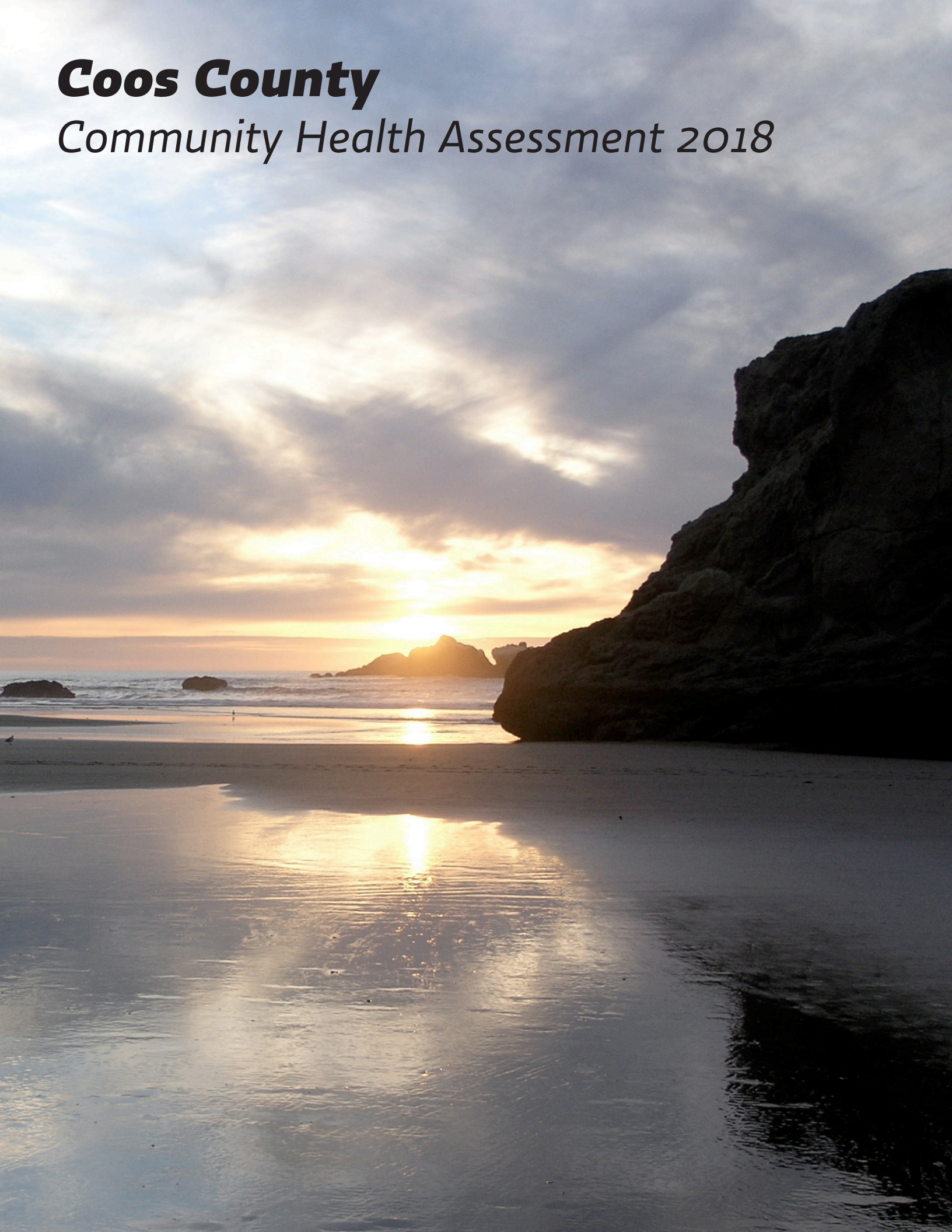
Coos County

Community Health Assessment 2018



Acknowledgments

Coos Community Health Assessment Committee

Betty Albertson, Department of Human Services
Susie Breuer, Coquille Valley Hospital
Lisa Hendricks, Advanced Health
Heidi Hill, Advantage Dental
Fauna Larkin, Coquille Indian Tribe Community Health Center
Amber Madigan, Coos Health & Wellness
Linda Maxon, Coast Community Health Center
Scott McEachern, Southern Coos Hospital and Health Center
Reneé Menkens, Coos County Friends of Public Health
Ruby Phillips, Advanced Health, Community Advisory Council
Florence Pourtal-Stevens, Coos Health & Wellness
Belle Shepherd, Oregon Health Authority
Cindy Shirtcliff, Advantage Dental
Anna-Marie Slate, Advanced Health Community Advisory Council
JoDee Tittle, Southern Coos Hospital and Health Center
Andrea Trenner, Waterfall Community Health Center and School Based Health Centers
Laura Williams, Advanced Health, South Coast Early Learning Hub
Corey Wampler, South Coast Head Start, Oregon Coast Community Action
Angie Webster, Bay Area Hospital

Consulting & Technical Writing by:
V Consulting & Associates Inc.

Executive Summary

The **purpose** of the Coos County Community Health Assessment (CHA) is to provide a view into the health of the community. The CHA is built on many years of previous community work. The unique and robust collaborative committee included stakeholders working across multiple sectors including: local public health, hospitals, federally qualified health centers, early learning and child focused groups, tribal health services, dental organizations, the local coordinated care organization and many other vital health and human services organizations. The process of engaging community members and organizations to identify strengths and challenges related to health will result in improved planning of services and an improved ability to prioritize resources to improve health outcomes.

The Community Health Assessment process was rooted in values including a desire to present **challenges**, **needs** and **strengths** in the county. The process used a broad framework to view these challenges and strengths based on the social determinants of health. The social determinants of health are the conditions in which people are born, grow, live, work and age. They include many factors that influence health that have not often been connected in a traditional health assessment document. Some of these factors include neighborhood and physical environment, education, social connectivity and economic stability. The 2018 CHA stands apart from past assessments because it identifies challenges and strengths while also recognizing many of the social determinants that influence health in Coos County.

Data used in the Community Health Assessment included primary and secondary data, qualitative and quantitative data. Primary data was collected through focus groups and a community survey. The focus groups and surveys gathered community perceptions on strengths and challenges related to health. Community perceptions and experiences sometimes matched what the secondary data illustrated and other times it did not paint the same picture. Secondary and primary data are intermingled throughout the document, a unique presentation of community health.

The number one **strength** identified in the primary data collection was appreciation for the physical environment and natural beauty of the county. This was followed by (1) recognition of the people that live in the county; (2) how people support one another through volunteerism; and (3) how people value community.

The CHA document is a comprehensive look at health in Coos County, but it does have limitations. The CHA is not meant to cover every possible factor that influences health nor is it an evaluation of services or the efficacy of the health care system itself. The CHA document is intended to inform continued work on health improvement. Future work will include prioritization of health issues and interventions and exploration of how to build on work that is already being done in the community. The CHA also lists data gaps in the community and areas that need additional study and data collection.

Contents

Introduction and Purpose

The 2018 Community Health Assessment (CHA) is a view into the health status of the people that live in Coos County. The assessment process results in an increased understanding of key health issues facing our communities, aids in better planning of services and helps to identify strengths and challenges to address with our health care resources. The development of the assessment also engages community members by listening to their perceptions and experiences about what influences health. The process includes comprehensive data collection and analysis, working across multiple sectors and bringing over a dozen local organizations together. The process of creating the CHA is as important and vital to the community as the document that is produced. The resulting CHA document assists organizations in planning and prioritizing efforts that ultimately improve health outcomes and the health of individuals and our communities. The 2018 Coos CHA was published in April, 2018.

Community Health Assessment Approach & Model

The 2018 CHA is built on several years of previous community work. After the 2013 publication of the Coos Community Health Assessment and subsequent Community Health Improvement Plan (CHIP), several committees organized their efforts to address specific CHIP health priorities. The group expanded to include local hospitals, federally qualified health centers, public health, early learning and child focused groups, the local Coordinated Care Organization (CCO), tribal health services, dental organizations and many other vital health and human service organizations. The desire to pool resources, reduce duplication of effort and meet individual requirements for health assessments drove the group to engage with a consultant to lead and facilitate the 2018 Community Health Assessment in the fall of 2017.

Organization Partners in 2018 Coos Community Health Assessment

- Department of Human Resources
- Oregon Coast Community Action
- South Coast Head Start
- Bay Area Hospital
- Southern Coos Hospital and Health Center
- Coos Health & Wellness
- Advanced Health
- Coquille Indian Tribe Community Health Center
- Advantage Dental
- Coast Community Health Center
- Coquille Valley Hospital
- Waterfall Community Health Center
- South Coast Regional Early Learning Hub
- Oregon Health Authority
- Coos County Friends of Public Health

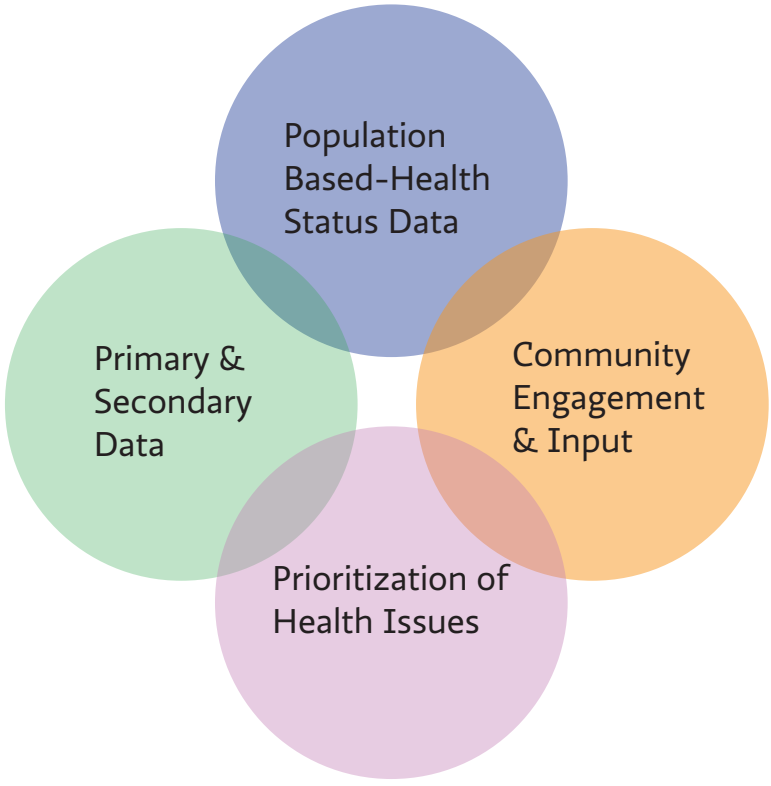
The Mobilizing for Action through Planning and Partnerships (MAPP) model was the approach chosen by the committee. The MAPP process is a national best practice. It is a community driven process that results in engagement of new stakeholders, provides a broad understanding of community health issues and helps to identify both strengths and challenges related to health in a community. Due to resources and time required for a robust MAPP process, the committee agreed upon a modified MAPP model with a timeline of October 2017-April 2018.

The work of the CHA was completed by both the consultant and the CHA committee. The CHA committee provided leadership to the process, assisted with primary data collection including focus groups and surveys and were key in engaging community voices. Specific methods used for data collection are outlined in the data section.

Collaborative Partner Key Requirements

Many community organizations are required to complete a health assessment. The regulatory bodies that require these assessments vary widely in their frequency, focus and requirements for assessments. They include a broad spectrum of organizations, from the Internal Revenue Service (IRS) to the Oregon Health Authority. Although vastly different, the regulatory requirements for all assessments articulate a need for community organizations to seek to understand strengths and needs in a community to better prioritize health efforts and services.

Overlapping Key Requirements for Community Health Assessments



There are many requirements that are shared across all entities that are required to go through a community health assessment process. These include having a balance of types of data, community engagement and input, population based health status data and some level of prioritization of health issues in the community.

Plans and Processes requiring Community Health Assessments

CHNA

Community Health Needs Assessment

Required by IRS

Focus is to identify and assess access and needs of community the hospital is serving.

Documentation must include written report.

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

Every 3 years

CCO

Coordinated Care Organization

Required by Oregon Health Authority

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

Led by CCO, with Community Advisory Council involvement.

Every 3 years

Public Health Accreditation

Local Health Department participates in/or leads CHA development process.

Collaborative process resulting in a comprehensive community health assessment.

Every 5 years

Other

Other includes Federally Qualified Health Centers (FQHCs), Head Start, Early Learning Hubs, Tribal Health Centers.

Various time lines/frequency/requirements and population focus

Vision & Values of Community Health Assessment Process

One of the first steps in the MAPP process is for the committee to discuss their vision for a healthy community and the values related to assessing and planning for that vision.

- ***We believe health is very connected to social determinants of health such as education, employment, housing, safety and food***
- ***We believe in addressing poverty and inequity as a root cause of poor health is important***
- ***We believe in a multi-sectoral approach to addressing community health is vital***
- ***We believe we must present a balance of challenges, strengths and assets related to health***
- ***We believe everybody is valuable, when people cease to think they are valuable it affects physical and behavioral health***
- ***We believe the process serves to engage consumers of health services and incorporates the voices of those we serve***
- ***We recognize that the resulting CHA document needs to meet requirements for several organizations and that we can't cover every possible health issue in one document so we will prioritize what we think is most important to emphasize***

Social Determinants of Health & Health Equity Framework

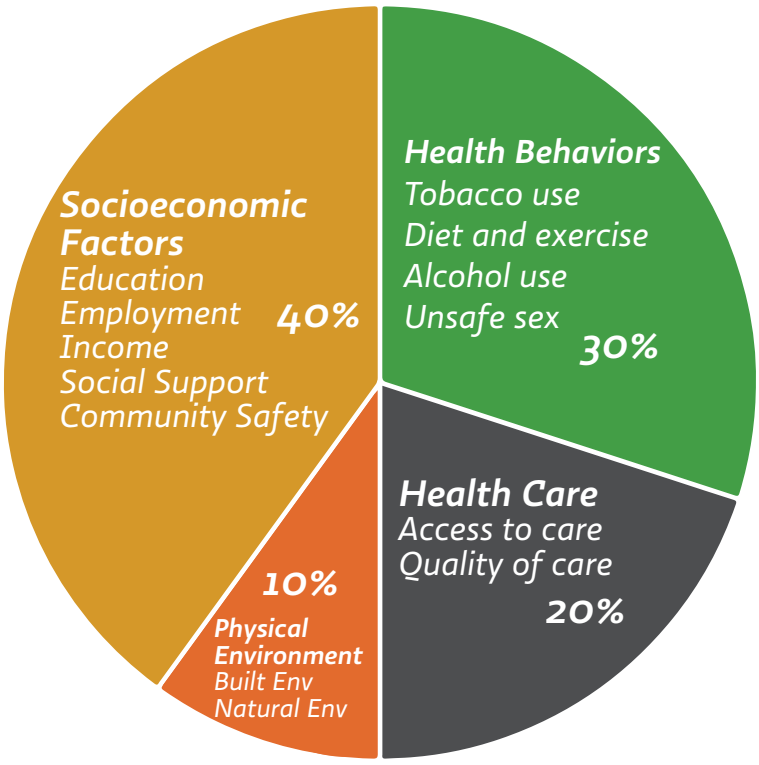
The CHA committee recognizes that multiple factors in a community impact the health of individuals, families and communities. These are often called the Social Determinants of Health. The term Social Determinants of Health is defined by the World Health Organization as "the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources." The social determinants of health influence health inequities. Health inequities are the avoidable, unfair and unjust differences in health status seen within and between individuals and communities.

The traditional way to approach health assessments and health improvement was to focus only on health care services. More recent research and practice has expanded that perspective to recognize that health is more than health care, more than what happens at the health care provider office.

Social Determinants of Health

Health care itself influences health, but socioeconomic factors, our physical environment and our individual behaviors also greatly influence our health. Many community health models suggest that up to 40% of the health in a community is related to socioeconomic factors and 30% related to individual health behaviors.

What affects health worldwide?



Source: *County Health Rankings and Roadmap*, Robert Wood Johnson Foundation and *Kings County Hospitals for a Healthier Community*, King County Community Health Assessement 2015-2016

Types of Data, Data Collection, Data Sources and Limitations

Data used in the community health assessment included secondary data, primary data, qualitative and quantitative data. Secondary data is data collected by another organization or group. Examples are rates of morbidity and mortality from Oregon Health Authority or demographic data from the US Census. Secondary data at the county level was used most often, but when available and reliable zip code and/or census tract data was used. Newer data was valued over older data, although some sources were older by necessity as the data is no longer being tracked or isn't available in newer years but still illustrates an important point about health status. Due to small population numbers in some areas of the county, multiple years were sometimes grouped together emphasizing trends over time instead of one year snapshots on some data points, an important consideration for rural community assessments.

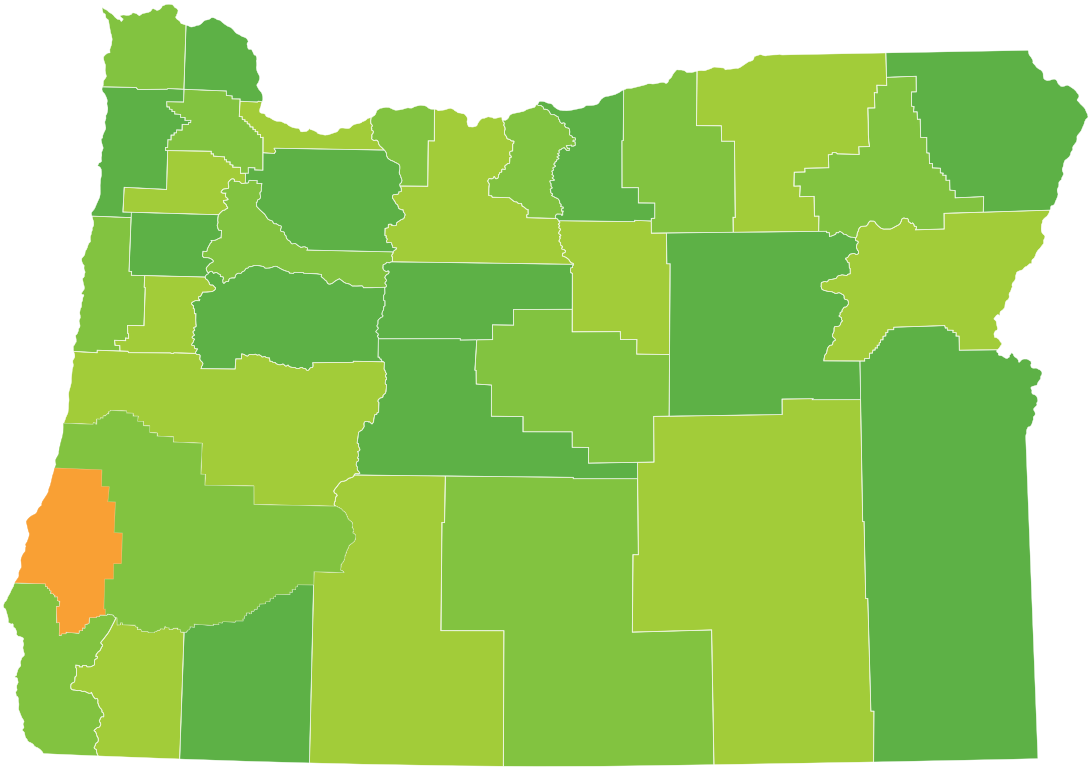
Primary data was collected for this assessment through focus groups and surveys. Details of the primary data collection methodology and results can be viewed in the Appendices.

The Community Health Assessment (CHA) has limitations; it is not meant to cover every possible factor that influences health, or every possible health related data point being tracked. It is not meant to be a complete list of all community health needs or health data. It relies heavily on other secondary data assessments and there are notable gaps in readily available local, county, state and national data. The CHA is not a rigorous research study or a process designed to evaluate the efficacy of services or community organizations. It is intended to provide a macro view of community data, help to identify strengths, assets and challenges and engage community in the process of addressing inequities and improving overall community health. Lastly, the CHA document is intended to be added to over the years, complimenting other assessments.

Demographics

Introduction to Coos County

Coos County is a rural county located on the Southern Oregon Coast. It was recognized as a county in 1853 and named after a local Native American Tribe, the Coos, which some have translated to mean "lake" or "place of pines." Coos County is the 16th most populated county in Oregon (out of 36 Counties) and it borders Curry and Douglas Counties.

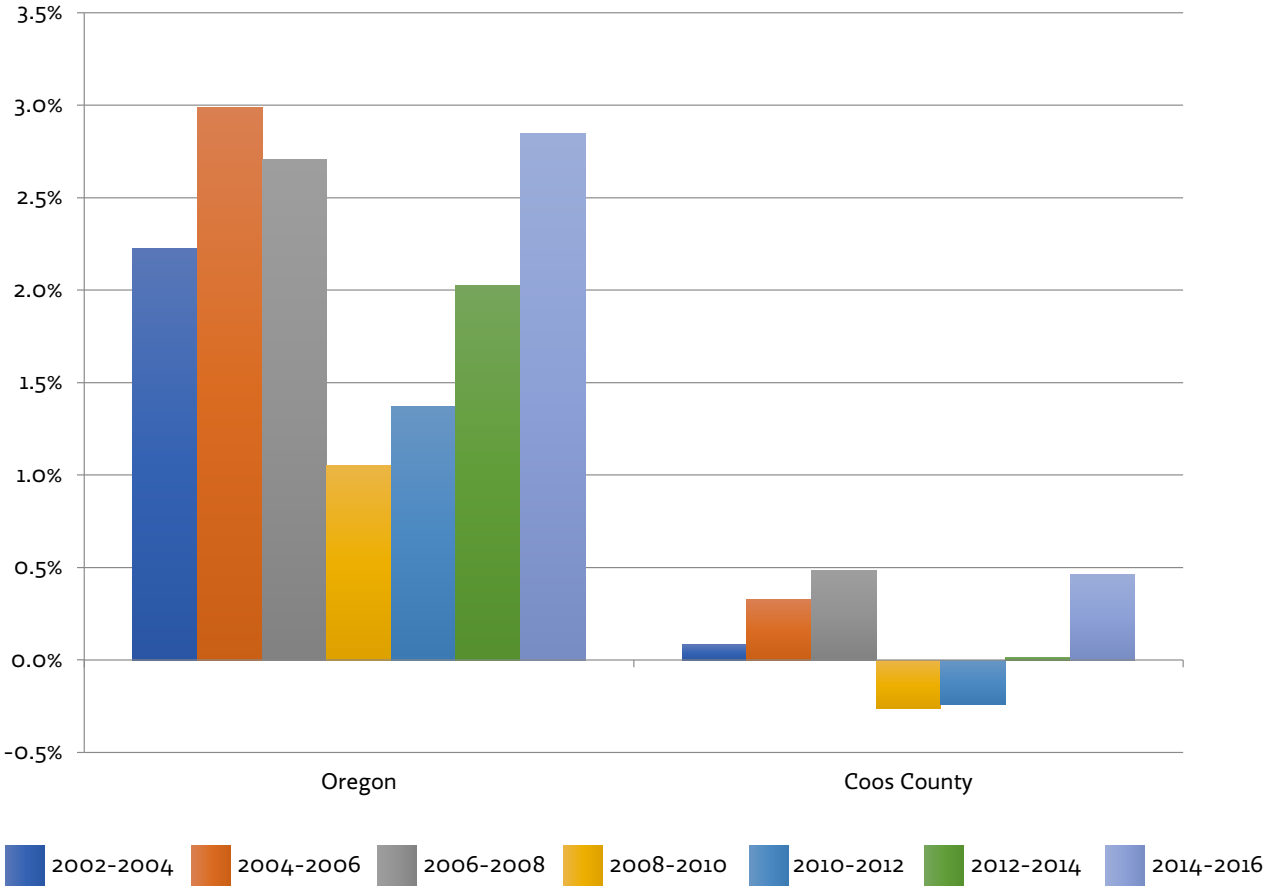


The county has an approximate population of 63,190 people, encompassing 1,629 square miles of land. The rugged mountainous terrain includes hundreds of lakes, rivers and streams stretching from mountains to the Pacific Ocean. There are many unincorporated and isolated rural communities, presenting challenges for transportation and access to services. The seven incorporated cities include Coquille, Coos Bay, Lakeside, Myrtle Point, Bandon, Powers and North Bend. The entire county is designated as rural, by the Oregon Office of Rural Health.

