2025 Community Health Needs Assessment

Report adopted by Hospital Advisory Board June 2025

CHI Mercy Health™

A member of CommonSpirit

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Community Health Needs Assessment – At a Glance

CHI Mercy Health

Data Analysis Overview

Secondary Data
Topic score of 1.50 or higher

Listening Sessions
Frequency topic was discussed during interviews

Community Survey
Selected by 20% or more of respondents as a priority health issue

Secondary data, or numerical health indicators, from HCI's 200+ community indicator database, were analyzed and scored based on their values.

Listening Sessions were conducted with **over 60 community groups , organizations, and hospital leaders** that represent the broad demographics or underserved populations in the community.

An online community survey was made available to people residing in Douglas County. The survey was offered in English and Spanish.

Prioritized Significant Health Needs

Adolescent and Youth Health, Early Childhood Development and Engagement

Access to Affordable, Quality, and Equitable Healthcare Services

Maternal, Fetal, Infant, and Children's Health

Substance Use and Alcohol Use Disorders

*Topic scores reflect the relative severity of issues based on standardized data; a score of 1.50 or higher indicates a higher-than-average concern compared to state or national benchmarks.

Executive Summary

Introduction & Purpose

The purpose of this community health needs assessment (CHNA) is to identify and prioritize significant health needs in the community served by CHI Mercy Health. The priorities identified in this report guide the hospital's community health improvement programs, community benefit activities, and collaborative efforts with other organizations sharing the mission to improve community health. This CHNA meets the requirements of the Patient Protection and Affordable Care Act, mandating not-for-profit hospitals to conduct a CHNA at least every three years.

CommonSpirit Health Commitment and Mission Statement

The hospital's commitment to engaging with the community, assessing priority needs, and helping to address them with community partners is in keeping with its mission.

Our Mission

As a member of CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Our Vision

A healthier future for all—inspired by faith, driven by innovation, and powered by our humanity.

Our Values

- **Compassion**: Care with listening, empathy, and love; accompany and comfort those in need of healing.
- **Inclusion**: Celebrate each person's gifts and voice; respect the dignity of all.
- **Integrity**: Inspire trust through honesty; demonstrate courage in the face of inequity.
- **Excellence**: Serve with fullest passion, creativity, and stewardship; exceed expectations of others and ourselves.
- **Collaboration**: Commit to the power of working together; build and nurture meaningful relationships.

CHNA Collaborators

CHI Mercy Health collaborated with various community organizations, local health departments, and healthcare providers. Conduent Healthy Communities Institute (HCI) was contracted to facilitate data collection, analysis, and community engagement efforts.

Community Definition

CHI Mercy Health serves Douglas County, Oregon, a predominantly rural region located in the southwestern part of the state. The service area includes 25 zip codes and a population of

approximately 112,373 residents, with the highest concentration in zip code 97471. This geographic area was strategically defined to reflect the community with the highest utilization of CHI Mercy Health's healthcare services, informed by inpatient discharge data and regional healthcare access patterns.

Process and Criteria to Identify and Prioritize Significant Health Needs

Health needs were prioritized based on magnitude and ability to impact, considering secondary data indicators, stakeholder input, and collaborative discussions. The process involved a comprehensive review of the available data, alongside surveys and input from key stakeholders, including healthcare professionals, community leaders, social service organizations, and school leaders. This collaborative approach ensured that diverse perspectives were considered, leading to a well-rounded understanding of the community's most pressing health concerns.

Upon identifying the significant health needs, the team categorized them into themes such as chronic disease prevention, mental health support, access to healthcare services, and health education. Each category was then evaluated to determine its potential impact on the community's overall well-being and its alignment with the hospital's mission and resources.

The prioritization process also considered the feasibility of addressing these needs, considering available resources, potential partnerships, and existing community initiatives. By aligning efforts with ongoing programs and leveraging partnerships, CHI Mercy Health aims to maximize the effectiveness of its community health improvement strategies.

As a result, the prioritized health needs will guide the development of targeted interventions and programs designed to address gaps in care and improve health outcomes for all community members, particularly those who are most vulnerable.

List of Prioritized Significant Health Needs

Health needs were ranked based on their importance and potential impact on the community. This prioritization process incorporated a comprehensive review of secondary data indicators, insights gathered through stakeholder interviews and focus groups, and collaborative discussions with community partners. The resulting list of significant health needs reflects both the prevalence and urgency of issues affecting the residents of Douglas County.

