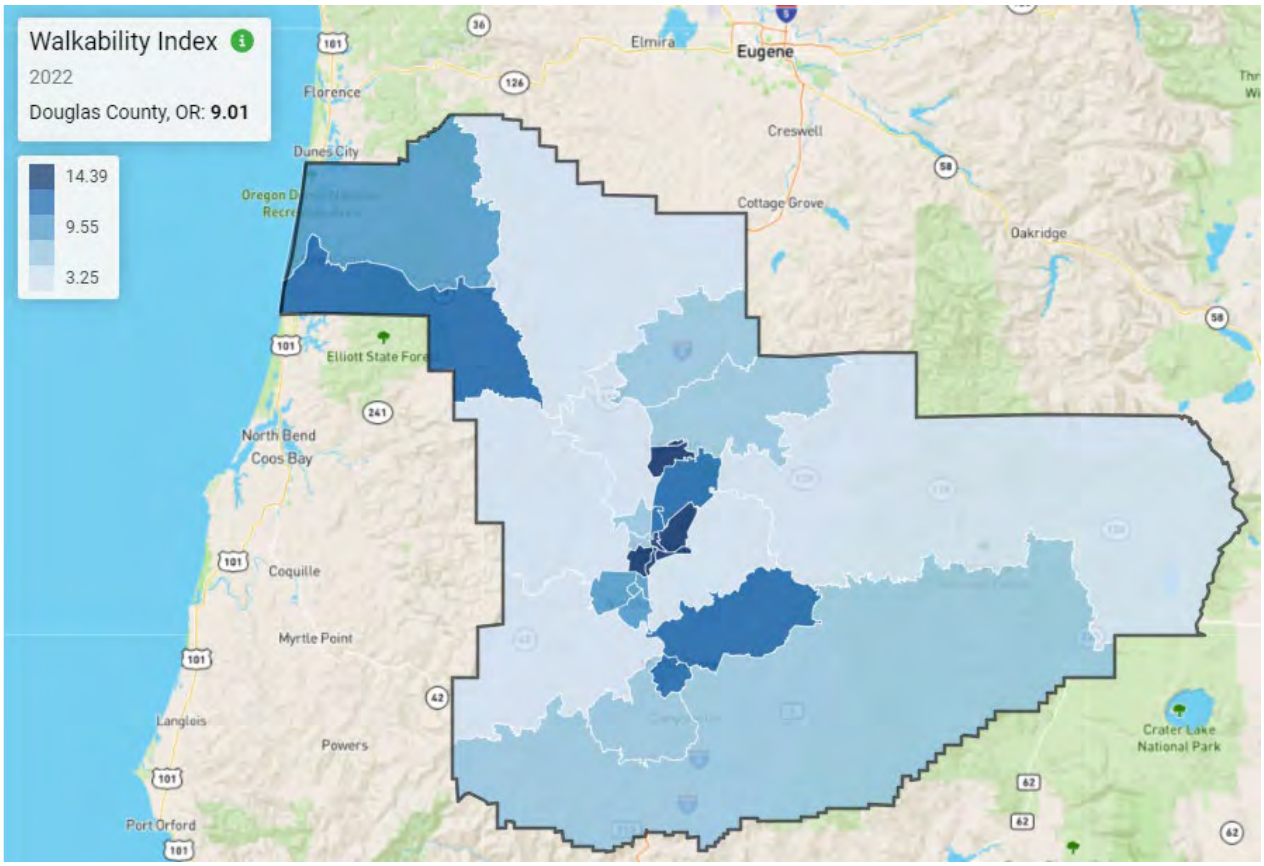
The walkability index is a ranking based on intersection density, proximity to transit, diversity of businesses, and density of housing. [57] The values range from one to 20, with 20 being the most walkable. Figure 9 is a map of the walkability index in Douglas County by ZIP code, with light blue representing the lowest walkability index to dark blue the highest walkability index. Douglas County has an average walkability index of 9.01 as of 2022. The highest ZIP code value is 14.39 located in the center of Douglas County in Roseburg North, Sutherlin, and Roseburg. The lowest values were estimated at 3.0 and 4.0, with ZIP codes in Tenmile and Porter Creek (3.25), Drain (4.50), Elkton (4.5), and Glide (4.06). The walkability index for Oregon ranges from 1.00–19.83, with the average index being 11.63.

55 Glazier, R.H., et al. “Density, Destinations or Both? A Comparison of Measures of Walkability in Relation to Transportation Behaviors, Obesity and Diabetes in Toronto, Canada.” PLoS ONE 9.1 (2014). http://www.journals.plos.org/plosone/article?id=10.1371/journal.pone.0085295

56 Younger, M., et al. “The Built Environment, Climate Change, and Health: Opportunities for Co-Benefits.” Journal of Preventive Medicine 35.1 (2008): 517-526.

57 The National Walkability Index is a nationwide geographic data resource that ranks block groups according to their relative walkability. The national dataset includes walkability scores for all block groups as well as the underlying attributes that are used to rank the block groups. The National Walkability Index User Guide and Methodology describes how to use the index and the methodology used to derive the index and ranked scores for its inputs.

Figure 9. Walkability Index



Source: U.S. Environmental Protection Agency (EPA), National Walkability Index 2022.

Environmental Quality

Air pollution particulate matter (PM 2.5) is the average daily density of fine particulate matter in micrograms per cubic meter. Some particles, such as dust, dirt, soot, or smoke, are large or dark enough to be seen with the naked eye. Some particles are so small that they can be inhaled deep into the lungs, potentially causing various health problems. Health effects associated with exposure to PM 2.5 include elevated risk of premature mortality from cardiovascular diseases or lung cancer and increased chronic conditions such as asthma. [58]

The average PM for 2023 in Douglas County was 6.7, and in the state, it was at 6.1, meaning the air quality in Douglas County was slightly worse than in Oregon overall. It had been increasing in both Douglas County and Oregon between 2019 and 2022.

Table 58. Air Pollution: Particulate Matter (PM 2.5) Concentration

	2019	2020	2021	2022	2023
Douglas County	5.3	8.0	8.0	8.0	6.7
Oregon	5.1	7.3	7.1	7.1	6.1

Source: EPA, Environmental Justice Screening, 2023.

58 EPA. Health and Environmental Effects of Particulate Matter (PM). Retrieved October 30, 2023, from https://www.epa.gov/pm-pollution/health-and-environmental-effects-particulate-matter-pm

Broadband Internet

Access to broadband Internet influences other more traditional SDOH, such as education, employment, and healthcare access and, therefore, is an important consideration to address in a community like Douglas County. [59] A total of 6,168 households in Douglas County had no Internet access in 2017–2021. [60] The percent of the population in Douglas County with computer and broadband Internet access was 91.1 percent (100,293 people), somewhat lower than all Oregonians (94.3%). [61] In Douglas County, 6,043 people (5.5%) had a computer but no Internet provider, and 3,538 people (3.2%) had no computer.

In Douglas County, adults ages 18 years and older were more likely than other Oregonians to lack access to the Internet and/or a computer. Adults ages 18–64 were most likely to lack access to the Internet. More than half (59.6%) of the people with a computer but no Internet provider were ages 18–64, compared with 29.2 percent of people ages 65 and older and 11.3 percent of people younger than 18 years old. These data are comparable to those for the rest of Oregon, where 56.3 percent of people 18–64 years old with a computer but no Internet access, and 29.5 percent among people 65 years of age and older.

Focus Group Participants

While virtual appointments have become more common, not everyone has equal access to the internet or the ability to check vitals remotely. Healthcare providers must recognize this reality and understand the importance of offering alternatives for those who cannot fully participate in virtual healthcare.

Table 59. Population Without Broadband Internet and/or Computer by Age Group

	Douglas County				Oregon	
	With a Computer and No Internet Subscription		No Computer		With a Computer and No Internet Subscription	No Computer
	Number	Percent	Number	Percent	Percent	Percent
Total population	6,043	5.5%	3,538	3.2%	3.8%	1.8%
Under 18 years	681	3.2%	0	0.0%	2.7%	0.5%
18 to 64 years	3,600	6.1%	2,181	3.7%	3.5%	1.0%
65 years and over	1,762	6.0%	1,357	4.6%	5.8%	6.0%

Source: American Community Survey, Five-Year Estimate, 2017-2021, Table S28002.

The cities and towns in Douglas County with the highest percent of households with no internet access includes Melrose (38.5%), Yoncalla (31.1%), and Days Creek (27.0%).

59 https://www.countyhealthrankings.org/online-and-on-air/webinars/broadband-a-super-determinant-of-health

60 American Community Survey, Five-Year Estimate, 2017-2021, Table B28002.

61 American Community Survey, Five-Year Estimate, 2017-2021, Table S2802.

Table 60. Households with No Internet, by City/Town

City Town	Percent of Households
Melrose	38.5%
Yoncalla	31.1%
Days Creek	27.0%
Lookingglass	22.8%
Roseburg North	20.5%
Reedsport	19.6%
Canyonville	19.4%
Elkton	19.0%
Sutherlin	18.6%
Glendale	18.2%
Tri-City	17.2%
Gardiner	16.8%
Green	15.5%
Riddle	14.2%
Dillard	13.3%
Winston	12.9%
Roseburg	12.4%
Myrtle Creek	10.5%
Oakland	9.9%
Glide	7.5%
Drain	5.4%

Source: American Community Survey, Five-Year Estimate, 2017-2021, Table B28002.

Healthcare Access & Quality

HEALTHCARE
noun

Efforts made to maintain or restore physical, mental, or emotional well-being especially by trained and licensed professionals

Access to Health and Wellness

Access to Health and Wellness refers to the ability of individuals to obtain necessary healthcare services when needed. Ensuring adequate access to care is essential for promoting good health and addressing medical needs within a community.

According to CSTA survey respondents, when they called or went to a doctor's office or a to get an appointment for immediate care, half (50%) said they "always" or "usually" got an appointment as soon as needed. People who identify as BIPOC (n=56), young adults (n=76), and LGBTQIA2S+ (n=51) were more likely to have this experience than survey respondents who did not identify as a person of color, young adults, or LGBTQIA2S+. Low-income and older adults where two priority populations who were less likely than their counterparts to always or usually get the appointment when they needed it.

Table 61. CSTA Respondents Who Always or Usually Got an Appointment as Soon as Necessary

Priority Population	Percent of CSTA Respondents who Reported Always/Usually
All CSTA respondents (n=269)	50%
People who identify as BIPOC (n=56)	64%
Young adults (18–34 years old) (n=76)	59%
LGBTQIA+ (n=51)	55%
Low income (<$49,000 household income) (73)	44%
Older adults (55+ years) (n=49)	35%

Source: CSTA Survey, 2023

CSTA survey respondents were most likely to report that it took two to three days to get an appointment and see a physician or other healthcare professional. Older adults (55+ years) were more likely to report it took 15 days or longer (24%, n=10). Younger respondents were more likely to indicate it would take two to three days to get an appointment—43 percent (n=50) of CSTA respondents 35–54 years old and 36 percent (n=24) of young adult (18–34 years old) CSTA respondents.

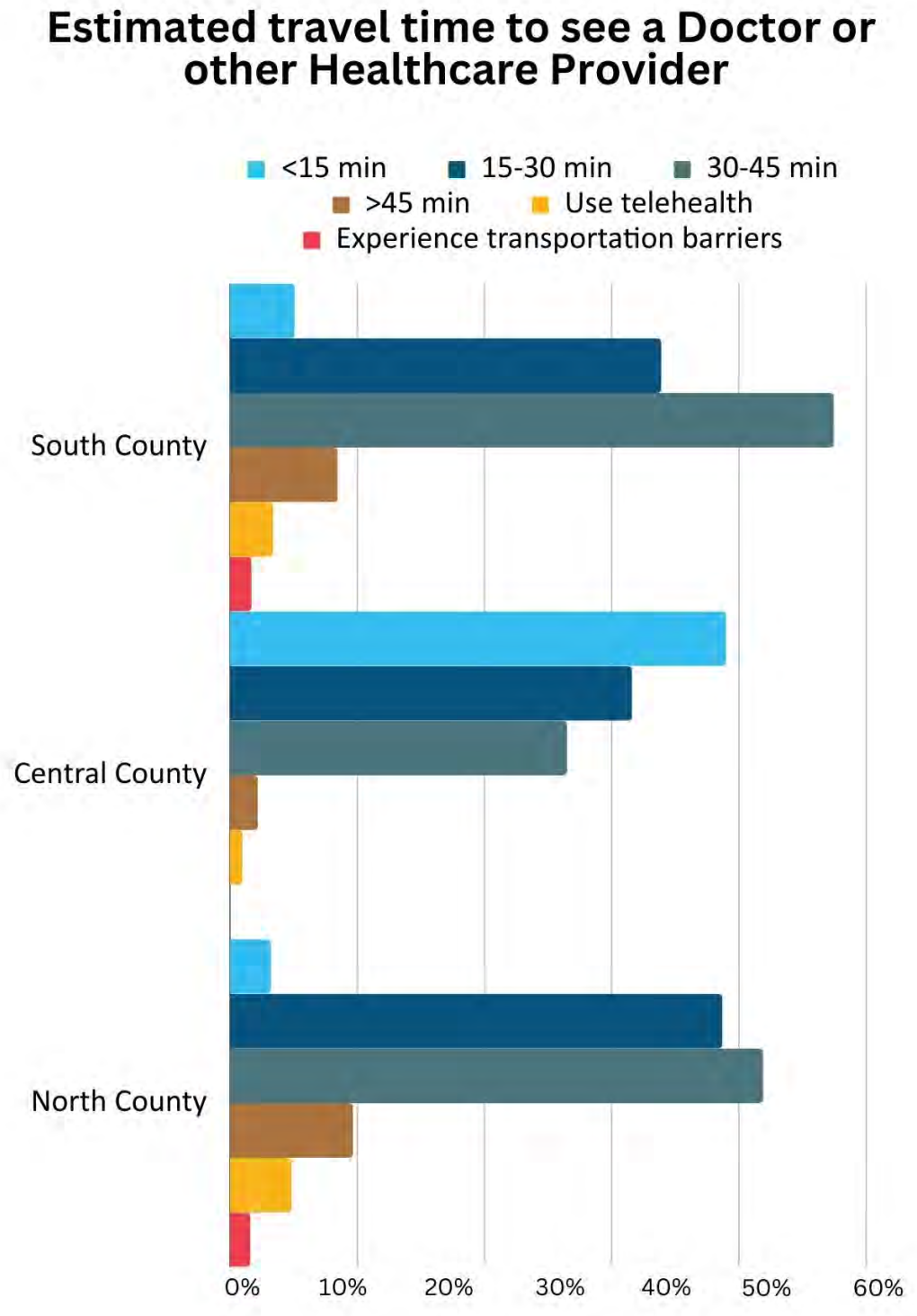
Two out of three CSTA survey respondents (68%) indicated that, on average, it takes 15–45 minutes to travel to see a doctor or other healthcare provider (nurse, nurse practitioner, physician assistant)., with 33 percent reporting 15–30 minutes and 35 percent reporting 30–45 minutes. One in five respondents (22%) reported it takes 15 minutes or less.

People in Central County (e.g., Roseburg West) were more likely to report it took less than 15 minutes or less to reach their provider's office (39% of respondents who selected this distance). North County and South County residents were most likely to have selected longer than 45 minutes (10% and 9% of respondents who selected this distance, respectively).

Focus Group Participants

Access to mental health services was a shared concern, with participants citing challenges such as limited availability, long wait times, and difficulties finding providers who accept specific insurance plans. Timely access to care was emphasized as crucial.

Table 62. Estimated Time to Travel to See a Doctor or Other Healthcare Provider



Source CSTA Survey

The following indicators related to access to healthcare and wellness are examined in this section:

- Barriers to seeking or receiving healthcare
- Health insurance coverage
- Provider-to-population ratio
- Availability of services
- School-based health centers

Focus Group Participants

Limited insurance options and long waiting lists, sometimes extending beyond six months, were cited as obstacles to receiving mental health care. Delayed appointment availability forces people to travel to other communities or even other states to receive timely mental health care.

Barriers to Seeking or Receiving Healthcare

The CSTA survey asked whether people experience barriers when accessing healthcare services, and if so, what barriers did they experience in getting services to support their health and wellness.

Approximately one in three survey respondents (35%, n=73) reported that they have not experienced barriers. Among those who did experience barriers (65%, n=135), the high out-of-pocket cost (56%, n=75), limited appointment availability (44%, n=59), and a lack of needed services in their area (33%, n=44) were the most commonly cited.

Table 63. Barrier(s) Encountered When Seeking Healthcare Services

Barriers to Care	Percent of Respondents Who Experienced Barriers to Care	
	Number	Percent
High out-of-pocket-costs/it costs too much money	75	56%
No appointments were available, or I couldn't get an appointment in a reasonable amount of time	59	44%
Needed service not offered in my area	44	33%
Needed evening and/or weekend hours of service	40	30%
I did not know what services and resources were available	26	19%
I was not eligible for services	26	19%
I could not find providers or services that understand, value, and respect my culture	17	13%
Forms were too complicated (Medicaid, health insurance, doctor's office/hospital forms etc.)	16	12%
I felt embarrassed about asking for help and/or getting services	15	11%
I could not find providers that looked like me or who speak my language	7	5%
I do not have Internet access or a device to use telehealth services	7	5%
Not easy to travel to/I don’t have transportation	6	4%
I did not feel safe	4	3%
I did not have health insurance	3	2%
Total	**135**	

Source: CSTA Survey, 2023.

Health Insurance Coverage

Health insurance coverage plays a critical role in whether people can access healthcare services. Without insurance, people are less likely to have a primary care provider, get recommended healthcare services, and have access to necessary medications. In Douglas County, 6.2 percent of the people are uninsured (6,844 people), and in Oregon, it was similar at 6.7 percent. The uninsured rates in both Oregon and Douglas County had significantly improved between 2012–2016 and 2017–2021, decreasing from 9.7 percent and 10.4 percent, respectively.

Focus Group Participants

Even with insurance, participant mentioned that they still have to pay a significant amount of money for healthcare. They also spoke about their difficulty understanding the information provided by their insurance company.

Among adults, 9.6 percent were uninsured in Douglas County compared with 9.5 percent in Oregon. Among children (0–17 years old), 3.6 percent were uninsured in Douglas County, similar to Oregon at 3.5 percent. Young adults, ages 18–39, had the highest rate of uninsurance in Douglas County at 12.0 percent, similar to Oregon at 11.2 percent. The rates have remained stable by age group in 2012–2016 and 2017–2021.

Table 64. Uninsured Rate by Age Group

Age	Douglas County	Oregon
Full population	6.2	6.7
Infants/toddlers (0–4 years old)	4.4	2.9
Juveniles (5–17 years old)	3.1	3.8
Young adults (18–39 years old)	12.0	11.2
Middle-aged adults (40–64 years old)	8.0	7.5
Seniors (age 65 and older)	0.3	0.5

Source: American Community Survey, Five-year estimates 2017-2020, Tables B27001/C27001.

Uninsured rates vary by race and ethnicity. However, given Douglas County's small population sizes, it is difficult to understand to what extent disparity exists. Though non-Hispanic Black, Pacific Islander/Native Hawaiian, and Asian residents had higher uninsurance rates than non-Hispanic White, Hispanic or Latino, or American Indian/Native American residents, the estimates were unstable.

Table 65. Uninsured Rate by Race and Ethnicity

Race/Ethnicity	Douglas County	Oregon
Full population	6.2	6.7
Non-Hispanic White	6.1	5.3
Non-Hispanic Black*	23.2	6.7
Asian*	13.4	5.1
Hispanic or Latino	6.5	14.7
American Indian/Native American	7.3	11.6
Pacific Islander/Native Hawaiian*	51.5	11.0

**Estimate should be interpreted with caution because of unstable estimates given the small number of people and wide confidence intervals.*
Source: American Community Survey, Five-year estimates 2017-2020, Tables B27001/C27001.

Among residents with insurance, 60.5 percent have public health insurance (67,572 people) compared with 41.2 percent in Oregon, followed by 59.5 percent (68.0% in Oregon) with private health insurance coverage. Nearly half of privately insured people in Douglas County rely on employer-based health insurance (45.8%) in Douglas County, with 13.3 percent relying on direct-purchase health insurance or 4.0 percent on Tricare/military. Medicaid is the primary public insurer with 33.6 percent of people using public insurance, followed by Medicare at 29.9 percent in Douglas County. The percent of people in Douglas County who rely on VA Health Care was more than twice as high at 7.3 percent compared with 2.8 percent of people in Oregon with public insurance.

Table 66. Insurance Type

Race/Ethnicity	Douglas County		Oregon
	Number	Percent	Percent
Private Insurance	**65,474**	**59.5%**	**68.0%**
Employer-based health insurance alone or in combination	50,366	45.8%	54.6%
Direct-purchase health insurance alone or in combination	14,640	13.3%	14.8%
Tricare/military health insurance alone or in combination	4,387	4.0%	2.1%
Public Insurance	**67,572**	**60.5%**	**41.2%**
Medicare Coverage Along or in Combination	33,335	29.9%	20.5%
Medicaid	37,514	33.6%	23.4%
VA Health Care	8,153	7.3%	2.8%

Source: American Community Survey, Five-year estimates 2017-2020, Tables S2703 and S2704.

Ratio of Providers to Population

Provider network adequacy influences a community's health and well-being because it directly affects individuals' access to care, the quality of care they receive, the cost of care, and their ability to make informed healthcare choices. It ensures that residents have access to a sufficient number and variety of healthcare providers within their health insurance plan, enabling them to receive timely and appropriate medical care when needed. Inadequate networks can lead to limited choices, longer wait times, and potential barriers to quality healthcare, affecting the overall well-being of policyholders.

Focus Group Participants

The importance of having ethnically diverse mental health providers was highlighted. Black doctors were specifically mentioned as providing excellent care.

Another theme regarding healthcare providers was the issue of doctor turnover. Participants noted that providers tend to leave after a relatively short time, leading to a lack of continuity in their care.

A participant also mentioned having to travel to Grants Pass to access dental care for their son because of difficulties in seeing a local provider.

The ratio of population to providers was generally lower in Douglas County than in the state.

- The primary care provider ratio in Douglas County was worse than in Oregon and the United States overall. In 2020, there was one primary care physician per 1,550 people in Douglas County or 72 providers. In Oregon, it was one physician for every 1,060 people. Between 2010 and 2020, Douglas County experienced no significant change in trend.60F 62
- In 2022, Douglas County had one mental health provider per 280 people, a higher ratio than in Oregon where it was one mental health provider per 160 people.61F 63
- In 2021, Douglas County had one dentist per 1,260 people, whereas Oregon had one dentist for every 1,190 people. The dentist per population ratio for Douglas County was improving in 2010–2021.62F 64

Understanding the extent to which Douglas County residents can access reported provider networks is crucial. Lists of providers and facilities exist, and they have been used in this assessment to understand proximity to providers, service continuum of providers, and network adequacy. Studies suggest widespread inaccuracies in provider directories, with growing concerns about "phantom networks," in which participating providers turn away patients for a variety of reasons. [65] This finding suggests that provider networks may not truly be meeting network adequacy because they potentially include providers who hold active licenses but are clinically inactive, have moved, or have closed their panels to new patients.

62 Primary care physicians include practicing non-federal physicians (MDs and DOs) younger than age 75 who specialize in general practice medicine, family medicine, internal medicine, and pediatrics. Health Resources and Services Administration Area Health Resource File/American Medical Association via county health rankings.

63 Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced practice nurses specializing in mental healthcare.

64 Registered dentists with a National Provider Identifier are counted. Dentists are classified by county, but dentists living on the edge of counties or who practice in multiple locations may see patients who reside in surrounding counties. These data are from the National Provider Identifier Downloadable File, which has some limitations. Providers that transmit electronic health records must obtain an identification number, but very small providers can abstain from obtaining a number. Though providers have the option of deactivating their identification number, some dentists included in this list may have stopped practicing or accepting new patients.

65 Zhu, J. M., Charlesworth, C. J., Polsky, D., & McConnell, K. J. (2022). Phantom Networks: Discrepancies Between Reported and Realized Mental Health Care Access in Oregon Medicaid: Study examines phantom networks of mental health care providers in Oregon Medicaid. *Health Affairs*; 41(7):1013-1022.

School-Based Health Centers

As of July 1, 2023, Oregon had 85 certified school-based health centers (SBHCs) in 28 counties. Of these SBHCs, 76 percent were federally qualified health centers (FQHCs), and 47.0 percent were state-recognized primary care homes. [66] As of 2023, the one SBHC in Douglas County was at Roseburg High School through Aviva Health. According to the Oregon SBHC Status Report 2021 - 2022, statewide, during the 2021 – 2022 service year:

- Oregon SBHCs provided 126,673 visits for 40,069 clients, or 3.2 visits per client. This is compared to 4.9 visits per client in Roseburg High School with 243 clients served across 1,191 visits.
- For SBHC visits among school-aged youth (5–21 years):
- 76 percent of visits were for primary care in Oregon, compared to 31 percent of visits in Roseburg High School.
- 10 percent of visits were for behavioral health (including mental health, behavioral health, and substance abuse treatment) in Oregon, which was slightly higher than in Roseburg High School which was 7.0 percent in 2021-2022 service year.
- One percent of visits were for dental health in Oregon compared to zero percent in Roseburg High School.
- 58 percent of all clients had Medicaid coverage in Oregon, which was similar in Roseburg High School at 57 percent.

Services offered at Oregon SBHCs (service provision varies by site) in the 2021-2022 service year included:

- Perform routine physicals, well-child exams, and sports exams
- Diagnose and treat acute and chronic illnesses
- Treat minor injuries/illnesses
- Provide vision, dental and blood pressure screenings
- Administer vaccinations
- Prevent and treat alcohol and drug problems
- Deliver preventive health and wellness messaging
- Provide and/or connect students with mental health counseling
- Provide reproductive health services
- Give classroom presentations on health and wellness
- Prescribe medication
- Help students find social supports

66 Oregon Public Health Division. Oregon School-Based Health Centers: 2022 Status Update. Oregon Health Authority. Portland, OR. July 2022. https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le3615.pdf

Social & Community Context

CONNECTION

noun

1.The act of connecting : the state of being connected: such as a causal or logical relation or sequence

2.Relation of personal intimacy (as of family ties)

3.A person connected with another especially by marriage, kinship, or common interest

4.A political, social, professional, or commercial relationship

Social and Community Context

Social and community context refers to the relationships and interactions people have with family, friends, co-workers, and fellow community members. Having strong social support and connections can protect people from forces and events that are outside of their control, like living in an unsafe neighborhood, the experience of poverty, and health challenges.

Community Context

The term "Community Context" is used earlier in this report to describe a discrete component of the MAPP 2.0 process, the Community Context Assessment (CCA), which is a qualitative data assessment of the perspectives of community members impacted by social systems to improve the functioning and impact of those systems. In this section, however, the term social and community context is used in reference to social support and connection as a social determinant of health.

Social and community connectedness matters for community health because it fosters a sense of belonging, support, and shared responsibility among individuals within a community. Strong social ties and a sense of belonging can lead to improved mental and emotional well-being, reduced stress, and increased resilience. Additionally, community connectedness promotes collaboration and resource sharing, which can lead to better access to healthcare, education, and social services, ultimately contributing to a healthier, more sustainable communities.

Douglas County CSTA survey respondents described a strong sense of social and community connectedness:

- Eight in 10 survey respondents (81%) strongly agreed/agreed that "every person and group has the opportunity to contribute to improve the quality of life in my neighborhood."
- Similarly, eight in 10 survey respondents (81%) strongly agreed/agreed that "there are networks of support for me and my family during times of stress and need," with residents living in North County having a significantly higher percentage of survey respondents reporting these sentiments
- Three in four survey respondents (76%) strongly agreed/agreed that "all residents in my neighborhood feel that they—individually and together—can make the neighborhood a better place to live." Survey respondents from South County were significantly more likely to strongly agree/agree with this statement.

Opportunities to improve social and community connectedness center on the extent to which trust and respect are thought to be increasing and communities can come together to achieve shared goals. Sixty-eight percent of CSTA respondents strongly agreed/agreed with this statement; however, some members of communities within the county reported the opposite was true. South County residents were more likely to strongly agree/agree that trust and respect are increasing, and communities can come together to achieve shared community goals.

Focus Group Participants

Focus group participants noted highlighted in their discussions how the community plays a crucial role in their well-being. They rely on support from neighbors and the sense of community to maintain their mental health. Social interactions and community engagement are essential components of their self-care. Participants expressed gratitude for having support while discussing the challenges they face.

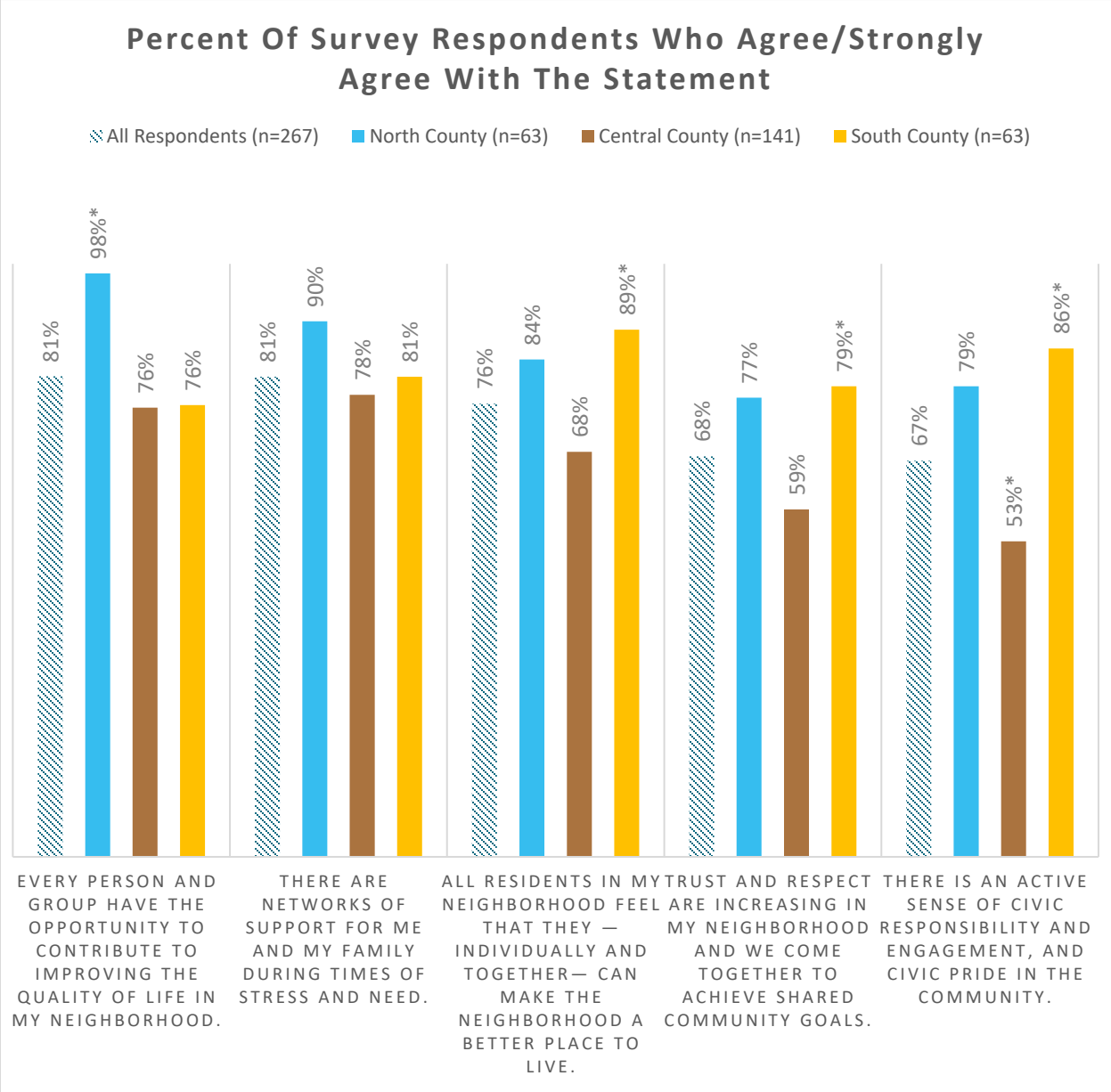
One example shared within the group was a school principal who provided fruits and vegetables from her garden to support students' access to healthy and nutritious food.