Population Growth

Coos County, like many rural counties in Oregon, has witnessed a slower growth than the state over the last several decades. Negative growth from outmigration was seen 2008-2012 with growth starting again in 2014.

Population change, 2002-2016, Coos County



Source: PSU Population Research Center Annual Population Report 2017

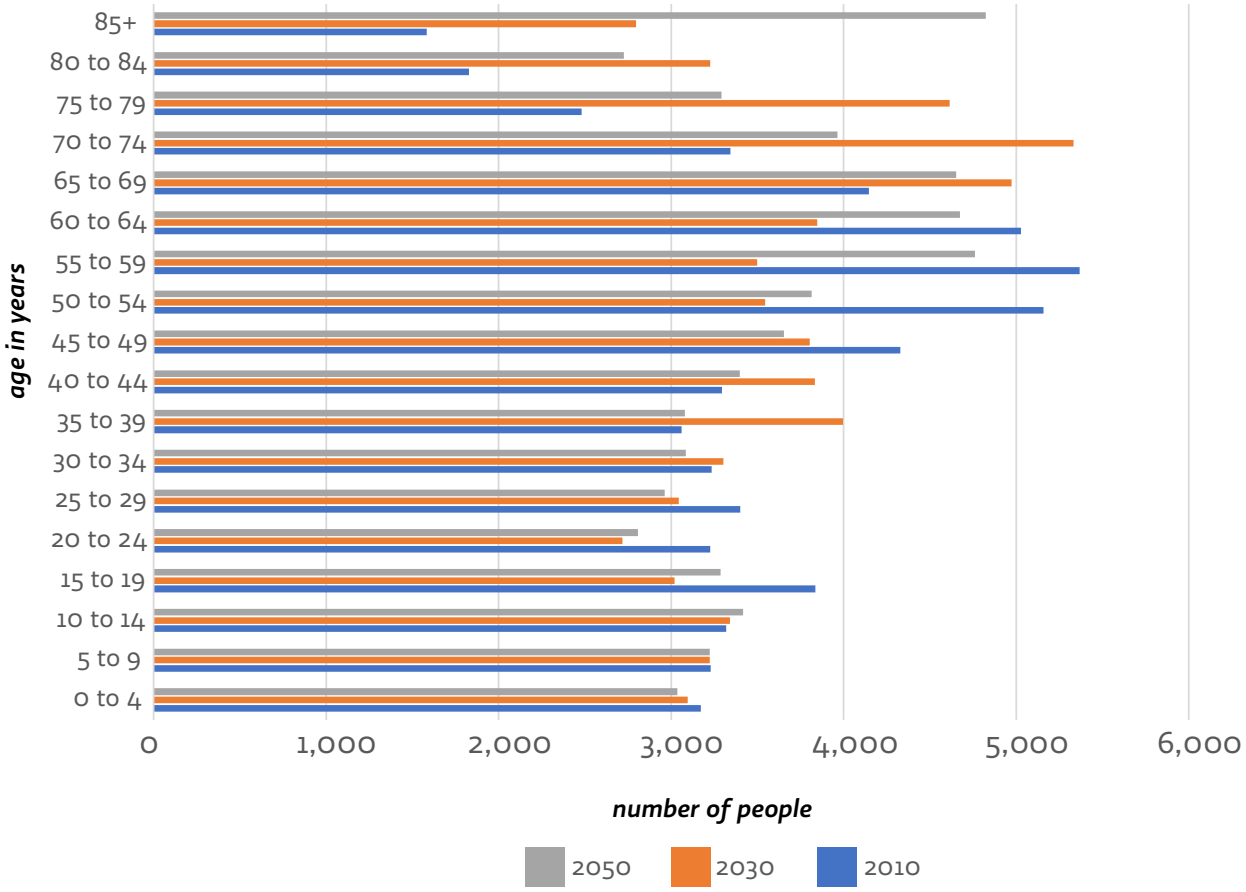
Age, race, ethnicity and language

The median age of residents in Coos County is 48 years old, older than the state median age of 39 years old. Coos County has an older population than the rest of the state. The percentage of those over 60 years of age is steadily increasing and accounts for a larger percentage of the overall population in Coos County. According to census estimates, close to 30% of the county's population was over 60 years of age in 2010. This percentage is expected to increase to nearly 40% by 2030 and continue to increase, driving changes to health and medical needs in the county.

*"Seniors move here expecting to retire and find there are no adequate health care services for them so they leave" —Survey Participant**

***Focus group and survey participant quotes throughout the document represent perceptions, verbatim, from community members. Sometimes they align with presented secondary data, other times they do not.**

Population forecast by age, 2010, 2030, 2050
Coos County



Source: Office of Economic Analysis, Department of Administrative Services, State of Oregon 2013

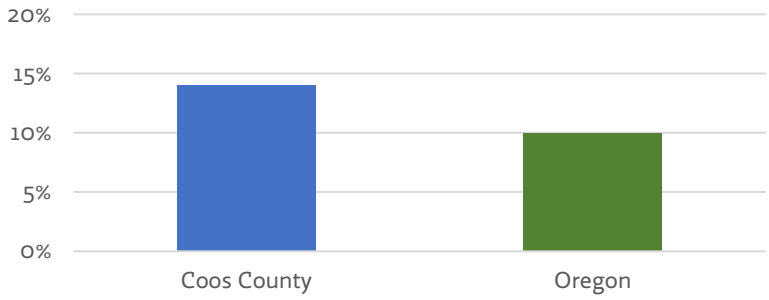
According to 2015 census estimates, there are 14.4 times more White people in Coos County, than any other race or ethnicity, accounting for 85.8% of the population (approximately 53,860 people). The total percentage of White non-Hispanic people has decreased slightly since the 2013 Community Health Assessment when it was 89.8% of all people in the county. This indicates that race and ethnicity other than White non-Hispanic is growing. The remainder of the population self-identifies as 5.95% Hispanic (3,735), 3.5% Multi-racial (2,191), 2.5% Native American (1,598), 1.2% Asian (765), .6% Black/African American, .3% Other and .1% Islander (datausa.io).

Non-English language speakers account for around 4.8% (approximately 3,074 people) of the total Coos population, considerably lower than the state and national percentages which hover around 21%. Spanish is the most common non-English language spoken. 2.7% of the total population of Coos County are native Spanish speakers (approximately 1,723 people). The next most common non-English language spoken in Coos County is German.

Veterans and people with disabilities

Coos County has a large population of veterans. Slightly more than 14% (approximately 7,159 from 2011-15 estimates) of the entire population in the county are veterans, higher than the state. 91% of the veterans are male, consistent with other areas. Veterans have higher rates of disability. The majority of veterans in Coos County served in Vietnam, with growth of the population slower than the state over the last several decades.

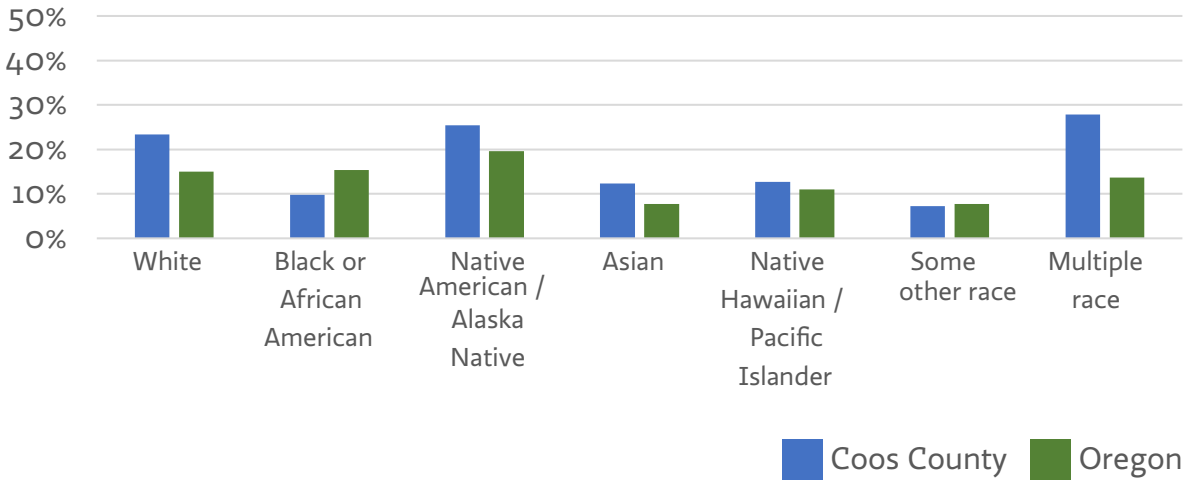
Veterans, 2011-2015
Coos County and Oregon



Source: US Census Bureau, American Community Survey 2011-15

The county has higher percentages of those with disabilities than state percentages.

Disability by race, 2011-2015
Coos County and Oregon



Source: U.S. Census Bureau, 2011-2015 American Community Survey 5-Year Estimates

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percents/ percentages.

Key

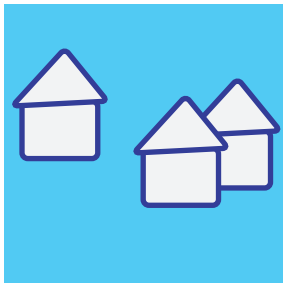
↑ =higher (than State)

↓ =lower (than State)

Demographic

Indicator	***Findings*** *(Coos County vs. Oregon)*
Population	Overall growth ↓
Race & Ethnicity	Hispanic or Latino ↓ Native American ↑
Age	Population 55 and older ↑ Under 18 years old ↓ Families with children ↓
Veterans	Veterans ↑
Disability	Disability ↑ Over age 65 with disability ↑

Neighborhood and Physical Environment



Where somebody lives, works and plays influences their health. Indoor and outdoor air quality and exposure to environmental toxins and other hazards affects health outcomes. Opportunities for physical recreation can have a positive affect on health behavior.

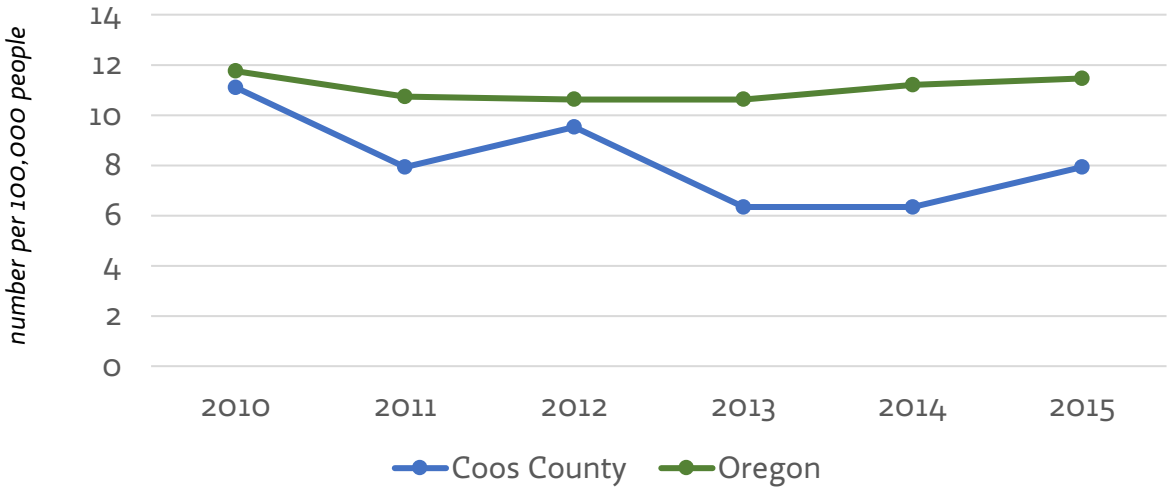
Air quality and recreational opportunities

Outdoor air quality is a **strength** in Coos County, being consistently better than state and national trends. Recreation opportunities are varied in the county. Physical fitness and recreation facilities (5 establishments listed in 2015) are at a lower rate than the state but open space and outdoor recreational opportunities are many. According to available online data, there are 69 parks in the county, multiple beaches, lakes, forests and streams to recreate (Oregon Hometown Locator 2018) in the county. Trails for hiking, biking and other use are also frequent in the area, providing rich opportunities to recreate outdoors. The weather impacts outdoor recreation while access to built walking and running paths are limited in the county. There are few sidewalks and bike lanes available for recreation along roads.

"In truth, we are a beautiful area with clean air and outdoor resources greater than most places in the world." —Survey Participant

"People walk less here, we have seasons so nobody wants to walk in the rain." —Focus Group Participant

Recreation and fitness facilities, 2010-2015
Coos County and Oregon



Source: US Census Bureau, County Business Patterns. Additional data analysis by CARES. 2015

Housing availability & quality

Where people live is core to their quality of life. Housing availability and quality is a well-established social determinant of health. Household problems such as overcrowding, incomplete kitchen or plumbing facilities and cost burden are experienced by 37% of the population in Coos County, slightly lower than the state which is at 39% (US Department of Housing and Urban Development 2013). Indoor air quality data is limited, focus groups and surveys elicited several comments about indoor air quality, mold and water damage.

"Lack of stable housing, or unsafe homes, a lot of moldy homes." "Mold and water damage from roof failure."—Focus Group Participants

Coos County has higher rates of HUD housing units than the state but the availability and affordability continues to be a problem for many people of the county. The county also has higher percentages of housing devoted to seasonal or vacation housing, reducing availability for local permanent people. Oregon Housing and Community Services (OHCS) surveyed service providers and recipients regarding housing in the fall of 2017. Key themes in the OHCS report that were consistent with the CHA focus groups included significant concerns about affordability of housing and rental housing, lack of supply of housing and the quality of housing in the county. Single family homes were listed as the highest need, followed by multi-family dwellings.

Homelessness

People experiencing homelessness, defined by anyone who lacks a fixed, regular and adequate nighttime residence, was listed as a significant concern in the 2018 CHA primary data focus groups and surveys.

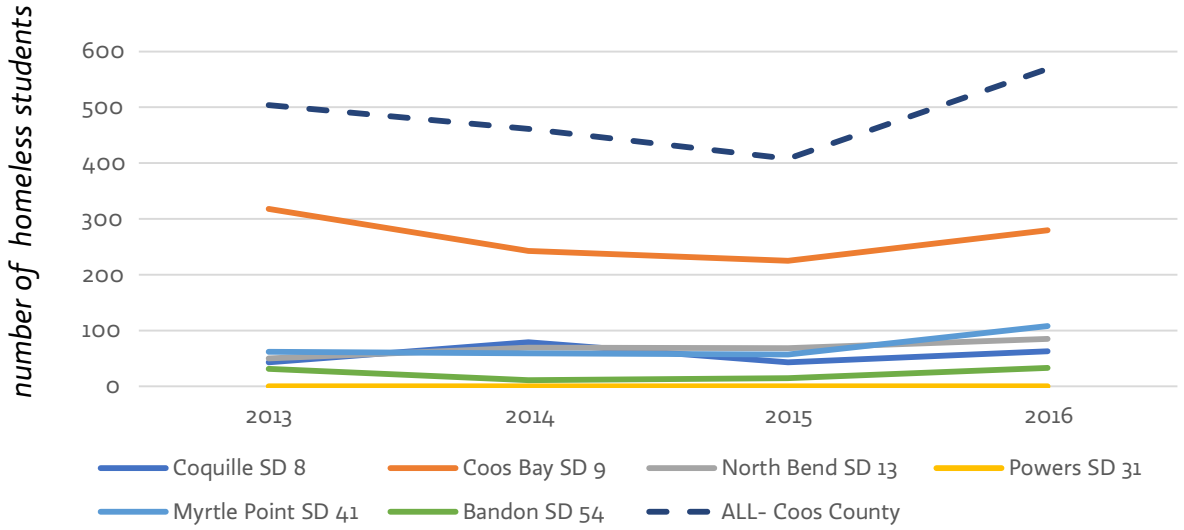
"I've been to 14 states and homelessness is quadrupled here, what are we going to do with that, what are we to do?" —Focus Group Participant

The local Devereux Center served more than 1,400 clients in 2017, averaging 200 unduplicated individuals a month. Their warming center averages 40-50 people per night, where they provide warmth, safety, food and a dry place to spend the night for those who live outside (Devereux report, 2017).

"If you live outside you wake up sick"—Focus Group Participant

"Not enough resources for homeless, there are people who give but a lot that need, pay it forward. It could happen to anyone." —Focus Group Participant

Number of homeless students by district, grades K-12
2013-2016
Coos County



Source: Oregon Department of Education 2017

The number of homeless students in the county is trending up. Homelessness in youth can include those without a permanent home but also includes those doubled up or "couch surfing." In the 2016-2017 school year, 559 children were homeless, 52 of those students were prekindergarten.

Transportation

Transportation and limited public transit remain a challenge in Coos County, particularly for those with limited resources. The people most affected by limited public transit are low-income individuals and families, people with disabilities and older adults. The 2011 Coos County Area Transit Plan lists a wide variety of transportation services but they remain limited in scope and geographic coverage.

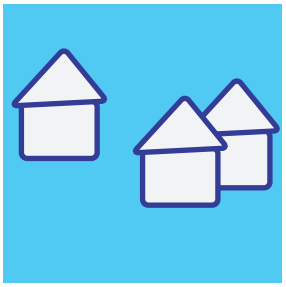
"Affordable public transportation is limited to 7am to 5 pm, Monday to Friday. The ability to get to places easily on foot or bike are difficult with the terrain and the spread of the city services here. This can affect ability to get jobs or keep jobs that may have benefits for some. Bike lanes are on some roads and not others. Lack of sidewalks and good lighting in neighborhoods decreases being able to walk safely to and from places and unsafe for kids to be out on street to play." —Survey Participant

Indicators

Key
↑ =higher (than State)
↓ =lower (than State)

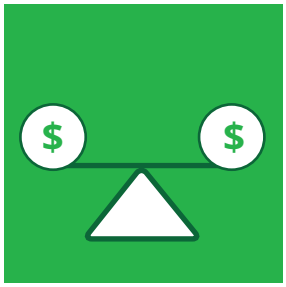
The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percent/ percentages.

Neighborhood and Physical Environment	
Indicator	***Findings*** *(Coos County vs. Oregon)*
Housing Costs	Cost burdened households in rentals & homes with mortgages ↑ Median value of a house since 2006 ↑
Housing Quality and Type	Older housing stock ↓ Severe household problems ↓
Homelessness	Homeless students ↑
Air Quality	Ambient air quality ↑
Recreation and Fitness	Recreational facilities ↓
Transportation	Use public transit to commute to work ↓ Walk or bike to work ↓



Economic Stability

Economic stability includes factors such as poverty, income, employment and unemployment. Income and income inequality is directly linked to an individual's health. Income inequality has been shown to have health impacts including increased risk for poor health and increased risk of death.

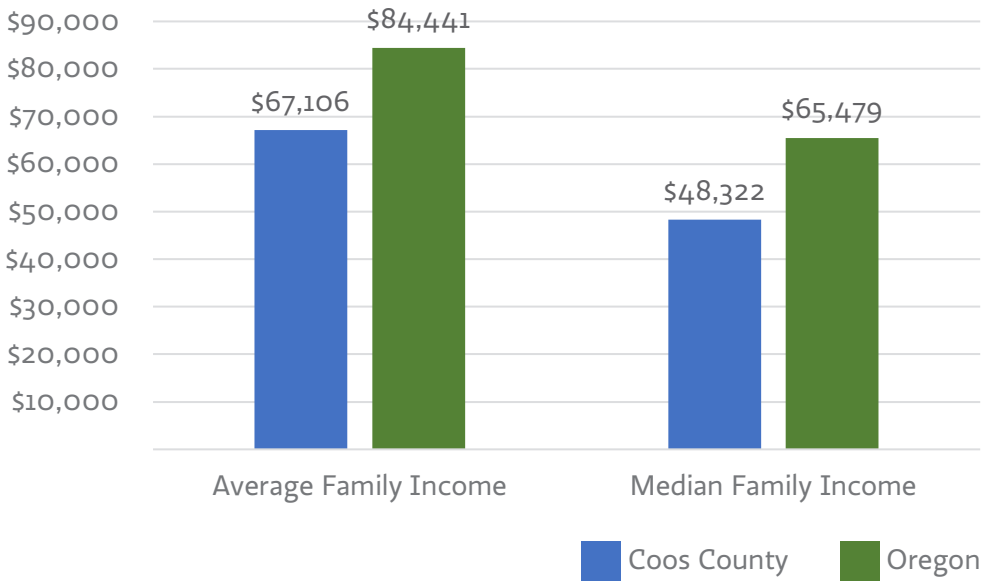


Income

The average and median incomes in Coos County are lower than the state. Poverty levels are higher in the county, compared to state and national percentages.

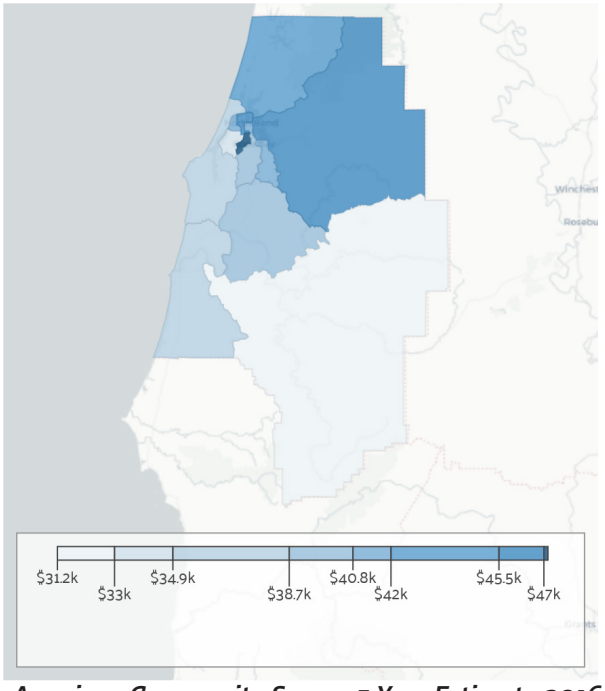
Within the county, highest incomes are in the Coos Bay census tract, lowest income levels are in the southeastern portions of the county. In 2015, 5,297 individuals were listed as living in extreme poverty, residing mostly on the eastern half of the county. In the county, there are more women than men and more people of color living in poverty.