The identified priority health needs include:

Adolescent and Youth Health, Early Childhood Development and Engagement

Access to Affordable, Quality, and Equitable Healthcare Services

Maternal, Fetal, Infant, and Children's Health

Substance Use and Alcohol Use Disorders

Resources Potentially Available

Resources potentially available to address these needs include existing community programs, local nonprofit partnerships, healthcare infrastructure investments, and ongoing collaborations with community-based organizations targeting the identified significant health needs within the service area.

Report Adoption, Availability and Comments

This CHNA report was adopted by the CHI Mercy Health's advisory board in June 2025. CHI Mercy Health invited written comments on the most recent CHNA report and Implementation Strategy both in the documents and on the website where they are widely available to the public. No written comments have been received. The reports are widely available to the public on the hospital's website, and a paper copy is available for inspection upon request at the hospital's Administration Office at 2700 NW Stewart Pkwy, Roseburg, OR 97471 or by e-mail to mercycommunications@commonspirit.org.

Looking Back: Evaluation of Progress since prior CHNA

Since the completion of the previous Community Health Needs Assessment, CHI Mercy Health has made strides in addressing the prioritized health needs through targeted programs, community partnerships, and system-level investments. Guided by the CHNA and Implementation Strategy including Schedule H reporting, the hospital's efforts have focused on Behavioral Health, Access to Health Care Services, Healthy Food and Nutrition, Physical Activity, and the Social Determinants of Health (SDOH). Below is a summary of progress made across each priority area.

Behavioral Health

Recognizing the critical need for mental health support, CHI Mercy Health completed construction of a 12-bed inpatient behavioral health unit, offering essential psychiatric care to vulnerable populations in Douglas County. School-based behavioral health programming previously disrupted by the COVID-19 pandemic was resumed, providing students with onsite mental health resources. In addition, the hospital expanded the use of telehealth services to connect youth in rural and remote areas to behavioral health care, enhancing both access and continuity of care.

Access to Health Care Services

To address provider shortages and improve service availability, the hospital successfully recruited physicians and other clinical providers, opening a new clinic offering both primary care and urgent care in northern Douglas County. CHI Mercy Health also strengthened its commitment to youth health by supporting onsite school-based dental clinics and health learning labs in partnership with the hospital foundation. Expanded outreach programs included collaboration with Oregon State University Extension's SNAP-Ed program to support health education for both youth and adults. The hospital also grew its T1D Beyond the Diagnosis initiative, reaching public, private, and homeschooled youth with diabetes education and support. In response to the rising incidence of interpersonal violence particularly along the I-5 corridor the hospital deepened its involvement in domestic violence and human trafficking prevention efforts.

Healthy Food, Nutrition, and Physical Activity

CHI Mercy Health collaborated with Thrive Umpqua and the SNAP-Ed program to promote healthy eating and physical activity throughout the county. To reduce tobacco-related harms, the hospital offered the "Become an Ex" tobacco cessation program free of charge to all Douglas County residents, including nicotine replacement therapies. The Mercy Foundation provided additional support for youth with Type 1 diabetes and their families, emphasizing disease management, nutrition, and long-term wellness.

Addressing the Social Determinants of Health

Although economic insecurity and poverty were identified as primary contributors to poor health outcomes, CHI Mercy Health acknowledged that the scope of these issues extends

beyond the hospital's direct capacity. Nonetheless, the hospital initiated two health equity-focused programs to address immediate needs:

Inpatient Dental Program: Provided preventive dental services through an expanded practice dental hygienist, helping patients receive critical oral health care during hospitalization.