Another example was affinity groups and school clubs. Participants noted that being part of BIPOC (Black, Indigenous, and People of Color) groups and school clubs provides a sense of belonging and an opportunity to connect with others who share similar experiences and backgrounds. These connections are valuable for discussing feelings and gaining support.

The least amount agreement throughout the county was in response to the statement that "there is an active sense of civic responsibility

and engagement, and pride in our community;" 67 percent of CSTA respondents strongly agreed/agreed. Residents of North County and South County expressed a greater sense of civic responsibility and engagement and pride in their community.

Figure 10. Social and Community Connectedness



**Percent of respondents who strongly agreed/agreed with the statement differed significantly from the percent of all respondents. Source: CSTA Survey, 2023.*

The following indicators related to social and community context are examined in this section:

- Adult connectedness among youth
- Bullying
- Voting

Adult Connectedness Among Youth

The Oregon Student Health Survey asks students in grades 6, 8, and 11 whether they have at least one teacher or another adult in their school who really cares about them. In 2020–2022, the percent of

students who reported having at least one teacher or other adult at school who really cared about them decreased for both Douglas County and Oregon, as well as across all grades.

In Douglas County, in 2022, rates among sixth, eighth, and 11th graders reporting these beliefs were 41.0 percent, 37.5 percent, and 32.6 percent, respectively. All rates dropped from 2020, when they were 48.0 percent, 41.4 percent, and 39.7 percent, respectively.

The number of sixth grade Douglas County students who reported feeling connected to an adult in their school dropped 7.0 percentage points in 2020–2022, a greater decline than for sixth grade students elsewhere in Oregon, where the number dropped 1.2 percentage points.

In both Douglas County and Oregon, the likelihood of having at least one teacher or other adult in their school who really cares about them decreases as students progress from grade six to grade 11. In 2022, 41.0 percent of Douglas County sixth graders reported they very much agree that they have at least one teacher or other adult in their school who really cares about them versus 32.6 percent of 11th graders. Oregon trends were similar.

Table 67. Percent of Students Who Report Feeling They Have an Adult in School Who Cares About Them

	Douglas County			Oregon		
	Grade 6	Grade 8	Grade 11	Grade 6	Grade 8	Grade 11
2020	48.0%	41.4%	39.7%	44.2%	35.5%	41.0%
2022	41.0%	37.5%	32.6%	43.0%	33.4%	33.5%
% Change, 2020–2022	**-7.0%**	**-3.9%**	**-7.1%**	**-1.2%**	**-2.1%**	**-7.5%**

Source: Oregon Student Health Survey Data Portal

Bullying

The Oregon Student Health Survey asks students in grades 6, 8, and 11 whether they have experienced bullying. In 2022, approximately one in three eighth and 11th grade students in Oregon reported having been bullied in the past 30 days, 35.1 percent and 33.9 percent respectively. Notably, Douglas County exhibited higher bullying rates than other students in Oregon (25.5% of eighth graders and 15.6% of 11th graders).

Furthermore, the data revealed an increase in bullying during 2020–2022 in both Douglas County and the rest of Oregon. Specifically, within Douglas County, the most significant increase in school-related bullying incidents occurred among grade 11 students, with a substantial 12.6 percentage point rise from 21.3 percent in 2020. In Oregon as a whole, the most substantial increase in bullying incidents was among eighth graders, with a 12.2 percentage point increase from 13.3 percent in 2020.

Table 68. Percent of Grade 8 and 11 Students Who Experienced Bullying at School

	Douglas County		Oregon	
	Grade 8	Grade 11	Grade 8	Grade 11
2020	30.8%	21.3%	13.3%	10.7%
2022	35.1%	33.9%	25.5%	15.6%
% change in 2020–2022	+4.3%	+12.6%	+12.2%	+4.9%

**Denominator is number of bullied students, not total. Source: Oregon Student Health Survey Data Portal.*

In 2022, among students who reported being bullied, approximately one in 10 grade 11 students were harassed because of their race, gender, disability, or sexual orientation. This percentage was slightly higher than the statewide figure, which stood at 7.1 percent for these students.

Notably, students in grade eight who reported being bullied were more likely to be bullied because of their race, gender, disability, or sexual orientation than students in grade 11. Specifically, in 2022, 16.4 percent of eighth graders students experienced this type of bullying, which was slightly higher than the overall Oregon rate of 11.6 percent for these students.

Table 69. Percent of Students in Grades Eight and 11 Who Reported Identity-Based Bullying*

	Douglas County		Oregon	
	Grade 8	Grade 11	Grade 8	Grade 11
2022	16.4%	9.9%	11.6%	7.1%

**Denominator is number of bullied students, not total. Source: Oregon Student Health Survey Data Portal.*

Voting

Voting can create a sense of connection to one's community by providing the opportunity to contribute to decision making. In 2017−2021, 89,045 people 18 years and older lived in Douglas County 99 percent of whom (88,323) are citizens and may vote. [67]

Total votes cast for president, as a percentage of voting-age citizens, was slightly lower in Douglas County than Oregon for the 2008, 2012, and 2016 presidential elections. In 2020, not only was the percent of votes cast for president was the highest turnout compared with the 2008, 2012, and 2016 presidential elections, but the turnout in Douglas County was slightly higher at 73.2 percent of voting-age citizens compared with 72.8 percent in Oregon.

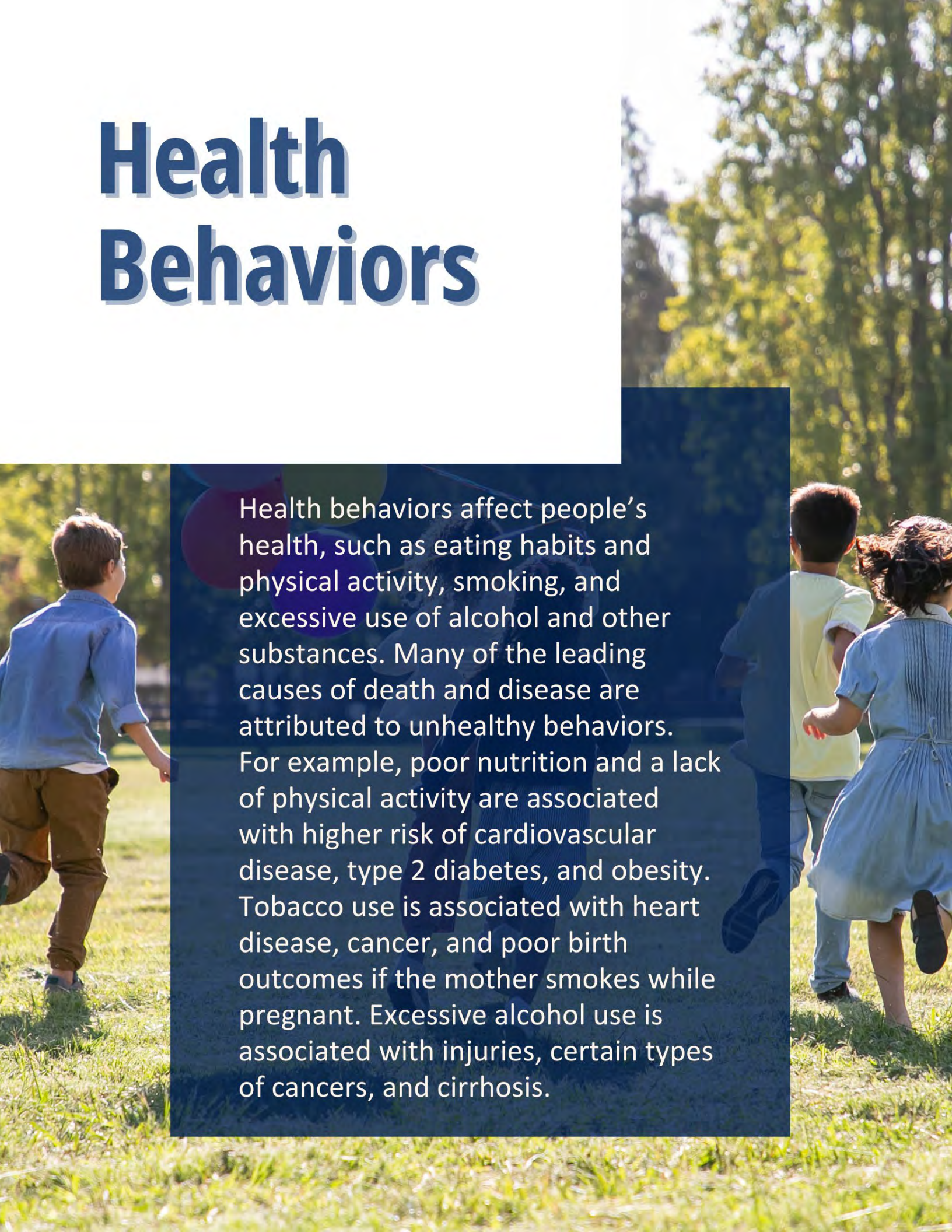
Table 70. Voter Participation Rate in Presidential Elections

2008	64.5%	67.3%
2012	57.4%	63.0%
2016	60.1%	66.2%
2020	73.2%	72.8%

Note: The actual voter participation rate is slightly higher because some ballots are cast without votes for president (not adjusted to exclude people who ineligible to vote for reasons of criminal history or other violations. Source: American Community Survey, One-Year Estimates, Table B05003

67American Community Survey, 5-Year Estimate, 2017-2021, Table DP05

Health Behaviors



Health behaviors affect people's health, such as eating habits and physical activity, smoking, and excessive use of alcohol and other substances. Many of the leading causes of death and disease are attributed to unhealthy behaviors. For example, poor nutrition and a lack of physical activity are associated with higher risk of cardiovascular disease, type 2 diabetes, and obesity. Tobacco use is associated with heart disease, cancer, and poor birth outcomes if the mother smokes while pregnant. Excessive alcohol use is associated with injuries, certain types of cancers, and cirrhosis.

Health Behaviors

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The percent of adults (18+ years) in Douglas County with one or more of these risk factors for chronic disease, including obesity, no exercise, tobacco use, high blood pressure, and high cholesterol was 81.6 percent in 2018–2021. [68]

This section looks at the following health behaviors:

- Physical activity
- Healthy eating and nutrition
- Obesity or being overweight
- Alcohol, tobacco, and other drug use
- Immunizations
- Cancer screening and prevention
- Oral health
- Sexual and reproductive health

It is important to note that many of the estimates provided in this section are self-reported and, therefore, subject to recall bias. People may underreport or overreport a behavior. The accuracy of the data depends on the survey methodology and the willingness of respondents to disclose their habits truthfully.

Adult Physical Activity

Adults (18+ years) in Douglas County had higher rates of physical activity outside of work compared with adults in Oregon in 2018–2021—approximately one in four adults (23.7%) versus one in five (19.8%) adults in Oregon.

Table 71. Percent of Adults (18+ years) Who Engage in Physical Activity Outside of Work

	Age-Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010–2013	19.1	22.7	20.9	17.7	18.6	18.2
2014–2017	16.7	23.0	20.0	18.1	17.6	17.8
2018–2021	24.8	22.5	23.7	20.5	18.9	19.8
Percentage point change 2010–2013 to 2018–2021	+5.7	-0.2	+2.8	+2.8	+0.3	+1.6

Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. Source: BRFSS via the Oregon Public Health Assessment Tool

68 BRFSS via the Oregon Public Health Assessment Tool, 2018-2021.

The percent of adults who meet recommendations for both aerobic and strengthening physical activity was available only for Douglas County. [69] In 2018–2021, nearly three in four adults (18+ years, 76.4%) fell short of meeting these guidelines. [70] Though this rate has been improving since 2010–2013 when it was 82.4 percent, growth was negligible.

Youth Physical Activity

In 2022, one in two 11th grade students (51.1%) in Douglas County were physically active for at least 60 minutes per day on five or more days in the past seven days. This rate was higher than among 11th graders living elsewhere in Oregon (41.3%).

In Douglas County, sixth grade students showed less likelihood of engaging in physical activity, with 37.5 percent of students being active, than students in grade eight (56.9%) and grade 11 (51.1%). Additionally, sixth graders in Douglas County also were less active than their peers in other parts of Oregon, where more than half (55.3%) of sixth graders were physically active for at least 60 minutes per day on five or more days within the past seven days.

Table 72. Physical Activity

		Douglas County	Oregon
	Grade	2022	2022
Percent of students who were physically active at least 60 minutes per day on five or more days in the past week	Grade 6	37.5%	55.3%
	Grade 8	56.9%	57.4%
	Grade 11	51.1%	41.3%

**Source: Oregon Student Health Survey Data Portal (Students) Question was "During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day)"*

Healthy Eating and Nutrition

Among adults, one measure of healthy eating and nutrition that can be studied is soda consumption. High carbonated beverage consumption is often associated with poor dietary habits. Excessive consumption of sugary sodas has been linked to health issues such as obesity, type 2 diabetes, and dental problems. Monitoring soda consumption can provide insights into a community's overall dietary patterns. Soda consumption may vary based on economic factors, cultural preferences, and accessibility to healthier beverage options. Understanding these factors can inform strategies to improve access to healthier dietary choices.

Soda consumption can provide a glimpse into dietary habits butt should be viewed alongside other health measures, such as obesity rates, physical activity levels, and overall nutrition, for a more comprehensive understanding of community health.

In Douglas County, the percent of adults (18+ years) who report consuming seven or more (non-diet) sodas per week was significantly higher at 26.5 percent in 2018-2021 compared to Oregon at 15.7 percent. This rate has been higher in Douglas County since 2014-2017. It nearly doubled between 2010-2013 from 11.9 percent of adults in Douglas County to 24.0 percent in 2014-2017. In Oregon, the rate

69 BRFSS asked, "During the past week, did you do any physical activities that increased your heart rate and made you breathe hard for at least 10 minutes continuously? This may include activities such as brisk walking, running, bicycling, swimming, or any other activities that cause the heart to beat faster and breathing to become hard." Individuals who answered "yes" to this question are considered to have engaged in aerobic physical activity. However, meeting recommendations for both aerobic and strengthening physical activity typically involves more than just aerobic exercise. It also requires strength training activities like weightlifting, bodyweight exercises, or resistance band exercises.

70 BRFSS via Oregon Public Health Assessment Tool

has remained stable between 2010-2013 and 2018-2021, and females have significantly lower soda consumption compared to males.

Table 73. Percent of Adults (18+ years) Who Report Consuming Seven or More (non-diet) Sodas Per Week

	Age Adjusted Rates					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010-2013	10.1	13.9	11.9	10.4	16.9	13.6
2014-2017	19.9*	28.3	24.0*	8.8	16.5	12.7
2018-2021	25.0*	29.5*	26.5*	13.2	18.3	15.7
Percentage Point Change 2010-2013 to 2018-2021	+14.9	+15.6	+14.6[+]	+2.8	+1.5	+2.1

*Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate in Douglas County compared to Oregon. [+]Significantly increasing trend in obesity between 2010-2013 and 2018-2021. Source: BRFSS via the Oregon Public Health Assessment Tool*

Among youth, one measure of healthy eating and nutrition is the extent to which youth consume five servings of fruits and vegetables a day. While significance is not known, the percent of students who have five or more servings of fruits and vegetables a day was lower for Douglas County students in grades six, eight, and 11 than the statewide rates.

Table 74. Five-a-Day Consumption of Fruits and Vegetables among Students, 2022

	Douglas County			Oregon		
	Grade 6	Grade 8	Grade 11	Grade 6	Grade 8	Grade 11
Zero servings per day	0.0%	2.3%	0.0%	1.0%	2.2%	2.5%
Less than one serving per day	7.6%	14.9%	20.5%	14.5%	18.9%	24.7%
One to less than three servings per day	60.8%	51.3%	55.9%	44.9%	47.0%	51.0%
Three to less than five servings per day	13.1%	19.8%	19.0%	19.0%	17.4%	14.1%
Five or more servings per day	18.5%	11.6%	4.5%	19.6%	14.5%	7.7%

Source: Oregon Student Health Survey, Data Portal

Access to food and/or food insecurity data, which includes adults, are provided in the Economy Stability section of this assessment.

Obesity

Body mass index (BMI) is widely used to determine whether an individual is overweight or obese. It is calculated by dividing a person's weight in kilograms by the square of their height in meters. BMI values are categorized as follows:

- Underweight: BMI less than 18.5
- Normal weight: BMI 18.5 to 24.9
- Overweight: BMI 25 to 29.9
- Obesity: BMI 30 or greater

Being overweight or obese are related but distinct health conditions. Overweight individuals have excess body weight, which may or may not be related to excess body fat. On the other hand, obesity specifically refers to the presence of excess body fat. By examining both weight and obesity rates, the assessor can get a more comprehensive understanding of the prevalence of these conditions and the associated

health risks. Being overweight and/or obese are associated with a range of health conditions, including heart disease, diabetes, certain types of cancer, and musculoskeletal issues. Overweight individuals are at risk for these health issues, albeit to a lesser extent than individuals who are obese.

The assessment examines rates of adults who are overweight and/or obese. Youth obesity rates were unavailable. Obesity (BMI ≥ 30) rates among adults (18+ years) were significantly higher in Douglas County than among other adults in Oregon. In 2018−2021, 37.0 percent of Douglas County adults (18+ years) were considered obese, compared with a statewide rate of 30.0 percent. There were no statistically significant different rates when comparing males and females in both Oregon and Douglas County. However, Oregon appeared to be experiencing a significantly increasing trend in obesity rates, driven in part by the growing trend among females. The obesity rate among females in Oregon increased from 26.6 percent in 2010-2013 to 30.8 percent in 2018-2021.

Table 75. Adult Obesity (BMI ≥ 30) Rates

	Age Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010-2013	37.1*	32.1	34.4*	26.6	26.8	26.7
2014-2017	30.7	34.7*	32.7*	28.8	28.4	28.6
2018-2021	39.5*	33.6*	37.0*	30.8	29.3	30.0
Percentage Point Change 2010-2013 to 2018-2021	+2.4	+1.5	+2.6	+4.2⁺	+2.5	+3.3⁺

*Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate in Douglas County compared to Oregon. ⁺Significantly increasing trend in obesity between 2010-2013 and 2018-2021. Source: BRFSS via the Oregon Public Health Assessment Tool*

When including the percent of adults considered overweight (BMI 25 to 29.9), approximately seven in 10 adults (18+ years, 71.7%) in Douglas County were overweight or obese in 2018−2021. This rate was significantly higher compared to statewide rate of 64.4 percent. In Douglas County, no significant differences in rates between male and female adults were detected.

Table 76. Overweight or Obesity (BMI ≥ 25) Rates among Adults

	Age Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010−2013	64.6*	71.8*	68.0*	53.9	67.5	60.8
2014−2017	56.5	71.1*	64.1	56.2	68.8	62.6
2018−2021	69.8*	75.7*	71.7*	59.6	69.1	64.4
Percentage Point Change 2010−2013 to 2018−2021	+5.2	+3.9	+3.7	+5.6⁺	+1.6	+3.6⁺

*Note: Douglas County estimates are available for four-year periods. Oregon rates are available only as one-year estimates. Therefore, an unweighted four-year estimate was created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate in Douglas County compared with Oregon. ⁺Significantly increasing trend between 2010-2013 and 2018-2021. Source: BRFSS via the Oregon Public Health Assessment Tool*

Alcohol, Tobacco, and Other Drug Use

Alcohol, tobacco, and other drug (ATOD) use is associated with a range of health issues, including addiction, chronic diseases, mental health problems, and injuries. Assessing ATOD use allows communities to understand the scope of these challenges and their effects on the population. It guides resource allocation, policy development, educational programs, and treatment services.

An estimated one in five (18.2%) of Douglas County residents ages 12 and older (17,691) have a substance use disorder. Statewide, this rate was similar at 18.2 percent. [71]

Understanding drug use relies on a combination of data sources, including surveys, toxicology screens, treatment center data, prescription records, emergency department admissions, mortality data, law enforcement statistics, and more.

The ATOD use estimates in this section rely on the Behavioral Health Risk Surveillance System (BRFSS) and the Oregon Student Health Survey, both of which collect self-reported data from individuals about their drug use. These surveys provide information on the prevalence of drug use, frequency, age of initiation, and trends over time. The extent to which county-level estimates are available is limited. This assessment allowed HMA to incorporate survey estimates of Douglas County alcohol, tobacco, and marijuana use among youth and adults.

Other sections in this assessment that begin to tell a comprehensive story on the ATOD in Douglas County include:

- The Crime and Safety section of the assessment notes the percent of offenses that involved drugs and suggests that methamphetamine/amphetamine use is a prevalent problem as the most common drug identified.
- In the Unintentional or Accidental Injuries section, the assessment notes the mortality rates from drug overdoses, including drug-induced deaths.

Alcohol

Binge drinking is defined as having five or more drinks (males) or four or more drinks (females) on at least one occasion in the past 30 days. In 2018–2021, 15.0 percent of adults (18+ years) reported binge drinking in the past 30 days. This rate was similar to Oregon at 18.0 percent. The prevalence of binge drinking did not significantly change between 2010–2013 and 2018–2021. Statewide rates among Douglas County females were significantly lower than for males only in 2014–2017.

Table 77. Binge Drinking among Adults (18+ years)

	Age Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010-2013	10.2	16.6	13.5	12.9*	21.4	17.2
2014-2017	9.2*	24.0	16.7	13.9*	22.0	17.9
2018-2021	11.7	19.9	15.0	14.0*	22.0	18.0
Percentage Point Change 2010-2013 to 2018-2021	+1.5	+3.3	+1.5	+1.1	+0.6	+0.8

Note: Douglas County data are available only as four-year estimate. Oregon rates are available only as one-year estimates. Therefore, an unweighted four-year estimate was created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate between males and female rates.

[71] Oregon Substance Use Disorder Services Inventory and Gap Analysis, September 30, 2022.

Source: BRFSS via the Oregon Public Health Assessment Tool

Tobacco Use

Tobacco use, particularly smoking, is a major risk factor for a range of serious health conditions, including heart disease, cancer, respiratory diseases, and stroke. It is a leading cause of preventable death and illness. Tobacco-related health problems impose substantial economic burdens on communities, including healthcare costs, lost productivity, and increased insurance premiums. Moreover, exposure to secondhand smoke can harm non-smokers. It is associated with various health issues, especially in children and individuals with preexisting health conditions.

Adults (18+ years) living in Douglas County had higher rates of tobacco use compared with their counterparts in other Oregon locales. In 2018–2021, nearly one in three adults (18+ years, 28.4%) used tobacco, slightly fewer than in 2015–2017. Males living in Douglas County in 2018–2021, were more likely to be tobacco users compared with males living elsewhere in Oregon.

Table 78. Percent of Adults (18+ Years) Who Were Tobacco (including Smokeless Tobacco) Users

	Age-Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2014–2017	23.8	38.6	31.5	18.4*	32.3	25.2
2018–2021	23.2*	38.4+	28.4	19.4*	29.1	24.3
Percentage Point Change 2014–2017 to 2018–2021	-0.6	-0.2	-3.1	+1.0	-3.2	-1.0

*Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. *Denotes significantly different rates between males and female rates. + Denotes rates that are significantly different in Douglas County than in Oregon. Source: BRFSS via the Oregon Public Health Assessment Tool*

The percent of adults (18+ years) who used electronic cigarettes for one to 30 days in the past 30 days was 5.4 percent in Douglas County, similar to Oregon at 6.2 percent. Use has changed significantly over time, (2014–2017 and 2018–2021), although trends were improving (not significant decrease in e-cigarette adult users). There was no significant differences in e-cigarette use between males and females.

Table 79. Percent of Adults (18+ Years) Who Were E-Cigarette Users

	Age-Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2014-2017	6.4	10.2	8.5	4.9	7.1	6.0
2018-2021	5.4	6.4	5.4	5.5	6.9	6.2
Percentage Point Change 2014-2017 to 2018-2021	-1.0	-3.8	-3.1	0.6	-0.2	0.2

Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, an unweighted four-year estimate was created for Oregon to compare Douglas County and Oregon rates more easily.
Source: BRFSS via the Oregon Public Health Assessment Tool

The percent of adults (18+ years) who used cigarettes was significantly higher in Douglas County than for adults (18+ years) living elsewhere in Oregon. This difference has been consistent back to 2010, as evident by the four-year estimates of 2010–2013, 2014–2017, and 2018–2021. While the rate had decreased (non-significantly at 5.2 percentage points) between 2010-2013 when it was 25.6 percent and

2018–2021 when it was 20.4 percent in Douglas County; the rate in Oregon decreased significantly from 19.4 percent in 2010–2013 to 14.5 percent in 2018–2021. Therefore, the prevalence of cigarette use in Douglas County was higher than in Oregon and has not improved.

Table 80. Percent of Adults (18+ Years) Who Used Cigarettes

	Age-Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010–2013	26.0*	25.1	25.6**	17.9	20.9	19.4
2014–2017	25.8*	24.4	25.1**	15.5	18.9	17.2
2018–2021	17.9	23.9*	20.4**	13.8	15.3	14.5
Percentage Point Change 2019–2013 to 2018–2021	-8.1	-1.2	-5.2	-4.2+	-5.6+	-4.9+

*Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate between males and female rates. **Significantly different rate in Douglas County compared to Oregon. +Significantly decreasing trend in cigarette users between 2010-2013 and 2018-2021. Source: BRFSS via the Oregon Public Health Assessment Tool*

Self-reported 30-day cigarette use in 2020 and 2022 was low (<4%) among students in grades six, eight, and 11 in both Douglas County and Oregon. However, past 30-day electronic cigarette use was higher, particularly among grade eight and 11 students in both Douglas County and Oregon. The past 30-day electronic cigarette use rates in Douglas County were nearly twice as high in Oregon. In 2022, nearly one in five (19.9%) grade 11 students reported past 30-day electronic cigarette use, versus one in 10 (10.8%) grade 11 students in Oregon. Self-reported electronic cigarette use rose as students progressed through school. Students in grade 11 had higher rates than in grade 6, increasing from 3.0 percent of grade 6 students to 19.9 percent of grade 11 students in 2022. Electronic cigarette use among grade 8 students declined by 7.0 percentage points, from 15.6 percent in 2020 to 8.6 percent in 2022.

Table 81. Tobacco and Electronic Cigarettes Past 30-Day Use among Sixth, Eighth, and 11th Graders

		Douglas County			Oregon		
		Grade 6	Grade 8	Grade 11	Grade 6	Grade 8	Grade 11
Current 30-day cigarette use	2020	n/a	1.5%	1.5%	0.4%	1.2%	2.9%
	2022	n/a	4.0%	2.5%	0.4%	1.3%	3.2%
Percentage point change (2020–2022)		n/a	+2.5	+1.0	0	+0.1	+0.3
Past 30-day electronic cigarette use	2020	2.6%	15.6%	21.2%	1.7%	5.1%	11.9%
	2022	3.0%	8.6%	19.9%	1.4%	4.7%	10.8%
Percentage point change (2020–2022)		+0.4	-7.0	-1.3	-0.3	-0.4	-1.1

Source: Oregon Student Health Survey Data Portal

Tobacco-related death rates per 100,000 people were higher in Douglas County than in Oregon. In 2018–2021, this rate was 215 deaths per 100,000 people compared with 147 deaths per 100,000 people in Oregon. This rate has been consistently higher in Douglas County than in Oregon since 2006–2009.

Between 2006–2009 and 2018–2021, Douglas County experienced a rise in tobacco-related deaths, whereas the State of Oregon saw a decline. In 2018–2021, the death rate in Douglas County stood at 215 per 100,000 individuals, marking a 3.9 percent increase from 2006–2009 when it was 206.9 deaths per 100,000 people. In 2018–2021, this rate represented 1,685 deaths.

Table 82. Tobacco-related Death Rates per 100,000 Population

	Douglas County	Oregon	Count of Deaths in Douglas County
2006–2009	206.9	169.6	1,358
2010–2013	201.3	159.4	1,408
2014–2017	205.6	150.8	1,533
2018–2021	215.0	147.0	1,685
Percent change in 2006–2009 to 2018–2021	+3.9%	-13.3%	+24.1%

Source: Oregon's Tobacco Fast Facts

In 2016–2020, the rate of lung and bronchus cancer diagnosis rates were higher among Douglas County residents (53.5 per 100,000) than among adults in Oregon (49.0 per 100,000). The rate of lung and bronchus cancer-related deaths was also higher in Douglas County (44.1 per 100,000) than in Oregon (33.4 per 100,000).

Table 83. Rate of Lung and Bronchus Cancer Diagnoses and Deaths per 100,000 Population, 2016–2020

	Douglas County	Oregon
Rate of new lung and bronchus cancer diagnoses	53.5	49.0
Lung and bronchus cancer death rate	44.1	33.4

Source: Oregon's Tobacco Fast Facts

Marijuana Use

Marijuana use has multifaceted implications for community health. It can affect physical and mental health, particularly among youth. Issues related to impaired driving, the impact of legalization and regulation, equitable access, substance use disorders, economic considerations, data collection, and public health campaigns all play a role in addressing the community health aspects of marijuana use. Balancing the potential benefits and risks is crucial to promoting overall well-being in a community.

In 2018–2021, adults (18+ years) who used marijuana or hashish for one to 30 days during the past 30 days was similar to Oregon rates at 21.5 percent or approximately one in five adults. This was similar to 2014–2017 estimates of 20.2 percent. Though males reported more use in Douglas County than females, it is not significant, unlike elsewhere in Oregon where male use was significantly higher.