Annual family income, 2012-2016 Coos County and Oregon



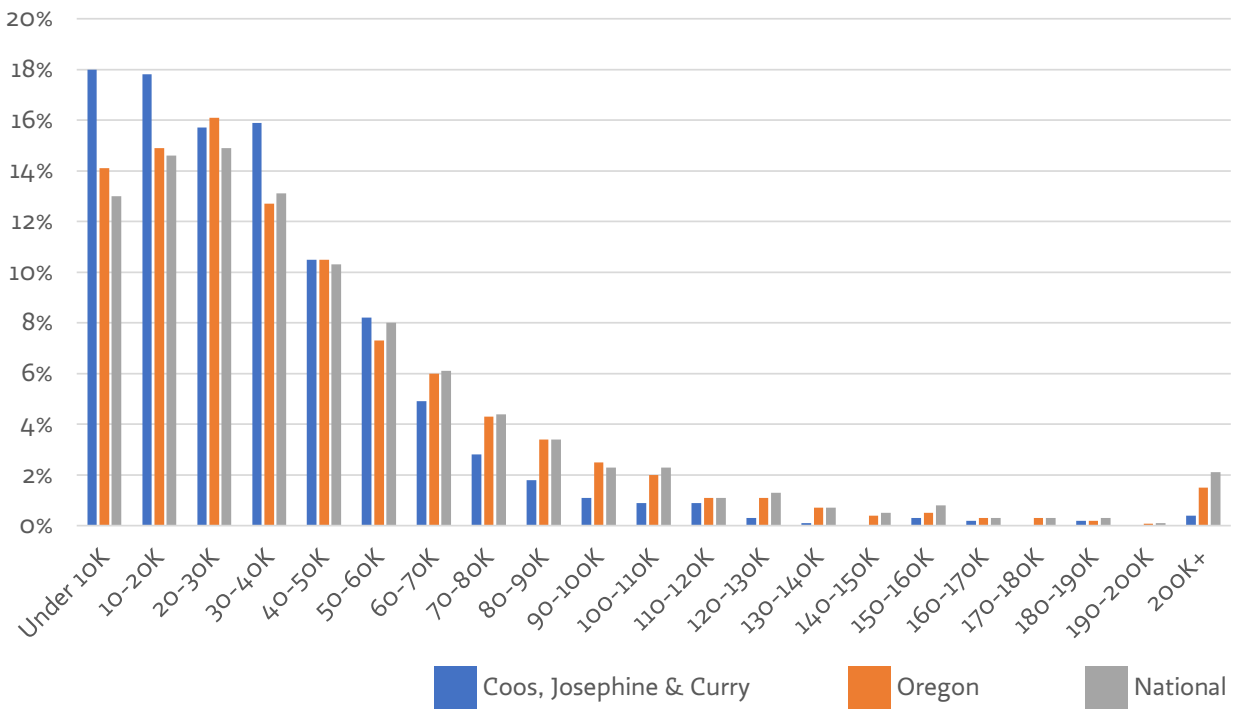
Source: US Census Bureau, 2016

Average household income by location, 2015 Coos County



Source: American Community Survey 5 Year Estimate 2016

Distribution of various wage buckets, 2015
Regional, Oregon, National



Source: American Community Survey PUMS 1-Year Estimate 2017

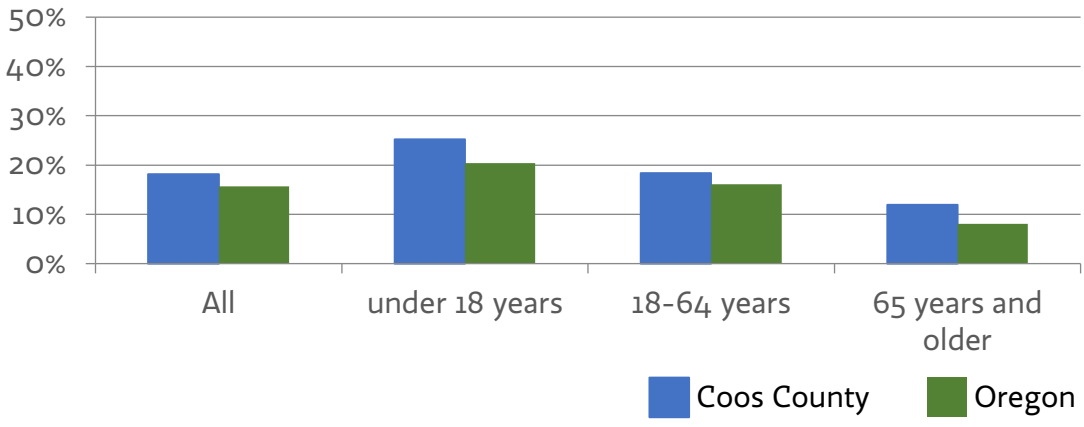
When compared to state and national wages, the county has more lower-wage jobs.

"Its not just having jobs, but having jobs that have a living wage with insurance for families. I see more families becoming homeless." —Survey Participant

Poverty

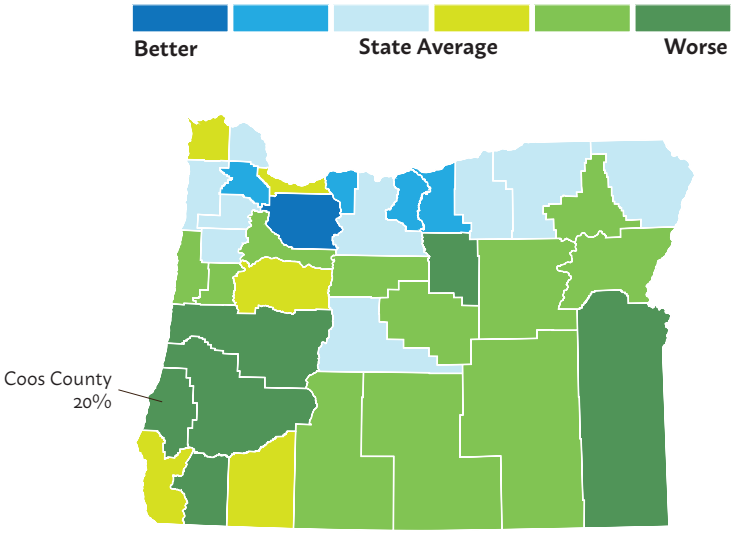
In 2015, one in three children in Coos County were living in poverty, much higher than statewide percentages. Coos County has higher levels of poverty overall, ranging from 18-20% of the population living in poverty, depending on source.

Poverty level by age, 2012-2016
Coos County and Oregon



Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates 2016

Poverty in Oregon 2015

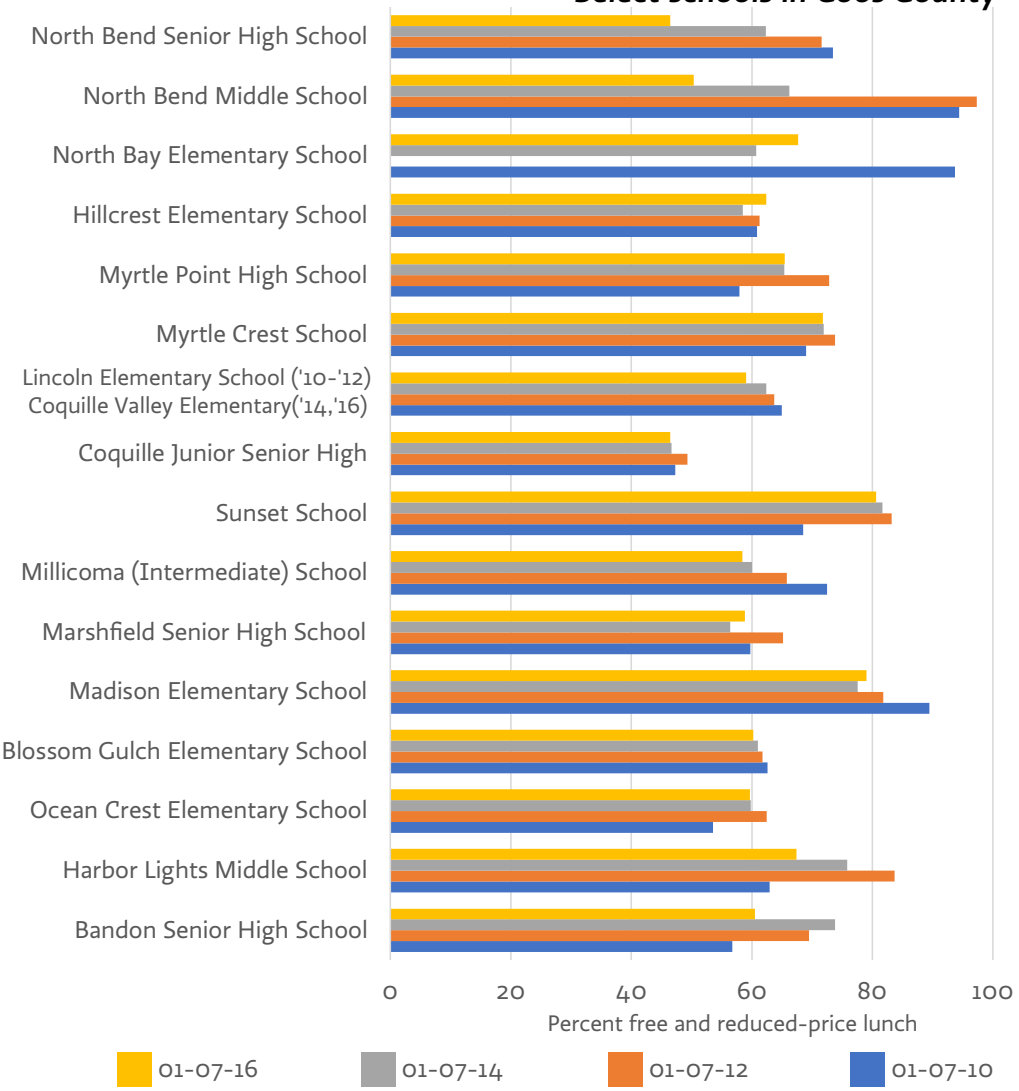


Source: OregonLive 2015

"Inform [others] about poverty in community, blame isn't helpful, but people have so many biases, they don't want to help others. So many people don't get it, they think that poverty just goes away without help. We have to accept it's here and work together to solve it." -Focus Group Participant

Close to 50% of children (4,745 children in 2016) are eligible for free and reduced lunch in Coos County, which is close to averages in the state. The percentage varies within the district, illustrating income inequalities in the county.

Students receiving free and reduced-price lunches, 2010-2016
Select schools in Coos County



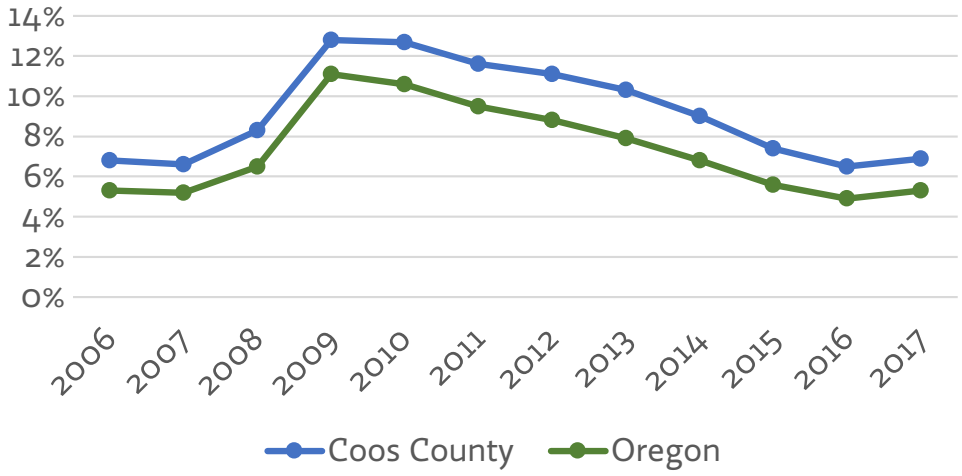
Source: Oregon Department of Education, 2017

Employment and unemployment

Unemployment rates are higher in Coos County compared to Oregon and peaked in 2009, but has steadily trended downward since 2010. Unemployment in Coos County in 2017 was 6.9%.

Employment and annual census of employees in Coos County have also seen a steady increase as reported by the US Bureau of Labor Statistics. Unemployment decreasing and employment increasing have both been positive indicators of economic growth in the county, a trend beginning in 2014. Growing employment and reducing unemployment since 2014 are considered a **strength** in the county.

Average Unemployment Rate, 2006 -2017
Coos County and Oregon



US Department of Labor, Bureau of Labor Statistics July 2017

"People who have productive lives with good jobs are just happier people. Get enough of them together and the whole community is happier and healthier." —Survey Participant

Indicators

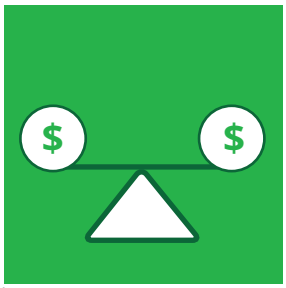
The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percent/ percentages.

Key

↑ =higher (than State)

↓ =lower (than State)

Economic Stability	
Indicator	***Findings*** *(Coos County vs. Oregon)*
Income	Median and average income ↓ Difference in income by race/ethnicity ↓
Living in poverty	Living in poverty ↑ Children live at or below 200% Federal Poverty Level ↑ Women in poverty ↑ Poverty by race/ethnicity ↑
Free and Reduced-price lunches	Students qualifying for free and reduced lunch ↑
Unemployment	Unemployed ↑



Education

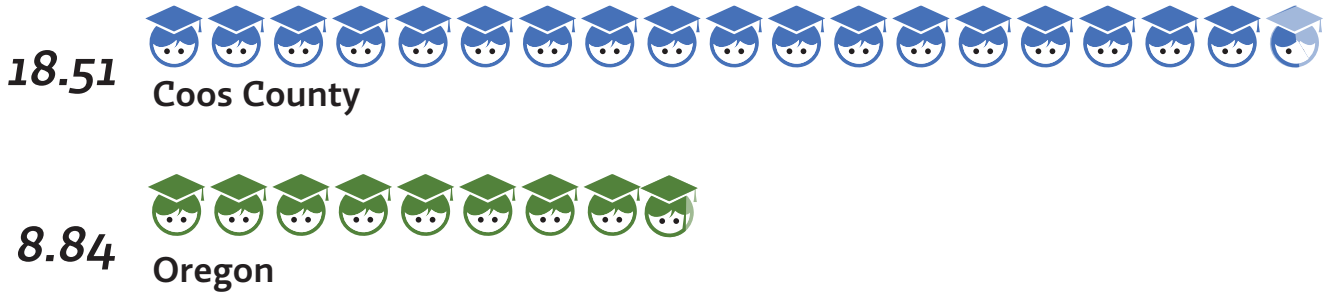
Education is an important social determinant of health, as education increases a person's overall health also often increases. More education is shown to be linked to longer life and increased income, while lower education attainment can be linked with poor health, higher levels of crime, unemployment and increased stress.

"Key is education. It's key for everything. Results in knowledge, more health, how to use knowledge and better able to manage every day." –Focus Group Participant

Early learning

Coos County has a robust early learning system that has benefited positively from many years of community focus. Although the rate of students enrolled in Head Start is significantly higher than the state, the recent needs assessment by the 2016 Oregon Coast Community Action Agency lists that program expansion is still needed to provide supports for families and children in the county. Additionally, the south coast generally has only 12 childcare slots per 100 children and the annual cost of care for a toddler is over 30% of the annual income of a minimum wage worker (ORCCA 2016 Needs Assessment). The early learning system in the county is strong but there continues to be significant needs.

Students in Head Start 2014 (per 10,000 children)

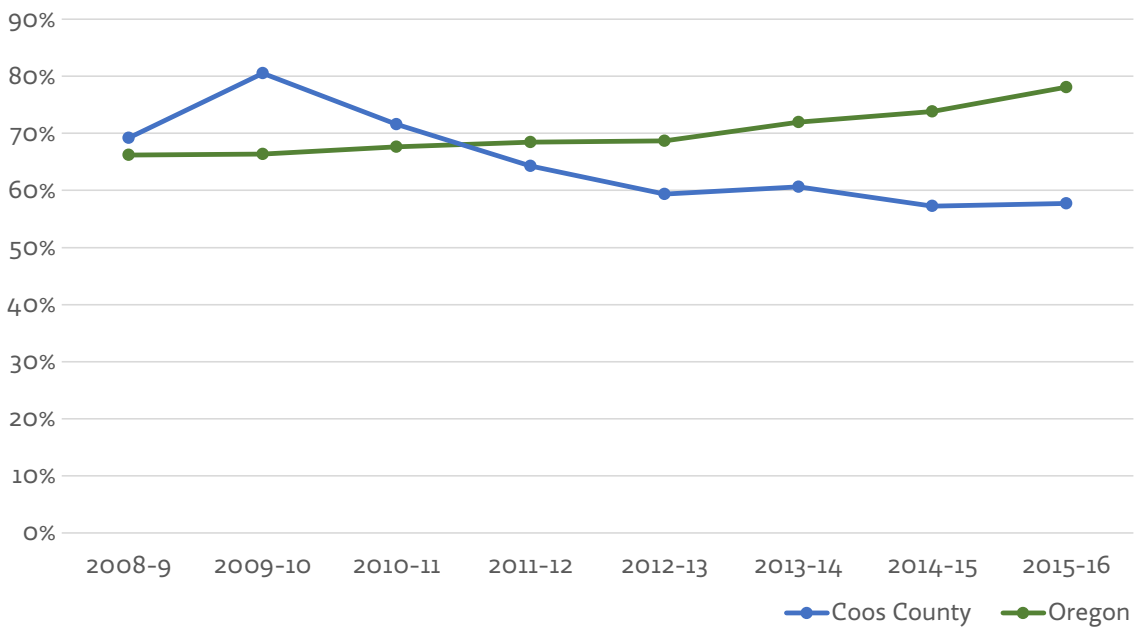


Source: US Department of Health & Human Services, Administration for Children and Families, 2014

Graduation

High school graduation rates have been lower in Coos County than Oregon since 2011 and on a downward decline, representing a significant challenge to health. Latest available data from the Oregon Department of Education shows 58% of ninth graders graduated from high school in their cohort (4 years later) in 2015-16.

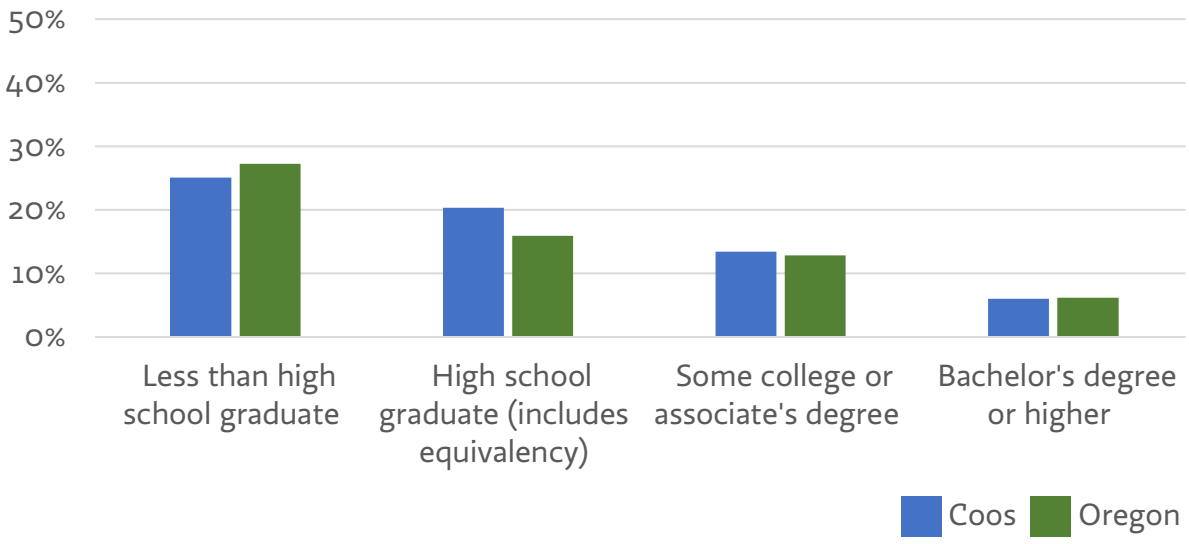
4-Year cohort graduation rates, 2014-2015
Coos County and Oregon



Source: US Department of Education 2016

"It's a cycle of poverty and lack of education. I've taught for 20 plus years and see generations that are older that didn't need it and didn't value it, but it is now. They can't or don't see the need for continuing their education. We need to create a different pathway. Perception is that it (education) is not valued and not seen as a way to a different life." —Focus Group Participant

Poverty status by educational attainment, 2011-2015
Coos County and Oregon



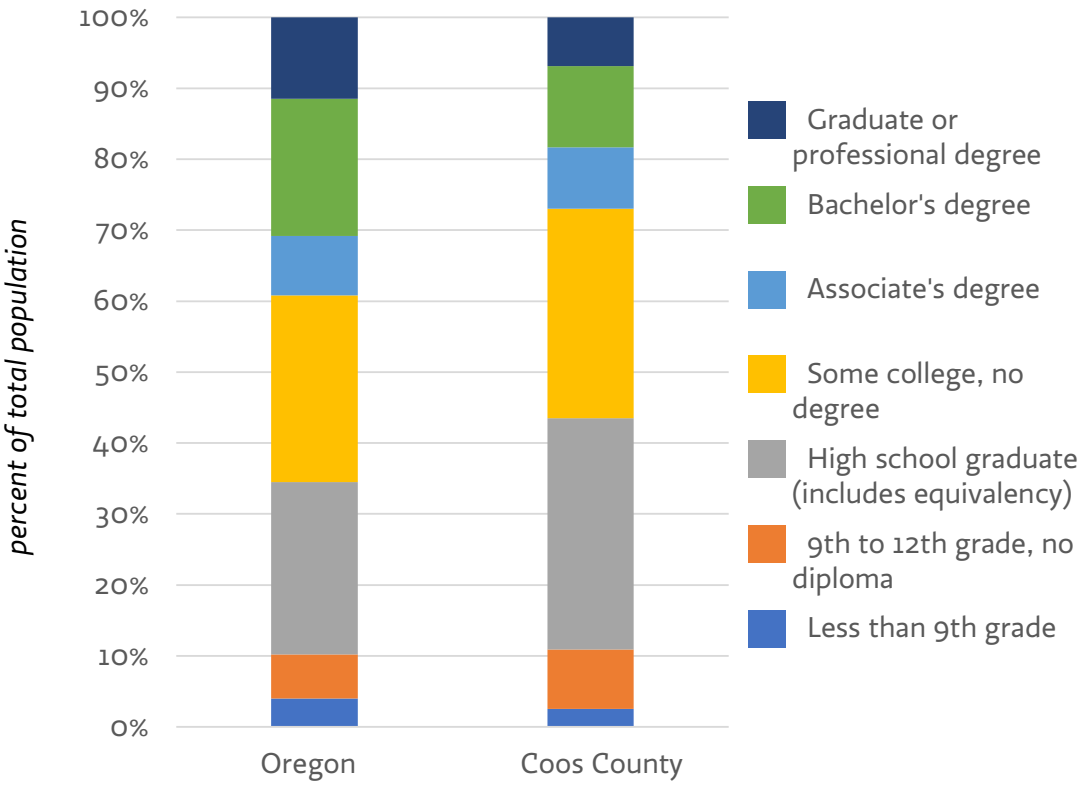
Source: US Department of Education 2016

Educational attainment

Compared to the state average, Coos County has a higher percentage of the population that attended some high school but did not receive a diploma, and fewer people with a bachelor, graduate or professional degree.

"There is still a nucleus of students that don't value education and stay here. It's a culture that doesn't value education." –Survey Participant

Educational attainment, 2011-15
Coos County and Oregon



Source: US Census, Fact finder 2018

"Lower education levels lead to the poverty and other issues we have here in our area. Research indicates that educational success-which begins in the elementary schools and goes onward and upward from there….are a huge determinant for future success and life skills. Our schools need to improve to start the chain reaction for improved lifestyles." —Survey Participant

Southwestern Oregon Community College is the higher education institution in the county, founded in 1961. The college serves approximately 8,306 students annually. 71% of students seeking a certificate or degree received financial aid or scholarships in 2015-2016 (SOCC.edu 2017).

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percents/ percentages.

Key

↑ =higher (than State)

↓ =lower (than State)

Education	
Indicator	***Findings*** *(Coos County vs. Oregon)*
Early Childhood	Students in Head Start ↑ Early education enrollment (% of 3 and 4 year olds in school) ↑
Graduation Rates	Graduation rate ↓
Educational Attainment	Bachelors or advanced degrees ↓

Food

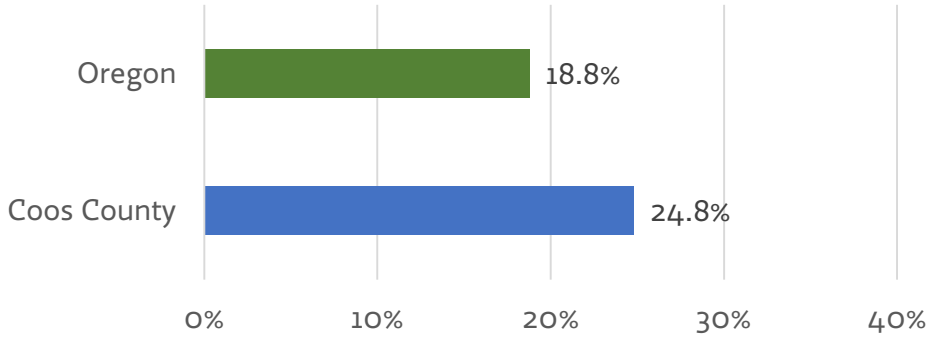
Eating nutritious food and maintaining a healthy diet are important to individual health. Poor nutrition has been shown to increase risk for various chronic health conditions and to increase morbidity and mortality.