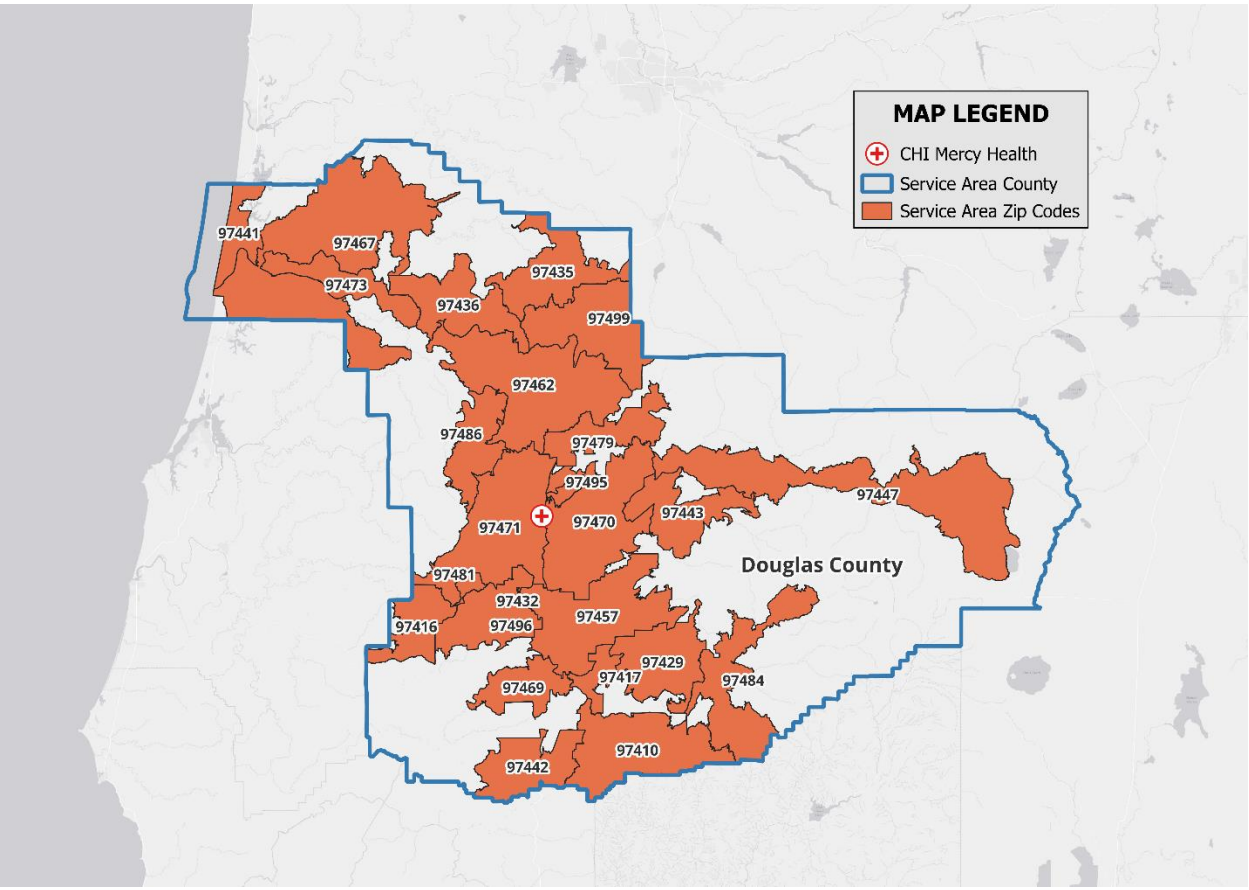
Food Closet Initiative: Ensured patients were discharged with nutritious food and education to support and reduce the risk of readmission.

Defining the Community

Douglas County is characterized by its geographic vastness, natural beauty, and strong community identity. Despite its scenic rivers, forests, and proximity to the Oregon coast and mountains, the region faces challenges tied to its rural status and historical economic transitions, most notably the decline of the timber industry. These shifts have contributed to long-standing issues such as generational and situational poverty, underemployment, and health inequities.

A complete map of the CHI Mercy Health service area and a summary of community demographic indicators are provided in the Appendix.