Table 84. Percent of Adults (18+ Years Old) Who Used Marijuana or Hashish During the Last 30 Days

	Age-Adjusted Rates					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2014–2017	16.8	24.8	20.2	12.6	18.9*	15.6
2018–2021	20.5	23.9	21.5	20.4	25.7*	23.0
Percentage point change, 2014–2017 to 2018–2021	+3.7	-0.9	+1.3	+7.9+	+6.8+	+7.4+

*Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate between males and female rates. + Rate significantly different in Douglas County compared to Oregon. Source: BRFSS via the Oregon Public Health Assessment Tool*

Approximately one in 10 Douglas County students (13.6%) in 11th grade reported using marijuana in 2020 and 2022. This rate was comparable with rates among grade 11 students in Oregon. In 2022, 5.3 percent, or about one in 20, sixth graders reported using marijuana for the first time in the past 30 days.

The likelihood of using marijuana increased as students progressed through school, with higher rates in grade 11 than in grades six or eight.

Table 85. Percent of Students Who Used Marijuana in the Past 30 Days

		Douglas County			Oregon		
		Grade 6	Grade 8	Grade 11	Grade 6	Grade 8	Grade 11
Past 30-day marijuana use	2020	n/a	7.7%	11.0%	0.9%	3.3%	13.5%
	2022	5.3%	4.1%	13.6%	1.2%	3.1%	12.2%
Percentage point change (2020–2022)		n/a	-3.6	+2.6	+0.3	-0.2	-1.3

Source: Oregon Student Health Survey, Data Portal.

Immunization Rates

Immunization rates are important in preventing the spread of infectious diseases, protecting vulnerable populations, reducing healthcare costs, and contributing to overall community health.

Influenza Vaccinations

In Douglas County, approximately one in five adults (18+ years, 26.5%) received the influenza vaccination during 2018–2021. This percentage was comparable to the rate in 2010–2013, which was 28.2 percent, indicating no significant change over this period. Notably, the influenza vaccination rate in Douglas County during 2018–2021 was lower than in Oregon as a whole, and Oregon experienced a significant increase in influenza vaccinations during the same period.

Table 86. Percent of Adults (18+ Years) Who Received an Influenza Vaccination in the Last Year

	Age Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010–2013	30.1	26.5	28.2	37.5	29.4	33.4
2014–2017	32.2	30.2	30.9	38.2	32.0	35.1
2018–2021	26.7*	26.1*	26.5*	43.0	35.0	39.0
Percentage point change, 2010–2013 to 2018–2021	-3.4	-0.4	-1.7	+5.6^{+}	+5.7^{+}	+5.6^{+}

*Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, an unweighted four-year estimate was created for Oregon to compare Douglas County and Oregon rates more easily. *Rate significantly different in Douglas County compared to Oregon. $^{+}$Significant increasing trend between 2010-2013 and 2018-2021. Source: BRFSS via the Oregon Public Health Assessment Tool.*

COVID-19 Vaccination

Statewide, as of December 2023, 83.68 percent of people were vaccinated with at least one dose and 74.33 percent pf people were fully vaccinated. The vaccination rate in Douglas County was lower. As of December 2023, 63.3 percent of people were vaccinated with at least one dose of a COVIC-19 vaccinate with just over half (55.5%) of people considered fully vaccinated. [72] Among people 65 years and older, as of May 15, 2023, the vaccination was higher at 81.3 percent. [73]

The ending of the federal public health emergency means that Federal Emergency Management Agency (FEMA) funding for some COVID-19 response activities also will end. That includes vaccines and therapeutics that have been provided at no cost to everyone in the country since December 2020. After

[72] https://data.dnj.com/covid-19-vaccine-tracker/oregon/41/

[73] COVID-19 Community Profile Report, County Level. Retrieved on December 9, 2023.

May 11, pharmaceutical companies will begin distributing and selling vaccines like other vaccines, such as the influenza vaccine; therapeutics commercialization is product-dependent with different timelines, and some are already available commercially. This transition is likely to take place sometime early fall 2023 for vaccines and by the end of 2023 for therapeutics. [74]

Kindergarten Immunization

Statewide, over 87 percent of kindergarten students completed all school-required vaccines in 2023. From 90 percent to 94 percent of kindergartners completed each individual required vaccine. [75] The immunization rate was slightly lower in Douglas County at 86.0 percent in 2023. From 89.0 percent to 92.7 percent of kindergartners completed each individual required vaccine. Approximately one in Douglas County in 10 (10.1%) of kindergarteners had a nonmedical exemption to at least one school-required vaccine in 2023. This was slightly higher than the statewide rate of over 8.0 percent.

Table 87. Kindergarten Immunization Rate, 2023

	Douglas County	Oregon
Complete	86.0%	87.1%
DTaP	89.0%	90.9%
MMR	92.7%	94.4%
Measles 2	90.3%	91.9%
Varicella	92.4%	94.1%
Polio	90.2%	91.5%
Hepatitis B	92.4%	92.9%
Hepatitis A	90.5%	91.1%

Source: Oregon Immunization Program, School Immunization Data.

[74]Oregon Health Authority, News release. (April 21, 2023) COVID-19 outlook good as cases, deaths, hospitalizations continue declines. Retrieved from https://content.govdelivery.com/accounts/ORDHS/bulletins/35655a1

[75]Oregon COVID-19 Vaccine Tracker. Retrieved on December 7, 2023 from https://public.tableau.com/app/profile/oregon.immunization.program/viz/SchoolLawTableau/Kimmunizations

Cancer Screening and Prevention

Cancer screening and prevention data for Douglas County are available. In 2018–2021, two out of three adults 66.2%) ages 50–75 met the recommended guidelines for colorectal cancer screening. This rate remained stable between 2010–2013 and 2018–2021. Notably, no significant differences were detected between males and females meeting these recommendations.

Cervical and breast cancer screening rates in Douglas County were higher than colorectal screening. Specifically, 76.6 percent of women ages 21–65 had the recommended pap smear in the past three years for cervical cancer screening, and 77.5 percent of females aged 50-74 had a mammogram in the past two years for breast cancer screening. Both rates were stable between 2010–2013 and 2018–2021; however, the prevalence of mammograms increased, rising from 70.6 percent in 2010–2013 to 77.6 percent in 2018–2021, while the prevalence of pap smears decreased from 83.3 percent to 76.6 percent among women ages 21–65 over the same period.

Table 88. Percent of Douglas County Adults Who Engaged in Preventive Care for Cancer

	Age-Adjusted Percentages				
	Meets Recommendations for colorectal cancer screening (ages 50-75)			Had a Pap smear in the past 3 years (women ages 21-65)	Had a mammogram in the past 2 years (women ages 50-74)
	Females	Males	Total		
2010–2013	62.4	66.5	64.5	83.3	70.6
2014–2017	72.1	69.5	70.9	78.3	77.5
2018–2021	68.6	63.5	66.2	76.6	77.6
Percentage point change, 2010–2013 to 2018–2021	+6.2	-3.0	+1.7	-6.7	+7.0

Source: BRFSS via the Oregon Public Health Assessment Tool

Other Preventive Health Care Utilization

Adults living in Douglas County and other parts of Oregon used preventive healthcare services at similar rates.

The percent of adults who had a routine checkup in the past year was similar in both Douglas County and Oregon. In 2018–2021, 71.9 percent of Douglas County adults (18+ years) had a routine checkup in the past year. In Oregon, the rate was 69.9 percent. Routine checkups were becoming increasingly common in both Douglas County and Oregon. In Douglas County, the rate significantly increased 15.2 percentage points from 56.7 percent of adults in 2010–2013 to 71.9 percent of adults in 2018–2021. In Oregon, the rate increased 15.9 percentage points from 54.0 percent in 2010–2013 to 69.9 percent of adults in 2018–2021. Females were more likely to have a routine checkup in the past year than males in both Douglas County and Oregon.

Table 89. Percent of Adults (18+ years) With a Routine Checkup in the Past Year

	Age-Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010–2013	61.5	52.2	56.7	58.8*	49.4	54.0
2014–2017	67.5*	54.8	61.3	65.8*	56.6	61.2
2018–2021	78.8*	60.8	71.9	75.3*	64.6	69.9
Percentage point change, 2010–2013 to 2018–2021	+17.3+	+8.6	+15.2+	+16.5+	+15.1+	+15.9+

*Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, an unweighted four-year estimate was created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate between males and female rates. +Significantly increasing trend between 2010-2013 and 2018-2021. Source: BRFSS via the Oregon Public Health Assessment Tool*

Eight in 10 adults (18+ years) in both Douglas County and Oregon, 83.6 percent and 84.5 percent, respectively, had a cholesterol screening. Among older adults, they are less likely to engage in a core set of clinical preventive services, such as a cholesterol screening. In Douglas County, nearly 40.0 percent of older adult men (65+ years) and older adult women (65+ years) were current on a core set of clinical preventive services in 2020. These rates were comparable to statewide rates.

Table 90. Percent of Douglas County Adults Who Used Other Preventive Services 2020

	Douglas County	Oregon
Cholesterol screening among adults (18+ years)	83.6%	84.5%
Older adult men (65+ years) who are current on a core set of clinical preventive services	37.1%	44.5%
Older adult women (65+ years) who are current on a core set of clinical preventive services	36.4%	38.8%

Source: CDC Places, BRFSS, 2020.

Oral Health

Oral health is interconnected with general health and well-being. Poor oral health can lead to a range of systemic health issues, including cardiovascular diseases, diabetes, and respiratory infections.

Focus Group Participants

Disparities in dental care, especially among people of color, were highlighted in the focus group discussions. It was noted that dental hygiene is often neglected when individuals are stressed.

Service providers should recognize and address these disparities, possibly through initiatives like free dental care programs.

In 2018–2021, 68.6 percent of adults (18+ years) in Douglas County had visited the dentist in the past year, a rate similar to the statewide figure of 67.3 percent in Oregon. Notably, dental visits increased in both Douglas County and Oregon in 2010–2013 and 2018–2021. In Douglas County, the rate substantially increased 13.8 percentage points from 54.8 percent of adults. Oregon also experienced a significant increase, albeit smaller, of 3.3 percentage points from 64.0 percent of adults in 2010–2013.

It is worth mentioning that, in the past, females in Douglas County were less likely to visit a dentist within the past year than other females in Oregon during 2010–2013 and 2014–2017. This changed in 2018–2021 when the dental visit rate for females significantly increased to 71.8 percent from 55.5 percent in 2014–2017.

Table 91. Percent of Adults (18+ Years) Who Have Visited the Dentist for Any Reason in the Past Year

	Age Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010-2013	53.4**	56.1	54.8**	67.2*	60.8	64.0
2014-2017	55.5**	57.5	56.6**	69.5*	62.9	66.2
2018-2021	71.8	62.8	68.6	70.7*	64.0	67.3
Percentage Point Change 2010-2013 to 2018-2021	+18.4⁺	+6.7	+13.8⁺	+3.5	+3.1	+3.3⁺

*Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate between males and female rates. **Significantly different rate in Douglas County compared to Oregon. ⁺Significantly increasing trend between 2010-2013 and 2018-2021. Source: BRFSS via the Oregon Public Health Assessment Tool*

Sexual and Reproductive Health

Sexually transmitted infections (STIs), also known as sexually transmitted diseases (STDs), are infections that are passed from one person to another through sexual contact. The most common STIs are chlamydia; gonorrhea; genital herpes; human papillomavirus (HPV); hepatitis B and C; syphilis; and HIV/AIDS. STIs can significantly affect the overall health of a community. High rates of STIs can lead to increased healthcare costs, strain healthcare systems, and contribute to public health burden. STIs can also cause serious health problems for individuals, including chronic pain, infertility, complications during pregnancy, and an increased risk of acquiring or transmitting other infections, including HIV. Certain populations, such as adolescents, LGBTQIA2S+ individuals, and marginalized communities, may face higher rates of STIs because of various factors, including stigma, discrimination, and limited access to healthcare. Addressing STIs is crucial for promoting health equity within communities.

Because STI rates can vary from year-to-year, prevalence rates are reported over a two-year period to provide a more stable picture of the overall trend. Monitoring these trends aids in assessing the community's overall health by identifying at-risk populations and SDOH's effects on access to care.

Compared with Oregon, Douglas County's rates for chlamydia, gonorrhea, and syphilis were lower in 2018–2020. Table 91 details the rate of STIs in Douglas County and Oregon.

Table 92. Sexually Transmitted Disease Rates in Douglas County and Oregon, 2018-2020

	Age Adjusted Rate per 100,000 Persons	
	Douglas County	Oregon
Chlamydia	324.4	466.3
Hepatitis C (chronic)	114.6⁺	71.3
Gonorrhea	107.3	154.5
Syphilis (Early)	5.9	19.9
HIV/AIDS	2.9*	5.0
Hepatitis B (chronic)	1.6*	8.0
Hepatitis C (acute)	0.7*	0.7
Hepatitis B (acute)	0.1*	0.5

*⁺Significantly higher rate compared to Oregon. *Indicates suppressed data results and rates are unreliable. Source: Oregon Public Health Assessment Tool.*

Douglas County's chlamydia rates were relatively stable between 2012−2014 and 2018−2020; however, since 2012–2014 chlamydia consistently has been the most prevalent STD in Douglas County and the state. Overall, gonorrhea has the most significant and consistent increase in Douglas County and is significantly increasing across the state. Hepatitis C is the second most common STI in Douglas County, whereas syphilis and HIV/AIDs rates remain steady. Table 92 provides a comparison of STIs between Douglas County and the state.

Table 93. Sexually Transmitted Disease Rates and Count of People in Douglas County

Age Adjusted Rate per 100,000 Persons							
	2012 - 2014		2015 - 2017		2018 - 2020		
	Rate	Number	Rate	Number	Rate	Number	Trend between 2012-2014 and 2018-2020
Chlamydia	347.4	872	383.3	940	324.4	794	No Change
Hepatitis C (chronic)	151.5	511	208.2	713	114.6	395	LOWER in 2018-2020
Gonorrhea	32.6	80	61.2	151	107.3	273	HIGHER in 2018-2020
Syphilis (Early)	9.0	22	5.0	14	5.9	16	No Change
HIV/AIDS	3.5	*	3.1	*	2.9	*	No Change
Hepatitis B (chronic)	5.6	17	7.0	28	1.6	*	No Change
Hepatitis C (acute)	2.0	*	2.4	*	0.7	*	No Change
Hepatitis B (acute)	0.7	*	0.5	*	0.1	*	No Change
Hepatitis A	0.0	*	0.8	*	0.0	*	No Change

**Indicates suppressed data results and rates are unreliable. Source: Oregon Public Health Assessment Tool.*

Health Outcomes

Health outcomes represent the physical and mental well-being of residents in Douglas County. By looking at measures indicating the length and quality of life, the CHA provides information needed to understand how well health improvement programs in Douglas County are working or whether new or different efforts are needed.

Additionally, it is important to look at differences in health outcomes based on the presence of various community health factors and demographics to identify disparities between different people and communities. Understanding where disparities exist informs changes in health improvement efforts to meet the needs of those experiencing disparity.

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Until now, the CHA has described many factors that influence health including access to healthcare, the availability of good jobs, clean water, affordable housing, and behaviors or choices individuals make that influence their health. This section describes the following health outcomes:

- Physical and mental health status
- Length of Life, including life expectancy and causes of death
- Injury and violence, including both intentional and unintentional injury
- Morbidity, including chronic disease, cancer incidence and communicable diseases
- Birthing person health and pregnancy, including fertility rate, teen birth rate, and infant mortality rate

Individual Health Status

Individual health status refers to the overall well-being, physical, mental, and social health of a single person. It encompasses factors such as nutrition, physical fitness, access to healthcare, lifestyle choices, and genetics. Self-reported health status (SRH) is a subjective measure of how individuals perceive their health. Understanding how individuals perceive their health is essential because it strongly predicts mortality and other health outcomes. People who report their health as fair or poor are at an increased risk of death, even after adjusting for other factors such as age, sex, and socioeconomic status. SRH is also a predictor of other health outcomes, such as chronic diseases, disability, and use of healthcare services. The individual health status of each person in Douglas County contributes to the overall health and resilience of Douglas County.

Adult Physical Health Status

In 2018–2021, in Douglas County, nearly one in five (17.8%) adults (18+ years) SRH status as fair or poor. This rate was higher than the statewide rate of 15.9 percent. Notably, the rate among female adults in Douglas County self-reporting poor health status was significantly lower in 2018–2021 at 17.5 percent than in 2010–2013 when the rate was 28.2 percent, which suggests that female adults in Douglas County feel better today than they did nearly 10 years ago.

CTSA Respondents

Approximately **2 out of 3** CSTA survey respondents rank their general health as healthy:

"healthy" (35%)
"somewhat healthy" (33%)
(n=352 respondents)

Table 94. Percent of Adults Who Self-Reported General Health Status as Fair or Poor

	Age Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010-2013	28.2**	20.5	24.3**	17.8	17.0	17.4
2014-2017	25.4**	19.3	22.2**	16.9	16.8	16.9
2018-2021	17.5	19.0	17.8	16.4	15.3	15.9
Percentage Point Change 2010-2013 to 2018-2021	-10.7+	-1.5	-6.5	-1.4	-1.7	-1.6

*Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. **Significantly different rate in Douglas County compared to Oregon. +Significantly decreasing trend between 2010-2013 and 2018-2021. Source: BRFSS via the Oregon Public Health Assessment Tool*

In 2020 residents of Douglas County had a significantly higher average of poor physical health days (i.e., days in the previous 30 days that a respondent's physical health was subpar because of illness or injury) compared with other residents of Oregon, at 3.5 days and 2.9 days, respectively. In both Douglas County and Oregon, the average number of poor physical health days declined between 2019 and 2020; yet was still significantly higher in Douglas County—4.5 days versus 3.9 days in Oregon. [76]

Focus Group Participants

One focus group participant acknowledged that it can be challenging to take care of themselves, especially when they are home alone, reminding themselves to eat when their parents are working. This may point to difficulties in maintaining regular routines.

Motivation and time constraints are noted as other factors that hinder self-care practices, suggesting that life's demands may sometimes make it difficult to prioritize one's well-being.

Youth Physical Health Status

In 2022, among Douglas County Student Health Survey respondents in grades six, eight, and 11, the latter were most likely to report fair or poor health status. One in five (25.0%) grade 11 students reported fair or poor health status, followed by 20.3 percent of eighth graders and 14.6 percent of sixth graders. The rates for fair or poor health status for students in Douglas County and Oregon increased between 2020 and 2022 (significance unknown).

Table 95. Percent of Students Who Self-Reported Fair or Poor Physical Health Status

	Douglas County			Oregon		
	Grade 6	Grade 8	Grade 11	Grade 6	Grade 8	Grade 11
2020	13.2%	19.0%	14.5%	10.2%	17.5%	18.2%
2022	14.6%	20.3%	25.0%	15.3%	21.4%	28.2%
Percentage Point Change from 2020 to 2022	+1.4%	+1.3%	+10.5%	+5.1%	+3.9%	+10.0%

Source: Oregon Student Health Survey, Data Portal.

76 Behavioral Risk Factor Surveillance System, 2019 and 2020 via County Health Rankings.

General Self-Reported Mental Health Status

CTSA Respondents

Approximately **3 out of 4** CSTA survey respondents reported "good" (35%) or "very good" (36%) mental or emotional health. (n=352 respondents)

Individual mental health status refers to a person's emotional, psychological, and social well-being. It encompasses factors such as emotional stability, coping abilities, stress management, and the absence of mental health disorders. Good mental health is vital for an individual's quality of life, productivity, and overall life satisfaction. The mental health of community members collectively influences overall community health. Communities with a higher prevalence of mental health issues, such as depression or anxiety, may experience higher healthcare costs, lower workforce productivity, and higher crime rates. On the other hand, communities with individuals who are mentally healthy tend to be more resilient, productive, and supportive of one another.

In 2020, residents of Douglas County reported 4.9 mentally unhealthy days (i.e., days in the previous 30 days that a respondent's mental health was not good), compared with 3.9 mentally unhealthy days for people elsewhere in Oregon. [77]

According to Oregon Student Health Survey results, students in Douglas County had higher rates of depression than other Oregon students. In Douglas County, the prevalence of students saying they felt sad or hopeless almost every day for two weeks or more in a row in 2022 and that they stopped doing some usual activities increased to nearly half of the 11th grade students (42.7%), compared with 20.8 percent of the grade six students. Between 2020 and 2022, the prevalence of depression decreased in Douglas County and Oregon, with the greatest decrease occurring among eighth grade students in Douglas County. Additionally, eighth grade students reporting feelings of depression dropped 13.8 percentage points from 44.3 percent in 2020 to 30.5 percent in 2020.

Table 96. Percent of Students Who Reported Ever Feeling So Sad or Hopeless for Almost Every Day for Two or More Consecutive Weeks in the Past Year that They Stopped Doing Some Usual Activities

	Douglas County			Oregon		
	Grade 6	Grade 8	Grade 11	Grade 6	Grade 8	Grade 11
2020	28.4%	44.3%	43.1%	28.6%	33.0%	42.9%
2022	20.8%	30.5%	42.7%	23.7%	29.8%	38.4%
Percentage Point Change from 2020 to 2022	-7.6%	-13.8%	-0.4%	-4.9%	-3.2%	-4.5%

Source: Oregon Student Health Survey, 2022.

77 Behavioral Risk Factor Surveillance System, 2019 and 2020 via County Health Rankings.

Longevity (Life Expectancy)

Life expectancy represents the average life span of a newborn infant and is frequently analyzed to understand community health outcomes. Many factors can shorten life expectancy, including hunger, injury, disease, the environment, and chronically poor health. Conversely, improvements in health and welfare increase life expectancy, and the higher the life expectancy, the better shape a community is in.

The average life expectancy for Douglas County residents has been significantly lower compared with other Oregonians since 2011 and has been on the decline. In 2021, the average life expectancy was 72.7 years in Douglas County, lower than 77.3 years in Oregon. Since 2019, life expectancy dropped in both Oregon and Douglas County. In Douglas County, the average number of years a person is expected to live is 77.1 years and in Oregon it was 79.9 years.

Table 97. Average Number of Years a Person Is Expected to Live

	2011	2019	2020	2021
Douglas County	77.4	77.1	76.1	72.7[+*]
Oregon	79.6	79.9	78.7	77.3[+]

*[+]Significant decreasing trend *Significantly different rate in Douglas County compared to Oregon. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

Race and ethnicity disparities affect life expectancy. Black/African American and White, non-Hispanic (NH), Douglas County residents have lower life expectancies at 70.7 years and 73.8 years, respectively. Hispanic and White NH residents had significantly lower life expectancy in 2020–2021 than in 2018–2019.

Table 98. Average Number of Years a Douglas County Resident Is Expected to Live, by Race and Ethnicity

	2018–2019	2020–2021
American Indian/Alaska Native NH	81.4	77.6
Asian NH	92.4	93.6
Black NH	81.5	70.7
Hispanic	95.8	86.8[+]
Pacific Islander NH	70.5	78.3
Two or more races NH	84.6	82.5
White NH	76.3	73.8[+]

[+]Significantly lower life expectancy rate in 2020-2021 compared to 2018-2019. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.

Mortality data provide a snapshot of current health problems, suggest persistent patterns of risk in specific communities, and shows trends in specific causes of death over time. Many causes of death are preventable or treatable and, therefore, warrant the attention of prevention efforts.

The age-adjusted death rate was significantly higher in Douglas County in 2021 at 1,121.6 per 100,000 compared with Oregon at 860.6 per 100,000. The age-adjusted death rate per 100,000 increased significantly for both Douglas County and Oregon in 2016–2021. However, the rate increased faster in Douglas County, increasing 41.5 percent from 792.6 per 100,000 in 2016 to 1,121.6 per 100,000 in 2021. The death rate in Oregon increased 20.6 percent, from 713.7 per 100,000 in 2016 to 860.6 per 100,000 in 2021.

Table 99. Age-Adjusted Death Rate per 100,000

	Douglas County	Oregon
2016	792.6	713.7
2017	835.1	717.1
2018	806.3	691.2
2019	823.9	698.9
2020	909.2	776.3
2021	1,121.6*+	860.6+
Percent change between 2016 and 2021	+41.5%	+20.6%

**Significantly higher rates compared to Oregon. +Significantly higher age adjusted death rate in Douglas County and Oregon in 2021 compared to 2016. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

Causes of Death

In 2021, cancer, heart disease, and COVID-19 were the top three causes of death for Douglas County and Oregon residents. In 2021, deaths rates for the following causes were significantly higher in Douglas County than in Oregon: Cancer (197.7 deaths per 100,000), heart disease (192.5 deaths per 100,000), COVID-19 (140.1 deaths per 100,000), accidents (92.0 deaths per 100,000), and intentional self-harm (suicide, 31.5 deaths per 100,000). Alzheimer's disease (28.0 deaths per 100,000) was significantly lower in Douglas County compared to Oregon.

Table 100. Cause of Death

	Age-Adjusted Rate per 100,000 People, 2021		
	Douglas County	Oregon	Number of Deaths in Douglas County
Malignant neoplasms (Cancer)	197.7*	155.2	384
Heart disease	192.5*	148.4	381
COVID-19	140.1*	69.2	245
Accidents (unintentional injuries)	92.0*	67.6	116
Chronic lower respiratory diseases	59.2	34.3	119
Cerebrovascular diseases (Stroke)	48.4	45.0	97
Diabetes mellitus	32.8	26.0	68
Intentional self-harm (suicide)	31.5*	19.6	38
Alzheimer disease	28.0*	41.0	56
Essential hypertension and hypertensive renal disease	21.5	13.9	42
Chronic liver disease and cirrhosis	20.7	17.6	34
Parkinson disease	8.8	12.0	17
Nephritis, nephrotic syndrome and nephrosis	8.4	7.6	16
Assault (homicide)	6.0	4.9	<10 deaths

**Significantly different age adjusted death rate in Douglas County compared to Oregon. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

Between 2016 and 2021, deaths resulting from heart disease and accidental injury significantly increased in Douglas County. Specifically, heart disease led to 192.5 deaths per 100,000 people in 2021, up from 138.5 deaths per 100,000 people in 2016, and accident-related deaths in 2021 rose to 92 deaths per 100,000 people from 46.0 deaths per 100,000 in 2016.

Table 101. Top Causes of Death Over Time, Douglas County

	Age-Adjusted Rates Per 100,000 People			
	Cancer	Diseases of heart	COVID-19	Accidents
2016	187.4	138.5	0.0	46.0
2017	176.1	148.9	0.0	65.2
2018	167.2	130.2	0.0	61.6
2019	180.9	136.3	0.0	51.6
2020	183.9	163.4	17.7	67.9
2021	197.7	192.5	140.1	92.0
Percent Change between 2016 and 2021	5.5%	38.9%+	n/a	100.0%+

+Significantly higher age adjusted death rate in Douglas County in 2021 compared to 2016. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.

Douglas County had significantly higher rates of all malignant cancers, at 180.9 cancer deaths per 100,000 people compared with Oregon at 151.1 cancer deaths per 100,000 people in 2017–2021. Specifically, the occurrence of the following cancers was higher than in Oregon: digestive system (47.4 per 100,000), respiratory system (45.7 per 100,000), and miscellaneous malignant cancer (14.4 per 100,000).

Although the number of cancer-related deaths declined in Oregon as a whole, with a decrease from 165.4 deaths per 100,000 in 2011–2015 to 151.1 deaths per 100,000 in 2017–2021, Douglas County did not experience the same level of improvement. In 2011–2015, the cancer death rate in Douglas County stood at 191.3 deaths per 100,000. Though the number of cancer-related deaths from various types of cancer types was similar during the two time periods (2011-2015 and 2017-2021), mortality rates attributed to respiratory cancer declined significantly, signifying an improvement in this specific area.

Table 102. Leading Types of Cancer Deaths

	Age-Adjusted Cancer Deaths per 100,000 by Type			
	Douglas County		Oregon	
	2011–2015	2017–2021	2011–2015	2017–2021
All Malignant Cancers	191.3	180.9*	165.4	151.1+
Cancer of digestive system	45.3	47.4*	41.5	40.8
Cancer of respiratory system	57.9	45.7*+	43.3	33.5
Miscellaneous malignant cancer	12.8	14.4*	11.7	10.7
Cancer of breast	10.1	11.7	11.0	10.4
Cancer of urinary system	8.8	10.7	8.7	9.0
Lymphoma	9.0	7.1	6.4	5.9
Leukemia	8.7	6.9	6.4	6.3
Cancer of skin	4.1	4.5	4.0	3.5
HPV-associated cancers	3.4	4.5	2.7	2.8
Cancer of brain and other nervous system	6.5	4.3	5.2	4.8
Cancer of oral cavity and pharynx	2.6	3.8	2.6	2.7
Myeloma	3.4	3.4	3.6	3.2
Mesothelioma	1.6	1.8	0.9	0.8
Cancer of soft tissue including heart	0.7	1.5	1.4	1.4

**Significantly higher in Douglas County compared to Oregon. +Significant change in trend between 2011-2015 and 2017-2021. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

The leading causes of death in 2020–2021 among youth, ages one to 14, were accidents or unintentional injuries and assault (homicide). Among younger adults, ages 15 to 44, unintentional injuries and suicide were the leading causes of death in Douglas County. For adults 45 years old and older, the leading causes of death were cancer, diseases of the heart, and COVID-19. Among the seven deaths for children younger than one year old, the top three were perinatal period conditions, congenital malformations, and COVID-19.

Table 103. Top Causes of Death in Douglas County by Age Group (Crude Adjusted Rates per 100,000), 2020–2021

	Age					
Rank	<1 = 328.9 (7 deaths)	1-14* = 11.9 (<5 deaths)	15-24 = 82.4 (18 deaths)	25-44 = 292.7 (146 deaths)	45-64 = 1,201.3 (688 deaths)	65+ = 4,951.6 (2,893 deaths)
1	Perinatal Period Conditions* (188.0)	Unintentional Injuries* (3.0)	Unintentional Injuries (55.0)	Unintentional Injuries (106.2)	Cancer (251.4)	Cancer (1,208.7)
2	Congenital malformations* (47.0)	Assault (Homicide)* (3.0)	Suicide (9.2)	Suicide (40.1)	Diseases of the Heart (195.6)	Diseases of the Heart (997.9)
3	COVID-19* (47.0)		Assault (Homicide)* Congenital malformations* COVID-19* Cancer* (4.6)	COVID-19 (24.1)	COVID-19 (125.7)	COVID-19 (332.1)
4				Cancer (20.0)	Unintentional Injuries (83.8)	Respiratory Disease (318.4)
5				Diseases of the Heart (14.0)	Respiratory Disease (64.6)	Stroke (280.7)
6					Chronic liver disease and cirrhosis (64.6)	Alzheimer disease (205.4)

**Rates and percentages based on 5 or fewer events are unreliable. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, OHA.*

Injury and Violence

Accidents and unintentional injuries are common, costly, and preventable, ranking as the fourth leading cause of death in Douglas County in 2021. Injury data shed light on when and why violence and injuries occur and how to prevent them.