A healthy food environment includes access to healthy foods and food security. Access has many facets including the cost, distance and availability of fresh and healthy food options. The USDA defines food insecurity as the lack of access to enough food for all members in a household and limited or uncertain availability of nutritionally adequate foods.

Food insecurity, access and consumption

Access to healthy foods has improved in Coos County and is better than some counties in the state. The USDA gives Coos County a food environment index of 6.9. The food environment index is on a scale of one to ten, with (0) being the worst and (10) being the best. Oregon is listed as having a slightly better food environment index at 7.3 (County Health Rankings 2018). A third of the population in Coos County lives in a food desert, which is also better than the state, but is still identified as a priority. A food desert is defined as a low income census tract where a substantial share of the population has low access to a supermarket or large grocery store.

Households receiving SNAP benefits, 2012-2016
Coos County and Oregon



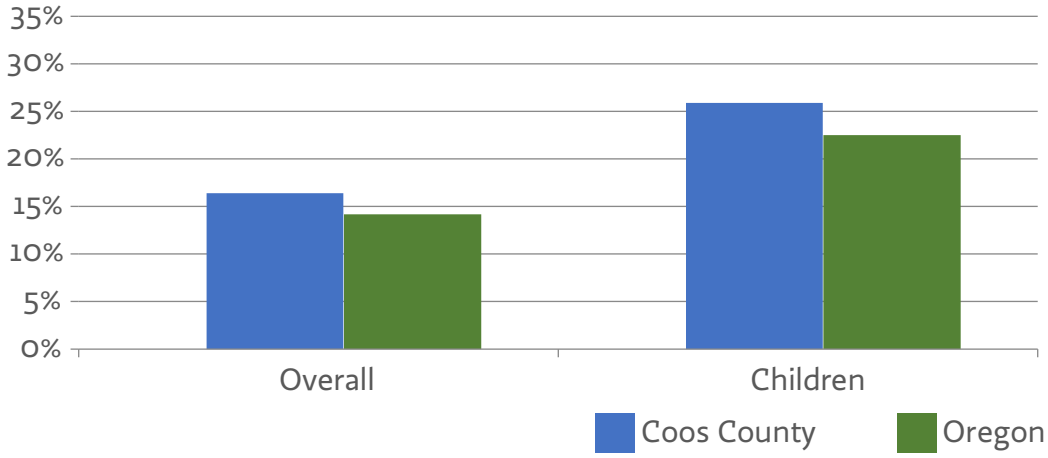
Data Source: US Census Bureau, American Community Survey. 2012-2016

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and the Supplemental Nutrition Assistance Program (SNAP) are public programs designed to address food access and insecurity. The rate of stores that accept either WIC or SNAP benefits is more than state averages, indicating a program asset and **strength** while also revealing that a large number of people qualify for these programs.

"The cost of healthy foods is rather high and unhealthy processed foods are more abundant with a more reasonable cost. We need healthier fresh food to be more reasonably priced. Education for the community showing them how to cook with healthier foods and from scratch in less time. I find that way too many people in our community default to quicker food preparations and quicker to cook products due to school, work, busy schedules, etc... We need to have healthier and quicker food preparation times for meals and less processed and chemically-filled foods." —Survey Participant

In 2017, 20% of teens in Coos County (in both 8th and 11th grade) answered yes when asked if they ate less than they felt they should because there wasn't enough money to buy food (Oregon Healthy Teens Survey 2017). This is higher than the state percentage (14%). Additionally, one in four children under 18 experience food insecurity in Coos County.

Food insecurity, 2015
Coos County and Oregon

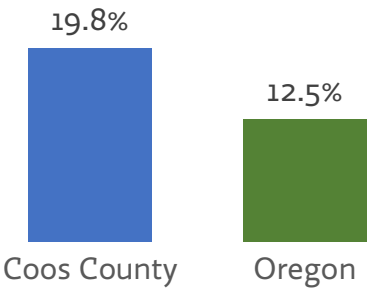


Data Source: Feeding America, 2017

"[We need] more access to fresh food. Have to travel far to get fresh food, babies want fruit and vegetables but I can't get fresh ones for them, mostly old or out of cans."
—Focus Group Participant

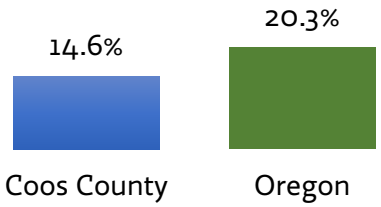
Consumption of unhealthy foods, including soda, is higher in Coos County. The percentage of adults who eat five or more servings of fruits and vegetables a day is lower in Coos County than Oregon.

Adults drinking 7 or more sodas per week, 2012-2015
Coos County and Oregon



Source: Oregon BRFSS County Combined Dataset 2012-15, Age-adjusted

Adults consuming at least 5 servings of fruits and vegetables a day, 2012-2015
Coos County and Oregon



Source: Oregon BRFSS County Combined Dataset 2012-15, Age-adjusted

Indicators

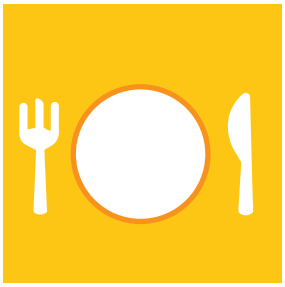
The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percent/ percentages.

Key

↑ =higher (than State)

↓ =lower (than State)

Food	
Indicator	***Findings*** *(Coos County vs. Oregon)*
Food Insecurity	Adults and children living with food insecurity ↑
Food Access	Rate of SNAP authorized retailers ↑ Rate of SNAP (food stamps) recipients ↑ Rate of WIC authorized stores ↑
Soda Consumption	Number of adults drinking 7 or more sodas a week ↑
Fresh Food Consumption	Adults ↓ Youth in 8th grade ↑



Community

Social associations and volunteerism

Social associations are one way to measure social connectivity in a community. Lack of social connectivity and resulting isolation can influence health outcomes of individuals and community.

The rate of social associations in Coos County (County Business Patterns, 2014) is 12.5 per 100,000 population, higher than the Oregon state rate of 10.4 per 10,000, (BRFSS 2014) a **strength** in the county.

"Volunteering helps with mental health, makes you feel better." –Focus Group Participant

"Lots of volunteerism, people want to help. There is a woman who goes to the mission every Tuesday for ten years, she has a volunteer spirit." –Focus Group Participant

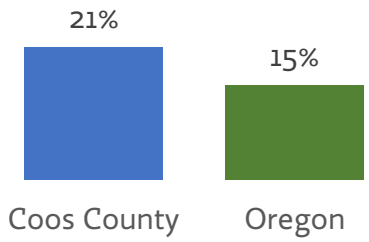
Social and emotional support

Participants in the 2018 CHA focus groups and surveys universally chose social support including religious and spiritual values as the second biggest **strength** in the community. The third biggest **strength** were the people that live here.

While social associations are strong, many individuals indicate that they still don't have adequate social and emotional support. Over 20% of youth state that they are neither working or in school, indicating disconnection from community. This is higher than the state.

"A lot of people are isolated, its generational." –Focus Group Participant

Disconnected youth, 2010-2014
Coos County and Oregon

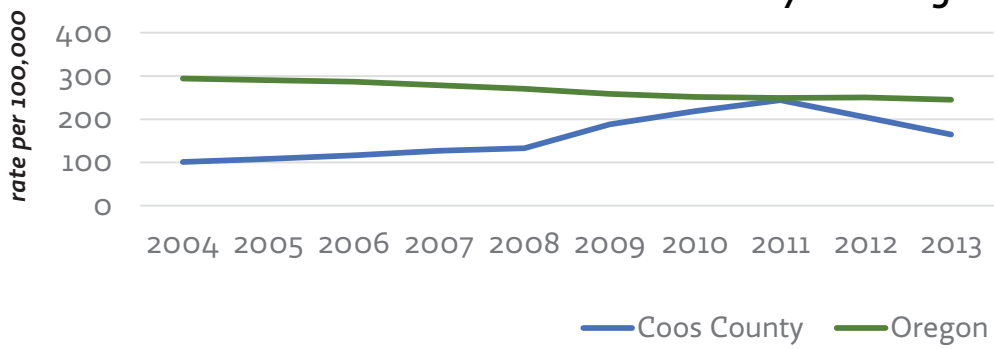


Source: Measure of America, 2014

Crime and safety

Violent crime is lower in Coos County than the state average. Violent crime was trending up until 2011 when it began to decline in the county.

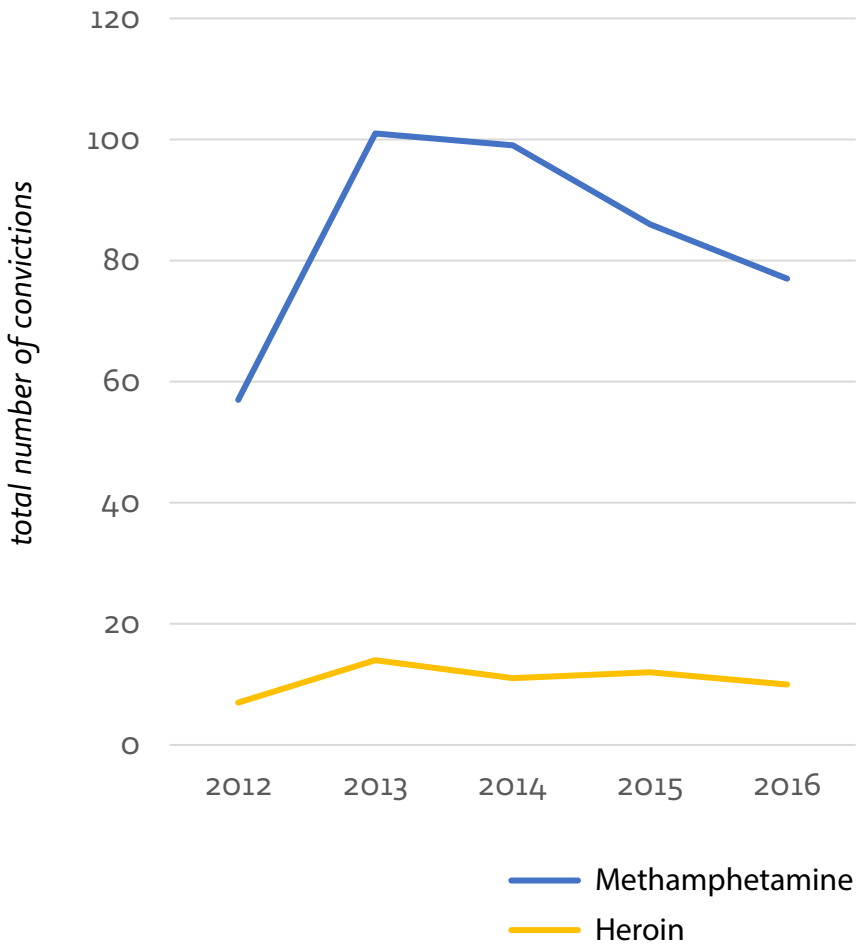
Violent crime, 2004-2013
Coos County and Oregon



Source: Federal Bureau of Investigation, FBI Uniform Crime Reports 2015

The number of convictions for methamphetamine and Heroin are also on a downward trend.

Convictions for Methamphetamine and Heroin, 2012-2016
Coos County



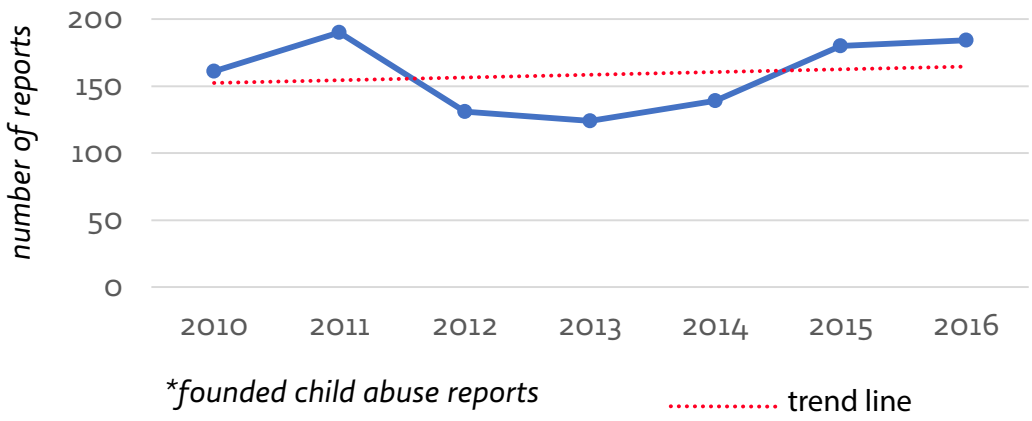
Source: Oregon Criminal Justice Commission, 2012-2016

"Drug abuse and crime are out of control." —Survey Participant

"We need police presence to combat drugs/crime." —Focus Group Participant

Intimate partner violence, specifically domestic violence and child abuse, are near state levels *(Oregon Annual Uniform Crime Reports, Child Welfare Data Book 2017).* However, the percentage of youth that report being intentionally hit or physically hurt by an adult in 2017 is nearly one in four (23.3% Oregon Healthy Teens Survey), consistent with national trends of victims of domestic/intimate partner violence. Child abuse reports are trending up in the county and the state, beginning in 2015 the number of founded reports began increasing from previous years. Coos County is third highest county in the state for children in foster care (Children First Data Book 2017).

Child Abuse Reports*
2010-2016
Coos County



Source: Child Welfare Data Book. 2010-16

In 2016, Coos County had slightly higher rate of law enforcement officers per 1000 people. However, community perceptions illustrate a different perspective and experience. Although violent crime and drug arrests are trending down and law reinforcement officers per capita are higher than the state, 2018 CHA focus group and survey participants identified crime, specifically from drug offenses and violent acts, as being of significant concern.

"Not enough police. Too many panhandlers. I'm always worried for my personal safety and my property being stolen." —Focus Group Participant

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percent/ percentages.

Key

↑ =higher (than State)

↓ =lower (than State)

Community	
Indicator	***Findings*** *(Coos County vs. Oregon)*
Social Associations and Volunteerism	Social associations/membership organization involvement ↑
Social and Emotional Support	Individuals without adequate social support ↑ Disconnected youth ↑
Crime and Safety	Violent crime ↓ Domestic violence offenses, arrests ↓ Law enforcement officers ↑

Health Care System

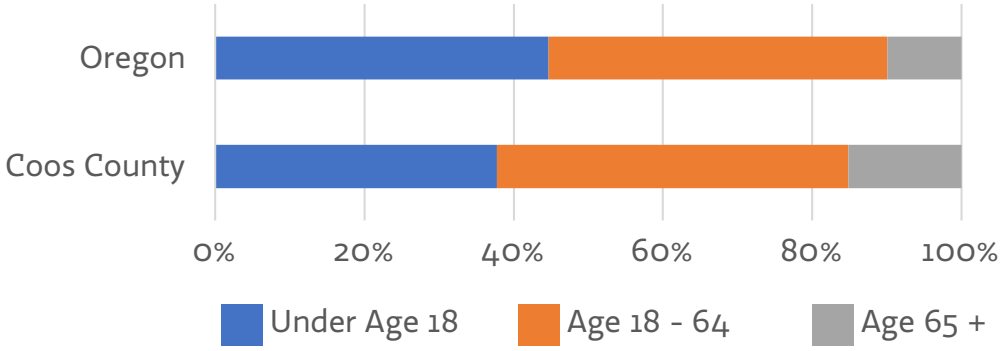
The health care system provides services to prevent and treat disease. It influences the health of individuals, families and communities. Health disparities, often created by the social determinants of health, affect access to health care services.

Insured and uninsured

Health insurance is one element of access to health care services. Coos County has a high percentage of the population on publicly funded insurance, which includes Medicaid/Oregon Health Plan/OHP, Medicare and Veterans Administration/VA. 2017 estimates from Oregon DMAP and RUPRI, show that 62.6% of the population in the county is on Medicaid, Medicare or both. The age distribution on Medicaid is older in Coos County than in the state as a whole.

The percentage of population with insurance statewide has been increasing since 2011, with a sharp increase in 2015. It was estimated that 96.8% of Oregonians are now covered (2016) by insurance (Oregon Annual Health Insurance Report, 2018).

Medicaid enrollees by age, 2011-2015
Coos County and Oregon



Source: U.S. Census, American Community Survey 2011-2015

Access to providers

Access to providers and specific health services is another element of access to health care services. 100% of people in Coos County are considered to be in a health service shortage area. A study by Oregon Health Sciences University in 2016 found multiple barriers to accessing primary care in Coos County. Trouble finding a provider was listed most often followed by transportation and wait time. These findings were supported by comments in the 2018 CHA focus groups and survey comments.

"People should have providers if it's a healthy community. I know a lot of people don't have providers. I was on a wait list for 9 months for a Primary Care Physician."
—Focus Group Participant

"Providers often are not taking new patients, specialists are booked out for months necessitating travel to Eugene and Portland for consultations." —Survey Participant

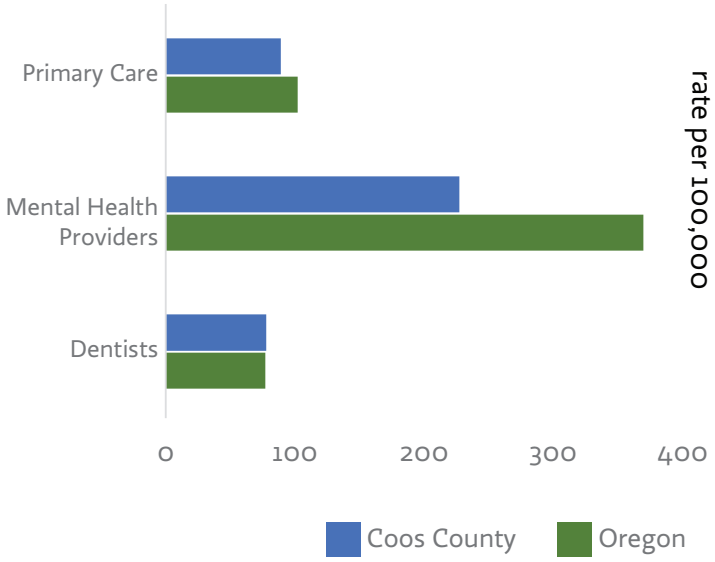
"For me personally I would like to see....more health care provider choice. Every time I choose a primary care provider they end up leaving the community and I have to change doctors." —Focus Group Participant

Access to primary care providers has increased since 2004 but not at the same rate as the state. In 2016 the county had 40.635 FTE/Full Time Equivalent primary care physicians, including family medicine, general practice and internal medicine physicians. Recruitment and retention of providers was consistently listed as a concern in focus groups and survey participant comments.

"Hard to get specialty care here. Hard to keep doctors here. It's a jumping stone to other communities." —Survey Participant

"Many specialty services are available here. However, a large number of patients that I see have a very difficult time getting in to see primary care physicians (especially to establish care but also when they have established care but have an urgent issue). Improving access to primary care physicians is essential to improving health care in the area." —Survey Participant

Access to care providers, 2015-2016
Coos County and Oregon



Source: US Department of Health & Human Services, Health Resources and Services Administration, Area Health Resource File, 2017

2016 Provider Numbers (FTE = Full time equivalent)

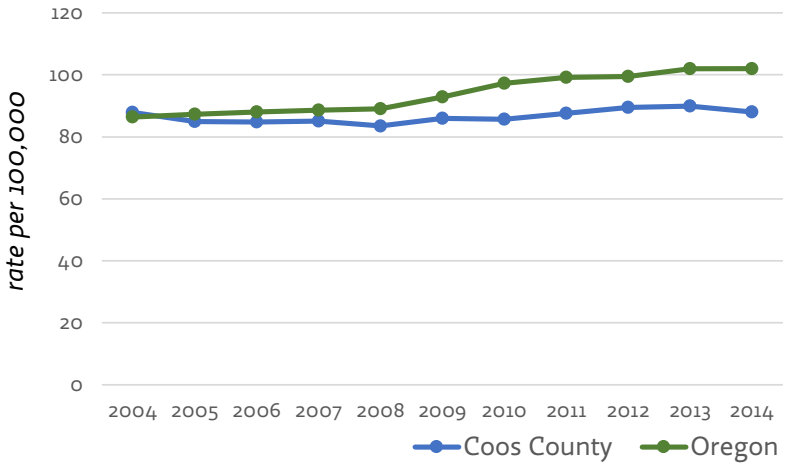
- 16.6 FTE Family Medicine Physicians
- 24.035 FTE Internal Medicine Physicians
- 26.528 FTE Nurse Practitioners
- 5.3 FTE Obstetricians/Gynecology
- 5.3 FTE Physician Assistants
- 4.5625 FTE Psychiatrists or Psychiatric Nurse Practitioners
- 20.89 FTE Dentists
- 28.0 FTE LCSW, LMFT, Psychologists
- 42.0 FTE Licensed Counselors

The majority of providers are in Coos Bay, followed by Bandon and Coquille zip codes.

Source: Oregon Office of Rural Health 2018

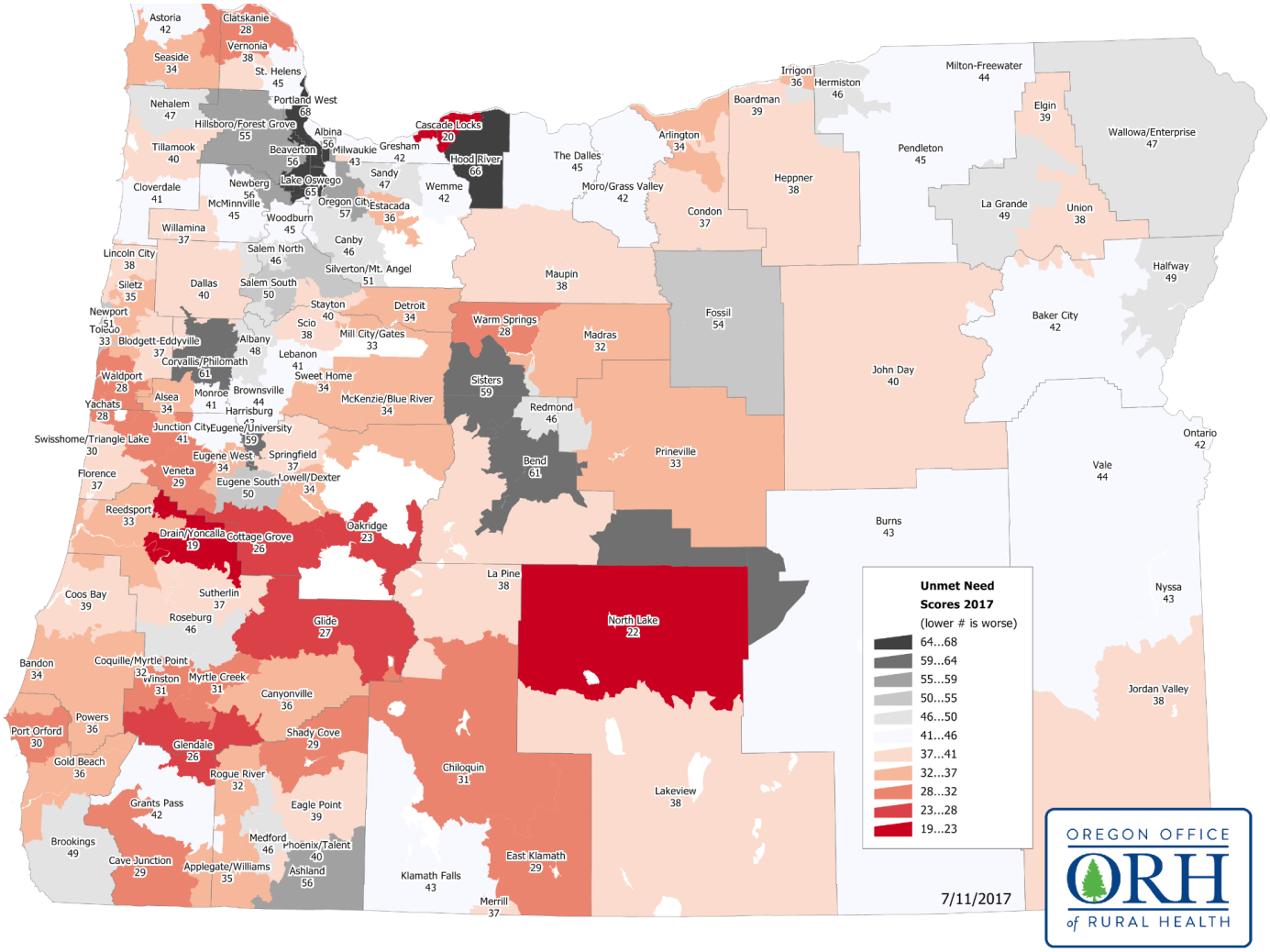
The Oregon Office of Rural Health has Coos County designated as a Medically Underserved Area (MUA), a Health Professional Shortage Area (HPSA), Health Professionals Shortage Area for Dental and Mental Health Providers. The Southern portion of the county has slightly higher scores of unmet need than Coos Bay and the Northern parts of the county.