FIGURE 1. CHI MERCY HEALTH SERVICE AREA



Demographic Profile

Geography and Data sources

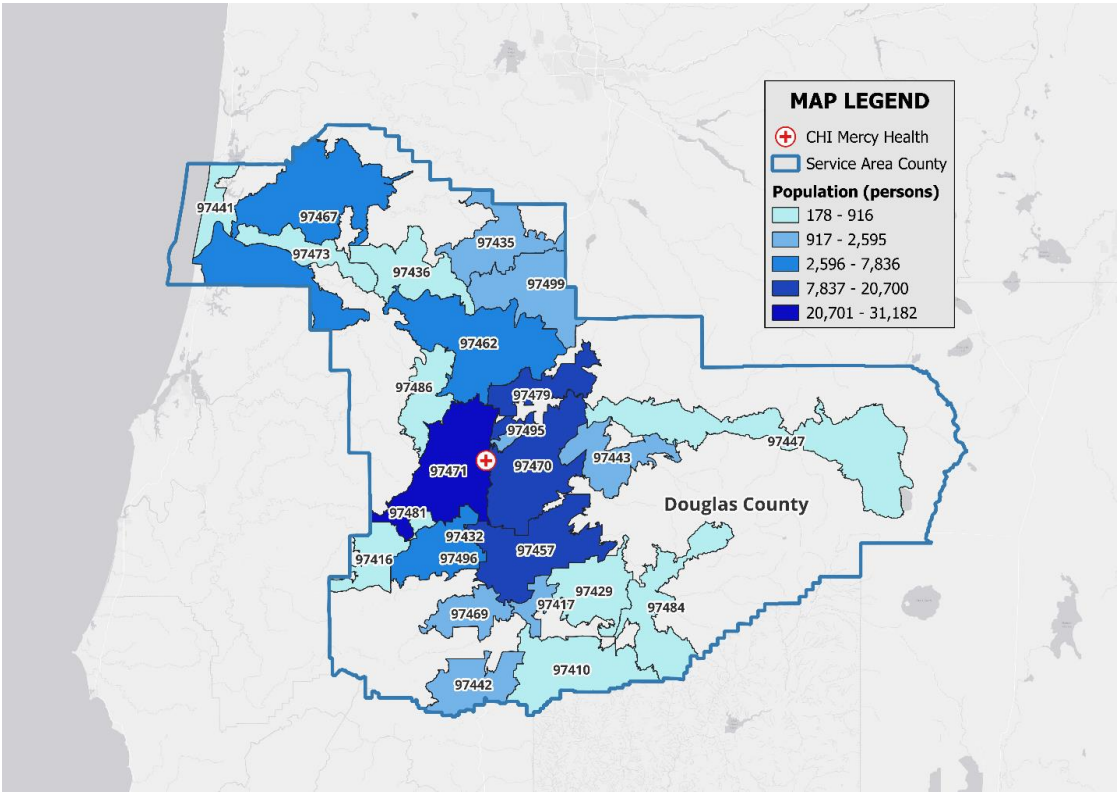
The following section explores the demographic profile of the CHI Mercy Health primary service area, which includes 25 zip codes in and around Douglas County, Oregon. A community's demographics significantly impact its health profile. Different racial/ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts.

Unless otherwise indicated, all demographic estimates are sourced from Claritas® (2025 population estimates). Claritas demographic estimates are primarily based on U.S. Census and American Community Survey (ACS) data. Claritas uses proprietary formulas and methodologies to calculate estimates for the current calendar year.

Population

Douglas County has an estimated population of 112,774 persons. Figure 2 shows the population breakdown for the service area by zip code.

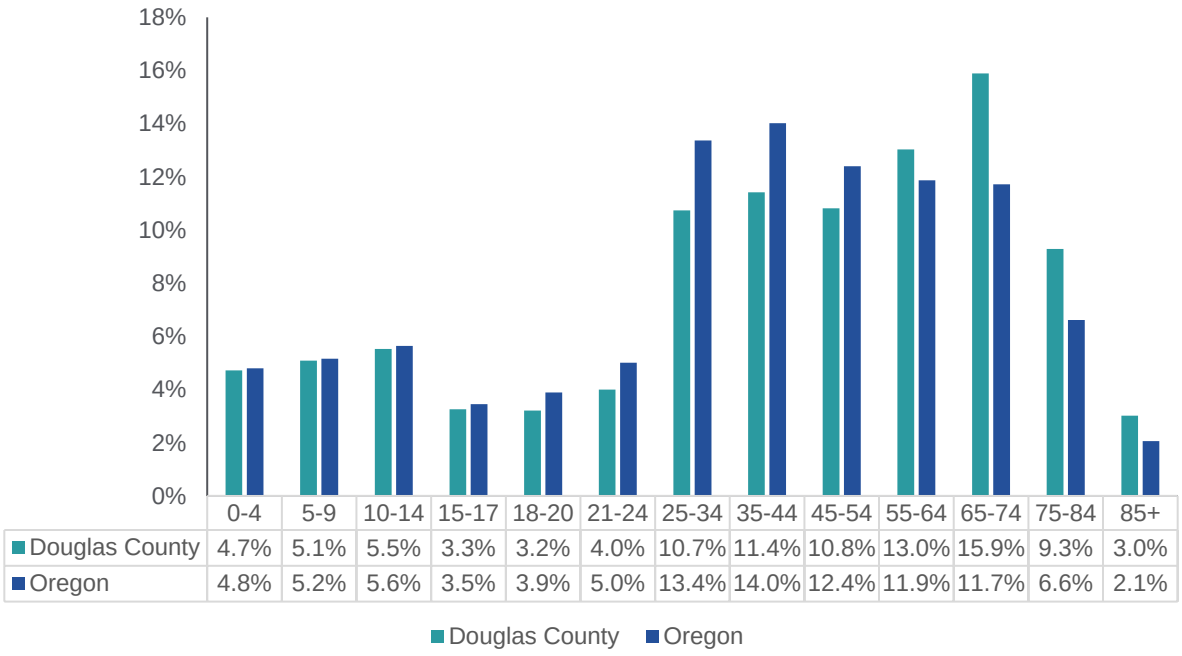
FIGURE 2. CHI MERCY HEALTH PRIMARY SERVICE AREA POPULATION DISTRIBUTION BY ZIP CODE