Injuries can be broadly categorized into two main types based on intent:

- Unintentional injuries occur without any premeditated intent to harm oneself or others. These injuries often result from unforeseen or accidental circumstances, and include motor vehicle accidents (e.g., car crashes, pedestrian accidents, and bicycle accidents), falls (e.g., slips, trips, and falls at home, work, or public places), burns, poisoning (e.g., accidental ingestion or exposure to toxic substances, including drug overdoses), drowning, or choking.
- Intentional injuries (violent injuries) result from deliberate acts with the intent to harm oneself or others. These injuries are often associated with violence and aggression. Some common examples include assault, homicide, suicide, child abuse, domestic violence, sexual assault, workplace violence, gang violence, or terrorism.

It is important to note that some injuries may fall into a gray area between unintentional and intentional, such as incidents resulting from reckless or negligent behavior that does not necessarily involve direct intent to harm, but rather a disregard for safety.

Efforts to prevent and address unintentional and intentional injuries may differ, as they often require distinct strategies and interventions. Public health measures often focus on preventing unintentional injuries through education, safety regulations, and awareness campaigns, whereas addressing intentional injuries typically involves law enforcement, social services, and mental health support.

Injury by Intent

For the last six years, accidental (unintentional) injury has been the leading cause of injury death in Douglas County, followed by suicide and homicide. In 2021, the age-adjusted injury death rate per 100,000 of 92.0 (116 deaths) was significantly higher in Douglas County than in Oregon at 67.6 deaths per 100,000. This rate also was significantly higher in Douglas County than in Oregon in 2017 and 2018. Both Douglas County and Oregon experienced significantly increasing trends in unintentional injuries between 2016 and 2021. In Douglas County, the rate increased 100 percent from 46.0 deaths per 100,000 people in 2016 (65 deaths) to 92.0 deaths per 100,000 people in 2021. In Oregon, the rate increased 45.9 percent from 46.3 deaths per 100,000 in 2016 to 67.6 deaths per 100,000 people in 2021.

Focus Group Participants

Participants were particularly surprised and concerned about the suicide rates, especially in the context of the age of the affected group. The data shared with participants showed that individuals as young as 15 to those in their mid-40s were experiencing high rates of suicide.

Participants found this trend toward younger individuals facing such challenges alarming and unexpected, emphasizing the need for more awareness and education on life-saving techniques like using Narcan to reverse overdoses or performing CPR.

The suicide rate in Douglas County was also significantly higher compared to Oregon in both 2019 and 2021. In 2021, the suicide rate in Douglas County was 31.5 deaths per 100,00 people (38 deaths) compared to a rate of 19.6 deaths per 100,000 people in Oregon. Though the suicide rate increased in both Douglas County and Oregon between 2016 and 2021, the change was considered minimal.

In 2021, the homicide death rate was 6.0 per 100,000 people (eight), which was similar to the rate in Oregon (4.9 deaths per 100,000 people). The rate in Douglas County remained stable between 2017 and 2021, whereas it significantly increased in Oregon, from 3.2 deaths per 100,000 people in 2016 to 4.9 deaths per 100,000 people in 2021.

Table 104. Injury Death by Intent

Age-Adjusted Rate per 100,000						
Year	**Douglas County**			**Oregon**		
	Unintentional	**Suicide**	**Homicide**	**Unintentional**	**Suicide**	**Homicide**
2016	46.0	25.0	7.3	46.3	17.8	3.2
2017	65.2*	24.4	6.3	44.6	19.0	3.1
2018	61.6*	27.8	4.7	43.5	19.1	2.5
2019	51.6	41.9*	1.1	46.4	20.4	3.0
2020	67.9	24.1	4.1	53.4	18.4	3.8
2021	92.0*	31.5*	6.0	67.6	19.6	4.9
% Change 2016 -2021	+100%$^{+}$	+25.8%	-17.1%	+51.3%$^{+}$	+10.1%	+45.9%$^{+}$

*Note: Legal Intervention was 0.0 per 100,000 for the last five years in Douglas County and was not included in the table. *Significantly different rate in Douglas County compared to Oregon. $^{+}$Significantly increasing trend between 2016 and 2021. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

Unintentional Injuries by Type

As noted previously, Douglas County had significantly higher rates of accidental deaths than other parts of Oregon. An examination of the type of injury revealed that the higher rate is partly attributable to higher rates of motor vehicle and downing/submersion-related injuries. In Douglas County, in 2021, the age-adjusted death rate per 100,000 people for motor vehicle related injury was 35.7 (37 deaths) compared with 14.2 deaths per 100,000 people in Oregon. In Douglas County, in 2021, the age adjusted death rate per 100,000 people for drowning/submersion related injury was 6.6 (<10 deaths) compared to 1.9 deaths per 100,000 people in Oregon.

Table 105. Unintentional Injury Deaths by Type of Injury, 2021

Death by Type	Age Adjusted Rate per 100,000	
	Douglas County	**Oregon**
Motor Vehicle	35.7*	14.2
Poisoning	28.1	25.9
Fall	14.9	17.1
Drowning/submersion	6.6*	1.9
Natural/environmental	3.3	3.0
Fire/burn	1.4	1.3
Unspecified	1.0	0.8
Struck by or against	0.9	0.2

**Significantly different rate in Douglas County compared to Oregon. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

In Douglas County, the significant increase in accidental injury deaths between 2016 and 2021 was because of statistically significant increases for the following injury types:

- Motor vehicle-related: 10.7 in 2016 to 35.7 per 100,000 in 2021 (37 deaths)
- Poisoning: 16.1 in 2016 to 28.1 per 100,000 in 2021 (30 deaths)
- Downing/submersion: 1.6 in 2016 to 6.6 per 100,000 in 2021 (7 deaths)

Table 106. Douglas County Accidental Injury Deaths by Cause

	Age Adjusted Rate per 100,000	
	2016	2021
Motor Vehicle	10.7	35.7+
Poisoning	16.1	28.1+
Fall	13.0	14.9
Drowning/submersion	1.6	6.6+
Natural/environmental	0.9	3.3
Other [1]	1.5	1.4

[1] "Other" includes accidents due to Fire/burn. Unspecified. Struck by or against, Cut/pierce, Firearm, Machinery, Other specified, classifiable, Other specified, not elsewhere classified, Overexertion, and Suffocation. +Accident injury death rate was significantly higher in 2021 compared to 2016. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, OHA.

Intentional Injuries by Type

Intentional injuries, also known as interpersonal violence or intentional harm, refer to injuries or harm that occur because of deliberate and purposeful actions by one person toward another or to oneself. Intentional injuries include homicide, assault, and battery (e.g., domestic violence, sexual assault and rape, child abuse, elder abuse), and self-harm or suicide. As previously noted, suicide was occurring at a significantly higher rate in Douglas County compared to Oregon. In this section, the assessment takes a closer look at the suicide rate in Douglas County.

Suicide and Suicidal Ideation

Suicide rates have not significantly changed between 2014–2015 and 2020–2021 for any age group.

Table 107. Douglas County Suicide Deaths by Age Groups

	Age-Specific Suicide Death Rate per 100,000 and Number of Deaths							
	14 to 24 Years		25 to 44 Years		45 to 64 Years		65+ Years	
	Rate	Number	Rate	Number	Rate	Number	Rate	Number
2014–2015	13.1	<10	38.0	17	44.1	27	23.6	12
2016–2017	13.6	<10	34.4	16	29.9	18	33.3	18
2018–2019	36.7	<10	56.0	27	34.3	20	40.1	23
2020–2021	9.2	<10	40.1	20	40.2	23	39.4	23

Note: Rates based on 10 or fewer events are unreliable. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.

In 2022, approximately one in five 11th graders (20.7%) self-reported that they had seriously considered attempting suicide in the past 12 months. Slightly more than one in 10 grade six (12.5%) and grade eight students (12.2%) self-reported that they have seriously considered attempting suicide in the past 12 months. Students in Douglas County generally had higher rates of suicidal ideation than other Oregon youth (significant differences are unknown).

Table 108. Suicide Ideation among Grade Six, Eight, and 11 Students

	During the past 12 months, did you ever seriously consider attempting suicide?					
Survey Response	Douglas County			Oregon		
	6th	8th	11th	6th	8th	11th
Yes	12.5%	12.2%	20.7%	7.2%	11.6%	14.6%
No	79.8%	71.2%	67.2%	76.3%	72.6%	70.9%
I'm not sure	1.2%	4.5%	4.8%	3.6%	4.6%	5.0%
I don't know what this question is asking		1.0%		2.3%	0.9%	0.4%
I prefer not to answer	6.6%	11.2%	7.3%	10.6%	10.3%	9.0%

Note: Douglas County schools administered the Student Health Survey in October 2022. Participating districts includes Oakland School District 1, North Douglas School District 22, and Reedsport School District 105. There were 71 Grade 6 students, 116 Grade 8 students, and 64 Grade 11 students in Douglas County who took the 2022 Student Health Survey. Source: Oregon Student Heath Survey, 2022

Injury Deaths due to Firearm

Firearm deaths were increasing between 2016 and 2021 in both Douglas County and Oregon. However, the rate increased in Oregon was statistically significant. In Douglas County, the rate increased 42.6 percent from 18.1 deaths per 100,000 (20 deaths) to 25.8 deaths per 100,000 people (31 deaths) in 2021. The Douglas County rates were significantly higher compared to Oregon in 2021 and 2019.

Table 109. Firearm Related Injury Age Adjusted Death Rate per 100,000

	Douglas County		Oregon
	Rate	Number of Deaths	Rate
2016	18.1	20	11.8
2017	14.5	18	12.1
2018	12.8	15	11.7
2019	26.6*	31	12.6
2020	15.6	20	13.1
2021	25.8*	31	14.9
Percent Change 2016 to 2021	+42.6%		+26.6%+

**Rate significantly higher in Douglas County compared to Oregon. + Injury death rate was significantly higher in 2021 compared to 2016. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

Between 2016–2021, the higher firearms deaths in Douglas County was driven by suicide. Firearm deaths due to suicide were significantly higher in Douglas County at 15.7 per 100,000 compared to Oregon at 9.9 per 100,000. Firearm injury death due to homicide was similar in Douglas County at 2.9 deaths per 100,000 compared to Oregon at 2.3 deaths per 100,000.

Table 110. Firearm Related Injury Age Adjusted Death Rate per 100,000 by Cause, 2016–2021

	Douglas County		Oregon
	Rate	Number of Deaths	Rate
Injury by firearms	18.9*	135	12.7
Accidental discharge	0.0	0	0.1
Homicide	2.9	18	2.3
Undetermined	0.4	2	0.1
Suicide	15.7*	115	9.9

**Rate significantly higher in Douglas County compared to Oregon. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

Drug-induced Death Rates

Drug-induced death rates increased in Douglas County between 2016 and 2021, from 16.7 deaths to 38.4 deaths per 100,000 people. Douglas County and Oregon have similar substance use-related death rates in 2021; however, in Oregon, alcohol and drug-induced deaths increased significantly in 2016 to 2021.

Table 111. Douglas County Age Adjusted Death Rate per 100,000 for Substance Use

	Douglas County				Oregon	
	Alcohol-induced deaths		Drug-induced deaths		Alcohol-induced deaths	Drug-induced deaths
	Rate	Number of Deaths	Rate	Number of Deaths	Rate	Rate
2016	31.0	39	16.7	17	16.9	14.9
2017	22.3	38	14.6	15	17.4	15.3
2018	25.1	41	22.1	25	18.1	15.0
2019	31.1	44	24.7	27	18.3	17.1
2020	40.7	57	32.9	33	22.1	22.7
2021	28.5	47	38.4	42	24.5	31.2
Percent Change 2016 to 2021	-7.9%		+129.8%		+44.9%+	+108.8%+

+ Injury death rate was significantly higher in 2021 compared to 2016. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.

Alcohol and drug-induced deaths in Douglas County primarily occurred among Native American/Alaska Native non-Hispanic, White non-Hispanic and Hispanic people. In 2020–2021, 35.6 alcohol-induced deaths occurred in 100,000 White non-Hispanic people in Douglas County, which was significantly higher than in 2016–2017 when it was 27.6 alcohol-induced deaths per 100,000. No noticeable trend in terms of race/ethnicity group is evident regarding drug-induced deaths in Douglas County.

Table 112. Douglas County Age-Adjusted Death Rate per 100,000 for Substance Use by Race and Ethnicity

	Alcohol Induced			Drug Induced		
	2016-2017	2018 - 2019	2020 - 2021	2016-2017	2018 - 2019	2020 - 2021
Total	26.7	28.1	34.6+	15.6	23.4	35.6
American Indian/Alaska Native NH	25.7	16.2	18.0	0.0	55.0	38.8
Asian NH	0.0	0.0	0.0	0.0	0.0	0.0
Black NH	0.0	0.0	0.0	0.0	0.0	0.0
Hispanic	23.5	20.2	26.2	12.0	10.8	9.8
Pacific Islander NH	0.0	0.0	0.0	0.0	0.0	0.0
Two or More Races NH	25.3	0.0	0.0	0.0	0.0	14.3
White NH	27.6	30.1	35.6+	17.1	24.8	39.1

[+]*Significant increasing trend between 2016-2017 and 2020-2021. Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

People who are 45−64 years old appear to have the highest burden of alcohol and drug-induced deaths. Though the increasing trends are minimal, the rates are higher in this age group. In 2020−2021, an estimated 106.5 per 100,000 people ages 45−64 died from alcohol-related causes and 62.9 per 100,000 experienced drug-induced deaths. Data suggest that older adults (65+ years old) are more affected by alcohol-induced deaths, whereas adults ages 25−44 years are more affected by drug-induced deaths.

Table 113. Douglas County Crude Adjusted Death Rate per 100,000 for Substance Use by Age

Age	Alcohol-Induced			Drug-Induced		
	2016-2017	2018 - 2019	2020 - 2021	2016-2017	2018 - 2019	2020 - 2021
14 to 24 Years	0.0	0.0	0.0	0.0	4.6	13.7
25 to 44 Years	10.8	18.7	16.0	25.8	39.4	58.1
45 to 64 Years	83.2	77.1	106.5	23.3	41.1	62.9
65+ Years	40.7	54.0	59.9	11.1	13.9	12.0

Source: Oregon Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.

Morbidity

Morbidity refers to the state of being diseased or unhealthy and often is used to describe the presence of illness or the occurrence of specific health conditions within a population. Morbidity can encompass a range of health issues, including infectious diseases, chronic conditions, injuries, mental health disorders, and more. By assessing the morbidity of specific diseases and conditions, public health officials can make informed decisions about vaccination campaigns, screening programs, treatment guidelines, and health education initiatives to promote overall well-being and reduce the burden of illness within a community or society. This section examines chronic conditions and cancer incidence.

Chronic Conditions

Data from the Centers for Disease Control and Prevention (CDC) suggest that chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. Chronic diseases are defined broadly as conditions that last at least one year and require ongoing medical attention, limit activities of daily living, or both.

The percentage of adults ages 18 and older in Douglas County who have one or more chronic conditions, including arthritis, diabetes, asthma, heart disease/stroke, cancer, depression, and/or chronic obstructive pulmonary disease, was notably higher than the statewide rate in Oregon. From 2018 to 2021, 58.9 percent of adults in Douglas County had at least one chronic condition. The prevalence of these chronic conditions among adults in Douglas County also was higher in the previous periods of 2010−2013 and 2014−2017; however, it is important to note that no significant increase in this rate occurred during these time frames. Females in both Douglas County and Oregon have higher rates of experiencing one or more chronic conditions.

Table 114. Percent of Adults (18+ Years) with One or More Chronic Condition(s)

	Age Adjusted Percentages					
	Douglas County			Oregon		
	Female	Male	Total	Female	Male	Total
2010-2013	66.6*	52.0	59.2**	58.4	46.4	52.4
2014-2017	66.6	55.8	61.2**	58.6	47.3	53.0
2018-2021	63.0*	51.3	58.9**	58.6	45.6	52.1
Percentage Point Change 2010-2013 to 2018-2021	-3.6	-0.7	-0.3	0.1	-0.9	-0.3

*Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. *Significantly different rate between males and female rates. **Significantly different rate in Douglas County compared to Oregon. Source: BRFSS via the Oregon Public Health Assessment Tool*

Adults ages 18 and older in Douglas County, experience a high rate of seven chronic diseases: depression, arthritis, asthma, diabetes, cancer, heart attack, and stroke. Of these chronic conditions, in 2018−2021, depression, arthritis, and asthma were the most common. Nearly three in 10 (29.4%) Douglas County adults self-report having been diagnosed with depression, followed by arthritis (28.0%), and asthma (12.8%). Arthritis rates were significantly higher in Douglas County than in Oregon, where 22.9 percent of adults self-report having been diagnosed with asthma. Females were more likely to experience these three chronic conditions than males. Less than 10 percent of adults self-reported having diabetes, cancer, heart attack, and stroke in both Douglas County and Oregon. There were no significant differences between the occurrence of these diseases in Douglas County and Oregon. It is notable, however, that females were more likely to have been diagnosed with cancer and that males were more likely to have been diagnosed with heart attack in Oregon.

Table 115. Percent of Adults Who Report Having Been Diagnosed with a Chronic Disease

Age Adjusted Percentages, 2018-2021				
Chronic Disease	Douglas County	Oregon	Benchmark: Douglas County Compared to Oregon	Gender Disparity in Douglas County and/or Oregon (Gender with Significantly Higher Rates)
Depression	29.4	24.8	No difference	Females in Douglas County and Oregon
Arthritis	28.0	22.9	Higher	Females in Oregon
Asthma	12.8	11.2	No difference	Females in Oregon
Diabetes	7.6	8.4	No difference	No Difference
Cancer	7.5	8.0	No difference	Females in Oregon
Heart Attack	4.1	3.4	No difference	Males in Oregon
Stroke	3.3	2.7	No difference	No difference

Note: Douglas County data are available only as four-year estimates. Oregon rates are available only as one-year estimates. Therefore, unweighted four-year estimates were created for Oregon to compare Douglas County and Oregon rates more easily. Source: BRFSS via the Oregon Public Health Assessment Tool

Communicable Disease

Communicable diseases, also known as infectious diseases or transmissible diseases, are illnesses caused by microorganisms such as bacteria, viruses, fungi, or parasites that can be transmitted from one person, animal, or source to another. These diseases can spread through various means, including direct or indirect contact, respiratory droplets, contaminated food or water, and vectors like insects. Controlling and preventing the spread of communicable diseases often involves public health measures such as vaccination, sanitation, vector control, safe practices in healthcare settings, and health education. Timely diagnosis, treatment, and quarantine measures can also help mitigate the impact of these diseases.

Food and waterborne diseases were the most common communicable disease in Douglas County, including Campylobacteriosi and Salmonellosis. Between 2013-2015 and 2018-2020, these two diseases significantly increased. In 2018-2020, there were 33.9 cases per 100,000 people of Campylobacteriosis (114 cases), an increase from a rate of 19.1 cases per 100,000 people in 2013-2015. In 2018-2020, there were 21.5 cases per 100,000 people of Salmonellosis (70 cases), an increase from a rate of 9.6 cases per 100,000 people in 2013-2015. The rate of both Campylobacteriosis, Salmonellosis, and Cryptosporidiosis were significantly higher in Douglas County compared to Oregon in 2018-2020.

The most common arthropod disease was Lyme disease at a rate of 3.4 cases per 100,000 people (11 cases) in 2018-2020. The rate of Lyme disease in Douglas County was similar to Oregon in 2018-2020 and has not been significantly increasing between 2013-2015. The most common vaccine preventable disease was Haemophilus influenzae, with 12 cases in 2018-2020, for a rate of 3.0 cases per 100,000 people.

Table 116. Communicable Diseases

		Age-Adjusted Rate per 100,000 Persons				
		Douglas County			Oregon	
Disease	**Type**	**2013-2015**	**2018-2020**	**Number (2018-2020)**	**2013-2015**	**2018-2020**
Campylobacteriosis	Food and Waterborne	19.1	33.9+*	114	22.1	22.1
Salmonellosis (non-typhoidal)	Food and Waterborne	9.6	21.5+*	70	11.1	11.5
Cryptosporidiosis	Food and Waterborne	9.0	10.5*	30	5.1	4.8
E. coli (STEC)	Food and Waterborne	5.8	9.7	33	5.4	7.2 *
Giardiasis	Food and Waterborne	5.9	6.2	21	9.2	5.1*
Carbapenem-resistant enterobacteriaceae		1.3	5.5+*	29	1.9	3.1*
Lyme disease	Arthropod	3.4	3.4	11	1.0	1.4*
Yersiniosis	Food and Waterborne	-	3.3+*	11	0.6	0.9
Haemophilus influenzae	Vaccine Preventable	1.5	3.0	12	1.9	1.6
Pertussis (whooping cough)	Vaccine Preventable	3.3	1.6*	4	14.3	10.1*
Non-tuberculous mycobacterial infection (no respiratory)	Waterborne	1.1	1.4	5	0.7	1.0
Shigellosis	Food and Waterborne	0.4	1.2+	4	1.9	5.1*
Cryptococcus	Airborne	-	1.1+	3	1.5	1.1
Listeriosis	Food and Waterborne	0.2	0.5	2	0.3	0.2
Vibriosis (non-cholera)	Food and Waterborne	0.2	0.5	2	0.7	1.0*
Legionellosis		0.3	0.3	2	0.8	1.1
Malaria	Arthropod	-	-		0.4	0.2
Meningococcal disease	Vaccine Preventable	1.6	-		0.5	0.2
Mumps	Vaccine Preventable	-	-		0.1	0.4*
Tuberculosis	Airborne	1.9	-		1.8	1.7

**Significantly different rate in Douglas County compared to Oregon. +Significantly changing trend between 2015-2017 and 2019-2021. Source: Acute & Communicable Disease Prevention Program, Center for Public Health Practice, Public Health Division, Oregon Health Authority*

Birthing Person Health and Pregnancy

Improving the well-being of birthing people, infants, and children is an important public health goal. It leads to healthier families and communities, reduces healthcare costs, and fosters economic productivity. It determines the health of the next generation and can help predict future public health challenges for families, communities, and the healthcare system. Health outcomes for birthing people, infants and children are related to social, environmental, and physical factors including race and ethnicity, age, and socioeconomic status. Ensuring a pregnant person receives appropriate prenatal care is one opportunity to positively influence their health and the health of the baby and systematically improve long-term outcomes and quality of life.

Approximately 1,027 births occurred in Douglas County in 2021, among which 867, or 84 percent, of births were to White non-Hispanic people.

Table 117. Number of Births per 1,000 Birthing People Ages 15–44 by Race and Ethnicity

	2017	2018	2019	2020	2021
Total	1,070	1,056	1,043	1,043	1,027
American Indian/Alaska Native NH	12	9	15	5	11
Asian NH	10	11	10	11	12
Black NH	3	2	6	3	3
Hispanic	61	61	86	63	89
Pacific Islander NH	2	3	1	-	1
Two or More Races NH	33	33	28	18	35
White NH	947	930	892	942	867

Source: Oregon Birth Certificates, Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.

In this section, data are shared on:

- Fertility rate
- Birth rate, including teen birth rate
- Birth outcomes, including low weight birth, preterm births, and access to prenatal care
- Payment methods for delivery

Fertility Rate

Fertility rate is an important driver of population change. The average number of children that 1,000 people (ages 15–44 years) would birth during their lifetimes was decreasing in both Douglas County and Oregon between 2015–2017 and 2019–2021. In 2019–2021, the rate was 64.6 children per 1,000 people in Douglas County, which was significantly lower than the rate in 2015–2017 at 64.6 children per 1,000 people. The fertility rate was significantly lower among White non-Hispanic Douglas County residents. All other race and ethnicities remained stable. The fertility rate in Douglas County was significantly higher in both 2015–2017 and 2019–2021 than Oregon's, driven by the fertility rate among White non-Hispanic people.

Table 118. Fertility Rate per 1,000 People Ages 15-44 Year by Race and Ethnicity

	Douglas County		Oregon	
Race/Ethnicity	**2015-2017**	**2019-2021**	**2015-2017**	**2019-2021**
Total	64.6*	59.1+	56.2	49.1+
American Indian/Alaska Native NH	40.5	31.7	45.7	39.2+
Asian NH	36.5	32.4	49.1	43.5+
Black NH	53.0	41.0	62.3	57.4+
Hispanic	51.2	53.3	68.6	59.2+
Pacific Islander NH	23.3	21.7	72.8	74.6
Two or More Races NH	51.5	40.3	56.8	47.2+
White NH	67.5	61.7+	53.4	46.3+

**Significantly different rate in Douglas County compared to Oregon. + Significantly changing trend. Source: Oregon Birth Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.*

While older age groups (30+ years) were trending upward in 2015−2017 and 2019−2021, it was not a significant change. Births to people ages 18−19 significantly decreased in Douglas County from 66.0 children per 1,000 people in 2015−2017 to 37.1 children per 1,000 people in 2019−2021.

Table 119. Fertility Rate per 1,000 People Ages 15-44 Year by Age Group

	Douglas County		Oregon	
Age Group	**2015-2017**	**2019-2021**	**2015-2017**	**2019-2021**
15 to 17	7.5	4.3	6.6	3.7+
18 to 19	66.0	37.1+	32.7	20. 4+
20 to 24	116.5	105.3	64.1	53.3+
25 to 29	126.8	113.1	92.2	78.3+
30 to 34	75.6	79.3	91.8	83.5+
35 to 39	32.4	36.3	49.7	48.2+
40 to 44	6.2	7.6	11.2	11.0

+ Significantly changing trend. Source: Oregon Birth Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.

Access to insurance coverage can significantly affect the quality of care and health outcomes for birthing people and babies, as well as contribute to addressing health disparities within communities. Compared with Oregon, publicly insured births (Medicaid/OHP) or self-pay births were significantly higher in Douglas County. In 2019-2021, among the 3,093 births, approximately three in five births (61.5%) in Douglas County were paid for through public insurance births versus two in five births (42.8%) in Oregon.

Table 120. Births by Payer Type

	Medicaid/OHP		Private Insurance		Self-Pay		Other	
	Douglas County	Oregon	Douglas County	Oregon	Douglas County	Oregon	Douglas County	Oregon
2015 - 2017	63.1%*	45.0%	32.7%	51.8%	2.4%*	1.9%	1.8%*	1.3%
2019 - 2021	61.5%*	42.8%	33.7%*	53.7%	2.8%*	2.2%	2.0%*	1.3%
Percentage point change (2016-2017 to 2019-2021)	-1.6%	-2.2%	+0.9%	+1.9%	+0.5%	+0.3%	+0.2%	-0.1%

**Significantly different rate in Douglas County compared to Oregon. Source: Oregon Birth Certificates, Center for Health Statistics, Center for Public Health Practice, Public Health Division, OHA.*

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) provides federal grants to states for supplemental foods, healthcare referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum people, as well as infants and children up to age five who are found to be at nutritional risk. WIC enrollment among births significantly decreased between 2017 and 2021, and WIC enrollment among birthing people was higher than in Oregon. In 2019–2021, the WIC enrollment rate among births was 46.0 percent of births (1,418 births), lower than in 2015–2017 when more than half (56.7%, 1,825) of births were to WIC enrollees. Specifically, WIC enrollment started to drop in 2018.

Table 121. Percent of Live Births with Birthing Person Enrolled in WIC One to Nine Months of Pregnancy

	Douglas County	Oregon
2017	55.4*	35.5
2018	47.2*	33.5
2019	46.6*	31.6
2020	47.0*	29.5
2021	44.4*	27.1
2015–2017	56.7*	37.9
2019–2021	46.0*	29.4
Percentage Point Change between 2015-2017 and 2019-2021	-10.7^{+}	-8.5^{+}

**Douglas County rate was significantly different compared to Oregon. +Significantly decreasing trend between 2015-2017 and 2019-2021. Source: Oregon Birth Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, OHA.*

Teen Birth Rate

In 2015, 81 babies were born to teenaged birthing people (ages 14-20). By 2021, Douglas County had 35 teen birthing people (ages 15–20). Douglas County had a significantly higher teen birth rate compared to Oregon. In 2019-2021, among teens ages 18–19, the teen birth rate was 37.1 births per 1,000 people in Douglas County compared to 20.4 births per 1,000 people. Teen birth rate was significantly decreasing for both Douglas County and Oregon, specifically among young people ages 18–19. In Douglas County, the teen birth rate among teens ages 18–19 decreased from 66.0 births per 1,000 people in 2015 – 2017 to 37.1 births per 1,000 people.

Table 122. Teen (Ages 15-19 Years) Births per 1,000 People

	2015 - 2017		2019 - 2021	
	Douglas County	Oregon	Douglas County	Oregon
15 to 17	7.5	6.6	4.3	3.7+
18 to 19	66.0*	32.7	37.1*+	20.4+

**Douglas County rate was significantly different compared to Oregon. +Significantly decreasing trend between 2015-2017 and 2019-2021. Source: Oregon Birth Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, OHA.*

Prenatal Care

Prenatal care plays a crucial role in birth outcomes for both the birthing person and the baby. Access to and the quality of prenatal care can significantly affect the health and well-being of birthing people and their newborns, but so can other factors, including socioeconomic status, birthing person age, underlying health conditions, and lifestyle choices. Furthermore, prenatal care mitigates risk and enhances the likelihood of positive outcomes. Access to timely and quality prenatal care is recommended to reduce the risk of adverse birth outcomes and improve the health and well-being of both the birthing person and the baby.

Douglas County's prenatal care use rates are comparable to Oregon's. In 2019–2021, 94.8 percent of births had adequate prenatal care in Douglas County, which was similar to Oregon at 94.0 percent. There was no significant change in birth outcomes between 2015–2017 and 2019–2021 in Douglas County.

Starting prenatal care early in pregnancy is essential for optimal birth outcomes. The first trimester is the ideal time to begin prenatal care to monitor the health of the birthing person and the developing fetus. In 2019–2021, 85.1 percent of births started prenatal care in the first trimester, followed by 10.9 percent of births that began care in the second trimester. Less than 3.0 percent of births (2.8%) in 2019–2021 started prenatal care in the third trimester, and 1.2 percent had no prenatal care at all. The only significant change between 2015–2017 and 2019–2021 was the percent of births that started prenatal care in the second trimester, which decreased from 14.3 percent in 2015–2017 to 10.9 percent in 2019–2021.

Table 123. Prenatal Care Utilization

Percent of Births for which Birth Risk Factor Is Present				
	Douglas County		Oregon	
Adequacy of Prenatal Care	**2015 - 2017**	**2019 - 2021**	**2015 - 2017**	**2019 - 2021**
Adequate Prenatal Care (5+ visits and 1st/2nd trimester)	94.9	94.8	94.0	94.0
Inadequate Prenatal Care - <5 visits or 3rd trimester	5.1*	5.2	6.0	6.0
Prenatal Care by Trimester	**2015 - 2017**	**2019 - 2021**	**2015 - 2017**	**2019 - 2021**
No Prenatal Care	1.0	1.2	0.8	1.0+
Prenatal Care Began in 1st Trimester	82.3	85.1	79.5	81.8+
Prenatal Care Began in 2nd Trimester	14.3*	10.9+	15.8	13.7+
Prenatal Care Began in 3rd Trimester	2.3*	2.8	3.9	3.5+

**Douglas County was significantly different than Oregon. +Significantly changing trend. Source: Oregon Birth Certificates, Center for Health Statistics, Center for Public Health Practice, Public Health Division, OHA.*

Among the births with inadequate prenatal care in 2019–2021 (317 births), birthing people ages 40 to 44 represented the highest proportion of births (12.1%, fewer than 10 births), followed by birthing people ages 18 to 19 years (8.3%, fewer than 10 births), and ages 35 to 39 years (6.8%, 23 births). Among these same birthing people who received inadequate prenatal care in 2019–2021, two or more race non-Hispanic births had the highest proportion of births at 12.3 percent (10 births), followed by Native American/Alaska Native non-Hispanic (10.0%, fewer than 10 births), and Hispanic births (5.0%, 12 births).