Access to primary care 2004-2014
Coos County and Oregon



Source: US Department of Health & Human Services, Health Resources and Services Administration, 2015

Overall scores of unmet health care needs, 2017



Source: Oregon Office of Rural Health 2018

Oral and dental care accessibility

Access to **dental care** and oral health services show higher percentages of adults with no dental exam. 41% (approximately 20,953) of adults in the county between 2006-2010 had no dental exam (BRFSS 2010), compared to 29.8% statewide. In 2014, 42.9% of adults stated that it had been more than a year since their last dental exam.

"I need access to preventive care and screening including dental care. I'm on Medicare, but it won't cover dental. It affects your health." —Focus Group Participant

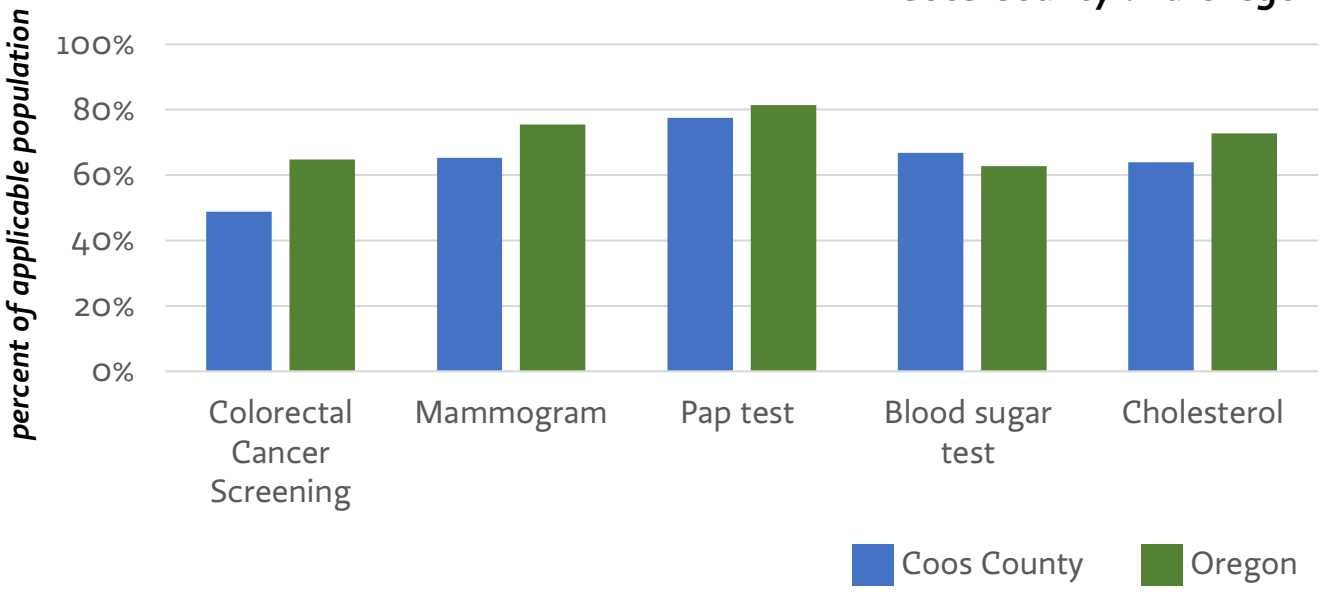
"We have very poor dental care here, I have a friend who moved here from California and she asked what's with the teeth here? Dental seems to be the last thing covered by insurance." —Focus Group Participant

"We without homes have a big bag of floss here but not enough teeth to use it." —Focus Group Participant

Preventive screening

The percentage of a population that has preventive screenings is an indicator of access to care, specifically quality and timeliness of care. The screenings provided the most often include colorectal cancer screening, mammogram, pap tests, blood sugar tests and cholesterol. Coos County has a lower percentage of the population participating in these screenings than Oregon, with the exception of blood sugar testing.

Health screenings, adults, 2012-2015
Coos County and Oregon



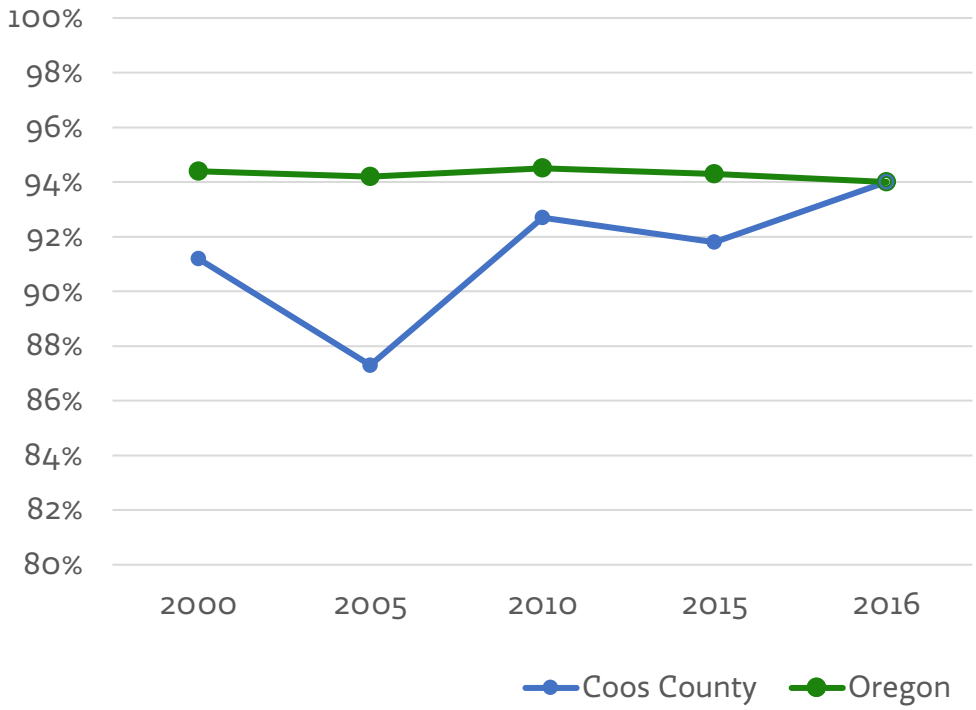
Source: Oregon Behavioral Risk Factors Surveillance System 2017

Prenatal care and school-based health centers

Prenatal care is an indicator of maternal and child health services access. Coos County has seen varied percentages of mothers that have had adequate prenatal visits during pregnancy since 2000 and is increasing in percentage, suggesting a positive trend and **strength**. Inadequate prenatal care is less than five visits prior to delivery or care began in third trimester or after.

"It's hard for single moms and babies." —Focus Group Participant

Women receiving adequate prenatal care, 2000-2016
Coos County and Oregon



Source: Oregon Vital Statistics, 2000-2017

School Based Health Centers provide physical and behavioral health services in elementary, middle and high schools in the county. The majority of services are provided at area high schools followed by fewer centers and services in the middle school. The number of School Based Health centers in elementary schools are limited in the county.

Hospitals

Coos County is served by three hospitals; Bay Area Hospital, Coquille Valley Hospital and Southern Coos Hospital and Health Center. Bay Area Hospital is a regional health district facility. Both Coquille Valley Hospital and Southern Coos Hospital are critical access hospitals, a designation given to certain rural hospitals by the federal Centers for Medicare and Medicaid Services (CMS).

Bay Area Hospital's mission is "We improve the health of our community every day." Recent additions to Bay Area Hospital include the Joint Replacement Destination Center, which opened in the spring of 2017 and the newly purchased da Vinci® Xi™ Surgical System, which now allows the robotics team to conduct a greater variety of procedures. Other key services include: Interventional cardiology, cancer care, inpatient dialysis, hyperbaric wound care, medical imaging, Obstetrical Care in our Family Birth Center, inpatient and outpatient psychiatric care, pediatrics, orthopedics, bariatric surgery, home health, and a Level 3 trauma center. The hospital also operates the Kids' Hope Center, caring for the needs of abused children.

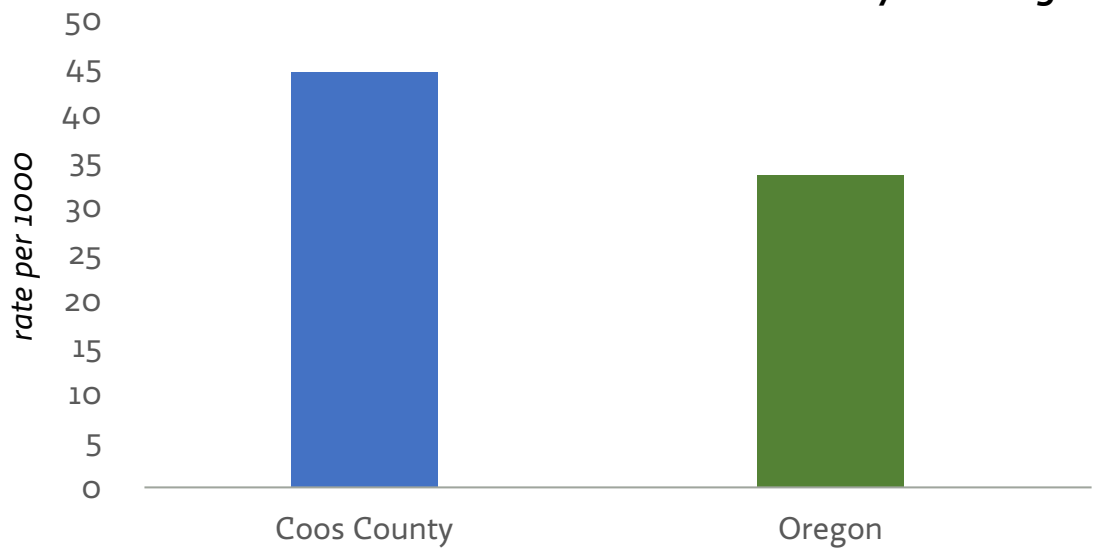
Bay Area Hospital has earned the Joint Commission Gold Seal of Approval for quality and patient safety. Individual programs with national accreditations include the Prefontaine Cardiovascular Center, cancer center, medical laboratory, pathology service, Women's Imaging, Sleep Study Center, home health, and Bay Bariatrics.

Bay Area Hospital is owned by Bay Area Health District and is governed by an elected board of directors. It is Oregon's only district-owned hospital operating without local tax support. The Bay Area Hospital Community Foundation accepts charitable donations and bequests, with which it supports health care programs as well as a variety of community organizations.

Coquille Valley Hospital's (CVH) mission is to improve the lives of people in the communities we serve by providing excellent quality, high value, health care services delivered with professional competence and compassion. The primary service area includes the Oregon communities of Coquille, Myrtle Point, Powers, Bridge, Fairview, Dora, Arago and a number of other neighboring communities within the Coquille River Valley, compromising a population of approximately 13,000 people. CVH provides 24-hour emergency, medical and surgical care together with an extensive array of clinical support services.

The mission of the Southern Coos Health District is to "provide quality health care with a personal touch." The service area is approximately 10,000 people from communities in Coos County and Northern Curry County, including Bandon, Coquille, Port Orford and Langlois. Services include an emergency department, inpatient acute care, swing bed, surgical services, outpatient infusion and wound care, medical imaging services, laboratory services, respiratory therapy and a multi-specialty health center with primary care, internal medicine, surgical, podiatry and behavioral health services.

Preventable hospitalizations for Medicare enrollees, 2014
Coos County and Oregon



Data Source:
Dartmouth College Institute for Health Policy & Clinical Practice, Dartmouth Atlas of Health Care 2016

The preventive hospitalizations for patients on Medicare with conditions that are ambulatory care sensitive is higher in Coos County than the state. Ambulatory care sensitive conditions include pneumonia, dehydration, asthma, diabetes and other conditions which could have been prevented if adequate primary resources were available and accessed. This indicator illustrates challenges in primary care access.

Focus group and survey participants mentioned frequently that they often had to travel out of the county for health care services. The reasons for traveling out of the county are many, including inpatient hospital services at a different level than available in the county, health care provider shortages and limited specialty services.

Top 3 Hospitals Medicaid patients, from Coos County, are going to outside of County 2016-2017	
1st most visited	Sacred Heart River Bend
2nd most visited	OHSU
3rd most visited	Legacy Emanuel Hospital

Top 3 Reasons Medicaid patients, from Coos County, are going outside of county for inpatient care 2016-2017	
1st	Vaginal delivery live-born infant
2nd	Cesarean live-born infant
3rd	Sepsis

Source: Coordinated Care Organization Enrollee data, 2017

"I go to Eugene or Portland for all my care due to lack of some basic needs here as well as expense of care here. " —Survey participant

Local Public Health System

Coos Health & Wellness (CHW) combines the local public health and mental health authority for Coos County. CHW is composed of four divisions including public health, behavioral health, health promotion and administration. CHW Director is appointed by the Board of Commissioners. CHW offers a wide array of public health and mental health services. Some of these include environmental health, WIC, vital records, reproductive and sexual health services, OHP enrollment assistance, home visiting, mental health counseling and treatment for adults and children with mental health issues, and other services. The public health division of CHW has been focusing on ensuring full access to its mandated services to our community. The division is also working on promoting health within the community through various projects such as the CHA, the CHIP, and a breastfeeding promotion campaign.

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall averages, percent/ percentages

Key

↑ =higher (than State)

↓ =lower (than State)

Health Care System	
Indicator	***Findings*** *(Coos County vs. Oregon)*
Insured and Uninsured	Public insurance (including Medicaid, Medicare and VA) ↑
Access to Providers	100% of population living in Health Professional Shortage Area ↑ Access to primary care physician ↓ Access to mental health providers ↓
Oral/Dental Health Accessibility	Adults with no dental exam in last 12 months ↑
Preventive Screening	Colorectal Cancer Screening ↓ Mammogram within last 2 years ↓ Pap Test w/in last three years ↓ Cholesterol checked in last 5 years ↓ Blood sugar test within last 3 years ↑ Screened for HIV ↑
Prenatal Care Accessibility	Moms getting adequate prenatal care ↓
Hospitalizations	Preventable hospitalizations ↑

Health Behaviors

Modifiable individual health behaviors such as tobacco use, inadequate physical activity and addictions have significant influence on the health of individuals and communities in Coos County.

Tobacco

Tobacco use has remained high in Coos County for many years. Premature death, various cancers, lung and respiratory issues, low birth weight and cardiovascular disease are all linked to tobacco use. The tobacco mortality rate has been high in Coos for over a decade. The percentage of adults in Coos County that are current smokers continues to be one of the highest in the state. More than 50% of adults have smoked at least 100 cigarettes in their life in Coos County, and close to 30% of adults are currently smoking, according to the most recently available BRFSS data 2012-2015.

The financial impact of tobacco in Coos County is also substantial. The latest tobacco fact sheets from the Oregon Health Authority estimates that Coos County experiences 42 million dollars in tobacco related medical costs and 34 million in lost productivity due to premature tobacco-related deaths (Oregon Health Authority Tobacco Fact Sheets 2014).

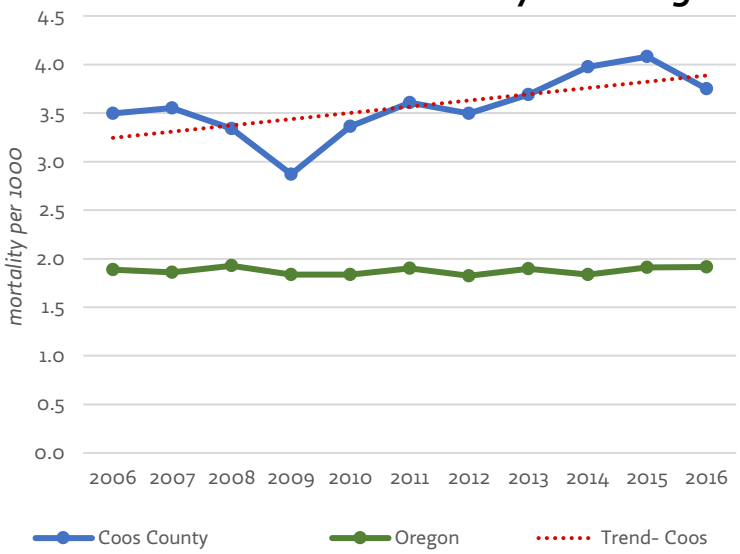
Smoking among Coos County children and teens is considerably higher than the state as a whole. In 2017, 7% of 8th graders in Coos County had smoked cigarettes in the last 30 days, compared to the state percent of 3%. Coos County 8th graders also had a higher overall tobacco use in 2017 with 11% of 8th graders having used any tobacco, including vaping products, in the past 30 days, compared with 8% in Oregon.

"High rates of smoking and cancer community norms influence our smoking rates. The culture of town affects smoking." —Focus Group Participant

"Tobacco is a big problem with kids. I walk around the high school and a lot of them are smoking or chewing, they think they are invincible." —Focus Group Participant

"Cigarette smoking and obesity are big problems in our community that I believe most often continue through family patterns and lack of education regarding healthy choices. Preventive health care in the schools may help." —Survey participant

Tobacco-related mortality, 2006-2016
Coos County and Oregon



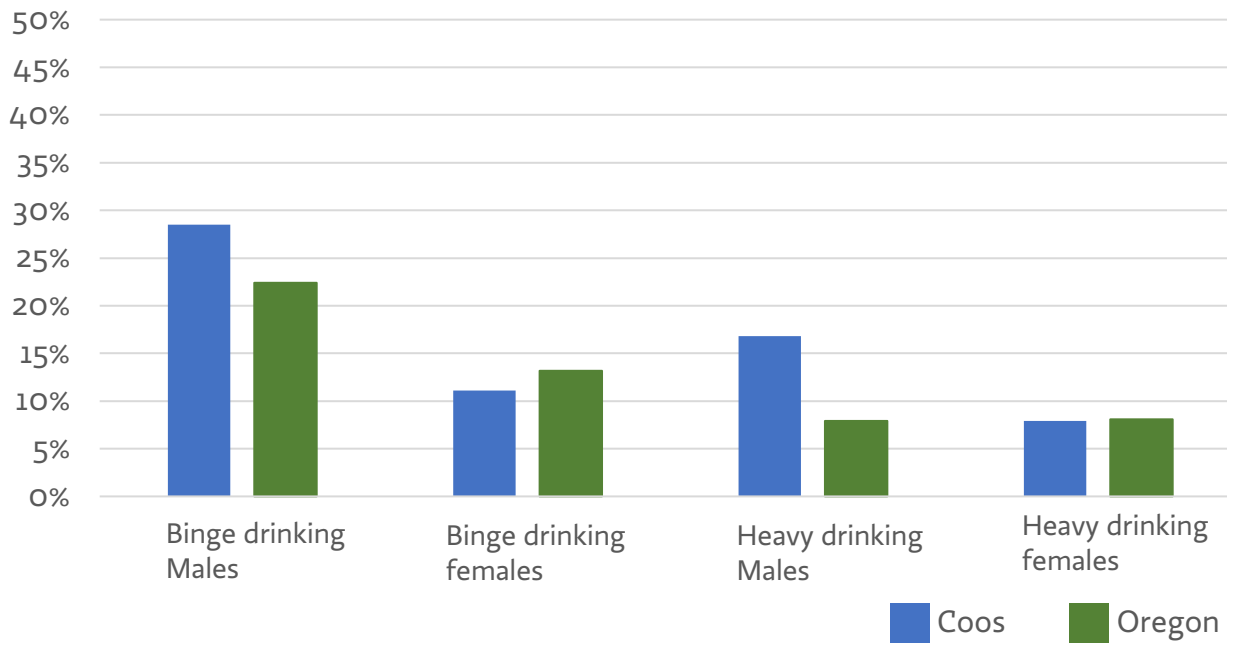
Source: Oregon Vital Statistics Annual Reports

Alcohol and other drugs

Excessive heavy **alcohol** consumption and binge drinking contributes to chronic health issues, including heart disease, cirrhosis of the liver, high blood pressure, stroke and even death. Close to 20% of adults in Coos County report binge drinking in the past month (BRFSS 2012-2015) while over 50% of people in the region (Coos, Curry, Douglas, and Jackson Counties) report using alcohol in the past month (2012-2014). In 2017, the percentage of 8th graders who have never had a first drink in Coos County is slightly less (70%) than statewide (73%) although this indicates that one in three 8th graders have already consumed at least one alcoholic beverage.

"We need inpatient alcohol and drug treatment beds. Sending our community members to Roseburg or further can be detrimental if their entire support system is in Coos Bay. If they have children even more so. I believe this is a barrier to rehab for many, make drug treatment REAL." –Focus Group Participant

Binge and heavy drinking by gender, 2010-2013
Coos County and Oregon



Source: National Survey on Drug Use and Health: Annual Averages Based on 2012, 2013, and 2014

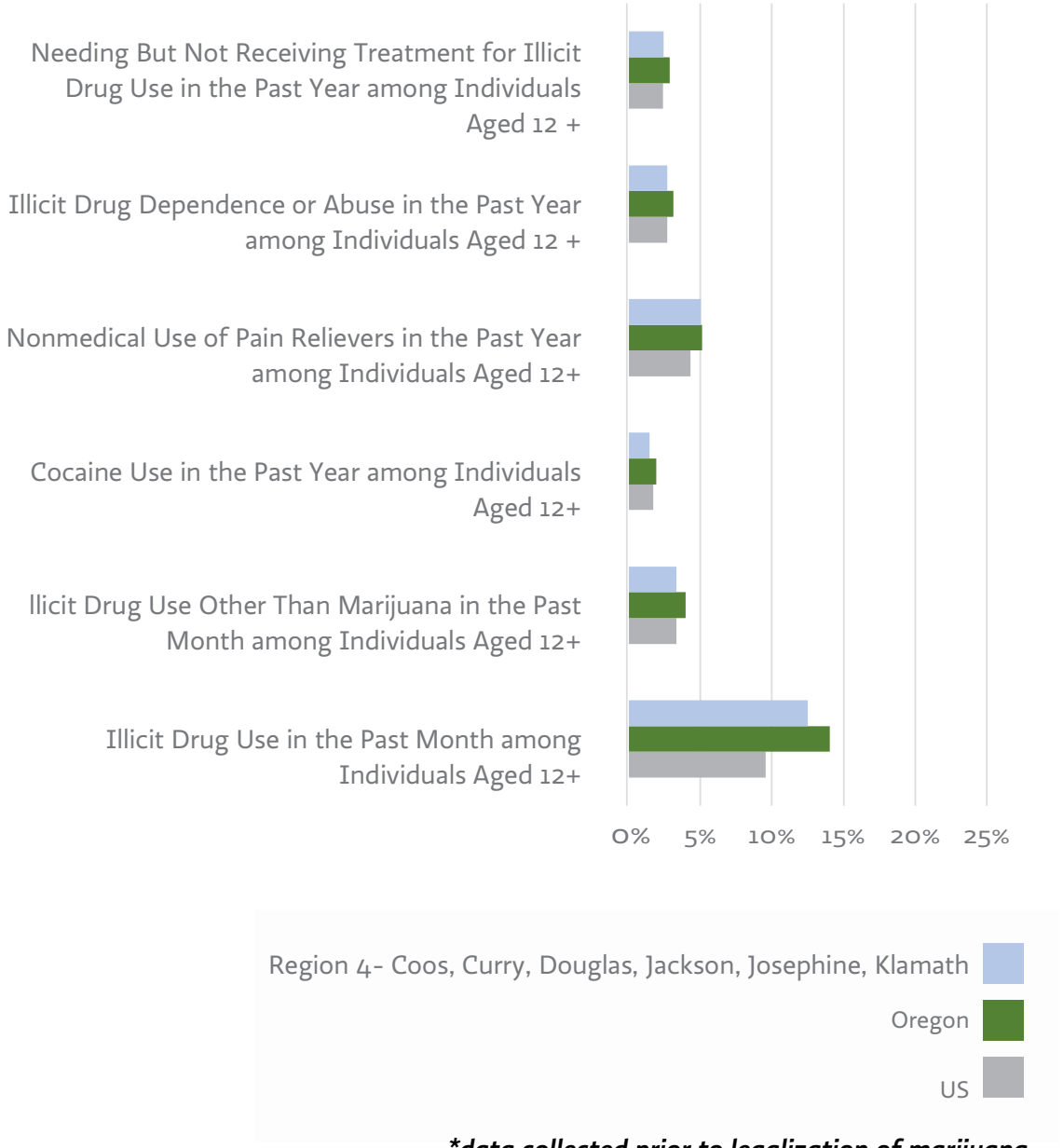
"Until we rid the area of drugs we have no chance of taking back our beautiful area. Drugs and homelessness are big, big problems we must address. I believe even if we build a detox treatment center that would be very helpful." —Focus Group Participant

Opioid and other drug use

Drug use was of high concern in the 2018 CHA focus groups and survey participants. Nearly 1 in 4 participants chose alcohol and/or drug use as the behavior that has the greatest influence on health.