Age

Figure 3 shows the population of CHI Mercy Health's primary service area broken down by age group, with comparisons to the state-wide Oregon population. Overall, the age distribution of CHI Mercy Health is older than the state-wide Oregon population. Twenty-nine percent of the population is between 55 and 74 years old.

FIGURE 3. PERCENT POPULATION BY AGE: PRIMARY SERVICE AREA AND STATE

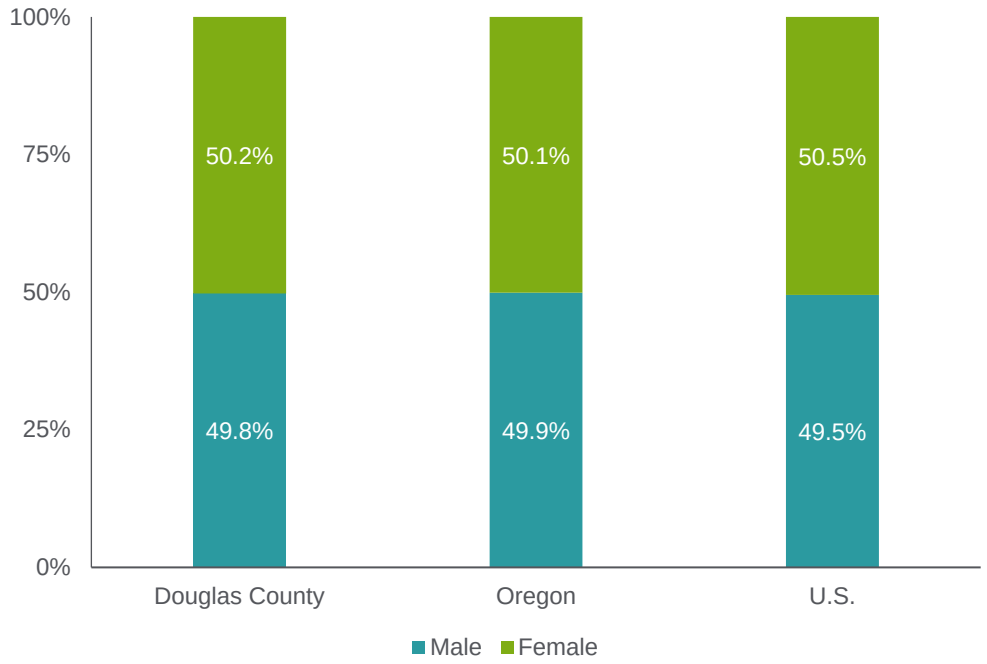


	0-4	5-9	10-14	15-17	18-20	21-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Douglas County	4.7%	5.1%	5.5%	3.3%	3.2%	4.0%	10.7%	11.4%	10.8%	13.0%	15.9%	9.3%	3.0%
Oregon	4.8%	5.2%	5.6%	3.5%	3.9%	5.0%	13.4%	14.0%	12.4%	11.9%	11.7%	6.6%	2.1%

Sex

As seen in Figure 4, 50.2% of the Douglas County population is female, which is similar to both state and national populations (50.1% and 50.5%, respectively).