Table 124. Douglas County Inadequate Prenatal Care by Race/Ethnicity and Age Group

Inadequate Prenatal Care, 2019-2021			
Age Group	**Percent of Births**	**Race and Ethnicity**	**Percent of Births**
10 to 14	0	American Indian/Alaska Native NH	10.0 (<10 births)
15 to 17	0	Asian NH	6.1 (<10 births)
18 to 19	8.3 (<10 births)	Black NH	0.0
20 to 24	5.2	Hispanic	5.0
25 to 29	4.6	Pacific Islander NH	0.0
30 to 34	4.4	Two or More Races NH	12.3
35 to 39	6.8	White NH	4.8
40 to 44	12.1 (<10 births)		
45 to 49	0		

Note: Rates and percentages based on 10 or fewer events are unreliable. Source: Oregon Birth Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, OHA

Birth Outcomes

This assessment examines two birth outcomes: preterm births and low birth weight: preterm birth refers to the delivery of a baby before completing 37 weeks of gestation, rather than the typical 40-week pregnancy. Various factors influence preterm birth, including birthing person age, multiple pregnancies (e.g., twins or triplets), infections, chronic health conditions, smoking, substance use, and inadequate prenatal care.

Low birth weight (LBW) is typically defined as a birth weight of less than 2,500 grams (5.5 pounds), regardless of gestational age. Factors contributing to LBW include preterm birth, poor birthing person nutrition, smoking, substance use, health conditions (e.g., hypertension, diabetes), and inadequate prenatal care.

Preterm birth and LBW infants are at higher risk of various health issues, including respiratory distress syndrome, developmental delays, and long-term health problems. They may require specialized care in a neonatal intensive care unit. In Douglas County, in 2019–2021, 7.8 percent of births (243 births) were preterm, which was significantly lower than the Oregon rate of 8.4 percent of births. Though no significant change in trend was spotted in Douglas County between 2015–2017 and 2019–2021, there was a significant increase in preterm births in Oregon to 8.4 percent of births in 2019–2021 from 8.0 percent of births in 2015–2017. LBW prevalence was also similar between Douglas County and Oregon. In 2019–2021, 7.0 percent (219 births) of births were LBW compared with 6.7 percent LBW births in Oregon. No significant changes occurred in LBW between 2015–2017 and 2019–2021 in either Douglas County or Oregon.

Table 125. Birth Outcomes

	Percent of Live Births by Birth Outcome			
	Douglas County		Oregon	
	2015 - 2017	2019 - 2021	2015 - 2017	2019 - 2021
Preterm Birth (<37 weeks)	8.2	7.8*	8.0	8.4+
Low Birth Weight (< 2500 grams)	7.2	7.0	6.6	6.7

**Douglas County was significantly different than Oregon. +Significantly changing trend. Source: Oregon Birth Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, OHA*

Infant Mortality Rate

Douglas County and Oregon have similar infant mortality rates. Infant mortality rates remained stable between 2014–2016 and 2019–2021 at approximately 4.0 infant deaths per 1,000 births.

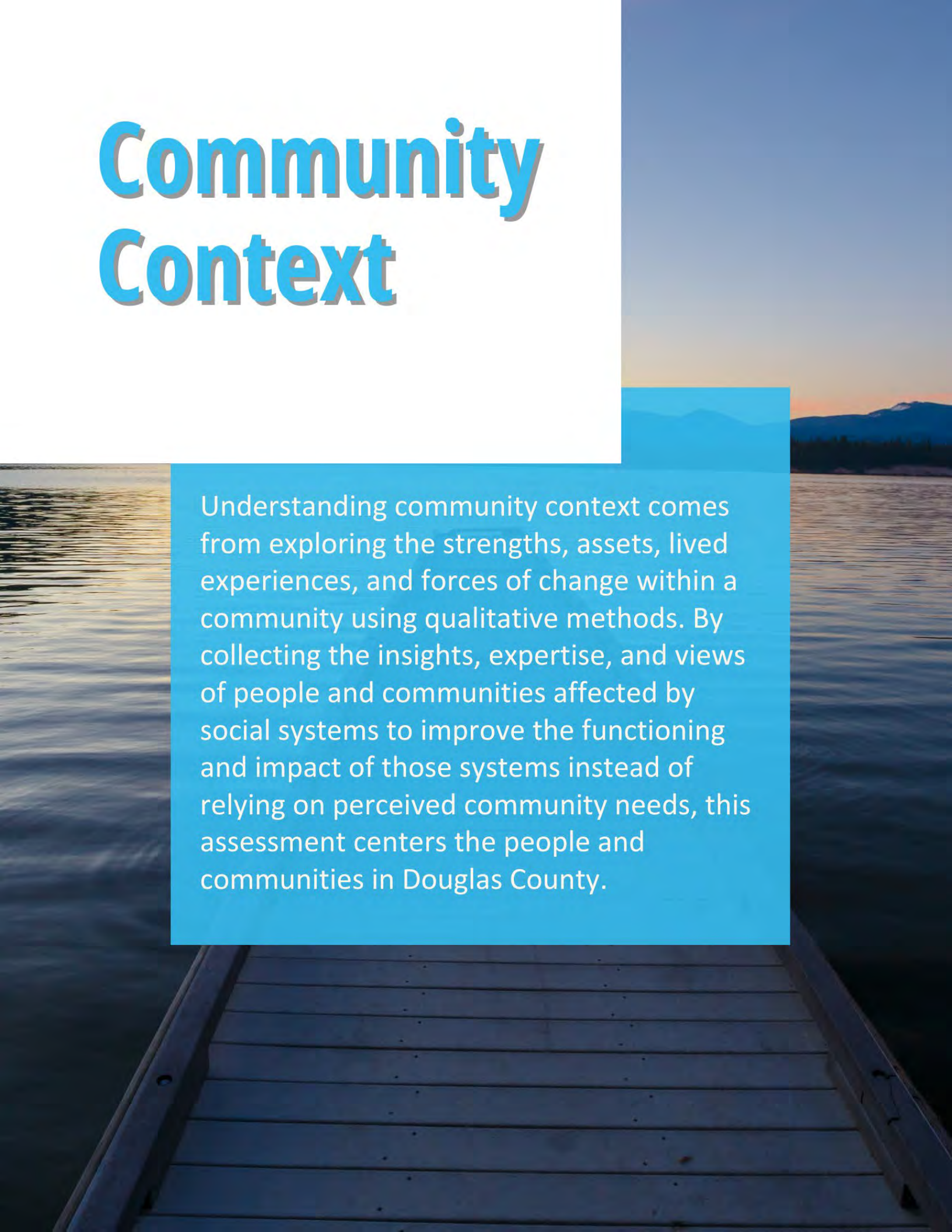
Table 126. Infant Mortality

	Rate per 1,000 Births		
	Douglas County	Oregon	Number of Deaths in Douglas County
2014–2016	4.9	5.0	16
2019–2021	3.5	4.3	11

Source: Oregon Linked Birth & Death Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority. 2) Oregon Birth Certificates: Center for Health Statistics, Center for Public Health Practice, Public Health Division, Oregon Health Authority.

Since 2014, congenital malformations, deformations, and chromosomal abnormalities have accounted for the highest rate of infant mortality, at 2.5 deaths per 1,000 live births in Douglas County. Disorders related to short gestation or LBW and sudden infant death syndrome (SIDS) are the second and third highest causes of infant mortality in the county and state.

Community Context



Understanding community context comes from exploring the strengths, assets, lived experiences, and forces of change within a community using qualitative methods. By collecting the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems instead of relying on perceived community needs, this assessment centers the people and communities in Douglas County.

Community Context

Understanding community context comes from exploring the strengths, assets, lived experiences, and forces of change within a community using qualitative methods. By collecting the insights, expertise, and views of people and communities affected by social systems to improve the functioning and impact of those systems instead of relying on perceived community needs, this assessment centers the people and communities in Douglas County.

Community Strengths and Assets

An important component of the Community Context Assessment is an exploration of community strengths and assets. As evident from the focus group discussion with community members, people in Douglas County have a deep sense of community awareness and compassion, which can be an essential starting point for addressing social issues. For example, a focus group participant shared owning a convenience store has led to personal connections with individuals who are insecurely housed.

Quality of Life

Quality of life matters for community health because it reflects the overall well-being and satisfaction of individuals within a community. A high quality of life encompasses factors such as sound physical and mental health, access to education, employment opportunities, safe living environments, and social connections. When these elements are present and flourishing in a community, it contributes to better health outcomes, lower stress levels, reduced healthcare costs, and a higher sense of contentment among residents. Improving the quality of life within a community is a fundamental goal in promoting and sustaining community health.

Nearly nine in 10 CSTA survey respondents (86%) strongly agreed/agreed that they were satisfied with the quality of life in their neighborhood. This level of agreement was similar across the three regions of the county.

Table 127. Percent of CSTA Respondents who Responded Strongly Agree/Agree

	All Respondents (n=274)	North County (n=63)	Central County (n=146)	South County (n=63)
I am satisfied with the quality of life in my neighborhood.	86%	92%	84%	86%

CSTA Survey, 2023.

Community Resources

Access to community resources correlates with community health because it ensures that individuals have the support and services needed to meet their basic needs and maintain well-being. These resources include healthcare facilities, educational opportunities, social services, and more. When people have easy access to these resources, it can lead to better physical and mental health outcomes, reduced health disparities, and improved overall quality of life within a community. Access to resources plays a crucial role in addressing and preventing health issues, promoting equitable healthcare, and enhancing the overall health and vitality of a community.

Focus Group Participants

Particularly among young adult focus group participants, ages 16 to 24 years, there was a concern about the lack of capacity or understanding of how to effectively help community members experiencing housing insecurity or who are unhoused. This points to a potential gap in knowledge about available resources and the most effective ways to support the homeless population.

In other focus groups participants described a need for better community support for individuals who are housing insecure, emphasizing the need for understanding, assistance, and access to resources to help people get back on their feet. The discussion of constant shortages, including nutrition, housing, clothing, and access to online resources, highlights the day-to-day struggles faced by community members. One participant noted that access to resources is different depending on who you are – for a male over age 26 in Oregon, the only resource is food stamps.

Easy access to healthcare services is vital for preventive care, early intervention, and the management of health conditions. More than half (56%) of CSTA survey respondents reported that they strongly agreed/agreed that they have access to a broad variety of affordable healthcare services. Even more respondents strongly agreed/agreed (78%) that they were satisfied with the healthcare available to them and their families.

North County and South County survey respondents had higher rates of satisfaction compared to all respondents when asked about the availability of affordable healthcare services and satisfaction with their healthcare.

Communities with job opportunities and workforce development programs can reduce unemployment rates and financial stress, which is linked to better mental and physical health. Seven in 10 respondents (70%) strongly agreed/agreed that they and their families enjoyed access to drivers of economic stability, as locally owned and operated businesses, jobs with career growth, access to job training/higher education, affordable housing, and reasonable commutes.

Nearly nine in 10 survey respondents living in North County (86%) strongly agreed/agreed that there was economic opportunity, which was a significantly higher percentage than for all respondents.

Focus Group Participants

Participants discussed the challenges they face in accessing activities and healthcare. These challenges include waitlists for programs like the Boys and Girls Clubs, affordability of services at the YMCA, difficulties with health insurance providers like UHA, and the complexities of pharmacy benefits.

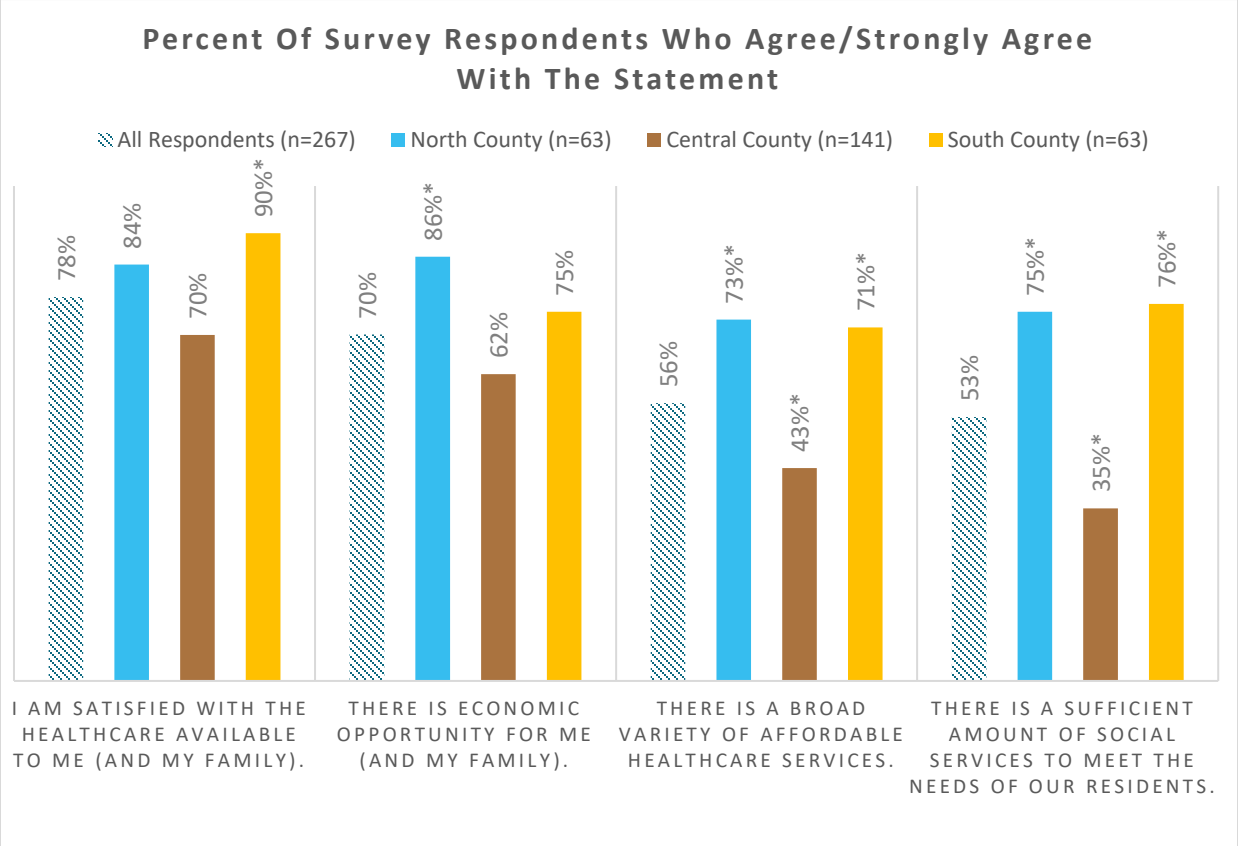
Participants identified the lack of knowledge about available resources as a major challenge. They emphasized the need for a centralized hub or location where people can access information about the various resources available to them. Many individuals, especially those dealing with addiction, may not know what specific resources they need, making it difficult to begin searching for help.

They noted the value of having a one-stop place for comprehensive resource information.

Access to social services, such as housing assistance, mental health support, and substance abuse treatment, helps address underlying SDOH and reduce disparities in health outcomes. More than half (53%) of all survey respondents strongly agreed/agreed that their communities offered sufficient social services to meet the needs of residents.

Survey respondents living in South County and North County were more likely to report that there were a board variety of affordable healthcare services and social services to meet the needs of their residents compared with residents of Central County.

Figure 11. Community Resources



**Percent of respondents who strongly agreed/agreed with the statement was significantly different from the percent of all respondents. Source: CSTA Survey, 2023.*

Focus group participants highlighted a range of community resources that have played vital roles in their lives. These resources encompass mental health support, housing, veteran-specific services, peer supports at school, food assistance, the faith community, access to information through libraries and social media, energy assistance, healthcare support, and community programs like the Chadwick Clubhouse.

Participants note that these resources have aided and supported them during challenging times. Specific resources noted included Peace at Home, Samaritan House, Oxford House, Coos Crisis, Rodeway Inn Housing, Orchard Knolls, school clubs, food pantries, houses of worship, public libraries, 211, United Community Action Network, Chadwick Clubhouse, and Dream Center.

Focus Group Participants

Issues related to racism and discrimination are discussed, including bias in the workplace, microaggressions, and the pressure on people of color to tolerate discriminatory behavior. There is a desire for more people of color in positions of power to promote diversity, equity, and inclusion (DEI).

Racism, Discrimination, and Health Equity

National research documents the impact of racism and discrimination on a person's health. However, we know less about the effects of racism or discrimination on the health of the people of Douglas County.

Historical undervaluing and minimizing the lived experiences of people contribute to ongoing health disparities. To begin to understand this impact, the CSTA survey asks questions about community member day-to-day experiences of racism and discrimination. The survey posed questions about how respondents and others like them are treated and how they typically react. The CTSA survey included questions created by Dr. David R. Williams, the Florence Sprague Norman and Laura Smart Norman Professor of Public Health, and chair of the Department of Social and Behavioral Sciences at the Harvard T.H. Chan School of Public Health.

We must acknowledge that collecting these data is not an end, but instead an important tool to develop the plan for achieving health equity. Without metrics we cannot determine whether the interventions that Umpqua Health Alliance or its partners have deployed are meaningfully reducing health disparities.

Survey respondents were more likely to say they sometimes/often felt that some racial/ethnic groups, such as African Americans, Latinos, and Asians, are discriminated against (59%) than report that they themselves had personally experienced discrimination because of their race, ethnicity, or skin color (26%); however, approximately seven in 10 survey respondents (69%) who identified as a person of color reported that they sometimes or often felt they had been personally discriminated against because of their race/ethnicity or skin color—higher than among survey respondents who did not identify as a person of color (15.0%).

Table 128. Discrimination

	Never / Rarely	Sometimes/Often
How often do you feel that racial/ethnic groups who are not white, such as African Americans, Latinos and Asians, are discriminated against? (n=219)	42%	59%
Among people of color (n=42)	48%	52%
Among non-people of color (n=168)	39%	61%
How often do you feel that you, personally, have been discriminated against because of your race, ethnicity, or skin color (n=208)	74%	26%
Among people of color (n=39)	31%	69%
Among non-people of color (n=160)	85%	15%

Source: CSTA Survey, 2023

CSTA respondents were asked if they ever experienced discrimination, been prevented from doing something, or been hassled or made to feel like they were not good enough in a selection of different situations. The most common situation where CSTA respondents said they experienced racism and/or discrimination was on the street or in a public setting (45%), followed by at work (36%) and getting services in stores or restaurants (36%).

Table 129. Percent of Respondents Who Have Experienced Racism and/or Discrimination, by Setting

	Percent of Respondents who Reported One or More times
On the street or in a public setting? (n=205)	45%
At work (n=206)	36%
Getting service in a store or restaurant? (n=206)	36%
Getting hired or getting a job (n=205)	35%
At school (n=208)	34%
Getting medical care (n=206)	33%
Getting housing (n=206)	31%
From the police, other law enforcement, or in the courts? (n=202)	30%
Getting credit, bank loans, or a mortgage? (n=206)	29%

The predominant reasons why CSTA respondents said they believed they had experienced discrimination in these situations were race (47%), followed by gender (36%), and ancestry or national origin (31%).

More than half (58%) of people who have been treated unfairly accept it as a fact of life, with the remainder of the CSTA survey respondents (42%) reporting that they "tried to do something about it." Moreover, among the people who reported unfair treatment, more than two in three CSTA survey respondents said they talked to other people about it and one in three reported they kept it to themselves. This reaction shifts when taking into consideration the perspective of CSTA respondents who identified as a person of color. CSTA respondents who identified as a person of color were significantly more likely to keep it to themselves (43%) compared with CTSA respondents who did not identify as a person of color (27%). CSTA respondents who identified as people of color also were more inclined to accept discriminatory behavior as an unpleasant reality (62%) than respondents who did not identify as a person of color.

Focus Group Participants

Participants pointed out that healthcare providers sometimes treat individuals differently based on their appearance or identity.

Those who "look normal" may receive care more easily compared to those who openly identify as LGBTQIA2S+.

Health Literacy

People and companies that provide healthcare services or insurance must make information easy to find and understand so people can make decisions for themselves and their loved ones.

The CSTA survey posed a set of questions designed to reveal community members' experiences locating, understanding, and using information from the Douglas County healthcare system and their communities. These questions were intended to help determine whether community members get the information they need to make well-informed healthcare decisions.

Understanding Health Plan Benefits

Understanding health plan benefits and their relationship to health outcomes is crucial for making informed healthcare decisions. Health plan benefits refer to the services, treatments, and coverage that an insurer provides. These benefits can vary widely depending on the type of plan and the insurer. Approximately one in five CSTA respondents report that information received from their health plan was always easy to understand. The most common responses were usually (38%) or sometimes (35%).

CSTA respondents most often went to the insurer's website (39%), followed by calling (30%) and emailing (25%) customer care to look for information about their health plan's coverage and benefits. One in 10 CSTA respondents did not look for any information about their health plan/s coverage and benefits in the previous year. Low-income respondents (less than $49,999 household income) were more likely to look for information about their health plan's coverage and benefits at community events (24%) or the member handbook (27%) compared with CSTA respondents with higher household incomes ($50,000 or more).

After visiting these sources of information, 86 percent reported they found the information they needed about their health plan benefits. Of those who found the information they needed, 71 percent reported it was easy to understand. Information shared about ***how*** the health plan works was confusing for nearly half of the CSTA respondents (48%).

Health Education

Some health plans offer resources and programs to promote healthy lifestyles and educate individuals about managing their health. Participation in these programs can contribute to better health outcomes.

In the last 12 months, one in four (24%) CSTA respondents reported that they looked for information about how to get or stay healthy. Nearly half (47%) of CSTA respondents went to their healthcare provider. Their health plan or the Internet was a common resource for 20 percent of CSTA respondents.

Understanding Health Information from Your Healthcare Provider

In the past six months, 70 percent of CSTA respondents spoke with a healthcare provider about any health questions or concerns. Approximately one in five (21%) CSTA respondents reported that the health provider gave easy-to-understand responses to those health questions and concerns. The most common response to this question, from nearly half of the CSTA respondents (49%), was that usually the healthcare provider gave an easy-to-understand answers to those health questions and concerns.

Understanding Your Experience with Healthcare Providers

CSTA survey questions asked respondents to describe to what extent their healthcare provider(s):

- Asks about their health and any concerns they have
- Listens to what they have to say
- Explains information about their health condition in a way that they can understand
- Explains why there is a need for certain medications, tests, or other appointments

On average, 39 percent of CSTA participants reported they always have a positive experience with their primary doctor or nurse, where the provider nurse explains things in a way that is easy to understand, listens carefully to them, shows respect for what they had to say and spends enough time with them. Respondents were also given the option to report never, sometimes, usually, or not applicable. There is some variation in report experience by priority population.

- Low-income (less than $49,999 household income) CSTA respondents were less likely to report that they always have had a positive experience with their primary doctor or nurse when compared with CSTA respondents in households with an income of $75,000 or more.
- CSTA respondents who identify as people of color were less likely to report that their primary doctor or nurse explains things in a way that was easy to understand and spends enough time with them when compared with CSTA respondents who did not identify as a person of color.
- Older adults were more likely to report they always have a positive experience with their primary doctor or nurse when compared with young adult (18-34 years) CSTA respondents.
- CSTA respondents who identified as LGBTQIA2S+ were less likely to report that they "always" have positive experiences with their primary doctor or nurse when compared to CSTA respondents who did not identify as members of the LGBTQIA2S+ community.

Table 130. Percent of CSTA Respondents who Responded "Always"

In the last 12 months, how often did your primary doctor or nurse	All CSTA Respondents	Low Income (<$ 49,999) (n=95)	Identify as a Person of Color (n=67)	Older Adult (n=63)	Identify as LGBTQIA2S+ (n=54)
…explain things in a way that was easy to understand?	36%	18%*	23%*	43%*	16%*
…listen carefully to you?	37%	25%*	30%	38%*	19%*
…show respect for what you had to say?	43%	34%*	40%	52%*	16%*
…spend enough time with you?	39%	25%*	23%*	45%*	16%*
AVERAGE	**39%**	**26%**	**29%**	**39%**	**17%**

**Significantly higher compared to the priority population's counterpart. Source: CSTA Survey, 2023.*

Community Partner Assessment

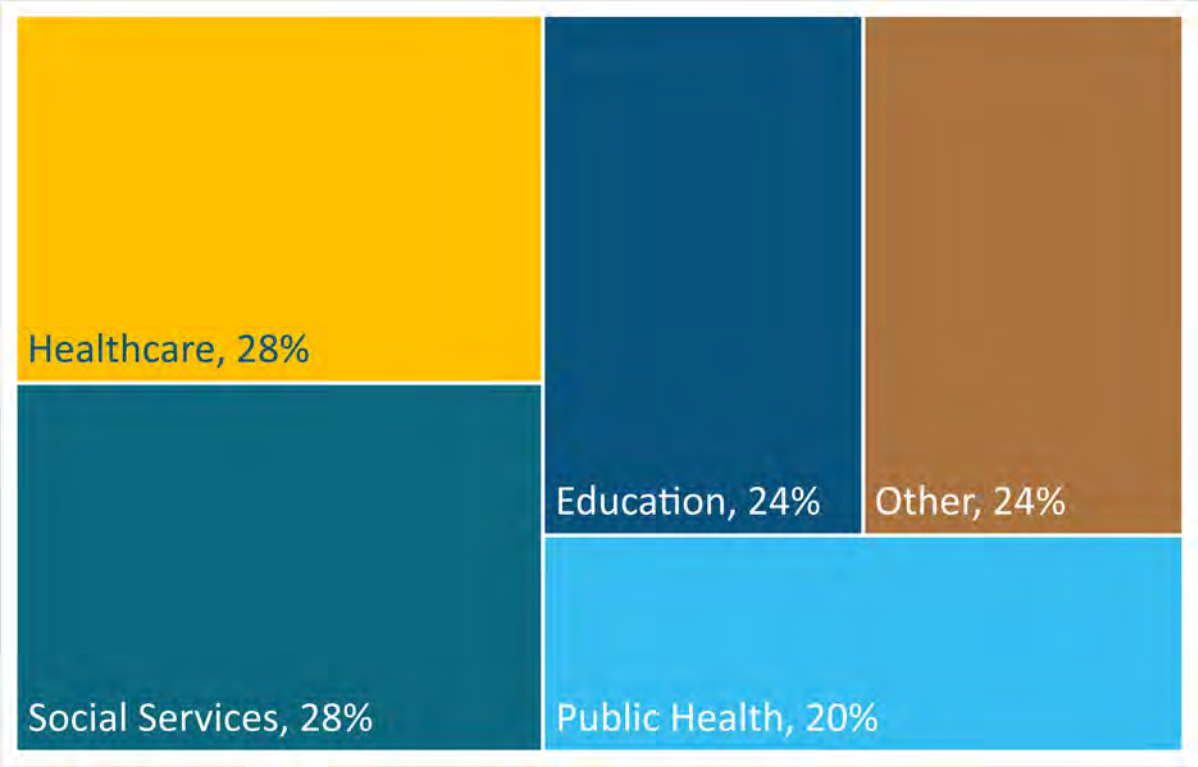
Steering Committee members participated in a Community Partner Assessment (CPA). The CPA is part of the MAPP 2.0 where all organizations involved in the MAPP process participate in a survey to identify whom they serve, what they do, and their capacities and skills to support their local community health improvement process. A total of 27 individuals representing 13 unique organizations and community members from the Steering Committee responded to the CPA survey in April 2023. Organizations included in the CPA were:

1. Adapt (3)
2. Aviva
3. Cow Creek Band of the Umpqua Tribe of Indians
4. Douglas County Commissioner
5. Douglas Education Service District (2)
6. Douglas Public Health Network (2)
7. Mercy Hospital (Mercy Foundation)
8. Peace at Home
9. Regional Health Equity Coalition
10. South Oregon Early Learning Hub
11. Thrive Umpqua (2)
12. UCAN Head Start
13. Umpqua Valley Rainbow Collective

Sector Representation

Among the Steering Committee member organizations, the most common represented sectors are healthcare and social services, followed by education and public health. Other included a coalition representation and political leader. Incorporating these sectors and stakeholders into community health planning ensures a well-rounded and informed approach that considers the complex interplay of factors influencing health. It also helps in the development of strategies that are not only effective, but also sustainable, equitable, and sensitive to the unique needs of the community.

Figure 12. Sector Representation Among CHA Steering Committee Member Organizations



Source: Steering Committee Partner Assessment Survey, April 2023.