"Drug abuse is prevalent and affects people and their family's health and kids' health. Affects minors too." —Focus Group Participant

*Drug use, 2012-2014 region, state, national**



***data collected prior to legalization of marijuana**

Source: National Survey on Drug Use and Health: Annual Averages Based on 2012, 2013, and 2014

"For children, it is parents with substance abuse issues. We have a meth and heroin epidemic in Coos County that is not actively being addressed in relation to the children of users." —Survey Participant

Youth drug use in Coos County is higher than statewide. 9.2% of 8th graders and 23.3% of 11th graders indicated they had used marijuana in the past 30 days. Also notable is how they consumed marijuana. When asked to choose how they had used it, 96.5% of 11th graders that said they had used marijuana said they had smoked it, 22.4% had eaten it in brownies, cakes, cookies or candy (Oregon Healthy Teen Survey 2017).

The morbidity and mortality associated with inappropriate use of opiate drugs such as codeine, oxycodone, morphine and methadone, have a negative impact on the health of the community. Prescribing patterns for Medicare enrollees in Coos County, during 2013-2014 show higher rates of opioid prescriptions than state and national trends *(Center for Medicare and Medicaid Services)*. This is consistent with prescription patterns in the Medicaid/Oregon Health Plan population, narcotic analgesics (opioids) were the second most prescribed medication in 2016-2017. According to the Oregon Opioid Dashboard in 2018, the fourth quarter of 2017 had Coos County ranked as one of the highest prescribing rate of opioids in the state, at 109.18 per 100,000. Additional data on overdose hospitalizations and deaths due to opioids are found in the health status and outcomes section.

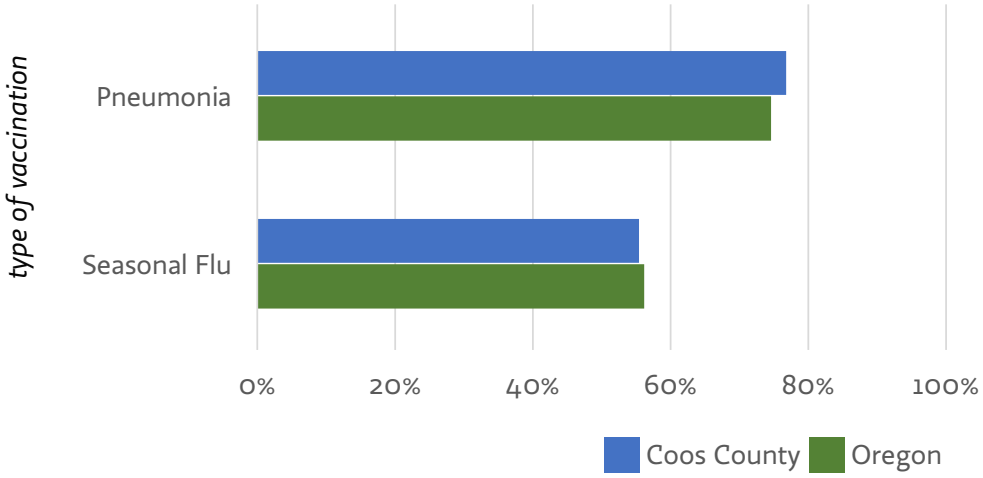
"Pain may lead to substance abuse addiction etc." —Survey participant

"We have to stop punishing everyone for the sins of others who make bad choices. Like taking effective pain medication away from non-abusing patients who need it to have a better quality of life. Because of "new studies" the opioid crisis has reduced my quality of life even tho I'm very responsible with no abuse issues." —Survey participant

Coos County has a high burden of **hepatitis C virus** (HCV). High burden is defined as number of people living with cases, chronic case reports and acute Hepatitis C Virus. Reported risk factors for acute HCV in Oregon include injection drug use, health care exposure, multiple sex partners and other risks, such as street drugs, tattoo, piercing or other blood exposure. Coos County has higher rates of those living with chronic HCV than the state rates. The region (Coos and Curry) has the highest mortality rate of HCV within the Medicaid and CCO population (Oregon Health Division 2017).

Vaccinations

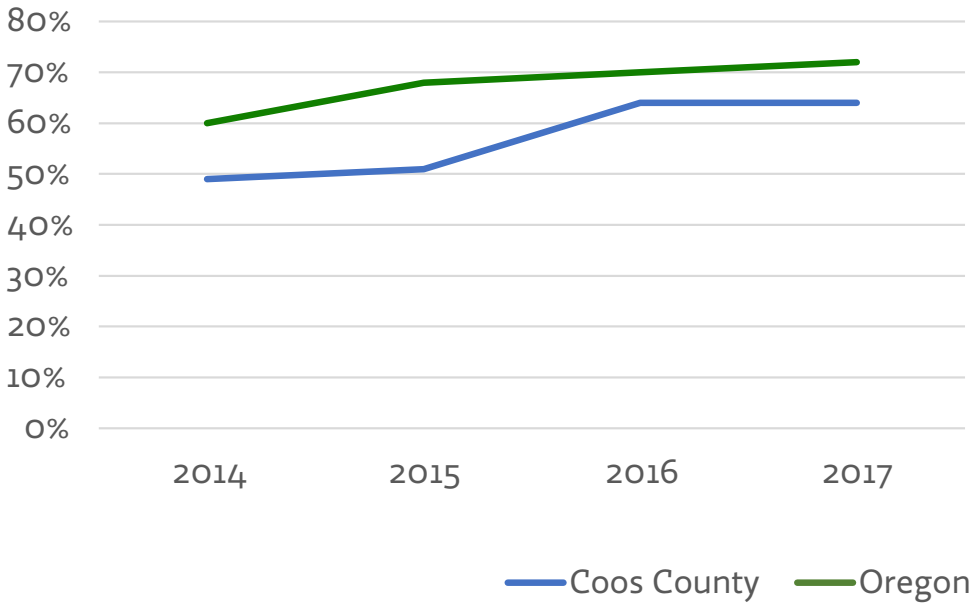
Adults 65+ who received vaccination within past year, 2010-2013
Coos County and Oregon



Source: BRFSS 2010-2013

Immunizations are an effective tool for preventing communicable disease and death. Coos County has lower rates of vaccinated children and lower rates of flu vaccination for adults over 65 years of age. Although the percent of two year olds that are fully vaccinated is lower than the state, it has been trending up since 2016.

Two-year-old immunization rates, 2014-2017
Coos County and Oregon



Obesity

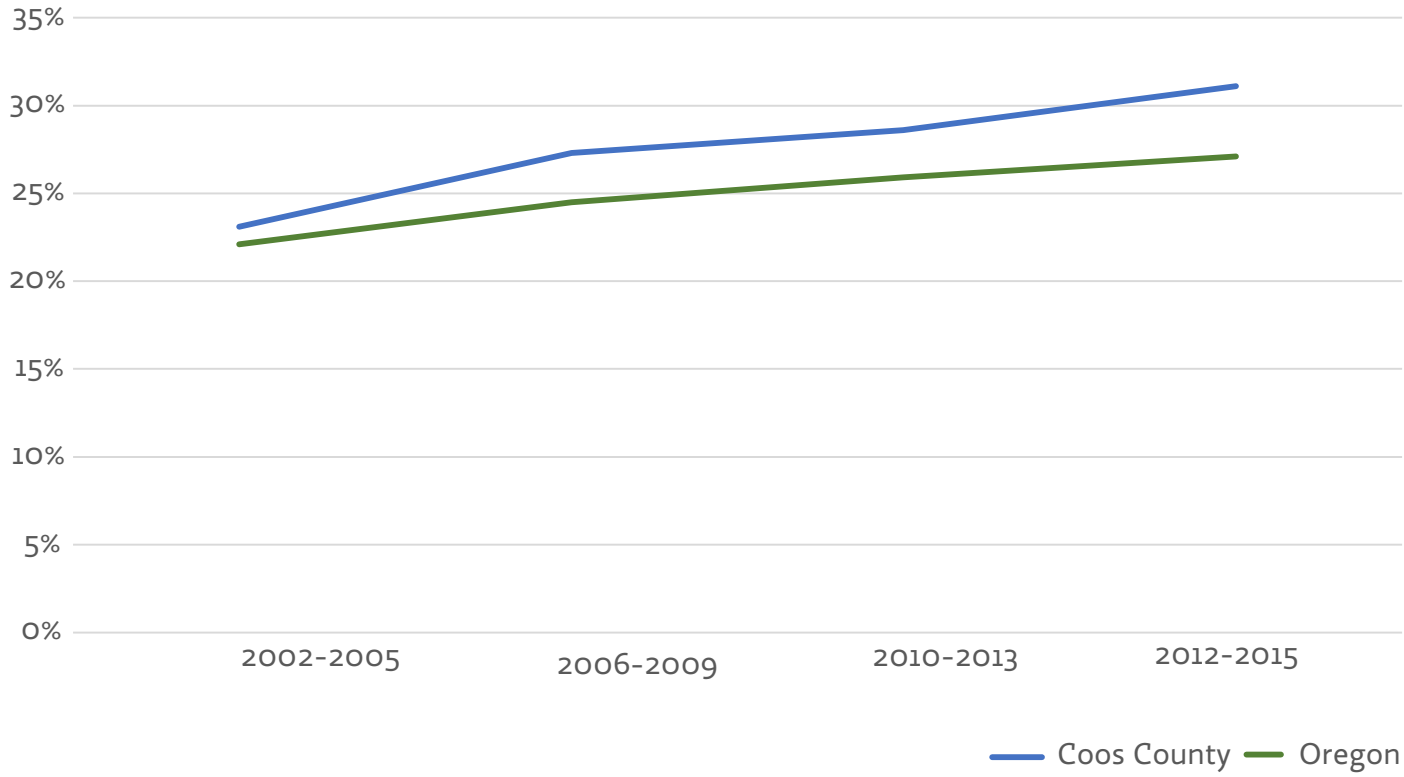
Obesity is a modifiable risk factor for several chronic conditions. Obesity is defined as a Body Mass Index (BMI) of 30 or higher. BMI is calculated using both height and weight. Being obese has been associated with increased risk of coronary heart disease, type 2 diabetes, cancer, high blood pressure, stroke, liver and gallbladder disease, among other morbidity and mortality. Nearly one in three people in Coos County are obese, higher than state percentages. The percentage of the population that is considered obese has been on an increase for many decades.

"Obesity is rampant" —Survey participant

"Cigarette smoking and obesity are big problems in our community that I believe most often continue through family patterns and lack of education regarding healthy choices. Preventative health care in the schools may help." —Focus Group Participant

Regular physical activity and a healthy diet reduce the risk of obesity. Only 14.9% of people in the county meet the Centers for Disease Control (CDC) physical activity recommendations, much lower than the statewide percentage of 24.2%. Adequate physical activity is defined as 2.5 hours a week of moderate intensity or 75 minutes of vigorous-intensity aerobic activity a week. The CDC recommends that children and youth be physically active for at least 60 minutes a day. 28% of 8th and 11th graders in Coos County met those guidelines in 2017 (Oregon Health Teens Survey 2017).

Obesity trend, 2002-2015 Coos County and Oregon

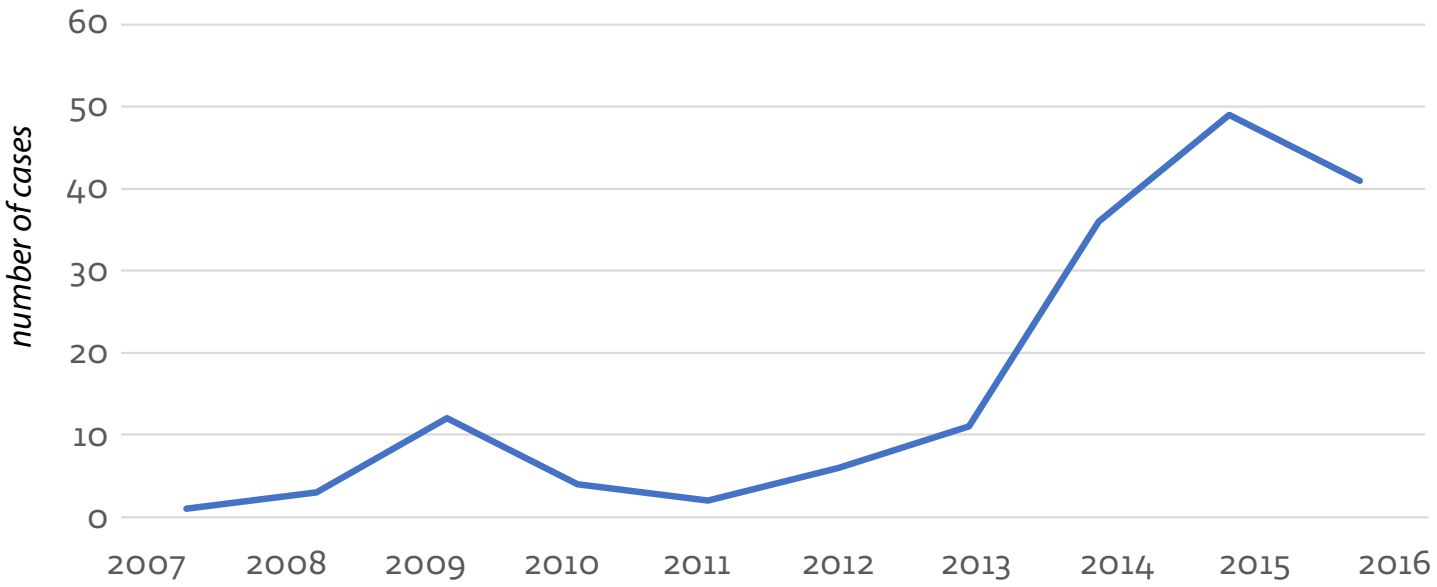


Source: BRFSS 2017

Sexually-transmitted diseases

Sexually-transmitted diseases, including chlamydia and gonorrhea have been generally trending up since 2012. There were 152 cases of chlamydia in Coos County in 2016. Gonorrhea cases increased from one case in 2007 to and 41 cases in the county in 2016 (Oregon Health Division 2017).

Gonorrhea cases by year, Coos County 2007-2016



Source: Oregon Health Division 2017

Indicators

The indicator table provides an overview of indicators in the county/ service area, including comparison with Oregon overall average, percent/ percentages.

Key

↑ =higher (than State)

↓ =lower (than State)

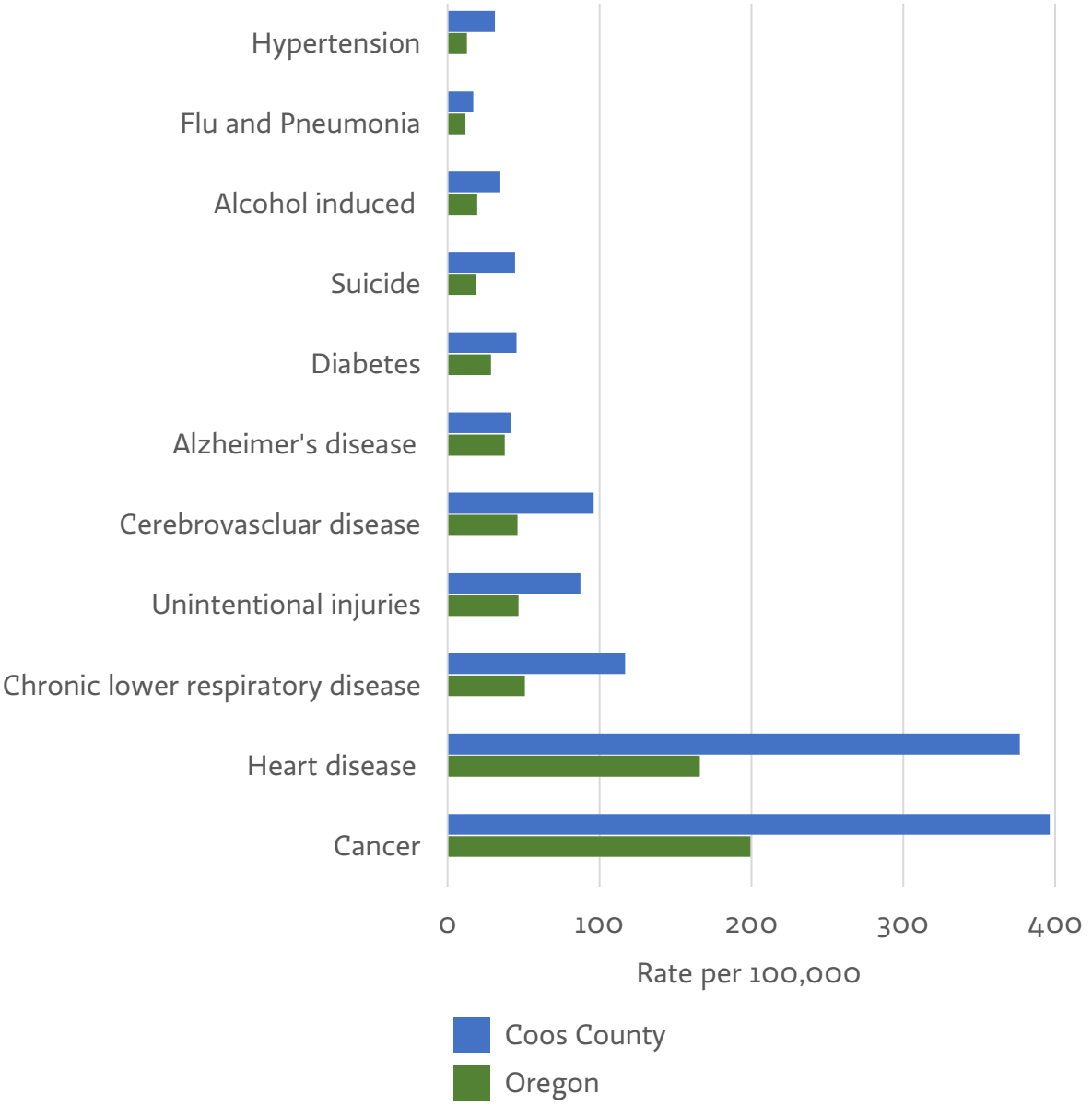
Health Behaviors	
Indicator	***Findings*** *(Coos County vs. Oregon)*
Tobacco	Smoking ↑
Alcohol and Other Drugs	Binge drinking ↑ Heavy drinking ↑ Youth had first drink ↓ Opioid prescriptions ↑
Vaccinations	2-year-old immunization rates (60% vs. 75%) ↓
Obesity	Obesity* ↑ **Fruits, vegetables and soda consumption in food section*

Health Status and Outcomes

Mortality

Mortality (death) has changed in Coos County over the last 80 years, consistent with state and national trends. Advances in science, medical care, living and working conditions have influenced causes of death and disability in the county. The leading causes of death in the county, as well as in the nation, are cancer and chronic disease.

Leading Causes of Death 2012-2016
Coos County and Oregon



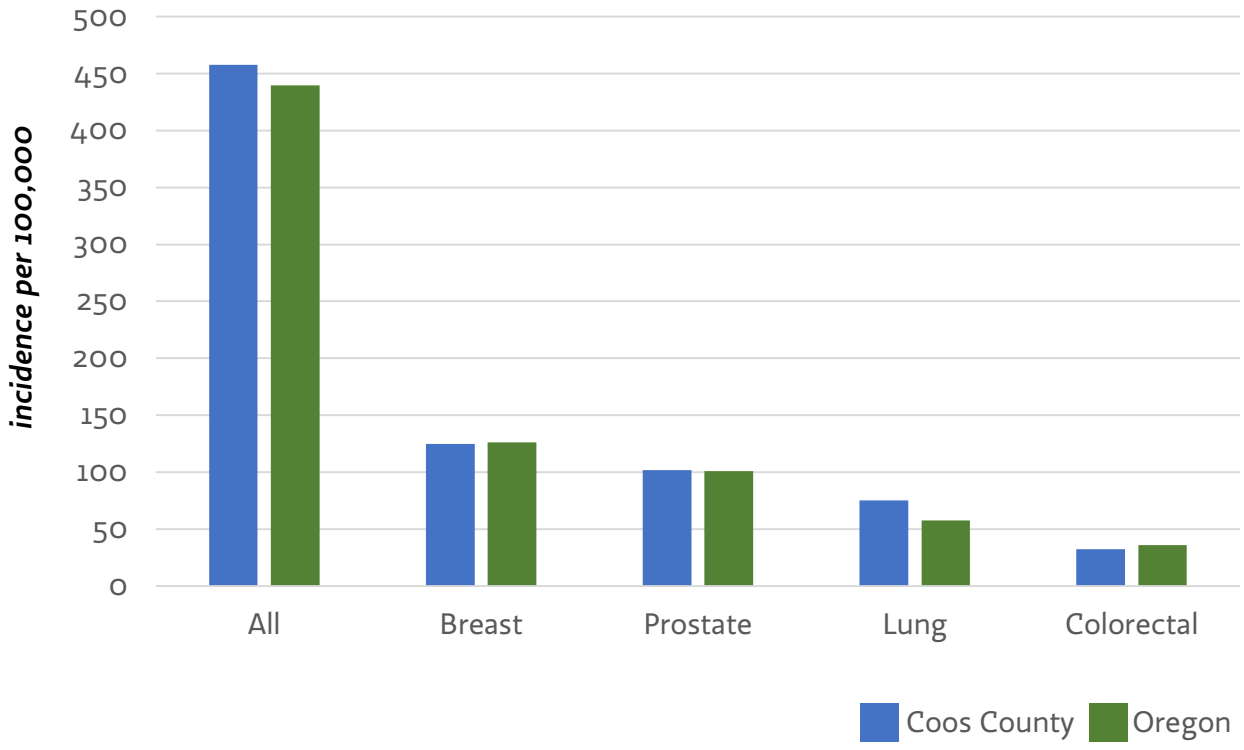
*crude death rates by cause

Sources: Vital Statistics Annual Report, Oregon Health Authority 2012-2016

Compared to the state of Oregon, Coos County has higher rates of several leading causes of death. The leading causes of death in the county are cancer and heart disease. The most recent trend data by county (2010-2014) shows that Coos County has the second highest rate of cancer death in the state, second to Sherman County and considerably higher than the state and national rates *(Vital Statistics Oregon Health Authority)*. Breast, prostate, lung and colorectal are the most common types of cancer in Coos County.