FIGURE 4. PERCENT POPULATION BY SEX: PRIMARY SERVICE AREA, STATE, AND NATION



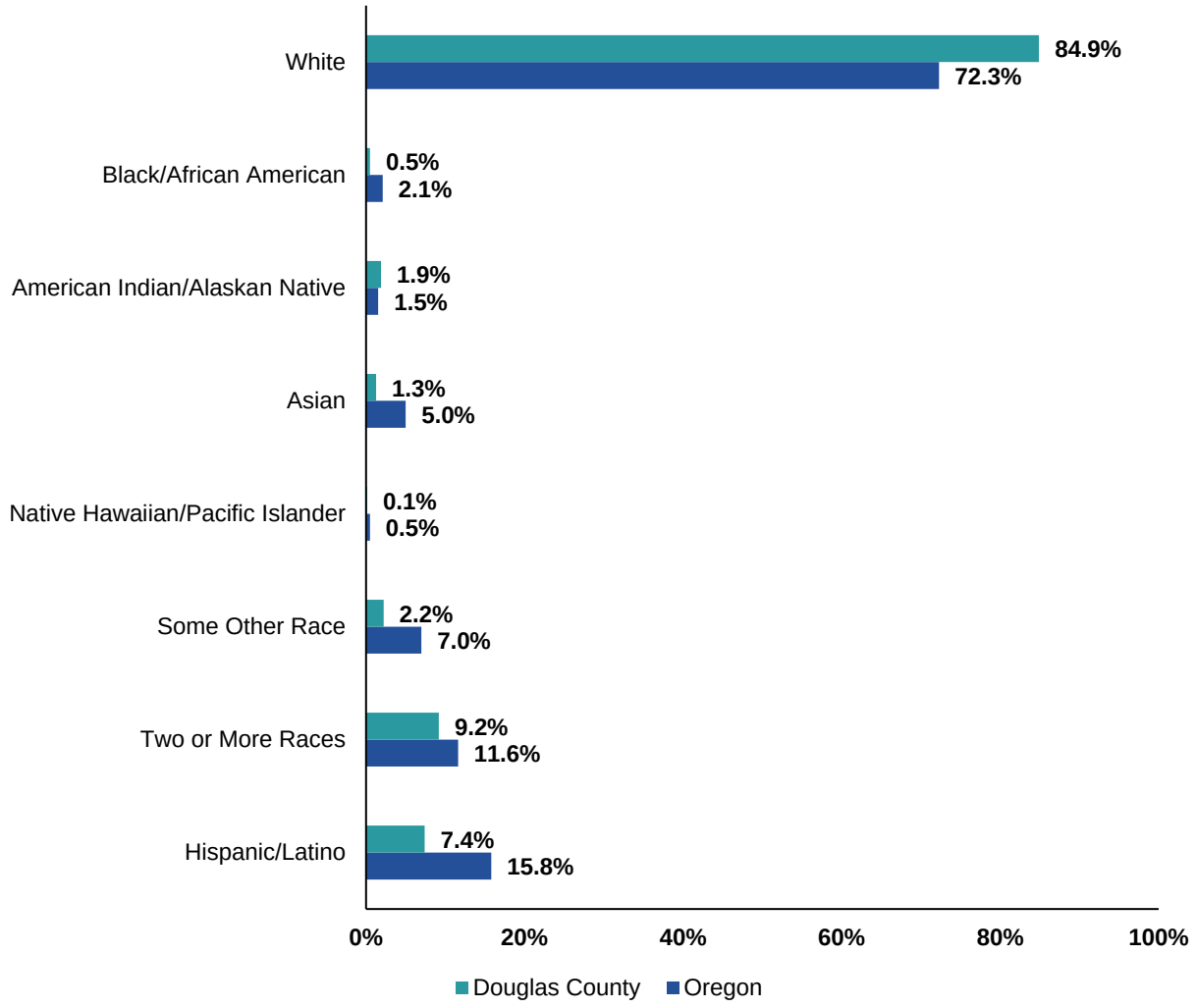
U.S. value taken from American Community Survey (2019-2023)

Race and Ethnicity

Considering the racial and ethnic composition of a population is important in planning for future community needs, particularly for schools, businesses, community centers, health care, and childcare. Analysis of health and social determinants of health data by race/ethnicity can also help identify disparities in housing, employment, income, and poverty.

The majority of the population in the CHI Mercy Health primary service area identify as White (84.9%), which is higher than state-wide rate (72.3%). Residents who identify as Hispanic/Latino represent 7.4% of the service area population.