Personal and Organizational Capacity

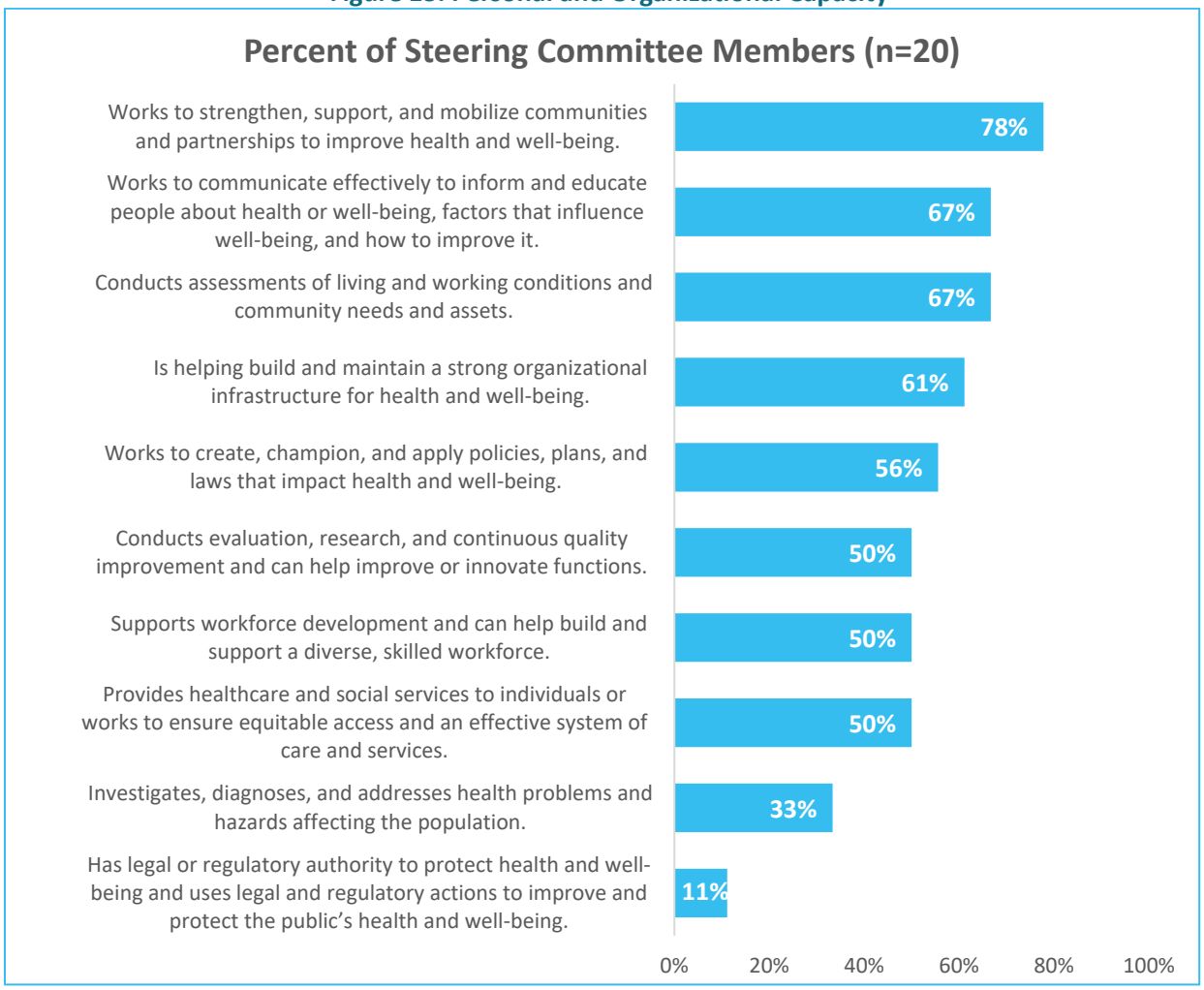
Organizations working to improve the well-being of individuals, families, and communities through improving housing, education, childcare, workforce development, or other conditions have an impact on the public's health. The collective capacity of the Steering Community to improve health in Douglas County begins with the activities that each organization or individual performs regularly. Members were asked to select all the activities that they conduct. The most common response was community engagement and partnership working to strengthen, support, and mobilize communities and partnerships to improve health and well-being (78%).

Related activities suggests that the work is through communication and education (67%) and assessment (67%). Members commonly work to communicate effectively to inform and educate people about health or well-being, factors that influence well-being and how to improve them. Members also conduct assessments of living and working conditions and community needs and assets. These efforts collectively contribute to community health improvement planning by creating a foundation of community engagement, data-driven decision-making, effective communication, and collaboration. This approach allows for a comprehensive and community-driven strategy to improve health and well-being, addressing not only medical care, but also the broader SDOH.

Approximately half of the members report activities that are important to a health improvement planning process, from policy and legal frameworks to service delivery, workforce development, research and evaluation, and overall organizational support. Collaboration among these organizations often is necessary to create comprehensive and successful community health plans.

Only 11 percent of members reported conducting legal and regulatory authority activities. When there is little capacity for legal and regulatory authority to protect health and well-being there may be limited ability to create and/or enforce laws and regulations that directly affect health and well-being.

Figure 13. Personal and Organizational Capacity



Source: Steering Committee Partner Assessment Survey, April 2023.

MAPP 2.0 Foundation Principles

MAPP 2.0 proposes nine foundational principles that articulate the guiding principles for the MAPP redesign and a vision for health improvement as a community-led process to improve population health. Members were asked to reflect on the previous CHA and CHP and the extent to which it aligns with the MAPP's foundational principles. Members were asked to rank each concept from most important (#1) to least important (#9) based on its relevance to the community they serve. Across the 20 members who ranked the standards, equity was ranked number one, followed by trusted relationships and inclusion. When a community places these values at the forefront of its health planning process, it demonstrates a commitment to a more equitable, participatory, and community-driven approach. It recognizes that true community health planning is not just about developing strategies, but also about building a foundation of fairness, trust, and representation, ensuring that the resulting plans and interventions genuinely serve the best interests of the entire community. This approach acknowledges the interconnectedness of community members, the importance of addressing SDOH and the value of unity in promoting well-being.

Table 131. Ranking of MAPP 2.0 Foundation Principles by CHA Steering Committee Members

Principles	MAPP 2.0 Definition	Rank
Equity	Encourage shared exploration of the social injustices, including structural racism, class oppression, and gender oppression, which create and perpetuate inequities. Mobilizes community action to address these injustices through transformative change to the structures and systems that perpetuate inequities and creates the opportunity for all to achieve optimal health.	1
Trusted Relationships	Build connection and trust by honoring the knowledge, expertise, and voice of community members and stakeholders.	2
Inclusion	Foster belonging and prevents othering by identifying and eliminating barriers to community participation and ensuring all stakeholders and community members, regardless of background or experience, can contribute to the MAPP process.	3
Community Power	Actively build community power to ensure those most impacted by the inequities and actions addressed through community health improvement are those that guide the process, make key decisions, and help drive action.	4
Data and Community Informed Action	Identify priorities, strategies, and action plans that are driven by the community's voice and grounded in community need as identified through timely qualitative and quantitative data.	5
Strategic Collaboration and Alignment	Create a community-wide strategy that appropriately aligns the missions, goals, resources, and reach of cross-sectoral partners to improve community health and address inequities.	6
Full Spectrum Actions	Encourage community improvement through approaches ranging from provision of direct services to policy, systems, and environmental change and community power building for supportive communities that enable health and well-being for all.	7
Flexible	Meet the real-time, evolving, and unique needs of diverse communities, organizations, and sectors through an adaptable framework.	8
Continuous	Maintain continuous learning and improvement through iterative community assessment, planning, action, and evaluation cycles.	9

Source: Steering Committee Partner Assessment Survey, April 2023.

Positive Forces and Potential Barriers

The Steering Committee members were tasked with identifying both positive forces and potential barriers that could influence the success of the CHA and CHP. They were given a list of factors and asked to indicate the extent to which they observed these factors during the previous CHA and CHP processes or experienced them as community members. The provided scale ranged from "very much a positive force to "very much a barrier."

One notable positive aspect of the CHA and CHP process is the presence of committed individuals. Mosty (85%) of the Steering Group members acknowledged that commitment to the work was a positive force. This commitment signifies a strong dedication to the objectives of community health improvement, resulting in a heightened drive to effect positive changes.

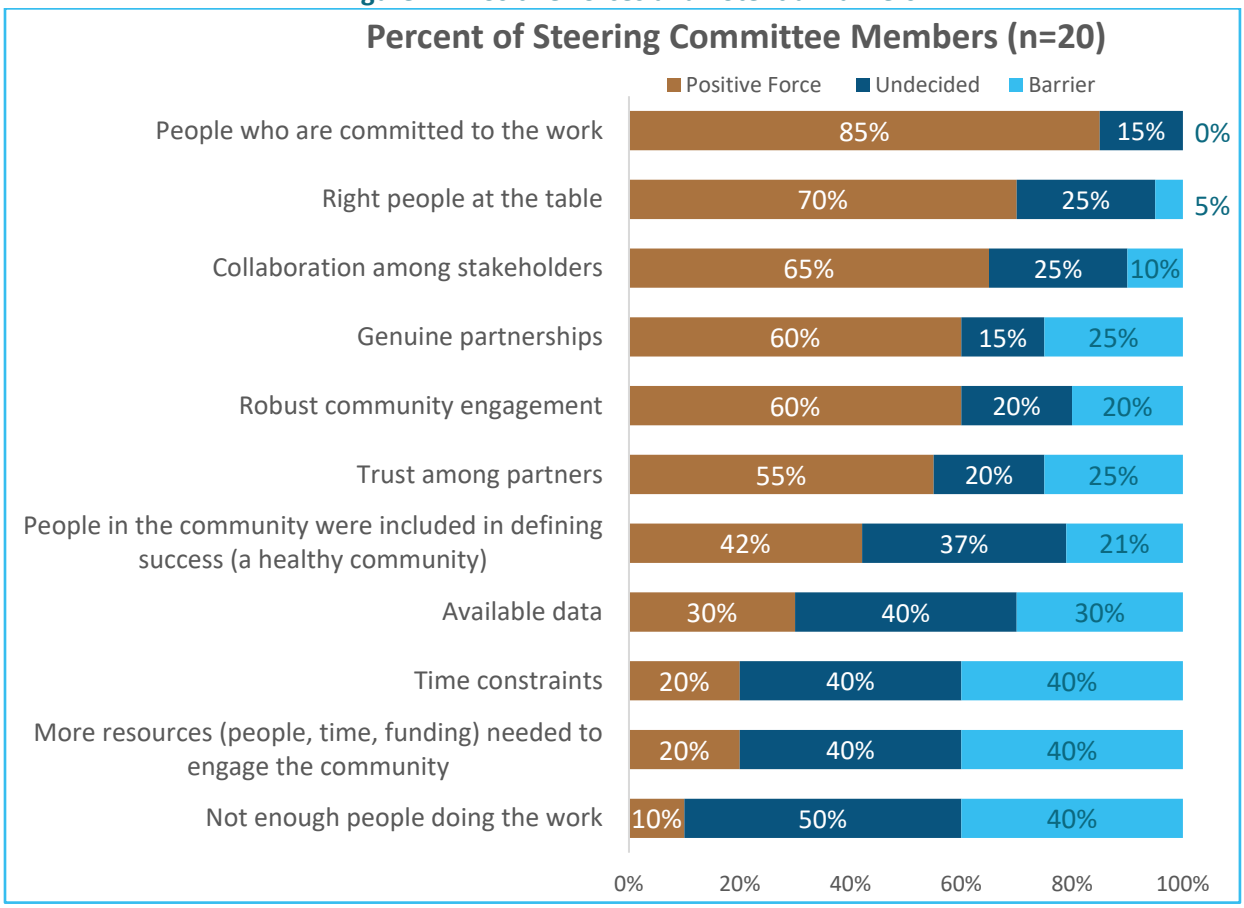
Other positive forces identified included engaging the right people (70%), fostering collaboration among stakeholders (65%), establishing genuine partnerships (60%), and promoting robust community engagement (60%). Having the right mix of individuals at the planning table adds diverse expertise, including healthcare professionals, community leaders, public health experts, and other stakeholders,

leading to more well-informed and comprehensive strategies. Collaboration often leads to the pooling of resources, financial and non-financial, enhancing access to funding and other resources necessary to implement health improvement initiatives. This indicates an excellent opportunity in Douglas County to develop and sustain effective, community-driven initiatives that enhance the health and well-being of its residents.

However, there are potential barriers to these efforts, with almost half (40%) of the steering group members recognizing a lack of resources as a potential obstacle. This scarcity of resources can impede the planning process, causing delays in addressing community health issues. It also may necessitate a narrower focus on specific health issues, potentially resulting in a less comprehensive approach. Furthermore, limited personnel can lead to overburdened partners, contribute to burnout and reduced productivity, and ultimately affect the quality and effectiveness of the planning process. Without enough people to engage in the planning process, community involvement and input may suffer, which can lead to a lack of representation of the community's diverse needs and viewpoints.

To overcome these challenges, Douglas County partners may need to explore various strategies, such as seeking external funding, forming partnerships, prioritizing critical health issues, and finding innovative ways to involve the community in the planning process, even with limited resources. It is vital for stakeholders to recognize the significance of resource allocation in improving community health and collaborate to secure the necessary support for the planning process.

Figure 14. Positive Forces and Potential Barriers



Source: Steering Committee Partner Assessment Survey, April 2023.

Forces of Change

One of the three MAPP assessments in the CHA process measures forces of change. The Forces of Change Assessment focuses on answering these questions: "What is occurring or what might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" These are forces that are or will be influencing the health and quality of life of the community, as well as the community's efforts to improve health outcomes.

These forces included:

- Trends: Consistent patterns and changes that occur over time, like shifts in population resulting from people moving in and out of a community or a growing sense of dissatisfaction with government actions.
- Factors: Distinct components or characteristics that influence a situation, such as being in an urban setting, or being close to a major waterway.
- Events: Singular incidents or happenings that are not ongoing, such as the closure of a hospital, a natural disaster, or the enactment of new legislation.

These forces can be related to social, economic, environmental, technological, or political factors in the county, the state, or the nation that have an impact on the local community. Information collected in this assessment was considered when identifying priority health issues.

Focus group participants were asked to describe the health issues they think their community can change for the better, and the challenges and opportunities for improving some of these health concerns. Their answers to these questions provide the basis for the forces of change assessment, which can and should be refined and grow as an important part of the CHP process.

Trends

- Ongoing racism and the expressed need for people of color to combat stereotypes by appearing a certain way to counter biases.
- The normalization of racism in schools and its potential to influence youth was highlighted as a worrisome issue.
- Concerns about housing affordability and inflation, particularly if wages lag behind cost of housing.
- Overcrowding and financial constraints may lead to decisions to abstain from having children.
- Concerns about the mental health and well-being of high school students, especially in light of the high levels of depression seen in the data.
- Perceived decline in traditional family values, reduced time spent on communal family meals, and the rise in fast-food consumption are seen as possible contributors to broader societal challenges.
- Concerns about the rapid maturation of children because of technology and smartphone access underscore concerns about the impact of technology on childhood and adolescence.
- Declines in logging on public lands has forced Douglas County to cut back on services because of losses in revenue. Douglas County has largely privatized its health care system and scaled back its land department. It cut its number of public employees by 60 percent to about 500. Community resources once free, such as landfills and parks, started charging fees.
- Service providers, such as Adapt Integrated Health Care and the Department of Motor Vehicles reportedly used to work out of the library but no longer do suggests that the availability and

accessibility of services have changed over time. Service providers should consider the evolving needs of the community and maintain convenient service locations.

- Some participants noted their surprise at the prevalence of accidents, particularly car accidents, leading to fatalities. They observed an alarming increase in incidents, including those involving pedestrians, even involving school-age children and youth.

Factors

- Housing conditions, including the lack of bike-friendly infrastructure, are seen as community challenges.
- Douglas County encompasses a vast area of 5,134 square miles, ranking it as the fifth-largest county in Oregon. Its large, rural nature poses challenges related to limited resources and accessibility to services across the county. Several significant challenges were identified:
- Language and transportation barriers, especially for migrant workers residing in rural areas with limited resources, which can lead to missed appointments.
- Concerns were raised about the dearth of options and resources for young individuals, especially teenagers, within the community. Participants observed that other areas like Eugene offer more opportunities and resources for youth, while the lack of community involvement and accessible activities can lead to boredom and potential issues for teenagers.
- Many residents derive comfort and revitalization from spending time in natural settings, including water bodies and mountains. The greenery and parks in Roseburg are particularly cherished for their soothing effects.
- Lack of diversity, where instances of racism in daily life, including racist comments and xenophobia, have come to the forefront. Participants emphasized the significance of addressing latent or implicit racism and stressed the need for a more diverse population. Concerns were voiced about the limited exposure to people of color within the community, leading to an emphasis on the importance of self-awareness and actively challenging racial biases.
- Some participants have suggested that the current system may create incentives for people to remain on welfare rather than actively seek employment. They believe that accessing specific benefits is easier than finding employment opportunities. They recommend restructuring the system in a way that empowers individuals to pursue employment and enhance their lives without the fear of losing essential benefits.

Events

- Participants commented on societal changes over the past 20 years, including an increase in school shootings.
- Some barriers to well-being were identified, including the closure of parks because of safety concerns, the influence of drug use in public spaces, and smoky air conditions.
- A library tax (Measure 10-145), defeated in November 2016, forced the closure of public libraries, which started to reopen in December 2019

Conclusion and Next Steps for the CHP

The purpose of the 2023 CHA process was to develop and document key information regarding the health and well-being of Douglas County residents. Though progress is being made and important community assets exist, the data show that Douglas County struggles to prevent and treat behavioral health challenges, including both mental health and substance use disorder, and to ensure adequate access to culturally and linguistically effective healthcare and preventive services that address risky

health behaviors and chronic disease. In Douglas County, these issues are negatively exacerbated by economic insecurity, access to quality education, and insecure housing.

The CHA is intended to drive discussions and data-driven decision making at the community level, and future alignment of strategies and resources to achieve wellness in Douglas County.

It is anticipated that organizations, residents, sectors, networks, and Umpqua Health Alliance partnerships will become galvanized and thus commit to acting to collectively address the priority health-related issues. Umpqua Health Alliance and its partners will use the CHA to develop a community health improvement plan.

This data report is one of many steps taken to move the needle toward positive health outcomes for Douglas County residents. Recommended next steps include:

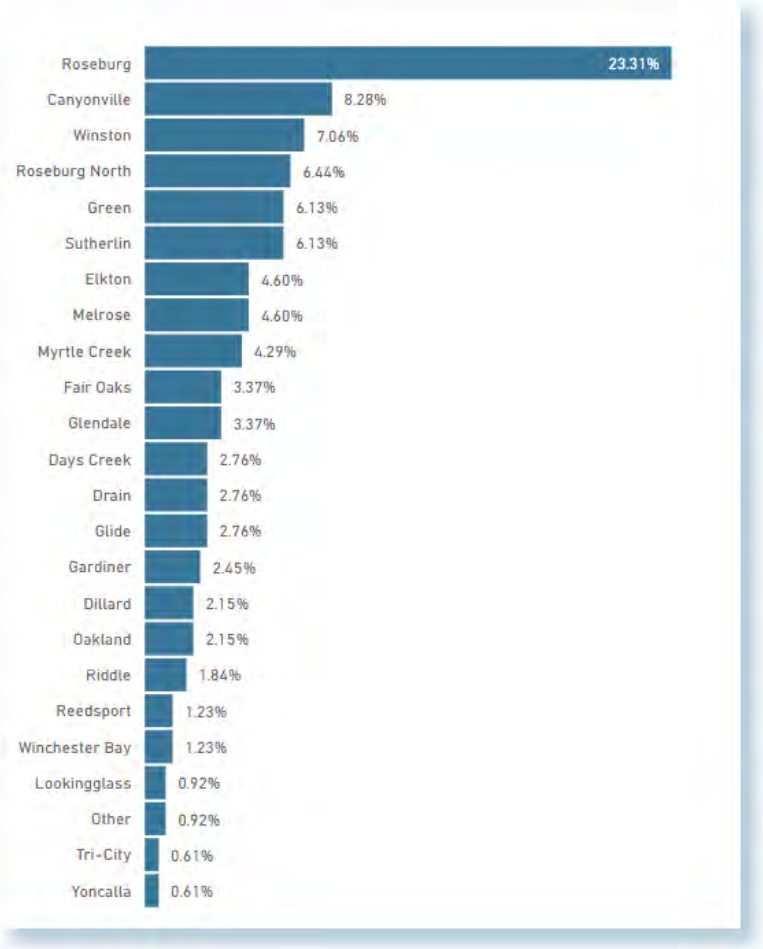
- Advancing population health solutions that are centered on equity.
- Encouraging continued community conversations to collectively develop Community Health Improvement Plans.

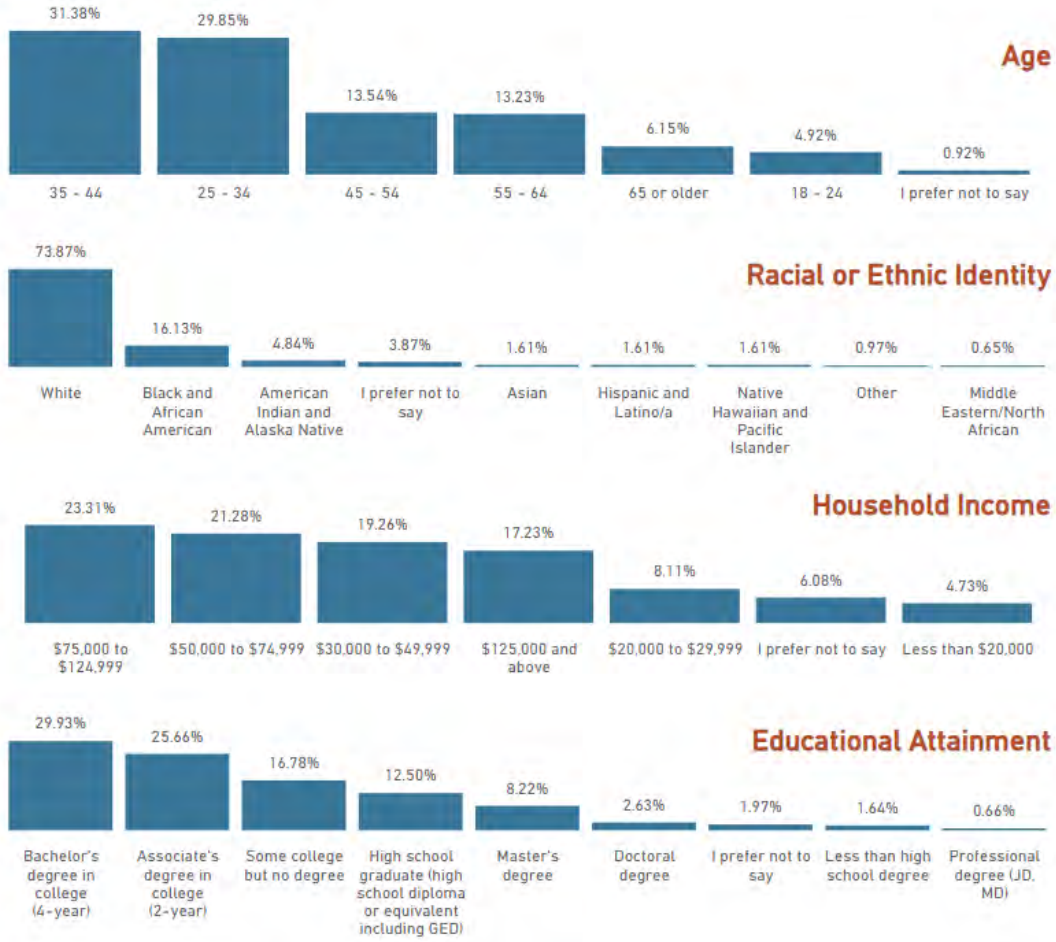
The CHA report is available as a resource to community partners interested in improving the health of the community. It is anticipated that, in this way, the CHA serves as a useful resource for further communitywide health improvement efforts.

Appendix A: CSTA Survey

To review the CSTA survey, click here.

Appendix B: CSTA Survey Respondent Demographics and Priorities





Where do you get your health insurance? (n=301))

Insurance Type	Percent
Employer (yours or your partner/spouse)	65.8%
Medicare	19.3%
Oregon Health Plan	17.9%
Health Insurance bought directly by you	7.6%
Health Insurance Marketplace	3.9%
Veterans' Administration	3.3%
Indian Health Services	1.9%
I do not have health insurance	1.7%
I prefer not to say	1.0%

What is your employment status? Please select the most appropriate response(s). If, for example, you are retired and work part-time, then choose both. If you work more than one job, select "Working multiple jobs."

Employment Status	Percent
I am a student	3.7%
Working full time	77.4%
Working part time	8.3%
Working multiple jobs	6.0%
Retired	6.6%
Unable to work due to a disability	3.0%
Unable to work due to being a caregiver full-time (parent, child, etc.)	1.0%
Unemployed	2.0%

Please review the factors and behaviors that contribute to a person's health. What three (3) things are most needed in your community to improve your health. (n=295)

Survey Response	Percent	Numerator
Access to mental health services (e.g., counselors, psychiatrists)	36%	102
Affordable housing	34%	95
Access to healthcare providers (e.g., family doctors, pediatricians)	33%	90
Low crime and safe neighborhoods	32%	89
Good jobs and a healthy economy	25%	69
Access to treatment services for substance use or misuse	19%	54
Fair and equitable treatment of people and groups no matter their race, gender identity, age, or sexual orientation	14%	37
Clean water and environment	11%	29
Healthy food and grocery stores nearby	11%	31
Parks and recreation	11%	29
Access to dental care	10%	27
Safe, stable, and nurturing relationships within the family and community	8%	21
Reliable transportation	7%	19
Services for children and youth with special healthcare needs	6%	15
Arts and cultural events	6%	16
Low rates of death and disease	6%	18
Business friendly environment	5%	16
Low rates of infant deaths	5%	14
Services for people experiencing violence within the home, including child abuse and intimate partner violence	5%	14
Social support and connections	5%	13
Religious or spiritual supports	4%	12

Please review the factors and behaviors that make a community unhealthy. What three (3) things do you think are the most damaging to the health of your community. (n=294)

Survey Response	Percent	Numerator
Mental health problems	45%	122
Drugs or alcohol	33%	90
Homelessness	31%	80
Community violence (i.e., assault, gang activity, homicide)	17%	49
No specialty medical care (genetics, pediatric neurology, psychiatry, developmental-behavioral, gynecology etc.)	14%	41
Environmental problems (i.e. air and water pollution, excessive heat, severe storms, etc.)	13%	37
Bullying and cyberbullying	12%	32
Diabetes	12%	32
Under-employment and low-paying jobs	11%	30
Overuse or inappropriate use of technology (i.e. too much screen time, social media)	10%	24
Firearm-related injuries	9%	26
Car accidents related to driver behaviors (texting/aggressive, distracted, or impaired driving)	9%	25
Cancer (all types)	9%	22
Problems related to aging (i.e.. hearing/vision loss, limited mobility, memory & cognitive issues, etc.)	9%	23
No affordable dental care	8%	22
Lack of healthy food and grocery stores	7%	22
Sexually Transmitted Diseases & Infections (i.e. gonorrhea, chlamydia, etc.)	6%	16
Social isolation and loneliness	5%	13
Rape and sexual assault	5%	13
Sex trafficking and human trafficking	4%	13
Intimate partner violence and domestic violence	4%	11
Heart disease and high blood pressure	4%	11
HIV and AIDS	4%	11
Infectious Diseases (Hepatitis, TB, Measles, etc.)	3%	9
Immigration	2%	6
Infant death, child abuse and neglect	2%	7
Risk of future pandemics	2%	7
Suicide	2%	5
Vaccine-preventable diseases (i.e., polio, measles, COVID)	2%	6
Unintentional injuries (i.e., motor vehicle accidents, drowning)	2%	4
Teenage pregnancy	1%	4

Please review the factors and behaviors that make people unhealthy. What three (3) things do you think are the most damaging to the health of people in your community. (n=292)

Survey Response	Percent	Numerator
Methamphetamine or other stimulants misuse or abuse	33%	89
Poor eating habits (i.e. regularly eating fast food, not eating fresh fruit or vegetables etc.)	32%	89
Opioid misuse or abuse (including Fentanyl or other synthetic opioids)	32%	84
Alcohol misuse or abuse	28%	76
Untreated mental illnesses (bipolar disorder, schizophrenia, etc.)	24%	65
Being overweight	18%	48
Lack of exercise	15%	40
Marijuana misuse or abuse	12%	33
Tobacco use	11%	33
Bullying or cyber bullying	11%	32
Unfair treatment because of gender or gender identity	11%	29
Unfair treatment because of race and ethnicity	8%	20
Unsafe driving behaviors (texting, aggressive, distracted, impaired)	7%	21
Not getting regular health screenings (i.e. yearly check-ups, breast exams, gynecological exams, colonoscopies etc.)	7%	20
Sugary drinks	7%	19
Unfair treatment because of sexual orientation	7%	18
Dropping out of school	5%	15
Not following public health recommendations for community safety (wearing masks, getting vaccinated etc.)	5%	15
Not getting vaccinated (childhood vaccines, Influenza, COVID-19 etc.)	5%	13
Vaping	4%	11
Untreated depression	4%	9
Unsecured firearms	4%	11
Not using seat belts or child safety seats	2%	7
Not getting prenatal and maternity care	2%	6
Untreated anxiety	2%	5
Unsafe sex	1%	4

Following is a list of issues that affect health and well being. The list includes items that are outside of UHA's services but would help us understand issues that have the most impact on the area where you live. Thinking about your community, what are the top three needs that, if met, would make your community healthier. (n=285)

Survey Response	Percent	Numerator
Affordable housing	35%	95
Education about behavioral health issues (e.g., substance use, suicide prevention, and mental health diagnoses like anxiety, depression, bipolar disorder)	34%	94
Affordable, healthy, and nutritious food	26%	71
Programs to prevent substance use or addiction to alcohol, marijuana, opioids, tobacco, vaping, etc.	25%	72
Help managing disease or chronic health conditions	21%	54
High-quality, culturally responsive healthcare services	16%	43
Jobs that pay enough money to support me and my family	15%	40
Positive activities, services, resources, and programs for youth	13%	35
Teamwork between healthcare organizations and community organizations to help families meet their needs	13%	35
Disease prevention services and education	12%	33
Quality and affordable childcare	12%	34
Safe recreational facilities that are multi-generational (e.g., community rec centers, parks, biking & walking trails)	12%	34
Healthy environment (e.g., clean air and water)	11%	32
Pediatricians or pediatric sub-specialists (e.g., pain clinics, arthritis, neurology, pulmonology)	9%	27
Enough resources to promote social support and connections (e.g., family, friends)	8%	20
Emergency preparedness for disasters such as fire, drought, flood, and pandemics	6%	16
Ending racism and discrimination	6%	17
Help for families transitioning to new healthcare providers or finding the type of healthcare provider they need	6%	16
Injury and violence prevention services and education	6%	16
School health and wellness programs	5%	14

Community Connectedness: Feeling like you belong is one of the main drivers of health and quality of life. Following are statements about the quality of life in your County. Please think about each statement from the neighborhood where you live and tell us if you agree, are neutral, or disagree with each statement.

Survey Response	Agree	Disagree	Strongly Agree	Strongly Disagree	No response	N
All residents in my neighborhood feel that they — individually and together— can make the neighborhood a better place to live.	61%	21%	12%	2%	4%	263
Every person and group has the opportunity to contribute to improving the quality of life in my neighborhood.	59%	17%	20%	1%	3%	265
I am satisfied with the healthcare available to me (and my family). (Consider access, cost, availability, quality, and options to see a provider who understands my culture, race, sexual orientation, gender identity, or disability as it relates to health care)	54%	18%	22%	4%	2%	268
I am satisfied with the quality of life in my neighborhood. (Consider your sense of safety, wellbeing, participation in community life and associations, etc.)	66%	12%	20%	2%	0%	274
My neighborhood is a good place to raise children. (Consider school quality, day care, after school programs, recreation, etc.)	64%	12%	20%	2%	3%	267
My neighborhood is a safe place to live. (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another Do they look out for one another)	61%	14%	19%	3%	3%	266
There are networks of support for me and my family during times of stress and need. (Neighbors, support groups, faith community outreach, agencies, organizations)	62%	17%	17%	1%	4%	264
There is a broad variety of affordable healthcare services.	41%	33%	13%	9%	3%	265
There is a sufficient amount of social services to meet the needs of our residents.	35%	37%	17%	9%	3%	266

Survey Response	Agree	Disagree	Strongly Agree	Strongly Disagree	No response	N
There is an active sense of civic responsibility and engagement, and pride in the community.	49%	27%	15%	5%	4%	264
There is economic opportunity for me (and my family). (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	49%	26%	19%	3%	3%	266
Trust and respect are increasing in my neighborhood and we come together to achieve shared community goals.	48%	28%	17%	3%	4%	264

Appendix C: Focus Group Facilitation Guide

To review the focus group facilitation guide, click here.