"We have high rates of cancer here, three people in my family died of cancer from here. So it's close to home." —Focus Group Participant

Leading types of cancer* 2010-2014 Coos County and Oregon

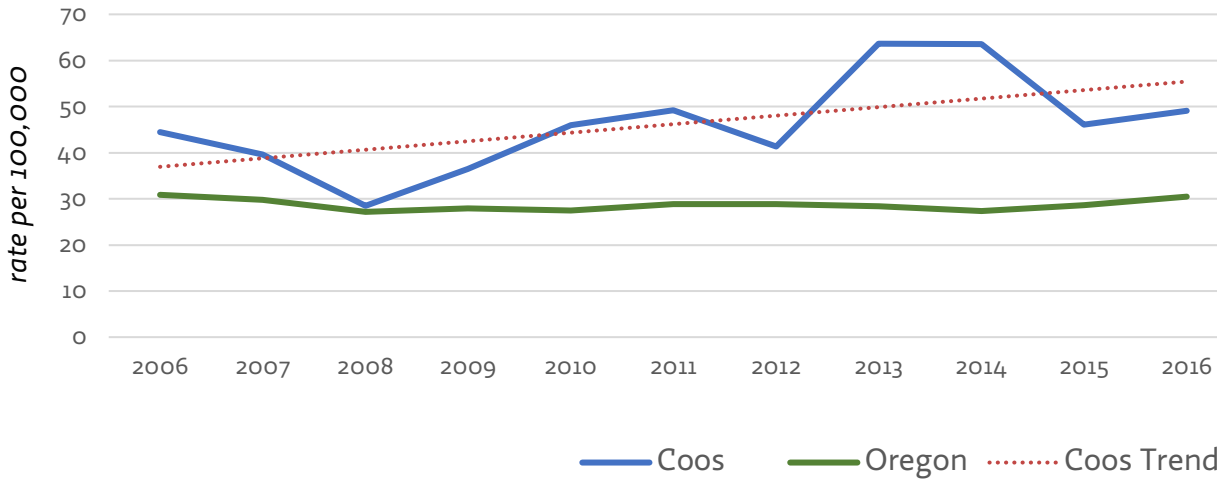


Source: Oregon State Cancer Registry, 2010-2014

*incidence/new cases

Mortality from diabetes is increasing in Coos County and also remains higher than the statewide mortality rates.

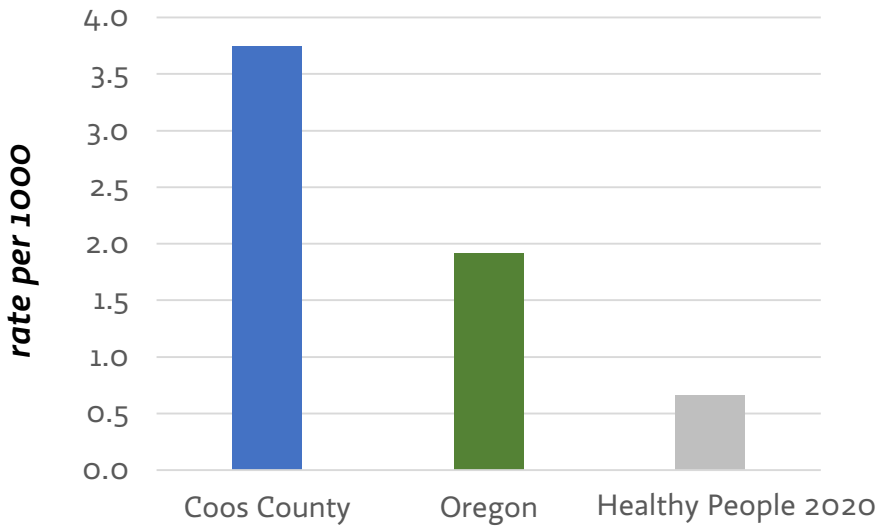
Diabetes-related mortality, 2006-2016
Coos County & Oregon



Source: Oregon Vital Statistics Annual Reports 2006-2016

Deaths attributed to tobacco, as already mentioned in the modifiable health behavior section, are also higher in Coos County than Oregon and considerably higher than the Healthy People 2020 national goals.

Tobacco-linked mortality 2016
Coos County, Oregon, HP 2020



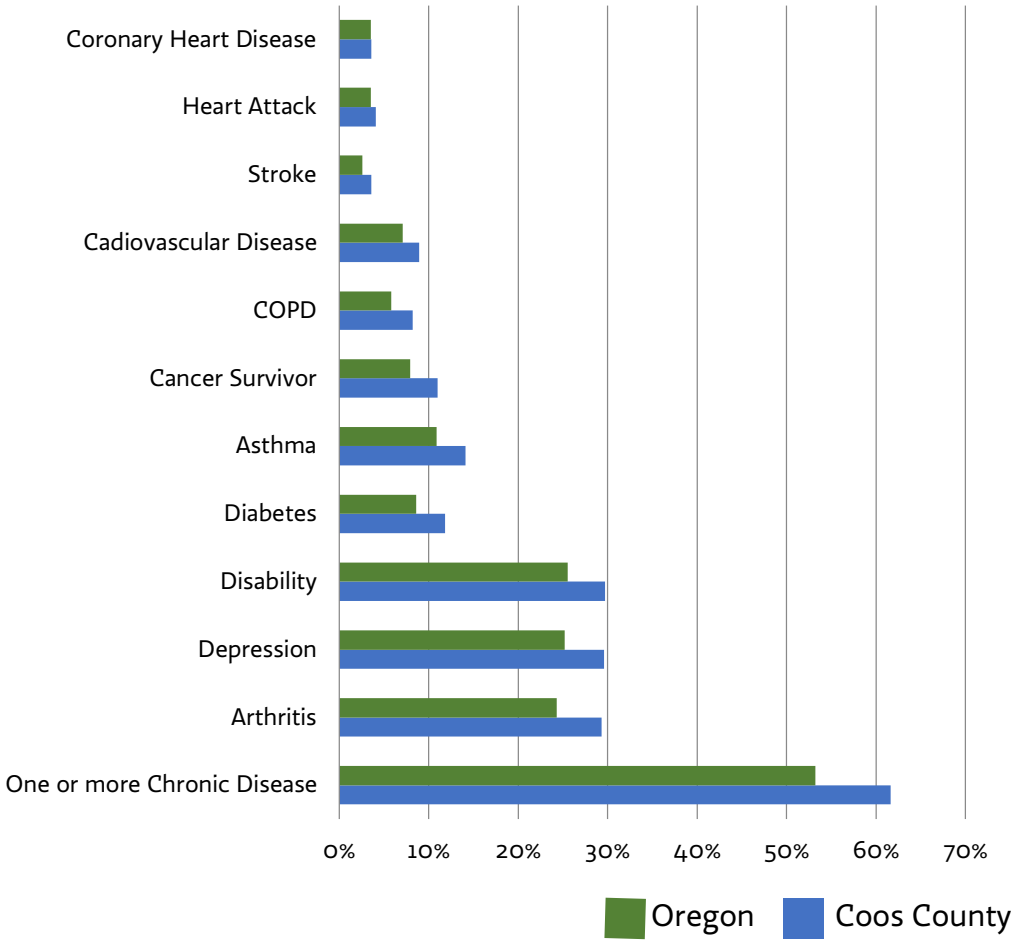
Source: Oregon Vital Statistics Annual Reports

The majority of deaths due to alcohol or drugs are from chronic alcoholic liver disease followed by unintentional injuries *(Oregon Health Authority 2016)*. According to the Oregon Opioid Dashboard (2018), the opioid overdose hospitalization rate per 100,000 was 16.59, representing less than five individuals from 2010-2014. The same data source lists a rate of 2.56 per 100,000 for opioid deaths from 2012-2016 in the county. Although small numbers, both hospitalizations and deaths are higher than the statewide rates.

Chronic Conditions

The prevalence and burden of chronic conditions is high in Coos County, higher when compared to the state. More than 60% of adults in Coos County have one or more of the following chronic conditions: angina, arthritis, asthma, cancer, COPD, depression, diabetes, heart attack or stroke. This illustrates a very high burden of chronic disease in the county. Also notable is that Coos County has higher percentages of the population with arthritis, disability and diabetes than the state.

Chronic conditions, 2012-2015
Coos County and Oregon

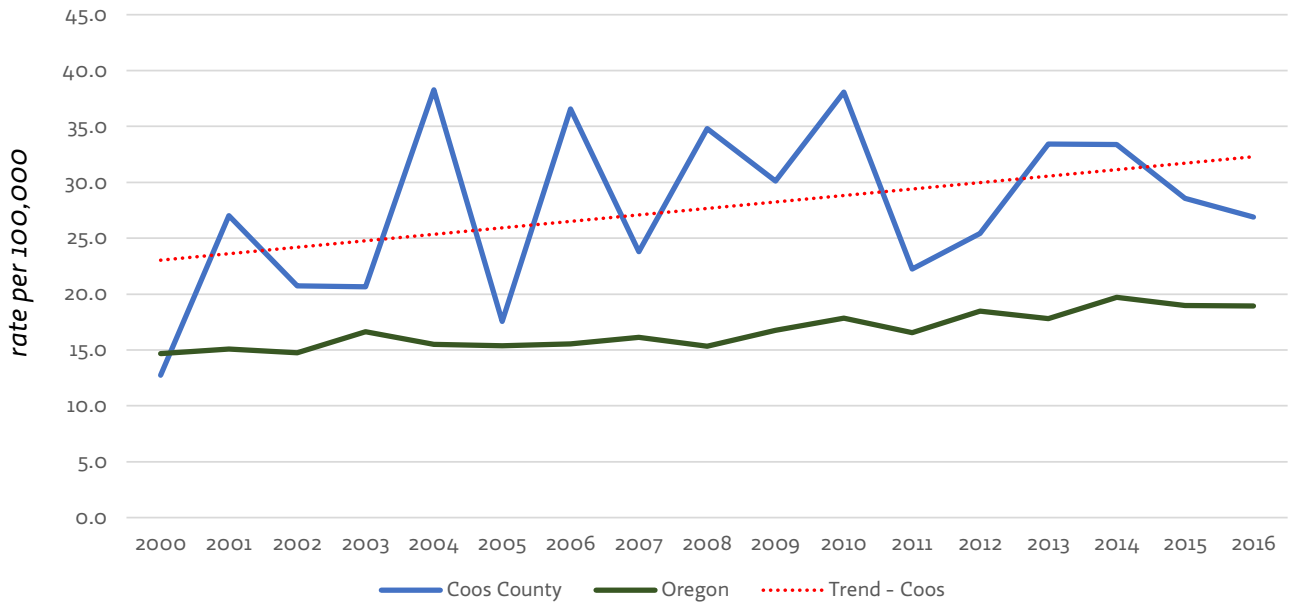


Source: BRFSS, 2017

Mental Health & Suicide

Mental health and depression were listed as top concerns by the 2018 CHA focus groups and survey participants. Indicators of mental and behavioral health include suicide rates and percentages of the population experiencing depression. The rate of **suicide** in Coos County shows an alarming upward trend and continues to be higher than the state.

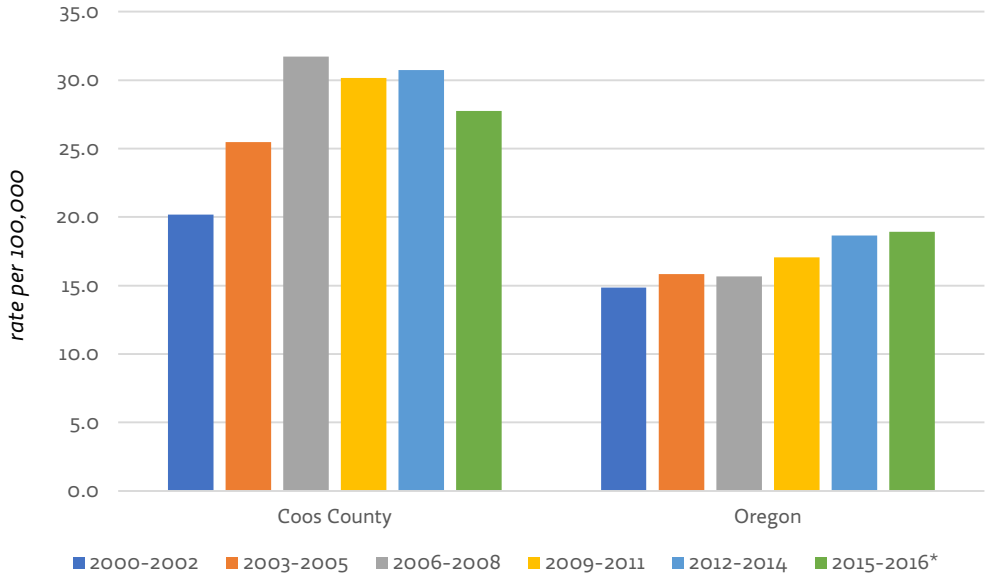
Suicide, 2000-2016, Coos County and Oregon



Source: Oregon Vital Statistics, Leading Cause of Death and Portland State University, Population Research Center 2017

"A lot of suicide is related to gambling here, needs more attention." —Focus Group Participant

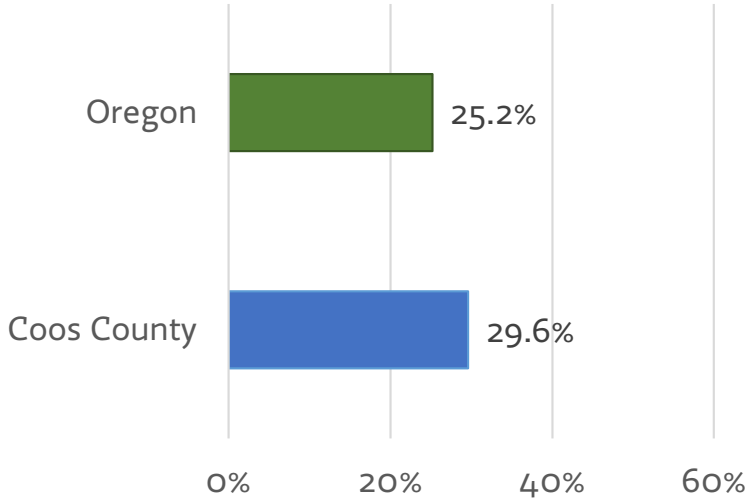
Suicide trend, 2000-2016 Coos County and Oregon



Source: Oregon Vital Statistics, Leading Cause of Death and Portland State University, Population Research Center 2017

Self-reported mental health issues and depression also show higher rates in Coos County than statewide, for both adults and youth. Nearly one in three adults in Coos County indicate that they are struggling with depression.

Adult depression, 2015
Coos County and Oregon



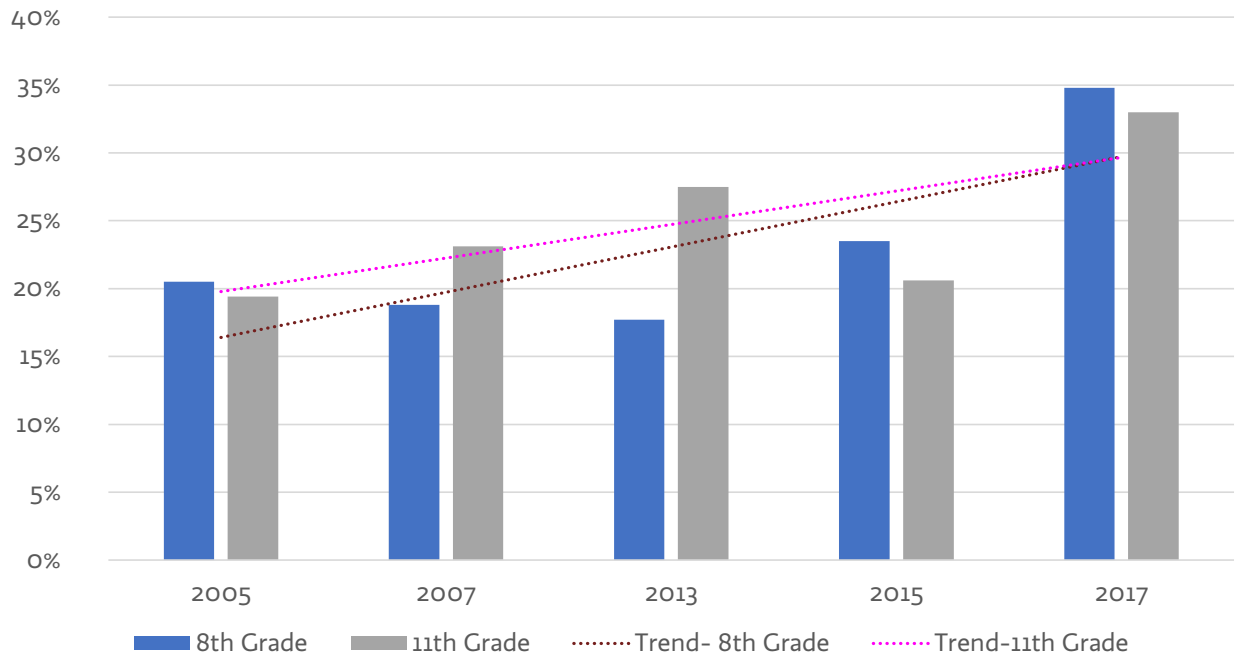
Source: BRFSS 2017

"We need less stigma and taboo. When somebody says you have cancer people are sympathetic. If you have a mental health or substance abuse issue you are taboo." —Focus Group participant

Depression in youth has been steadily increasing for both 8th and 11th graders in Coos County for the last decade and also continues to be higher than the state numbers.

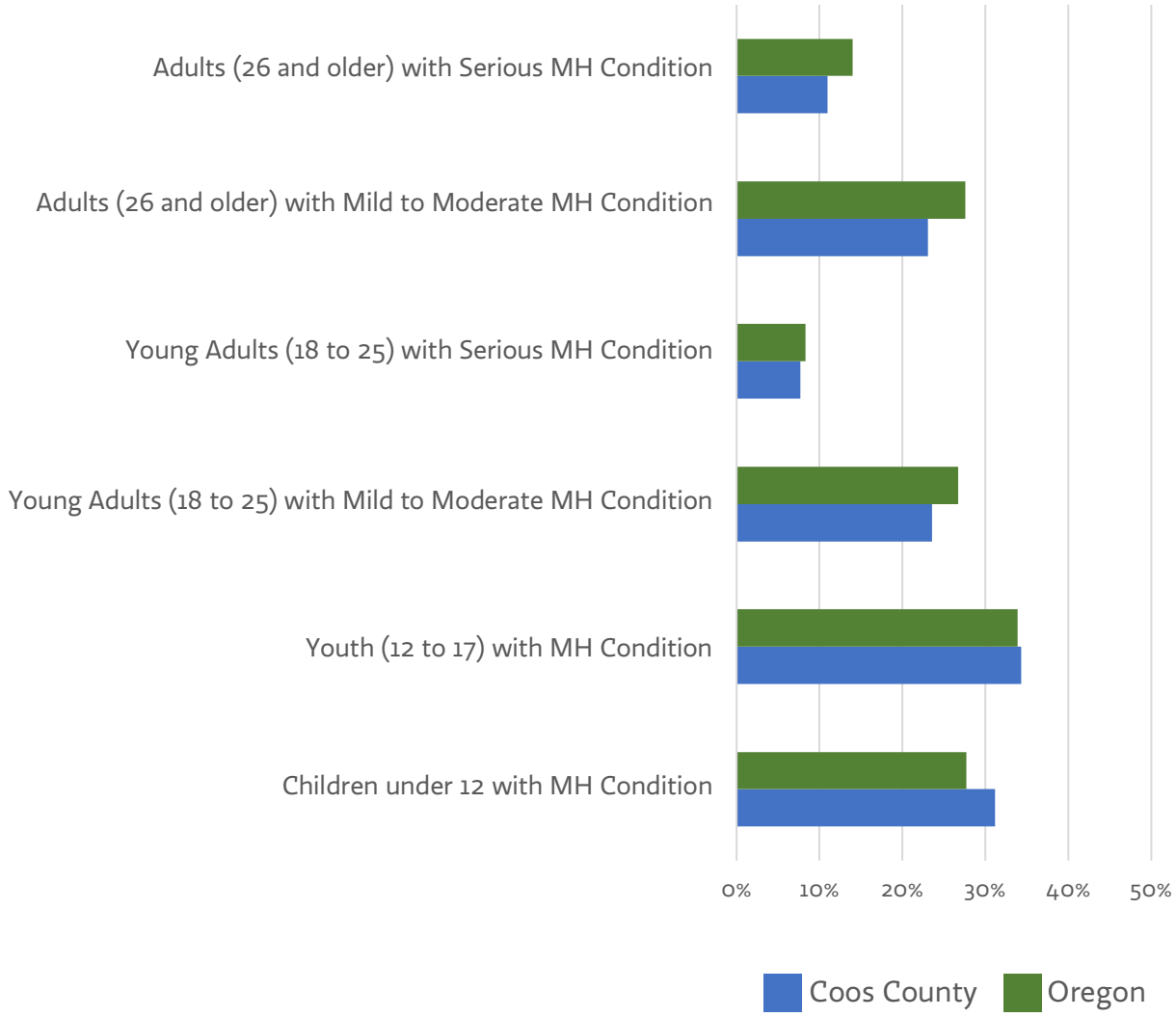
"I have been out of my depression meds for 2 months. I see my psychiatrist infrequently and my parents can barely pay for rent, let alone my meds." —Focus Group Participant

Youth Depression 2005-2017
Coos County



Source: Oregon Healthy Teen Survey, 2017

Mental Health Conditions in Medicaid Population, 2015
Coos County and Oregon



Source: Avatar, DSSURS, HSD-Budget, OHA-Actuarial Unit, Oregon Employment Division, SAMHSA, US Census

"Mental health issues are extreme"—Survey Participant

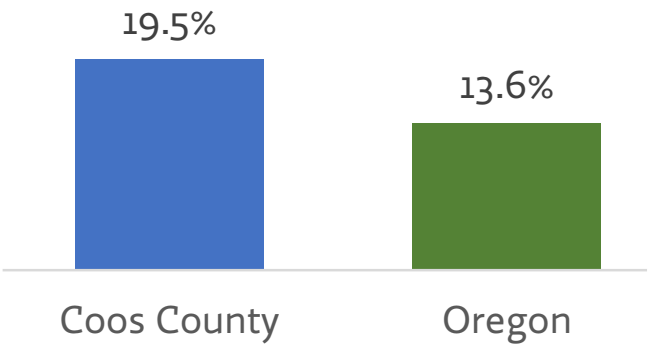
"It can take six weeks to get a client into mental health services and often people need weekly [treatment], at least to stabilize, only to get every two weeks or a month for the next appointment. Where is the group therapy, life skills training, wrap-a-round services?" —Survey Participant

"Give voice to those that need it. We've come a long way but still have a lot to go. 50 years ago mentally ill people were locked in the basement." —Focus Group Participant

Oral Health

In Oregon, oral disease is on the rise and Coos County is not an exception. The most recent data shows that adults in Coos County have a higher percentage of poor dental health and youth are less likely to have seen a dentist or dental hygienist for a check-up in the last year. In the 2017 Healthy Teens Survey, only 62.7% of 8th graders in Coos County have seen a dentist or dental hygienist for a check up, exam, teeth cleaning or other dental work in the last 12 months.