FIGURE 5. POPULATION BY RACE AND ETHNICITY

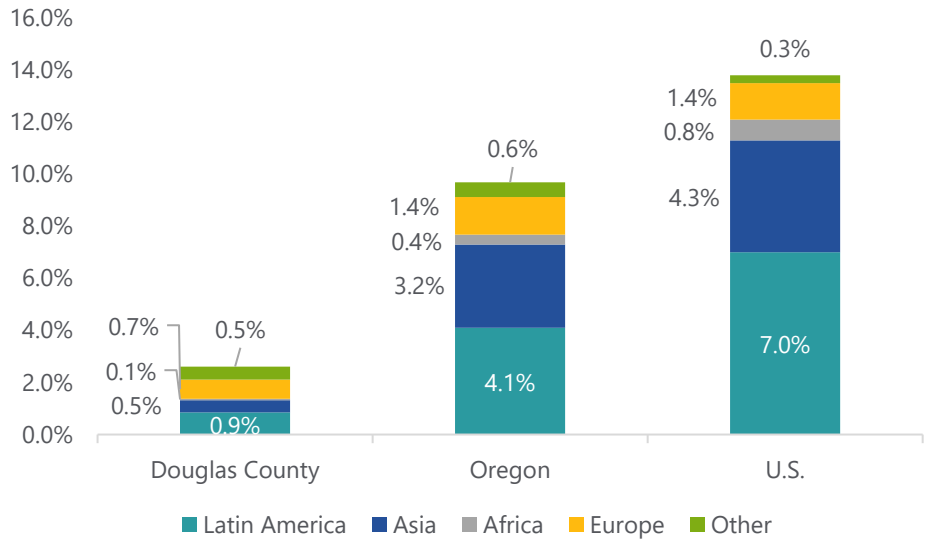


U.S. Value taken from American Community Survey (2019-2023)

Language and Immigration

Understanding countries of origin and spoken languages can help inform a community's cultural and linguistic context. According to the American Community Survey, 2.7% of residents in Douglas County were born outside the U.S., which is lower than the state value (9.7%) and national value (13.9%). Figure 6 provides a breakdown of region of birth for any persons born outside the country.

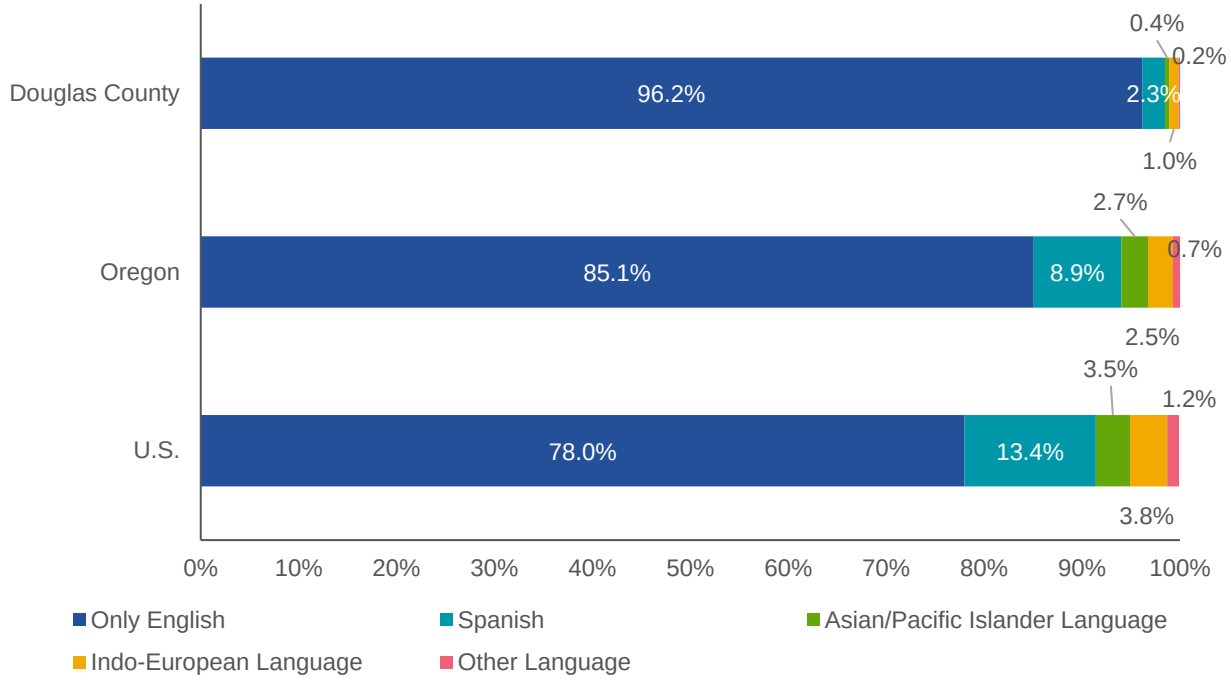
FIGURE 6. REGION OF BIRTH FOR ANY PERSONS BORN OUTSIDE THE COUNTRY



County, State, and U.S. values taken from American Community Survey (2019-2023)

As shown in Figure 7, the majority of residents in the CHI Mercy Health primary service area speak English at home. The CHI Mercy Health population is more likely than the state-wide Oregon population to speak English (96.2% vs. 85.1%).