Appendix D: Focus Group Participant Demographics

Age Groups	Percent	Count
16-17	5%	2
18-24	10%	4
25-34	13%	5
35-44	23%	9
45-54	31%	12
55-64	8%	3
65 or older	8%	3
I prefer not to say	3%	1
Total	100%	39

Please choose your neighborhood/region		
	Percent	Count
North County	23%	
Reedsport	3%	19
Sutherlin	21%	8
North Umpqua	**3%**	
Wilbur	3%	1
Roseburg West	69%	
Dillard	3%	1
Green	10%	4
Lookingglass	5%	2
Melrose	3%	1
Roseburg	49%	19
South County	**5%**	
Myrtle Creek	3%	1
Tri-City	3%	1
Total	100%	39

	Which category best describes your household's income? If living with a partner/spouse, please consider the income of both individuals.	
	Percent	Count
Less than $20,000	41%	16
$20,000 to $29,999	10%	4
$30,000 to $49,999	10%	4
$50,000 to $74,999	10%	4
$75,000 to $124,999	8%	3
$125,000 and above	3%	1
I prefer not to say	18%	7
Total	**100%**	**39**

Do you identify as a member of the LGBTQIA+ community?		
	Percent	Count
I am an ally	18%	7
No	64%	25
Yes	18%	7
Total	100%	39

Do you identify as a person of color?		
	Percent	Count
No	56%	22
Yes	44%	17
Total	100%	39

What is your gender? Check all that apply.		
	Percent	Count
I prefer not to say	3%	1
Man	33%	13
Non-binary	5%	2
Transgender male	3%	1
Woman	56%	22
Total	100%	39

Are you transgender?		
	Percent	Count
Don't know	3%	1
No	95%	37
Yes	3%	1
Total	100%	39

Appendix E: Focus Group Results

Focus group notes were analyzed and summarized into key themes. Themes were identified across all focus groups, as well as for each priority population, include:

- BIPOC focus group
- Family with child welfare involvement focus group
- Youth 16-24 years old focus group
- People who are houseless focus group
- People with behavioral health (BH) needs focus group
- Tribal focus group

Six focus group questions and their responses were analyzed, including:

1. What are the top thee health concerns or needs in your community?
2. How do you or your community holistically take care of itself (social, physical, and mental health)? This can be in or outside of a medical setting.
3. What specific supports and resources, such as jobs, food, housing, etc., do your communities most need?
4. Where or who do you or members in your community go to when you need help navigating health care or healthcare information?
5. What do service providers need to understand about you or your community when it comes to investing in communities' health and wellness?
6. What do you think your greatest concerns will be in 10 years?

A comparative analysis to identify what was unique and similar across the focus groups concludes each focus group question thematic summary.

What are the top 3 health concerns or needs in your community?

Summary

Across the focus group participants, there were diverse perspectives on several critical social and health issues, particularly focusing on challenges related to mental health, homelessness, and access to essential resources. There is the need for improved access to health services, better support for marginalized communities, addressing economic stability and social determinants of health, and reducing stigmatization to create a more inclusive and supportive community.

Participants expressed difficulties in accessing mental health services, including issues with timely appointments, high provider turnover, limited insurance options, and extended waiting lists. Some individuals are forced to travel to other communities or states to receive timely mental health care. Specifically:

- The high rate of substance use in the community was acknowledged, with concerns that some providers may mischaracterize patients as drug seekers, particularly targeting people of color, which can discourage individuals from seeking help.
- Access to mental health services was a shared concern, with participants citing challenges such as limited availability, long wait times, and difficulties finding providers who accept specific insurance plans. Timely access to care was emphasized as crucial.

- The need for providers who represent ethnic diversity, including Black doctors, was emphasized as essential for providing quality care.
- Some individuals feel disrespected in healthcare settings due to language barriers, discouraging them from seeking help.
- Language and transportation barriers were identified as significant challenges, particularly for migrant workers living in rural areas. Some miss appointments due to resource limitations, such as lack of transportation.
- Participants expressed frustration with fragmented services, including physical health and mental health services, and emphasized the need for better coordination and communication between providers, as well as integrating mental and physical health services.

Economic Stability and Cost of Living: Economic challenges, including housing affordability and high childcare costs, were major concerns. These issues impact families' access to health care, with some having to reduce work hours due to a lack of affordable childcare. The role of family dynamics in mental health, particularly the challenges faced by parents in balancing work, family responsibilities, and addressing the mental health needs of their children during crises, was discussed.

Generational Attitudes and Stigma: Generational attitudes toward seeking help for health, in particular mental health, issues were discussed, with recognition that many individuals have been raised with reluctance to ask for help or trust healthcare professionals, potentially hindering early intervention and treatment. The intergenerational cycle of health challenges, including mental health and substance abuse, was highlighted as an issue that persists within families over generations.

Lack of Knowledge and Action: There is a sense of a lack of capacity to effectively help homeless individuals, suggesting a gap in knowledge about available resources and the most effective ways to support the homeless population. Concerns were raised about the prevalence of homeless youth in the community and the need for more comprehensive solutions to address this issue.

Impact of Technology on Children: Concerns were raised about how technology, such as smartphones, is influencing childhood and adolescence, potentially causing children to mature too quickly.

BIPOC Focus Group

Access to mental health care /SUD care was a theme, specifically:

- Participants expressed difficulties in accessing mental health services, including challenges in getting timely appointments and facing high turnover among providers. Limited insurance options and long waiting lists, sometimes extending beyond six months, were cited as obstacles to receiving mental health care. Delayed appointment availability forces people to travel to other communities or even other states to receive timely mental health care.
- The importance of having mental health providers who represent ethnic diversity was highlighted. Black doctors were specifically mentioned as providing excellent care.
- There is a sense of distrust of traditional Western medicine, particularly among people of color, which can affect their willingness to seek mental health care.
- Some individuals reported feeling disrespected in healthcare settings because they are non-English speakers, which can discourage them from seeking help.
- Language and transportation barriers were identified as significant challenges, particularly for migrant workers living in rural areas with limited resources. Some individuals miss appointments due to a lack of resources, such as not having enough gas to travel to appointments.

- The high rate of substance use in the community was noted, and participants mentioned that some providers may mischaracterize sincere patients as drug seekers, particularly targeting people of color (POCs), which can deter individuals from seeking help.

Overall, these statements underline the multifaceted challenges faced by individuals in accessing mental health care, including issues related to availability, insurance, stigma, diversity of providers, language, and transportation.

Family with Child Welfare Involvement Focus Group

Discussion highlighted various personal experiences and community challenges related to mental health and other support services:

- Participants expressed frustration with fragmented mental health services, emphasizing the need for better coordination and communication between providers. The integration of mental and physical health services was seen as essential for comprehensive care.
- Economic challenges, particularly housing affordability and high childcare costs, were major concerns. These issues can impact families' ability to access mental health care, with some individuals having to reduce work hours to care for their children due to the lack of affordable childcare options.
    - Challenges related to housing and childcare were mentioned, with the participant highlighting the difficulties of finding suitable childcare that allows parents to work and the impact of high childcare costs on families.
    - One participant credited a program for providing sober living and rent support, which had a positive impact on their life. However, they also discussed the challenges of finding someone with a clean record to care for their child, leading to a reduction in work hours.
- The community's struggle with drug addiction was acknowledged as a significant issue affecting mental health and overall well-being. Individuals in recovery face barriers when attempting to give back to the community, often due to past issues related to addiction.
- The role of family dynamics in mental health was discussed, particularly the challenges faced by parents in balancing work, family responsibilities, and addressing the mental health needs of their children during crises.
- Access to mental health services was a shared concern, with participants citing challenges such as limited availability, long wait times, and difficulties finding providers who accept specific insurance plans. Timely access to care was emphasized as crucial.
    - One participant shared personal experiences of dealing with a crisis and the differences they observed in the level of support and outreach from mental health services in different locations. They appreciated the outreach efforts of mental health services during their crisis.
    - There was a discussion about generational attitudes toward seeking help for mental health issues, with a recognition that many individuals have been raised with a reluctance to ask for help or trust healthcare professionals, potentially hindering early intervention and treatment.
    - The influence of generational addiction on the community's mindset was highlighted, where individuals are taught not to talk, trust, or express their emotions, perpetuating a cycle of silence and stigma around mental health.
- Concerns were raised about the prevalence of homeless youth in the community and a lack of understanding about the reasons behind this issue. Participants discuss efforts to support homeless teens and the need for more comprehensive solutions.

Overall, the statements shed light on the complex interplay of economic, social, and cultural factors that affect mental health and access to care within the community. Coordination of services, destigmatization of mental health issues, and improved access to affordable care were identified as crucial areas for improvement.

Youth 16-24 Years Old Focus Group

Focus group participants discussed several interconnected social and health issues, especially within the context of a specific community or family:

- Despite being familiar with homeless individuals, there was a concern about a lack of capacity to effectively help them. An observation was shared that many people are scared to seek assistance or services is indicative of the stigma and challenges often associated with homelessness and related issues. This fear can hinder efforts to provide help.
- The reference to older individuals not receiving proper treatment and subsequently passing on health issues to younger generations highlights the cycle of health challenges, including mental health and substance use, that can persist within families over generations. For example, one participant shared personal concerns about the risk of liver failure due to a family history of alcohol-related issues. This highlights the intergenerational impact of health problems stemming from substance use.
- The discussion of children growing up too fast due to technology and access to smartphones underscores concerns about the influence of technology on childhood and adolescence.
- Mental health issues are identified as a significant contributing factor to various social problems, including substance use and homelessness. The difficulty in finding mental health services underscores an existing challenge within the community, which can limit the support available for those in need.

In summary, focus group participant comments highlighted the need for better access to mental health services, community education, and support systems to break generational cycles of health problems. It also underscored the challenges posed by technology.

People who are Houseless Focus Group

In response to the question "What do you feel is the biggest risk to your health or the health of your community?", participants shared:

- Several focus group participants noted the negative public awareness of homeless individuals and their mistreatment due to the stigma attached to homelessness. The perception of homeless people as drug addicts or criminals can lead to discrimination and bias against them.
- A participant shared a story of being unjustly arrested and mistreated by the police while getting a drink underscores the need for better understanding and treatment of homeless individuals by law enforcement agencies.
- Focus group participants described a need for better community support for the homeless, emphasizing the need for understanding, assistance, and access to resources to help individuals get back on their feet. The discussion of constant shortages, including nutrition, housing, clothing, and access to online resources, highlights the day-to-day struggles faced by homeless individuals. Access to resources is different depending on who you are – one participant noted that for a male over 26 in Oregon, the only resource is food stamps,
- Lack of access to phone services can be a significant hindrance to connecting with support systems and employment opportunities, further perpetuating the cycle of homelessness.

In summary, focus group participants reflect the challenges faced by homeless individuals, including stigmatization, limited access to essential resources, and a lack of appropriate services. Addressing these issues may require community awareness, improved public services, and more targeted support for homeless individuals to help them rebuild their lives and overcome barriers to self-sufficiency.

People with BH Needs Focus Group

The focus group participants discussed several critical issues related to healthcare, housing, temporary housing solutions, educational gaps, positive attitudes, and the need for comprehensive education.

- Concerns were raised about difficulties in accessing specialists and the demand for more affordable and accessible healthcare. A personal example highlighted a denial of treatment, potentially linked to the participant's medical history. Barriers to receiving necessary care were attributed to issues with insurance and the broader healthcare system.
- Participants discussed challenges in finding affordable housing, emphasizing high expectations for deposits and rent. A comparison between previous affordable housing in Texas and current high costs ($1450 a month) underscored the housing crisis. Advocacy for more homeless shelters and a call to address housing problems were voiced. Reference was made to positive experiences in a remodeled hotel room provided by a local organization, focusing on the benefits of lowered rent. Different perspectives on living conditions were discussed, with a consensus that any housing is preferable to being on the street.
- Participants emphasized the need for more education, specifically on life-saving skills. A real-life example involving a child ingesting methadone underscored the potential benefits of education on using Narcan. Suggestions were made to integrate education on critical life skills into schools and emphasized starting education at home.
- There was a consensus among participants on the necessity of comprehensive education, covering various aspects such as healthcare, life-saving skills, and responsible parenting.

Tribal Focus Group

Focus group participants discussed several issues affecting individuals, regardless of race, related to healthcare access, insurance coverage, and the affordability of housing. There was a shared sentiment that people may be unaware of available healthcare services, unsure about insurance coverage, and may hesitate to seek care. The participants express the importance of knowledge in facilitating access to healthcare.

Regarding housing, there was a notable concern about the surprisingly high cost of affordable housing in the area, particularly in South County. The limited availability of affordable housing in that region was highlighted, with the observation that such housing is quickly taken up. Participants note that while some individuals have a roof over their heads, the quality of housing is often subpar, emphasizing both a quantity and quality issue.

Comparative Analysis

Focus groups highlight various challenges and concerns related to mental health and access to care in their respective communities. The themes include disparities in access to care, the importance of diversity and representation in healthcare, the impact of economic and social factors on mental health, generational issues, and the stigmatization and mistreatment of vulnerable populations like the homeless. Unique themes across groups are describe below.

BIPOC:

- Difficulty accessing mental health services due to challenges like long waiting lists, limited insurance options, and turnover among providers.
- A desire for more diversity among mental health providers, highlighting the importance of representation.
- Distrust of traditional Western medicine.
- Language and transportation barriers, affecting access to care.
- Concerns about the stigma faced by non-English speakers in healthcare settings.

Families with Child Welfare Involvement:

- Frustration with fragmented mental health services and a need for better coordination and communication between providers.
- Economic challenges, including housing affordability and high childcare costs, impacting access to care.
- Recognition of the community's struggle with drug addiction and barriers faced by individuals in recovery.
- Discussion about generational attitudes toward seeking help for mental health issues.
- Concerns about the prevalence of homeless youth in the community and the need for comprehensive solutions.

Youth 16-24 Years Old:

- Concerns about a lack of knowledge and action in effectively helping the homeless population, pointing to a gap in understanding available resources.
- Observations about children growing up too fast due to technology and access to smartphones.
- The intergenerational impact of health challenges, including mental health and substance abuse, within families.
- Difficulty in finding mental health services, highlighting the need for improved access.

People who are Houseless:

- Stigmatization and mistreatment of homeless individuals due to negative public awareness and biases.
- Unjust interactions with law enforcement, highlighting the need for better treatment and understanding by police.
- A need for community support, resources, and assistance for homeless individuals.
- Daily struggles faced by the homeless population, including access to basic resources like nutrition and clothing.
- Communication barriers and lack of access to phone services affecting the ability to connect with support systems and employment opportunities.

People with BH need:

- Personal experiences of denied treatment due to medical history.
- Positive experiences with temporary housing solutions, emphasizing the importance of any housing over street living.

Tribal populations:

- Unawareness of available healthcare services and uncertainties about insurance coverage.
- Concerns about both the high cost and limited availability of affordable housing in South County.

How do you or your community holistically take care of itself (social, physical, and mental health)? This can be in or outside of a medical setting.

Summary

The participants in the focus groups take a holistic approach to self-care and well-being. Findings on different strategies include:

- Emphasis on the importance of a healthier lifestyle, which includes regular exercise, better dietary choices, and participation in activities like yoga and meditation. These practices are aimed at maintaining physical health and well-being.
- Participants highlighted the value of spirituality and a positive outlook in dealing with life's challenges. This includes attending church services and practicing mindfulness to address issues such as depression.
- The community plays a crucial role in their well-being. They rely on support from neighbors and the sense of community to maintain their mental health. Social interactions and community engagement are essential components of their self-care.
- Some participants expressed challenges related to accessing resources such as healthcare and community programs. They mention barriers like waitlists and affordability concerns, which impact their ability to access services.
- Participants expressed a desire for more community support, particularly for youth. They suggest mentoring programs, outdoor activities, and more resources to address issues like boredom among teenagers. They seek to instill good work ethics and values in the younger generation.
- Cultural practices, traditions, and connections with one's cultural roots were highlighted in the BIPOC and Tribal focus groups as essential for mental and emotional well-being.

In summary, focus group participants prioritized physical and mental well-being through self-care practices, spirituality, and community support. They acknowledge the importance of access to resources and express a desire for improvement, particularly in addressing the needs of youth.

Family with Child Welfare Involvement Focus Group

The provided statements touch upon several key points related to self-care, community support, youth engagement, and healthcare access:

- The importance of self-care in maintaining mental health is emphasized. A participant discusses their personal journey in long-term recovery, highlighting activities such as attending sweat lodges, listening to drums, and engaging in exercise as crucial for their well-being. They also mention their experience with therapy, which helped them address trauma and improve their mental health.
- Concerns were raised about the limited options and resources available for young people, particularly teenagers, in the community. Participants note that there are more options and resources for youth in other areas like Eugene, and the lack of community involvement and accessible activities can lead to boredom and potential issues for teenagers.

- Some participants expressed a desire for increased community support and a focus on helping families become self-reliant. They emphasized instilling good work ethics and values in the younger generation. The importance of mentoring and providing opportunities for youth to engage in outdoor activities like hunting and fishing is highlighted as a means to address youth mental health issues.
- Participants discuss the challenges they face in accessing activities and healthcare. These challenges include waitlists for programs like the Boys and Girls Clubs, affordability concerns for the YMCA, and difficulties with health insurance providers like UHA and the complexities of pharmacy cards.

In summary, the statements emphasize the importance of self-care, youth engagement, community support, and addressing challenges in accessing activities and healthcare. Solutions in this area would collectively contribute to the overall well-being of the community, particularly among youth and individuals in recovery.

BIPOC Focus Group

The statements provided highlight various strategies and activities that individuals engage in to promote their well-being and mental health:

- Many individuals find solace and rejuvenation by spending time in natural settings, such as being near water or mountains. The greenery and parks in Roseburg are particularly appreciated for their calming effect.
- Sharing and enjoying food with family and community members is seen as a sacred practice. It serves as a means of communication and a way to have meaningful conversations, especially in tough times.
- Being part of BIPOC groups and school clubs provides a sense of belonging and an opportunity to connect with others who share similar experiences and backgrounds. These connections are valuable for discussing feelings and gaining support.
- Participants express an interest in having more meditation spots in parks, highlighting the importance of mindfulness practices for mental well-being.
- Some barriers to well-being are identified, including the closure of parks due to safety concerns, the influence of drugs in public spaces, and smoky air conditions.
- Engaging in cultural practices, returning to one's cultural roots, and participating in traditional healing practices are seen as therapeutic and preventive measures for overall well-being.
- Activities like going to the gym, being mindful of dietary choices (such as adopting a vegan diet), and getting enough sleep are mentioned as important components of maintaining overall health

In summary, the statements underscore the significance of connecting with nature, community, cultural identity, and mindfulness practices for mental and emotional well-being. They also acknowledge the challenges posed by certain environmental and societal factors.

Youth 16-24 Years Old Focus Group

Focus group participants describe self-care, social activities, and challenges related to access to food resources. Focus group participants noted sitting outside as a cost-effective way to take care of themselves, indicating the importance of spending time in nature for their well-being.

- Playing games and spending time with friends as part of their self-care routine, highlighting the positive impact of social connections on mental health.

- One focus group participant acknowledged that it can be challenging to take care of themselves, especially when they are home alone, reminding themselves to eat when their parents are working. This may point to difficulties in maintaining regular routines.
- Motivation and time constraints were noted as factors that hinder self-care practices, suggesting that life's demands may sometimes make it difficult to prioritize one's well-being.
- Among youth, there was a willingness to seek help. Participants noted food pantries, which suggests a proactive approach to addressing their food needs.
- There's criticism of the food pantry for having non-edible items, implying that the quality and utility of food resources may not always meet the needs of the community.
- One participant noted having lived in other states with more to offer in terms of food resources, indicating that the local availability of food support may be relatively limited compared to their previous experiences.

In summary, focus group participants noted the importance of self-care, social connections, and food resources. Challenges in maintaining self-care routines and expressing concerns about the adequacy of available food resources were noted. There is a willingness to seek help, but there may be limitations in the quality and accessibility of local support services.

People who are Houseless Focus Group

- Participants noted collective efforts to help each other. They make sure everyone is fed and clothed to the best of their ability, even providing donated tents to those in need. This reflects a strong sense of unity and support within the community.
- The community benefits from regular food donations. The food pantry brings food every two weeks, and local churches contribute meals 3-4 days a week, ensuring that people have access to regular meals.
- Focus group participants discussed the potential for more resources or support, such as the idea of bringing a "first Thursday" event to their location or involving organizations like "Onward" with their bus.
- The statement concludes by highlighting the community's determination to "try to figure out how to make it another day" and ensure that everyone has access to a vehicle, indicating resourcefulness in the face of challenges.

In summary, focus group participants portray a community that relies on mutual support and various sources of donated food to meet their basic needs. It also suggests a desire for additional resources and support to improve their quality of life and highlights their resilience in the face of adversity.

People with BH Needs Focus Group

Participants note their approach to maintaining their mental and physical well-being, as well as the importance of spirituality and community support:

- The individual emphasizes the importance of eating healthier and engaging in regular exercise. They participate in Adapt's weekly yoga classes and practice at home, showing a commitment to physical fitness. One participant indicated practices yoga and meditation, highlighting their commitment to physical and mental well-being. There was a spiritual outlook on life, focusing on taking things day by day and handling situations as they arise. This approach suggests a positive mindset and resilience in dealing with life's challenges.
- A focus group participant mentions dealing with depression and being homebound due to physical limitations. They attribute a significant portion of their mental well-being to attending

church services on Sundays and Wednesdays, which provides a sense of purpose and social interaction.

- Focus group participant acknowledges the support of their neighbors, emphasizing the value of having nearby neighbors to talk to and share in community connections; recognizes the importance of simple social interactions in building community bonds.
- Importance of Communication: The statement underlines the significance of reaching out to neighbors and maintaining a sense of community by saying hello and keeping in touch, as it ensures that important events are not missed.

In summary, focus group participants with BH Need note the importance of physical fitness, spirituality, and community support. They emphasize the importance of social interactions and staying connected with neighbors as an essential part of their mental and emotional health. This holistic approach to well-being reflects their proactive stance in maintaining a positive outlook on life.

Tribal Focus Group

Focus group participants discussed the following topics:

- Participants expressed challenges with social interaction within the community, noting that Roseburg tends to be reserved and less open to conversations, especially on the sidewalk. The perception of Roseburg as conservative, in contrast to more liberal cities like Portland or Eugene, was highlighted as impacting the social dynamics of the community.
- Concerns were raised about the historical racism in Southern Oregon, with mentions of the state constitution prohibiting African Americans from living in the area. This history affects social connections, making it difficult to identify individuals who may hold discriminatory beliefs.
- Participants discussed the availability of resources for physical activity, mentioning Stewart Park but noting its challenges with homelessness. Safety concerns in natural settings were raised, including encounters with wildlife and potential dangers in the woods.
- Cultural activities, such as sweat lodge ceremonies and powwows, were highlighted as important for connecting with the land and maintaining spiritual and social bonds.
- The presence of homeless individuals occupying public spaces, including parks, was noted as a challenge for those seeking outdoor activities. Homelessness was acknowledged as impacting the use of spaces for cultural and social activities, creating a barrier for community members to engage in these events.
- Despite challenges in the broader community, participants emphasized the positive impact of tribal communities on meeting social needs. Tribal activities, sweat lodge ceremonies, and connections with behavioral health groups were highlighted as fulfilling social and cultural needs. The tribal community was recognized as a supportive environment for maintaining social connections and addressing mental health needs.

The positive influence of tribal communities highlights the importance of supportive environments for maintaining social and cultural connections. The data suggests a need for community-wide efforts to foster inclusivity, address historical issues of racism, and create spaces that accommodate diverse social and cultural activities.

Comparative Analysis

The group findings from the different focus groups each highlight distinct themes and challenges within their respective communities:

Family with Child Welfare Involvement:

- Emphasized the importance of self-care, access to youth resources, community involvement, and challenges in accessing activities and healthcare.
- Highlighted the need for support for both parents and teenagers, mentorship, and opportunities for outdoor activities.
- Identified issues with waitlists, affordability, and the complexities of health insurance providers.

BIPOC:

- Focused on the role of nature, food, community, and cultural immersion in promoting well-being.
- Highlighted the importance of community and support groups for individuals with shared experiences.
- Acknowledged environmental and societal challenges such as park closures and drug influence in public spaces.
- Stressed the need for more BIPOC providers in healthcare.

People who are ages 16-24:

- Highlighted the importance of self-care practices and social activities in the lives of young individuals.
- Showed an awareness of food resources and a willingness to seek help.
- Addressed challenges in prioritizing self-care and maintaining routines.

People who are Houseless:

- Focused on the community's support for each other, including providing food and donated tents.
- Highlighted regular food donations and contributions from local churches.
- Suggested a desire for more resources and support for the community.

People with BH Needs:

- Participants focused on physical fitness, spirituality, and community support.
- The emphasis on communication with neighbors highlighted the importance of social interactions for mental and emotional health.

Tribal:

- Challenges in social interaction within Roseburg, historical racial issues, and concerns about homelessness impacting cultural activities
- Tribal communities were recognized as supportive environments for meeting social and cultural needs.

In summary, while each group has unique experiences and challenges, common themes across these focus group findings include the importance of community support, self-care, access to resources, and maintaining physical and mental well-being. These insights collectively shed light on the various aspects of well-being and the need for comprehensive support systems within these communities.

What specific supports and resources, such as jobs, food, housing, etc., do your communities most need?

Summary:

The focus group participants provided valuable insights into the specific supports and resources their communities most need.

Families with Child Welfare Involvement Focus Group

- No responses from Family with Child Welfare

People of Color Focus Group

- Participants stressed the need for affordable housing as high prices impact physical, mental, and emotional health. Affordable housing was a significant concern, particularly for young adults seeking independent living.
- Participants expressed a desire for more resources to guide them after high school, including information on applying to colleges and scholarships. They mentioned the need for accessible career centers and supportive counseling services.
- First-generation students feel pressure to set an example for their siblings and would benefit from resources and support tailored to their unique needs.
- Participants highlighted the importance of comprehensive translation services, not just for meetings but also for written documents. They emphasized the need for accurate translations in both English and Spanish to facilitate communication with family and friends.
- Concerns were raised about the role of education and employment in perpetuating discrimination. Some participants feel that qualifications and certifications were given more weight than experience, which can be a barrier for marginalized communities.
- Issues related to racism and discrimination were discussed, including bias in the workplace, microaggressions, and the pressure on people of color to tolerate discriminatory behavior. There was a desire for more people of color in positions of power to promote diversity, equity, and inclusion (DEI).
- Participants expressed skepticism about the effectiveness of some anti-racism and DEI programs, particularly when they are taught by white individuals. Some feel that these programs may be weaponized or not genuinely address systemic issues.

In summary, the participants raise several interconnected issues related to affordable housing, education, employment, discrimination, and the need for more comprehensive translation services to address disparities and promote inclusivity of their community.

Youth 16-24 Years Old Focus Group

The focus group participants highlighted crucial needs related to housing, income, and accessibility. Here's a summarized analysis of their responses:

- Participants expressed concerns about housing affordability and the quality of available housing options. They mentioned that if housing payments were not in the form of monthly rent, it would be better, allowing individuals more time to accumulate savings for homeownership. They also raised issues of discrimination against service animals and shared personal experiences of almost being evicted due to keeping pets. Some faced challenges with the quality of housing, including rundown conditions with structural issues, pests, and inadequate living conditions.
- Income-related challenges were a significant concern. Participants mentioned that even when hourly rates are decent, employers sometimes reduce hours, making it difficult for individuals

and families to make ends meet. This highlights the need for stable employment and income security to afford housing and other basic needs.

- Accessibility issues were noted, particularly a lack of elevators and rails, which can be barriers for individuals with mobility challenges. Veterans in the community also face difficulties in accessing VA services since the nearest office is located in Eugene, despite a substantial veteran population in the area. Additionally, obtaining disability benefits was cited as a challenging process.
- Participants mentioned that food stamp benefits might not be sufficient to meet their food needs. They emphasized the importance of affordable and accessible food resources to ensure that community members have access to adequate nutrition.
- While discussing the challenges, a positive note was struck when participants expressed gratitude for community support. For instance, a school principal was commended for providing fruits and vegetables from her garden, highlighting the value of such support in addressing food-related needs.

In summary, focus group participants pointed out housing affordability, income stability, accessibility, and the adequacy of food resources as the key support and resource needs in their communities. These challenges are interconnected and have significant implications for the well-being of community members.

People who are Houseless Focus Group

The focus group participants highlighted several specific supports and resources that their communities most need, which primarily revolve around employment resources, identification documents, communication tools, and access to basic amenities:

- Participants stressed the importance of employment resources, such as job opportunities and support for gaining and maintaining employment. They mentioned the need for showers and clothes to facilitate gainful employment, as limited access to showers could pose challenges to job seekers. Additionally, access to the town for work-related purposes is limited, further emphasizing the need for local job opportunities.
- Multiple participants expressed the need for assistance in obtaining or replacing their identification documents. Issues related to losing IDs and the challenges in obtaining new ones were mentioned, underscoring the significance of having proper identification for various purposes, including accessing services, employment, and communication.
- Access to communication tools, particularly functional phones with working services, was highlighted as a vital resource. Participant noted the lack of reliable phones and the need for phones with Wi-Fi capabilities. Running out of data on phones was also mentioned as a common challenge, suggesting that access to data and communication tools is essential for staying connected and accessing important information and resources.

In summary, participants identified critical needs related to employment resources, identification documents, and communication tools. These needs are often those essential for individuals to secure employment, access services, and stay connected within their communities.

Probe Question: "What do you feel is the biggest thing that, if you had access to it, would make you or your community healthier?"

- Participants emphasized the importance of basic needs, such as cleanliness, access to showers, washer and dryer facilities, and reliable electricity. They mentioned a lack of heating and the

struggle to stay warm, indicating that addressing these fundamental needs is crucial for overall health and well-being.