Adults with poor dental health, 2006-2012 Coos County and Oregon



Source: BRFSS 2006-2012

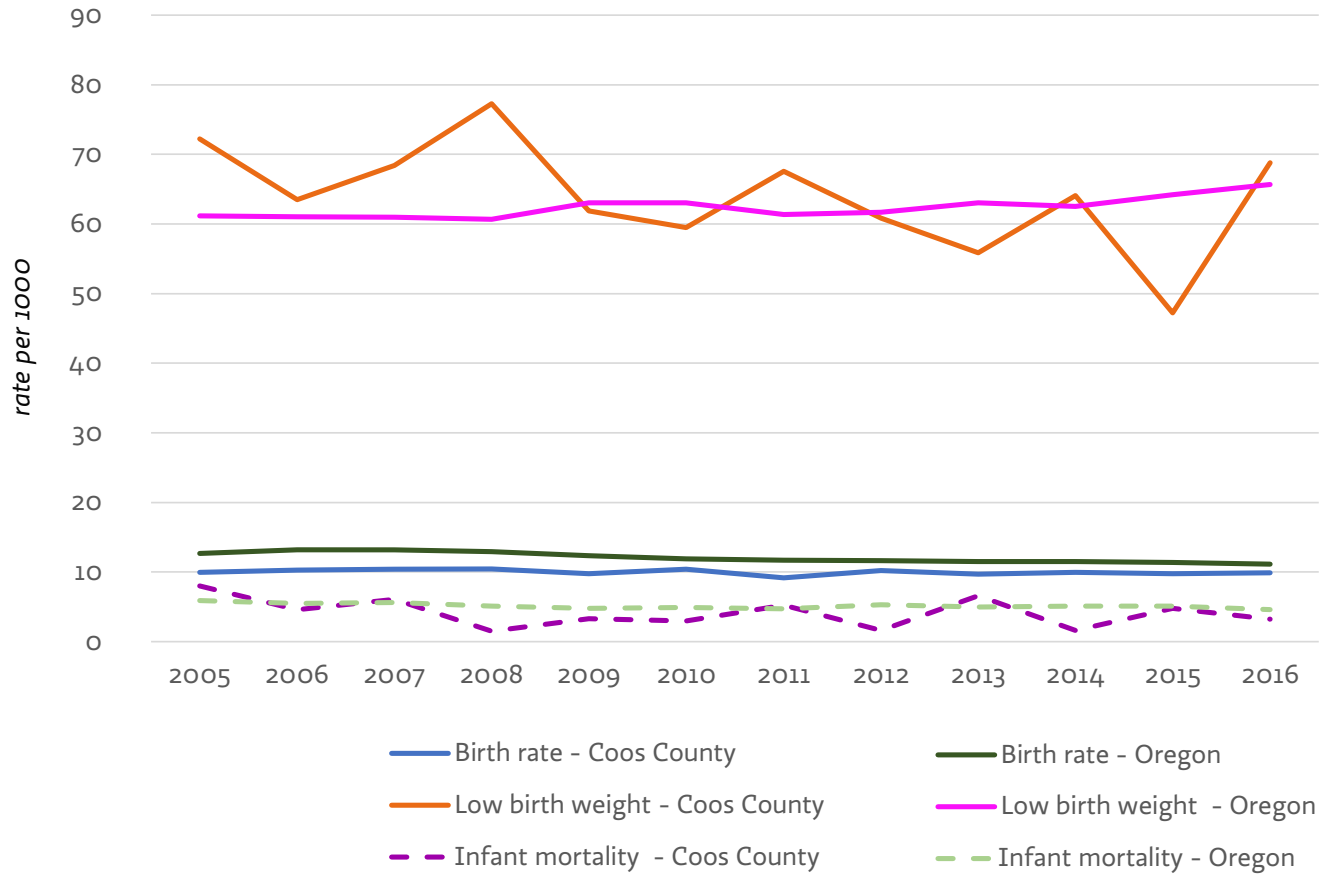
"More dental insurance and options. Not straight teeth, people that can't get teeth pulled, people can't get braces that need them so they can't chew." —Survey Participant

"While pediatric services are easily and rapidly attainable the same services for an adult are painstakingly slow. Both primary health care and dental visits cannot be booked within a reasonable time period. The average for me has been no less than 3-4 months for a primary physician and 6 months for a dental visit. I feel this could be considerably improved." —Survey Participant

Births

Indicators such as low birth weight have long indicated general maternal and child health in a community. Babies born with low birth weight typically have more long-term disabilities and developmental issues. The rate of low birth weight babies in Coos County has historically been higher than the state until 2009 when it began its downward trend. The Infant Mortality Rate (IMR) in Coos County is now lower than the state, indicating a community **strength.** Meanwhile, birth rates in Coos County and the state have stayed relatively steady for the last decade. Access to prenatal care is listed as an indicator in the previous Health Services section.

Birth rate, low birth weight and infant mortality, 2005-2015
Coos County and Oregon

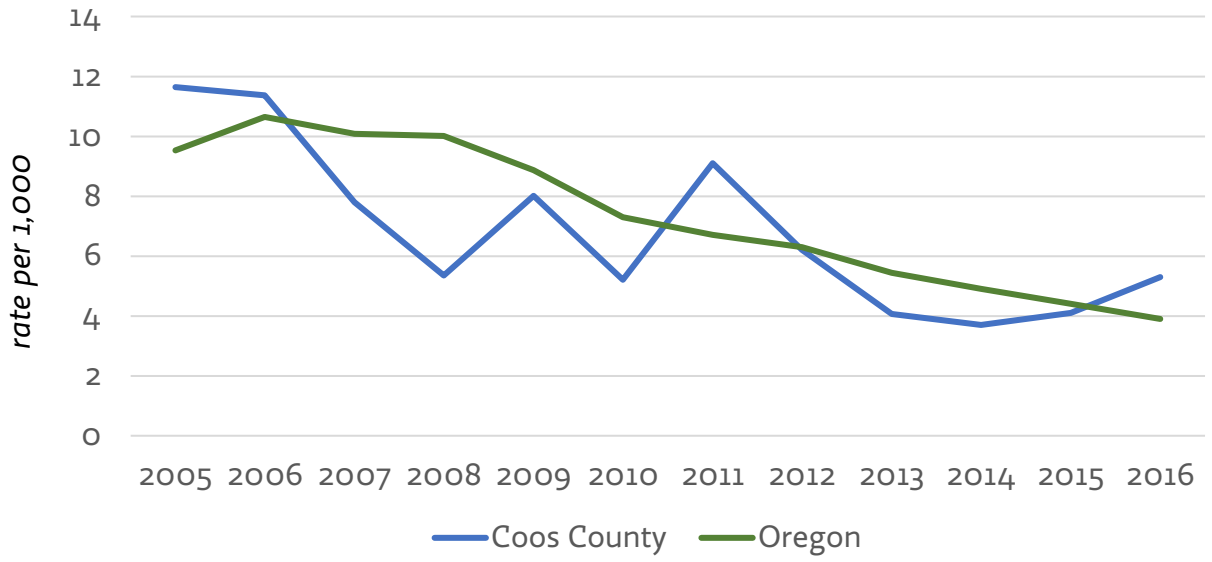


Source: Oregon Vital Statistics, 2005-2016

*low birth weight defined as weighing less than 5 pounds 8 ounces at birth

Teen pregnancies and births, among young women age 15-19, have been similar to the state rate with an increase over the state rate in 2016. The trend has had a slight dip since 2005. Teen births are an important indicator. Teen parents have unique social, economic and health services support needs. High rates of teen pregnancy can also indicate prevalence of unsafe sex practices.

Teen births, 2005-2016
Coos County and Oregon



Source: Oregon Health Authority, Center for Health Statistics, 2017

Health Status and Outcome Indicators	
Indicator	***Findings*** *(Coos County vs. Oregon)*
Leading causes of death	Cancer, Heart Disease and COPD ↑ Diabetes-related mortality ↑ Tobacco-related mortality ↑
Chronic conditions	Burden of chronic disease ↑ One or more chronic diseases, arthritis, depression and disability
Cancer	"All cancers" ↑ Lung cancer ↑
Mental health	Suicide ↑ Adults depression ↑ Youth depression ↑
Dental/oral health	Poor dental health ↑
Maternal and pediatric health	Birth rate ↓ Low birth weight ↑ Teen birth rate ↑

Key

↑ =higher (than State)

↓ =lower (than State)

Data Gaps and Next Steps

The CHA document is a broad snapshot of health in Coos County, and it has limitations. As mentioned in the executive summary, the CHA is not meant to cover every possible factor that influences health nor is it an evaluation of services or the efficacy of the health care system itself. The CHA is also limited by what data is currently being gathered and published and the validity, frequency and level of which the data is presented. The CHA committee identified several data gaps in the process, with the hope that it will drive future data collection and study. The list is not meant to be all inclusive and community members were invited to review and add to the list.

Data Gaps, Possible Future Data Collection and/or Study Topics
Built environment: specifically sidewalks, running/walking paths, lighting on roads for safety
Homelessness & housing availability
Dental & oral health utilization and patterns
Current resource/services mapping
Generational health traits & behaviors
Genetic health issues
Opioid use & abuse
Access to specialty health care and patterns of patients getting care outside of county
Transportation
Types & characteristics of employment in area

The CHA document is intended to inform and build on current health improvement efforts in the community. **It is one step in an ongoing process of community health assessment, planning and improvement.** Future work includes prioritization of health issues and interventions and exploration of how to compliment and integrate work that is already being done in the community. The work of improving the health of people in Coos County moving forward will include recognition of strengths, identification of needs and continued collaboration to improve health outcomes of individuals, families and community.

Appendices

Primary Data Collection Summary

2018 Coos County Community Health Assessment

Process & Methods

Two primary methods were used to solicit feedback from the community regarding the 2018 Coos County Community Health Assessment. Primary data collection, through focus groups and a community wide survey, provided additional data and context to the secondary data cataloging and analysis. The purpose of the primary data collection was to gather perceptions about health priorities, experiences and gain an understanding of what community members believe influences health the most. Methods included surveys (both paper and online) and targeted focus groups. The primary data collection process was part of a larger community health assessment, following a modified Mobilizing for Action through Planning and Partnerships model (MAPP).

The community **survey** was written for easy reading and comprehension, resulting in a 99% completion rate. Survey questions mirrored the questions in the targeted focus groups. The survey was available online and in paper/hard copy format, in English and Spanish languages. Additional accommodation for language and/or reading and comprehension was offered. The survey was advertised through many formats: including flyers, social media and via email. 469 people took the survey, eliciting both quantitative health priority ranking data and 371 unique comments.

The 2018 Coos CHA collaborative committee also sponsored ten targeted community focus groups. Eighty-six (86) community members participated in the **focus groups**. The meetings were held around the county during November and December of 2017. The committee identified and prioritized which groups of individuals they wanted to have targeted feedback from, after lengthy discussion. The committee then chose local champions for each group. The role of the local focus group champion was to lead recruitment, coordination of focus group location, selection of small incentives for participants and introduction of the consultant and facilitator to the participants of the group.

Prioritized Populations for 2018 Coos County Community Health Assessment Focus Groups

- ***People living with cancer & chronic conditions***
- ***People with disabilities***
- ***Teens/young adults***
- ***Behavioral health, mental health and addictions***
- ***People experiencing homelessness***
- ***Retired & seniors***
- ***Education sector***
- ***Hispanic/Latino and Spanish Speakers***
- ***People working in service industry***
- ***CCO Community Advisory Council and CHA subcommittee***

Data was gathered in the focus groups with a combination of instant polling questions utilizing "clickers" that captured instant demographic data and polling on health priorities and perceptions. The second type of tool was open-ended discussion questions. The multiple feedback collection tools ensured 100% participation. Light refreshments and $10 gift cards or equivalent were provided to focus group participants as incentives. The focus groups were complete within two hours and averaged almost nine people per group. 464 unique comments were gathered from focus groups.

Total primary data collection 2018	
Total focus group participants	86
Total surveys completed	469
Total individual participants (both survey and focus group)	555
Total qualitative comments	835

There are limitations to focus group and survey data. Neither should stand on its own; the processes are meant to complement and balance the secondary data analysis. The primary data collection methods used in the 2018 Coos County CHA are also not random and instead are considered a convenience sample, not intended to be a complete and random sampling of the community but instead, to provide insight into the health concerns, perceptions and experiences of specific groups within the county. The selection of populations for the focus group and the advertising of the survey were driven by the local CHA committee.

Qualitative and quantitative data were reviewed for themes in both the survey and focus groups. A combined number of 835 unique qualitative comments and several quantitative ranking questions were reviewed for themes. The combined themes and summary data are as follows.

Primary data themes

3 Biggest strengths in community

- *Physical environment (such as air quality and recreational opportunities etc.)*
- *Social support (including religious/ spiritual values, volunteerism etc.)*
- *The people that live here*

3 Things that would most improve quality of life here

- *Meeting basic needs for everyone (like food, shelter etc.)*
- *Improved access to affordable housing*
- *Improving availability of jobs*

3 Behaviors with the most influence on health

- *Alcohol and/or drug abuse*
- *Eating habits and nutrition*
- *Tobacco use*

3 Health issues you see the most

- *Mental health problems*
- *Substance Abuse*
- *Abuse and/or neglect*

3 Community Conditions you see the most

- *Poverty or ability to meet financial responsibilities*
- *Homelessness/availability of housing*
- *Availability of jobs with a living wage (lack of)*

Health Equity

55% of participants don't believe that everyone in Coos County has an equal opportunity to live a long healthy life if they choose to.

Local Public Health Assessment 2018

Purpose of Local Public Health System Assessment

The primary purpose of the NPHPS Local Public Health System Assessment Report is to promote continuous improvement that will result in positive outcomes for system performance. Local health departments and their public health system partners can use the Assessment Report as a working tool to:

- ***Better understand current system functioning and performance***
- ***Identify and prioritize areas of strengths, weaknesses, and opportunities for improvement***
- ***Articulate the value that quality improvement initiatives will bring to the public health system***
- ***Develop an initial work plan with specific quality improvement strategies to achieve goals***
- ***Begin taking action for achieving performance and quality improvement in one or more targeted areas***
- ***Re-assess the progress of improvement efforts at regular intervals***

This summary report is designed to facilitate communication and sharing among and within programs, partners, and organizations, based on a common understanding of how a high performing and effective public health system can operate. This shared frame of reference will help build commitment and focus for setting priorities and improving public health system performance. Outcomes for performance include delivery of all ten essential public health services at optimal levels.

Acknowledgments

The National Public Health Performance Standards (NPHPS) was developed collaboratively by the program's national partner organizations. The NPHPS partner organizations include: Centers for Disease Control and Prevention (CDC); American Public Health Association (APHA); Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Local Boards of Health (NALBOH); National Network of Public Health Institutes (NNPHI); and then Public Health Foundation (PHF). We thank the staff of these organizations for their time and expertise in the support of the NPHPS.

Background

The NPHPS is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPS assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites can consider the activities of all public health system partners, thus addressing the activities of all public, private and voluntary entities that contribute to public health within the community.

The NPHPS assessments are intended to help users answer questions such as ""What are the components, activities, competencies, and capacities of our public health system?"" and ""How well are the ten Essential Public Health Services being provided in our system?"" The dialogue that occurs in the process of answering the questions in the assessment instrument can help to identify strengths and weaknesses, determine opportunities for immediate improvements, and establish priorities for long term investments for improving the public health system.

Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health. These instruments are the:

- ***State Public Health System Performance Assessment Instrument,***
- ***Local Public Health System Performance Assessment Instrument, and***
- ***Public Health Governing Entity Performance Assessment Instrument***

The information obtained from assessments may then be used to improve and better coordinate public health activities at state and local levels. In addition, the results gathered provide an understanding of how state and local public health systems and governing entities are performing. This information helps local, state and national partners make better and more effective policy and resource decisions to improve the nation's public health as a whole.

Introduction

The NPHPS Local Public Health System Assessment Report is designed to help health departments and public health system partners create a snapshot of where they are relative to the National Public Health Performance Standards and to progressively move toward refining and improving outcomes for performance across the public health system.

The NPHPS state, local, and governance instruments also offer opportunity and robust data to link to health departments, public health system partners and/or community-wide strategic planning processes, as well as to Public Health Accreditation Board (PHAB) standards. For example, assessment of the environment external to the public health organization is a key component of all strategic planning, and the NPHPS assessment readily provides a structured process and an evidence-base upon which key organizational decisions may be made and priorities established. The assessment may also be used as a component of community health improvement planning processes, such as Mobilizing for Action through Planning and Partnerships (MAPP) or other community-wide strategic planning efforts, including state health improvement planning and community health improvement planning. The NPHPS process also drives assessment and improvement activities that may be used to support a Health Department in meeting PHAB standards. Regardless of whether using MAPP or another health improvement process, partners should use the NPHPS results to support quality improvement.

The self-assessment is structured around the Model Standards for each of the ten Essential Public Health Services, (EPHS), hereafter referred to as the Essential Services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health. Altogether, for the local assessment, 30 Model Standards serve as quality indicators that are organized into the ten essential public health service areas in the instrument and address the three core functions of public health.

About the Report

The NPHPS assessment instruments are constructed using the ten Essential Services as a framework. Within the Local Instrument, each Essential Service includes between 2-4 Model Standards that describe the key aspects of an optimally performing public health system. Each Model Standard is followed by assessment questions that serve as measures of performance. Responses to these questions indicate how well the Model Standard—which portrays the highest level of performance or ***gold standard***—is being met.

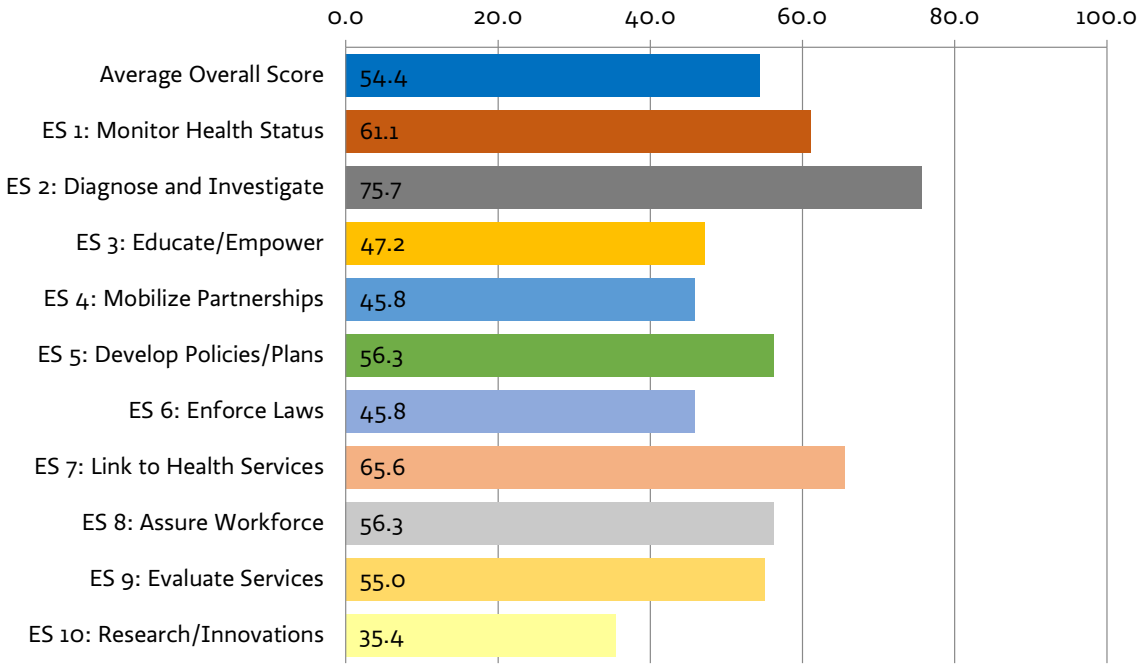
The table below characterizes levels of activity for Essential Services and Model Standards. Using the responses to all of the assessment questions, a scoring process generates score for each Model Standard, Essential Service, and one overall assessment score.

Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met
Significant Activity (51-75%)	Greater than 50%, but no more than 75% of the activity described within the question is met
Moderate Activity (26-50%)	Greater than 25%, but no more than 50% of the activity described within the question is met
Minimal Activity (1-25%)	Greater than zero, but no more than 25% of the activity described within the question is met
No Activity (0%)	0% or absolutely no activity

Summary of Local Public Health Assessment Response Options
Understanding Data Limitations

There are a number of limitations to the NPHPS assessment data due to self-report, wide variations in the breadth and knowledge of participants, the variety of assessment methods used, and differences in interpretation of assessment questions. Data and resultant information should not be interpreted to reflect the capacity or performance of any single agency or organization within the public health system or used for comparisons between jurisdictions or organizations. Use of NPHPS generated data and associated recommendations are limited to guiding an overall public health infrastructure and performance improvement process for the public health system as determined by organizations involved in the assessment.

Summary of average ES performance scores



All performance scores are an average; Model Standard scores are an average of the question scores within that Model Standard, Essential Service scores are an average of the Model Standard scores within that Essential Service and the overall assessment score is the average of the Essential Service scores. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which may be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Action Planning

In any systems improvement and planning process, it is important to involve all public health system partners in determining ways to improve the quality of essential public health services provided by the system. Participation in the improvement and planning activities included in your action plan is the responsibility of all partners within the public health system.

Overall Performance, Priority and Contribution Scores by Essential Public Health Service and Corresponding Model Standard

Overall Scores for Each Essential Public Health Service for Coos County

Performance Scores by Essential Public Health Service for Each Model Standard

The following table displays the average performance score for each of the Model Standards within each Essential Service. This level of analysis enables you to identify specific activities that contributed to high or low performance within each Essential Service.

Table 2. Overall performance, priority, and contribution scores by essential public health service and corresponding model standard

Model Standards by Essential Services	Performance Scores
ES 1: Monitor Health Status	61.1
1.1 Community Health Assessment	75.0
1.2 Current Technology	33.3
1.3 Registries	75.0
ES 2: Diagnose and Investigate	75.7
2.1 Identification/Surveillance	58.3
2.2 Emergency Response	75.0
2.3 Laboratories	93.8
ES 3: Educate/Empower	47.2
3.1 Health Education/Promotion	50.0
3.2 Health Communication	41.7
3.3 Risk Communication	50.0
ES 4: Mobilize Partnerships	45.8
4.1 Constituency Development	25.0
4.2 Community Partnerships	66.7
ES 5: Develop Policies/Plans	56.3
5.1 Governmental Presence	41.7
5.2 Policy Development	50.0
5.3 CHIP/Strategic Planning	75.0
5.4 Emergency Plan	58.3
ES 6: Enforce Laws	45.8
6.1 Review Laws	62.5
6.2 Improve Laws	25.0
6.3 Enforce Laws	50.0
ES 7: Link to Health Services	65.6
7.1 Personal Health Service Needs	56.3
7.2 Assure Linkage	75.0
ES 8: Assure Workforce	56.3
8.1 Workforce Assessment	25.0
8.2 Workforce Standards	75.0
8.3 Continuing Education	75.0
8.4 Leadership Development	50.0
ES 9: Evaluate Services	55.0
9.1 Evaluation of Population Health	50.0
9.2 Evaluation of Personal Health	65.0
9.3 Evaluation of LPHS	50.0
ES 10: Research/Innovations	35.4
10.1 Foster Innovation	31.3
10.2 Academic Linkages	50.0
10.3 Research Capacity	25.0
Average Overall Score	54.4
Median Score	55.6

Helpful acronyms	
BAH	Bay Area Hospital
BMI	Body mass index
BRFSS	Behavioral Risk Factor Surveillance System
CCO	Coordinated Care Organization
CHA	Community Health Assessment
CHNA	Community Health Needs Assessment
CMS	Centers for Medicare and Medicaid Services
CT	Computerized Tomography
FTE	Full Time Equivalent
HCV	Hepatitis C Virus
IMRT	Intensity-modulated radiation therapy
LPHD	Local Public Health Department
MAPP	Mobilizing for Action through Planning and Partnerships
MRI	Magnetic Resonance Imaging
OHA	Oregon Health Authority
ORCCA	Oregon Coast Community Action
PET	Polyethylene Terephthalate
SNAP	Supplemental Nutrition Assistance Program
WIC	Special Supplemental Nutrition Program for Women, Infants and Children

PHAB Measures for Accreditation Chart PHAB 1.5	*Reference Page of Report*
1.1.1.1 Community Partners	1
1.1.1.2 Regular Meetings	1 (see documentation)
1.1.1.3 Process to identify health issues	1-5
1.1.1.2a Qualitative and quantitative data, primary and secondary data	6-75, 61-63
1.1.2.1 b, 3.2.6.1 Demographics of population	6-10
1.1.2.1c Description of health issues and inequities linked to specific population groups	11-58
1.1.2.1 d Factors that contribute to specific populations' health challenges	11-58
1.1.2.1 e Existing assets and resources that address health issues	31-39
1.1.2.2 Community review and contribution to CHA (survey and presentations of document)	see documentation
7.1.3.2a Assessment of capacity and distribution of health care providers	31-33
7.1.3.2 b Availability of health care services	31-39
7.1.3.2c & d Identification of causes of gaps in services and barriers to care, results of data gathered periodically concerning access	59

CHNA list for nonprofit hospitals *IRS Form 990, Schedule H (2017)*	*Reference page of Report*
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	6-10
Part V Section B Line 3c Existing health care facilities and resources in the community that are available to respond to the health needs of the community	35-39
Part V section B Line 3d How data was obtained	1-5, 61-63
Part V Section B Line 3e Significant health needs of the community	11-58
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons and minority groups	48-58
Part V Section B Line 3g Process for identifying and prioritizing community health needs and services to meet the community health needs	1-5, 61-63
Part V Section B Line 3h Process of consulting with persons representing the community's interests	1-5, 61-63
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	59