- Concerns were raised about housing affordability and the quality of available housing options. Participants expressed dissatisfaction with the idea of tiny apartments at high costs and compared them to internment camps. They called for affordable, decent housing solutions, especially for those who have been homeless for several years.
- Participants highlighted the need for a crisis resource team to support individuals who have been displaced or become homeless. They stressed the absence of a clear starting point for those trying to transition from homelessness to stable housing.
- The participants expressed the need for resources that can be quickly and easily accessed. They mentioned the challenges of qualifying for resources and how they can be limited or unavailable in smaller cities. They called for a system that efficiently connects displaced individuals with the programs and assistance they require.
- There were discussions about creating job opportunities based on an individual's job history, especially for those who have lost their homes and jobs. The participants suggested that the state could play a role in providing tailored employment opportunities to help people get back on their feet.
- Transitioning from unemployment or homelessness to employment was identified as a significant challenge. Participants mentioned the lack of access to basic facilities like showers, transportation, and clean clothing when someone secures a job. They called for resources to help with this transition.
- The participants expressed frustration with the limitations of existing state programs. They felt that some programs, like mandatory drug treatment, are primarily designed to generate revenue for the state and do not effectively help those in need.
- Participants appreciated the assistance provided by organizations like UCAN, particularly during the winter months. They highlighted the importance of energy assistance and expressed a desire for such services to be more accessible. They also emphasized that housing programs should be available for people who don't have substance abuse or mental health issues but are still struggling to afford housing.

In summary, the participants' responses underscored the importance of addressing basic needs, affordable housing, streamlined access to resources, tailored job opportunities, and improved transition support for individuals trying to escape homelessness and unemployment. They also raised concerns about the limitations of existing programs and advocated for more inclusive housing options.

People with BH Need

Participants highlighted the importance of education, life skills, and access to information.

- Participants emphasized the need for improved education and life skills training. They highlighted the importance of catching people before they reach a point where they require extensive services. This includes teaching individuals better coping skills and basic life skills. The participants expressed that current educational systems often lack adequate preparation in these areas. They suggested that high schools, in particular, could play a significant role in providing this education, especially for those who lack traditional family structures.
- Participants acknowledged that a major challenge was the lack of knowledge about available resources. They emphasized the need for a centralized hub or location where people can access information about the various resources available to them. Many individuals, especially those dealing with addiction, may not know what specific resources they need, making it difficult to

begin searching for help. They noted the value of having a one-stop place for comprehensive resource information.

- The participants also discussed the importance of efficiently distributing resource information. They shared an example of someone in their community who used to gather resources and distribute them widely, demonstrating the need for proactive outreach and community involvement in sharing this information. The participants mentioned methods like community bulletin boards, social media, and a service like "211" as effective means of resource distribution.
- Access to healthcare and the challenges individuals face with healthcare providers were mentioned. The participants pointed out issues with long waiting times for appointments, leading to delayed care. They also noted concerns about healthcare providers dismissing patients' concerns or not adequately addressing their health needs.
- A participant expressed a desire for more human-to-human interaction and community engagement. They highlighted the declining importance of face-to-face communication in an age dominated by technology. The participant discussed the loss of social skills and the increasing fear of personal contact. They stressed the value of traditional methods like the public library for information dissemination but also acknowledged the importance of adapting to modern technology and social media for reaching people.

Tribal Focus Group

The focus group participants express a pressing need for increased mental health resources in the county. Several key points are highlighted:

- Participants indicate that existing mental health resources, particularly at Mercy and Adapt, are insufficient. For example, Adapt, while offering a mobile crisis unit, was reported to have lengthy waitlists.
- The discussion touched on the influence of weather on mental well-being, suggesting that the local weather conditions can have a negative impact on individuals' stability and mental health.
- High poverty levels in the county were identified as a significant challenge. Difficulty in securing housing was mentioned, with the cost of available apartments, particularly around Diamond Lake, being prohibitively high for many residents. Lack of awareness about available resources, including affordable housing options, contributes to the challenges faced by the community.
- Participants expressed the need for trained professionals who can guide individuals in accessing available resources. There was a specific emphasis on the importance of mental health professionals as a crucial resource for the community.

Comparative Analysis

It's important to note that the Family with Child Welfare Involvement group did not provide responses, so there are no findings to compare with the other groups.

- The BIPOC group expressed several specific concerns, including affordable housing, post-high school resources, translation services, education and employment challenges, racism and discrimination, and concerns about the effectiveness of anti-racism and DEI programs. These issues revolve around disparities in housing, education, employment, and the need for greater inclusivity and diversity in the community.
- The group of people aged 16-24 highlighted housing affordability, income stability, accessibility, food assistance, and community support as their key needs. These concerns are interconnected, and they underscore the importance of addressing basic living conditions, income security, and access to resources for this age group.

- The houseless group emphasized employment resources, identification documents, and communication tools as their primary needs. These needs are fundamental for securing employment, accessing services, and staying connected within their communities.
- The Tribal focus group emphasized the pressing need for increased mental health resources, with existing resources described as insufficient. Impact of local weather conditions on mental well-being and the challenge of high poverty levels, particularly in securing affordable housing.

The focus group data collectively reveals interconnected issues surrounding housing, discrimination, education, and access to resources across diverse demographic groups. Participants consistently emphasize the importance of affordable housing, education, and community support. Unique challenges and needs were also identified within each focus group, underscoring the importance of tailored solutions to address the specific concerns of different communities.

Where or who do you or members in your community go to when you need help navigating health care or healthcare information?

Summary:

Common themes across the focus groups include the importance of trust in healthcare professionals, challenges with consistent providers, the role of family and community networks, and the need for accessible preventative care. Affordability, advocacy, and reluctance to seek healthcare are consistent concerns, and specific community resources play a pivotal role in healthcare navigation. Addressing disparities, stigma around mental health, and creating inclusive healthcare services are overarching themes that emerge from the diverse experiences and perspectives shared across the focus groups.

Families with Child Welfare Involvement Focus Group

Urgent care was not seen as a suitable substitute for preventative care, as healthcare should ideally focus on prevention rather than addressing issues when they become urgent, The participant highlights challenges in maintaining consistent Primary Care Providers (PCPs) for their children, as providers frequently come and go. This inconsistency led them to rely on urgent care services for their children's healthcare needs.

Participants discussed the extended waiting periods for healthcare appointments, whether for mental health, dental care, or other services. The long waits often lead individuals to choose urgent care as a quicker alternative. When a trusted healthcare provider leaves, it can be emotionally challenging, especially for children who have built connections. Sharing personal histories and stories with new providers can feel burdensome.

In summary, less about “where people turn to for information” but on access to care - participants highlighted the challenges of accessing consistent and timely healthcare services, especially when providers change frequently. Long wait times for appointments and the importance of preventative care were emphasized, as well as the need for better patient experiences in healthcare facilities.

BIPOC Focus Group

BIPOC participants faced challenges related to the affordability of healthcare, insurance complexities, changing careers, and the need for self-advocacy within a healthcare system that often lacks consistency due to high provider turnover. They also expressed a desire for support and understanding from allies while addressing potential safety concerns in their community.

- Even with insurance, participants mentioned that they still must pay a significant amount of money. They find it difficult to understand the information provided by their insurance company.
- Participants emphasized the importance of being one's own advocate in the healthcare system, particularly for non-emergency situations, as it can be challenging to access care promptly.
- The discussion touched on the issue of doctor turnover, where providers tend to leave after a relatively short time, leading to a lack of continuity in care.
- Participants expressed a desire for trusted individuals, including white allies, to support people of color (POCs) in navigating the healthcare system. There was a recognition that asking for help can be challenging due to potential stereotypes and condescending attitudes.
- Participants mentioned concerns about personal safety, particularly when driving around town at night, emphasizing the need to avoid dangerous situations.

Youth 16-24 Years Old Focus Group

Participants provided insights into how they navigate healthcare and healthcare information in their community:

- Participants mentioned challenges with customer service when seeking healthcare information and services. They described a negative experience when they went to Cow Creek, emphasizing rude treatment. This highlights the need for better customer service and communication in healthcare organizations
- Some participants rely on family members for guidance and healthcare information. One participant mentioned consulting their aunt, who used to be a nurse. Another participant mentioned seeking guidance from their father, who works in the medical field. This illustrates the role of family and community networks in healthcare navigation.
- Several participants expressed concerns about their medication and their experiences with healthcare providers. One participant mentioned being on the same medication since childhood and having concerns about potential side effects, such as liver failure. Others shared their experiences with medications that had undesirable side effects, making them feel like zombies.
- Participants discussed challenges in their interactions with healthcare providers. They felt that providers didn't listen to their concerns and instead prescribed medication as a one-size-fits-all solution. There were also concerns that providers didn't believe or take them seriously, especially if they were underage. This indicates a need for improved communication and patient-centered care.
- Participants pointed out that healthcare providers sometimes treat individuals differently based on their appearance or identity. Those who "look normal" may receive care more easily compared to those who openly identify as LGBTQ+.
- Some participants expressed the need for mental health care but without medication. They emphasized the importance of receiving care that focuses on non-medication-based strategies for managing mental health conditions.
- A participant mentioned difficulties in sharing their personal trauma and experiences with their counselor. They felt that their counselor was focused on a single aspect and not receptive to their broader story.

In summary, the responses highlight challenges in healthcare navigation, including issues with customer service, concerns about medication, communication problems with providers, and disparities in care based on appearance and identity. The participants also expressed a need for more holistic mental healthcare and better support for sharing personal stories and traumas in therapeutic settings. These

insights underscore the importance of improving healthcare services and ensuring that they are patient-centered and equitable.

People who are Houseless Focus Group

The focus group participants shared their experiences and challenges when it comes to navigating healthcare and healthcare information in their community:

- Participants expressed frustration and a sense of hopelessness regarding access to healthcare information and support. They mentioned that there isn't a dedicated place or resource where community members can go to get help with healthcare-related questions or issues. This lack of access to healthcare navigation resources is a significant challenge for the community.
- Some participants mentioned relying on personal connections or individuals in their community for healthcare information. These personal connections play a crucial role in helping community members navigate healthcare issues.
- One participant mentioned using the library as a resource for healthcare information. However, they noted that the library's limited hours and potential issues with visiting during school hours can be barriers to accessing this resource.
- Several participants expressed a general reluctance to seek out healthcare or navigate the healthcare system due to various reasons. This reluctance may be attributed to a lack of trust in the medical system, frustration with healthcare providers, or the perception that doctors are primarily focused on medication rather than overall health.

In summary, the responses highlight challenges in accessing healthcare information and support within the community. Participants rely on personal connections, make limited use of resources like the library, and express reluctance to seek healthcare due to various concerns. There is also a need for increased awareness and knowledge about local healthcare providers and resources to improve healthcare navigation in the community.

People with BH Need Focus Group

The focus group participants provided insights into where they and members of their community go for help when navigating healthcare or healthcare information:

A few places were noted:

- Adapt Clinic: Participants mentioned that they turn to Adapt, specifically the Adapt Clinic, as a valuable resource for navigating healthcare. It's a go-to place for accessing healthcare services and assistance, indicating that it plays a central role in their community. Adapt is mentioned again as having a coordinator who can provide support not only for food and clothing but also potentially for peer support. This suggests that Adapt offers a range of services beyond traditional healthcare, including assistance with basic needs and peer support.
- Chadwick Clubhouse: The Chadwick Clubhouse is highlighted as another essential resource. Participants find the people at the Chadwick Clubhouse to be helpful and willing to assist with healthcare-related inquiries or challenges. It's described as a supportive and resourceful program in their community.
- Dream Center: While the Dream Center is acknowledged, it's primarily seen as a place to access items rather than information. This indicates that the Dream Center may focus more on material assistance rather than healthcare guidance.

- Some participants expressed concerns about long appointment wait times when trying to access a healthcare provider. This issue, especially with wait times extending up to six months, can pose challenges in receiving timely care. However, there is a mention of improvements over time.
- There is a distinction made between different healthcare providers in their community. Adapt is noted for having good doctors, while Evergreen is mentioned as having less favorable healthcare providers. This indicates variations in the quality of care in different healthcare facilities in their area.

In summary, the participants rely on a combination of healthcare providers like Adapt and community programs like the Chadwick Clubhouse when seeking help with healthcare information or navigating the healthcare system. These resources offer various forms of support, including assistance with basic needs, peer support, and access to doctors. The challenges related to appointment wait times and the variation in the quality of healthcare providers highlight the complexities of healthcare access in their community.

Tribal Focus Group

- Participants highlighted the influence of word of mouth in healthcare decision-making, especially when searching for services like dentistry and healthcare clinics. The tribal clinic's accessibility and word of mouth played a significant role in attracting tribal members, emphasizing the impact of reputation and location.
- Participants recognized the importance of advertisement and the convenience of location in influencing their choices, particularly in healthcare decisions. The tribal clinic's government office appearance initially led to confusion about its services, emphasizing the role of clear communication and advertising.
- Participants acknowledged a shift in services, expanding from serving only tribal individuals to offering services to the general public in 2017. The transition to serving a broader population highlighted the need for effective communication to reach potential non-tribal users.
- Participants discussed their reliance on word of mouth and reviews when choosing healthcare services. Trust in the information source was identified as a crucial factor, with some participants mentioning a step process involving both word of mouth and reviews.
- Many tribal members prefer seeking healthcare within their families first, indicating a strong reliance on close-knit community networks.
- Some participants admitted avoiding or delaying important healthcare, including medical, mental, or dental care, due to fear or discomfort.
- Stigma around mental health was identified as a significant barrier, with concerns about judgment and negative labels like "crazy" affecting individuals' willingness to seek help.
- Age was identified as a factor influencing healthcare decision-making, suggesting that different age groups may have varying approaches to seeking and receiving healthcare.

In summary, the focus group data highlights the multifaceted nature of healthcare decision-making, with word of mouth, trust, and age influencing individuals' choices. Addressing stigma, improving communication strategies, and understanding the preferences of diverse community members are crucial for promoting accessible and inclusive healthcare services.

Comparative Analysis

Overall, challenges in healthcare access are a common theme across all focus groups. Provider turnover and the emotional impact on patients are recurring concerns. Reliance on personal connections, family networks, and community resources is prevalent. Desire for patient-centered care, understanding, and support from allies was expressed. Stigma around mental health was identified as a barrier across

different groups. Improved communication strategies and addressing disparities were universal needs. Focus groups did differ in the following ways:

Families with Child Welfare Involvement:

- Emphasis on the difficulties of accessing consistent and timely healthcare services.
- Provider turnover affecting care continuity and emotional connections.
- Long wait times for appointments leading to reliance on urgent care.
- Importance of preventative care over urgent care.
- Desire for better patient experiences in healthcare facilities.

BIPOC Focus Group:

- Challenges with the affordability of healthcare even with insurance.
- Emphasis on the need for self-advocacy within a system with high provider turnover.
- Desire for support and understanding from allies, acknowledging potential stereotypes.
- Concerns about personal safety, especially for people of color.
- Reluctance to ask for help due to potential stereotypes and condescension.

People Ages 16-24 Years Focus Group:

- Challenges with customer service and rude treatment in healthcare settings.
- Reliance on family and community networks for guidance.
- Concerns about medication, side effects, and communication issues with providers.
- Disparities in healthcare based on appearance and identity.
- Desire for non-medication-based strategies for mental health care.

People Who Are Houseless Focus Group:

- Frustration with limited access to healthcare information and support.
- Reliance on personal connections and a lack of dedicated resources in the community.
- Reluctance to seek healthcare due to trust issues and frustration with providers.

People with BH Need Focus Group:

- Relying on healthcare providers like Adapt and community programs for support.
- Challenges with appointment wait times and variations in provider quality.
- Differentiated quality of care in various healthcare facilities.

Tribal Focus Group:

- Word of mouth and trust playing a significant role in healthcare decision-making.
- Impact of reputation and location in choosing healthcare services.
- Importance of effective communication, especially during transitions in services.
- Stigma around mental health affecting willingness to seek help.

What do service providers need to understand about you or your community when it comes to investing in communities' health and wellness?

Summary:

The focus group discussion provides valuable insights into what service providers need to understand about the participants' community when investing in health and wellness:

- Participants emphasized the need for more on-the-ground drug and alcohol services. While they acknowledge the expansion of Crossroads for detox, there is a lack of support for individuals who are not actively using. The absence of services for relapse prevention was a significant concern.
    - Challenges for Those in Recovery: Participants in recovery highlight that even after achieving sobriety, they face difficulties and challenges in various aspects of life. The process of recovery is not a guaranteed path to success in all areas. There is a need for continued support for individuals in recovery to address the broader challenges they may encounter in life.
- Some participants expressed concerns that the system can make it more attractive to stay on welfare rather than pursuing employment. They believed that accessing certain benefits is easier than working. It was suggested that the system should empower individuals to seek employment and improve their lives without facing the risk of losing benefits.
- The linkage of housing to employment was mentioned as a form of blackmail, forcing individuals into jobs they may not appreciate. The limited availability of housing options makes this situation challenging. This situation illustrates the significance of affordable housing and its impact on people's employment choices.
- Participants suggested that healthcare providers should review the entire history of a patient to better understand their ailments and provide more personalized care.
- Participants suggested that income levels need to be reevaluated to match the community's needs. Ensuring that income thresholds align with the community's financial realities is crucial.
- Participants advocated for reinvesting in the community. They mention that businesses like Rite Aid and Grocery Outlet have left the community, resulting in inconveniences. The community benefits when businesses invest in the area and contribute to the overall well-being of residents.
- The accessibility and effectiveness of virtual healthcare appointments were raised. Some individuals may lack internet access or may require in-person appointments. Service providers should consider the community's access to technology when offering virtual healthcare services.
- Participants expressed the need to overcome stereotypes that label individuals within the community as "druggies" with mental health issues and criminal backgrounds. Service providers should approach individuals with an open mind and without preconceived notions.
- There was a call for improved communication and a return to compassionate care, as some participants feel that doctors have lost their bedside manner. Effective communication and nurturing relationships with patients are essential for quality healthcare.
- The community faces a shortage of doctors, which can lead to burnout among healthcare providers. The healthcare system should address the need for an adequate number of healthcare professionals.

In summary, service providers need to understand the community's need for accessible drug and alcohol services, the challenges faced by those in recovery, the importance of affordable healthcare, and the broader socio-economic factors affecting individuals. Community investment, reevaluation of income levels, and access to comprehensive healthcare are essential considerations for improving health and wellness within the community. Additionally, the need for empathy, better communication, and the avoidance of stereotypes in healthcare interactions is emphasized.

Families with Child Welfare Involvement Focus group

- Participants emphasized the need for increased drug and alcohol services within the community. They mentioned the challenge of accessing timely help during relapse, as they were turned down for not being actively using drugs, and they had limited support options. The absence of

services for individuals who want to prevent relapse or seek support without actively using was noted as a significant gap in available resources.

- Participants who have worked on their recovery note that achieving sobriety doesn't necessarily guarantee success in all aspects of life. There's frustration about the difficulty of transitioning to a life of stability and success after overcoming addiction. The existing support system may not adequately address the comprehensive needs of individuals in recovery.
- Participants discuss the challenges within the healthcare system, particularly when it comes to addiction and recovery services. There's frustration about the requirement to be in active addiction to access services, which, in turn, can discourage people from seeking help. The increase in drug addiction within the community is alarming and underscores the urgency of improving support services.
- One participant shared their experience with a single mom conference focused on providing support. They consider starting a similar group in their area to promote health and wellness among single mothers. Building a support network for single parents is seen as a positive step toward community health and wellness.
- There were concerns about the welfare system potentially discouraging individuals from seeking employment. Participants feel that the system can make it easy to stay on welfare and receive various benefits, leading to a disincentive for individuals to pursue employment. The trade-off between benefits and the effort required to find employment was discussed, highlighting the need for a balanced approach.
- The discussion touched on the challenges related to housing, employment, and their interdependence. Participants expressed frustration about being "blackmailed" into working due to their employment being tied to their living situation. The limited availability of housing is a significant concern, as it forces individuals into unfavorable employment situations and doesn't allow them the opportunity to improve their circumstances.

In summary, the participants' feedback highlights the need for more accessible and responsive drug and alcohol services, particularly addressing the issue of relapse and providing support beyond active addiction. The concerns regarding the welfare system's impact on employment and the challenges of reintegrating into society after recovery are crucial considerations for investing in the community's health and wellness. Additionally, addressing housing availability and its relationship with employment is essential for comprehensive support.

BIPOC Focus Group

The focus group discussion provides valuable insights into what service providers need to understand about the community's health and wellness:

- Service providers should have access to thorough patient history and records. This includes understanding who the patients are and their medical history, including any ailments or conditions they may have.
- The high costs of healthcare, particularly dental care, can be a significant barrier to access for the community. Service providers should understand the financial challenges faced by community members and explore options for affordable or subsidized care.
- Disparities in dental care, especially among people of color, were highlighted. It was noted that dental hygiene is often neglected when individuals are stressed. Service providers should recognize and address these disparities, possibly through initiatives like free dental care programs.

- The income criteria for assistance programs and health services should be reevaluated to better align with the community's needs. This is crucial to ensure that those who require assistance are eligible for it.
- Community members expressed concerns about the closure of businesses like Rite Aid and Grocery Outlet, which required them to travel across town for essential services. Service providers should consider the impact of such closures on community accessibility to healthcare and wellness resources.
- While virtual appointments have become more common, service providers must recognize that not everyone has equal access to the internet or the ability to check vitals remotely. This highlights the importance of offering alternatives for those who cannot fully participate in virtual healthcare.
- Service providers should invest in communities to promote overall well-being. The focus should be on practices that benefit the community rather than extracting resources. This reflects a commitment to community health and vitality.
- It is essential for service providers to maintain integrity in their business practices. This includes ensuring transparency, fairness, and ethical conduct in healthcare services.
- Community members shared instances where they needed specialist care but initially faced barriers through primary care provider. Service providers should facilitate and streamline referral processes to ensure that patients can access the specialized care they need without unnecessary delays or obstacles.

In summary, service providers should prioritize understanding the unique needs and challenges faced by the community. This includes offering affordable healthcare options, addressing disparities in dental care, maintaining accessible healthcare services, and investing in the community's well-being.

Youth 16-24 Years Old Focus Group

The focus group discussion revealed important insights into what service providers need to understand about the community's needs when it comes to investing in health and wellness:

- Participants emphasized the importance of service providers advocating for the community's health and wellness. This suggests that service providers should actively support and champion the health and well-being of community members, possibly by advocating for better resources and support.
- Participants identified TikTok and Instagram as the primary social media channels for reaching and engaging with the community. This indicates that service providers should leverage these platforms for disseminating health and wellness information, as they are effective ways to connect with people.

In summary, service providers should take into account the community's need for advocacy and support in the context of health and wellness. Additionally, they should consider the community's preference for social media channels like TikTok and Instagram for communication and information dissemination.

also underscores the challenges posed by technology.

People who are Houseless Focus Group

The focus group discussion provided valuable insights into what service providers need to understand about the community regarding investing in health and wellness:

- The sarcastic remark, "We’re not all the same (we’re all druggies here and all have mental health issues and are all criminals)," indicates that community members often face stereotypes and

stigmatization. Service providers should understand that individuals within the community have diverse backgrounds and experiences. Avoiding such generalizations is essential to providing effective and respectful services.

- Participants highlight the challenges faced by homeless individuals, including not having a permanent address or phone line. Many services and opportunities require these, which can be a barrier for community members. Service providers should recognize the difficulties related to homelessness and adapt their services to be more inclusive.
- The mention of the limitations related to not having a permanent address, such as difficulties with receiving mail or applying for services like phones, underscores the need for service providers to be flexible and accommodating in their processes. The fact that Adapt and the DMV used to work out of the library but no longer do suggests that the availability and accessibility of services have changed over time. Service providers should take into account the evolving needs of the community and maintain convenient service locations.
- The inconvenience of not having certain services, like the DMV, in town, affects community members' ability to access essential resources, such as driver's licenses. Service providers should understand that accessibility plays a critical role in community members' well-being.

In summary, service providers should recognize the diversity within the community and avoid perpetuating stereotypes. They should also understand the challenges faced by homeless individuals, adapt to the changing needs of the community, and prioritize accessibility to essential services. This understanding can lead to more effective and inclusive investments in community health and wellness.

People with BH Need Focus group

The focus group discussion highlights several important points about what service providers need to understand about the participants and their community when it comes to investing in health and wellness:

- Participants emphasize the need for personalized, one-on-one communication with healthcare providers. They reference the concept of "bedside manner" that has seemingly disappeared, expressing a desire for compassionate and nurturing interactions. They value the idea of being treated as partners in their healthcare journey.
- The participants feel that some doctors make assumptions about their care and treatment based on their medical history or profile without thoroughly assessing their current needs. This can lead to misunderstandings and misaligned care.
- The community faces the challenge of a high patient-to-doctor ratio, with "too many people and too few doctors." This scarcity of healthcare providers can affect access to timely and comprehensive care.
- Participants acknowledge that doctors may experience burnout, potentially leading to a level of fatigue when dealing with patients. It's noted that physicians may need to differentiate between patients who genuinely require care and those with other intentions.
- The group highlights the delicate balance between wanting doctors to fill their schedules to accommodate all patients and, at the same time, desiring more personal and unhurried time with healthcare providers.
- Some participants mention that their health issues may resolve on their own by the time their medical appointments come around.
- Instances of negative experiences with healthcare providers, such as being forgotten by a doctor in Myrtle Creek or experiencing long wait times with no interaction, have left participants with concerns about the healthcare system's effectiveness and attentiveness.

In summary, the discussion emphasizes the importance of person-centered care, open communication, compassion, and treating patients as partners. It also addresses the challenges associated with a shortage of healthcare providers, potential burnout, and the need for a balanced approach to appointments. These insights provide service providers with valuable feedback on improving the healthcare experience for this community, focusing on personalized care, accessibility, and positive interactions.

Tribal Focus Group

- Acknowledgment of two types of healthcare facilities – tribal and non-tribal. Emphasis on the importance of understanding and respecting tribal beliefs and history in healthcare.
- Negative connotation associated with the term "Tribal," countered by recognizing the historical roots of medicine in plants.
- Concerns about provider attitudes affecting trust and patient return. Participants stress the importance of patience, kindness, and non-judgmental attitudes from healthcare providers. Building trust involves understanding the historical context, governmental distrust, and intergenerational trauma within the tribal community.
- POCs feeling the need to combat stereotypes and act a certain way to overcome prejudice. Concerns about the impact of political figures like Trump on BIPOC populations.
- Worry about housing issues, potential overcrowding, and affordability challenges. Economic concerns tied to inflation, wage growth, and the ability to afford children.
- Concerns about normalized racism in schools influencing impressionable children. Lack of exposure to POCs and experiences of hidden racism.
- Accessibility issues, like lack of bikeability, affecting the community.

Comparative Analysis

The focus group data collectively emphasized the multifaceted nature of community health and wellness. Key themes include the need for improved addiction services, addressing disparities in healthcare, advocating for community well-being, adapting to evolving needs, and fostering respectful and compassionate interactions. Each group provides unique insights, showcasing the diversity of challenges and priorities within the community. Service providers should consider these perspectives to tailor interventions that comprehensively address the distinct needs of each group, fostering inclusivity and positive community health outcomes. Unique themes by group were:

Families with Child Welfare Involvement Focus Group:

- Emphasis on the need for improved drug and alcohol services, particularly addressing relapse prevention and support beyond active addiction.
- Frustration about challenges in transitioning to stability after overcoming addiction and the inadequacy of existing support systems.
- Concerns about welfare system impact on employment and the interconnected challenges of housing and employment.

BIPOC Focus Group:

- Call for service providers to have thorough patient history and records, considering financial challenges faced by community members.
- Highlighting disparities in dental care and the need for initiatives like free dental care programs.
- Advocacy for reevaluating income criteria for assistance programs and addressing the impact of business closures on community accessibility.

People 16-24 Years Focus Group:

- Emphasis on service providers advocating for community health and wellness.
- Recognition of TikTok and Instagram as primary social media channels for engaging with the community.

People who are Houseless Focus Group:

- Recognition of stereotypes and stigmatization faced by the community, emphasizing the diverse backgrounds of individuals.
- Challenges related to homelessness, including the lack of permanent addresses affecting access to services.
- Importance of service providers adapting to the evolving needs of the community and maintaining convenient service locations.

People with BH Need Focus Group:

- Need for personalized, one-on-one communication with healthcare providers and a desire for compassionate interactions.
- Challenges associated with a high patient-to-doctor ratio, potential burnout, and the delicate balance between scheduling and personal time.
- Concerns about negative experiences with healthcare providers, highlighting the need for attentiveness and effectiveness.

Tribal Focus Group:

- Emphasis on understanding and respecting tribal beliefs and history in healthcare.
- Concerns about provider attitudes affecting trust, with an emphasis on patience, kindness, and non-judgmental interactions.
- Worries about housing, economic challenges, and the impact of normalized racism on children.

In summary, the feedback from these diverse groups emphasizes the importance of personalized and compassionate care, addressing disparities in healthcare, recognizing the unique needs of each community, and providing accessible and inclusive services. Service providers should actively engage with their communities, avoid stereotypes, and adapt their practices to better meet the needs of the populations they serve.

What do you think your greatest concerns will be in 10 years?

The focus group discussion provided valuable insights into the participants' greatest concerns for the future, particularly in the context of racism, social issues, housing, education, and community dynamics.

- Concerns about housing affordability and inflation are raised, particularly if wages do not keep pace. Overcrowding and financial constraints may lead to decisions not to have children. Housing conditions, including the lack of bike-friendly infrastructure, are seen as community challenges.
- The participants express concerns about the lack of exposure to people of color in their community. The need to be mindful of one's reactions and challenge racial biases is emphasized.
- Participants express concerns about ongoing racism and the need for people of color to combat stereotypes by appearing a certain way to counter biases. A potential return of leaders like Trump is seen as a negative impact on the BIPOC population, raising concerns about increased racial tension. The normalization of racism in schools is highlighted as a worrisome issue, as it can influence young and impressionable individuals.

- Instances of racism in daily life, such as racist comments and xenophobic attitudes, were highlighted. The importance of addressing hidden racism and the need for a more diverse population was noted.
- The discussion included concerns about the mental health and well-being of high school students, especially given the high levels of depression. Participants comment on societal changes over the past 20 years, including an increase in school shootings. The decline in family values, less time spent on traditional family meals, and increased fast-food consumption are discussed as potential factors contributing to societal issues. The discussion briefly touched on the topic of bullying and school shootings.

In summary, the focus group participants' concerns center around racism, housing, inflation, education, community diversity, and societal changes. They express apprehensions about the perpetuation of racism, future leadership, and housing affordability, along with worries about the mental health of high school students and the broader societal implications of changes in family dynamics. The discussion reflects a complex interplay of social, economic, and cultural factors that are likely to shape their concerns for the coming decade.

Appendix F: List of Recent Community Assessments

1. United Community Action Network, Douglas and Josephine County, 2022 Community Needs Assessment. Retrieved from ucan-2022-needs-sssessment.pdf (ucancap.org)

2. Oregon State University, Oregon Child Care Research Partnership June 2023. 2022 County Profile. Retrieved from Douglas County Early Learning Profile 2022 (oregonstate.edu)

3. Umpqua Health Alliance SHARE 2021. Supporting Health For All Through Reinvestment Initiative. https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Cooper-UHA-Navigation-Center.pdf

4. Oregon Health and Science University, Portland State University (OHSU-PSU). Oregon Substance Use Disorder Services Inventory and Gap Analysis, September 30, 2022. Retrieved from oregon.gov/adpc/SiteAssets/Pages/index/OHSU - Oregon Gap Analysis and Inventory Report.pdf