FIGURE 7. POPULATION AGE 5+ BY LANGUAGE SPOKEN AT HOME

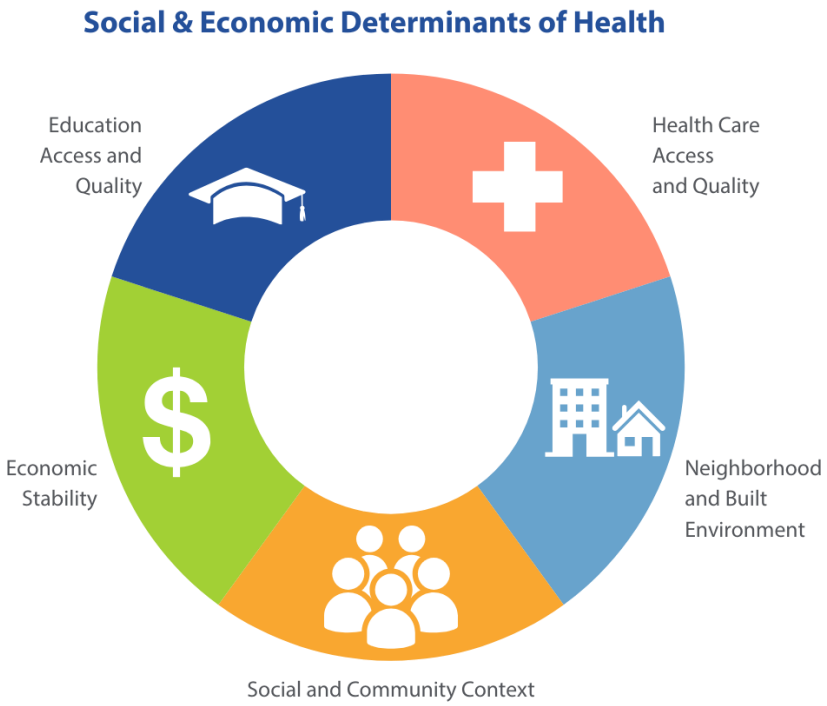


U.S. value taken from American Community Survey (2019-2023)

Social & Economic Determinants of Health

This section examines the economic, environmental, and social factors of health impacting the CHI Mercy Health primary service area. Social Determinants of Health (SDOH) are the conditions in which people are born, grow, work, live, and age, and the wider range of forces and systems shaping the conditions of everyday life. The SDOH can be grouped into five domains. Figure 8 shows the Healthy People 2030 Social Determinants of Health domains (Healthy People 2030, 2022).

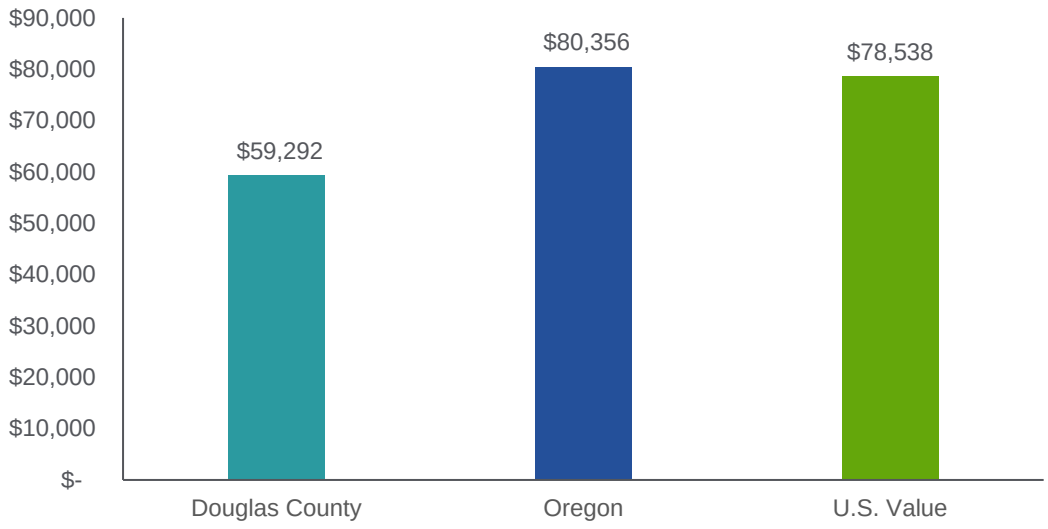
FIGURE 8. HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH



Income

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work. Figure 9 provides the median household income in the service area, compared to the state and nation.

FIGURE 9. MEDIAN HOUSEHOLD INCOME



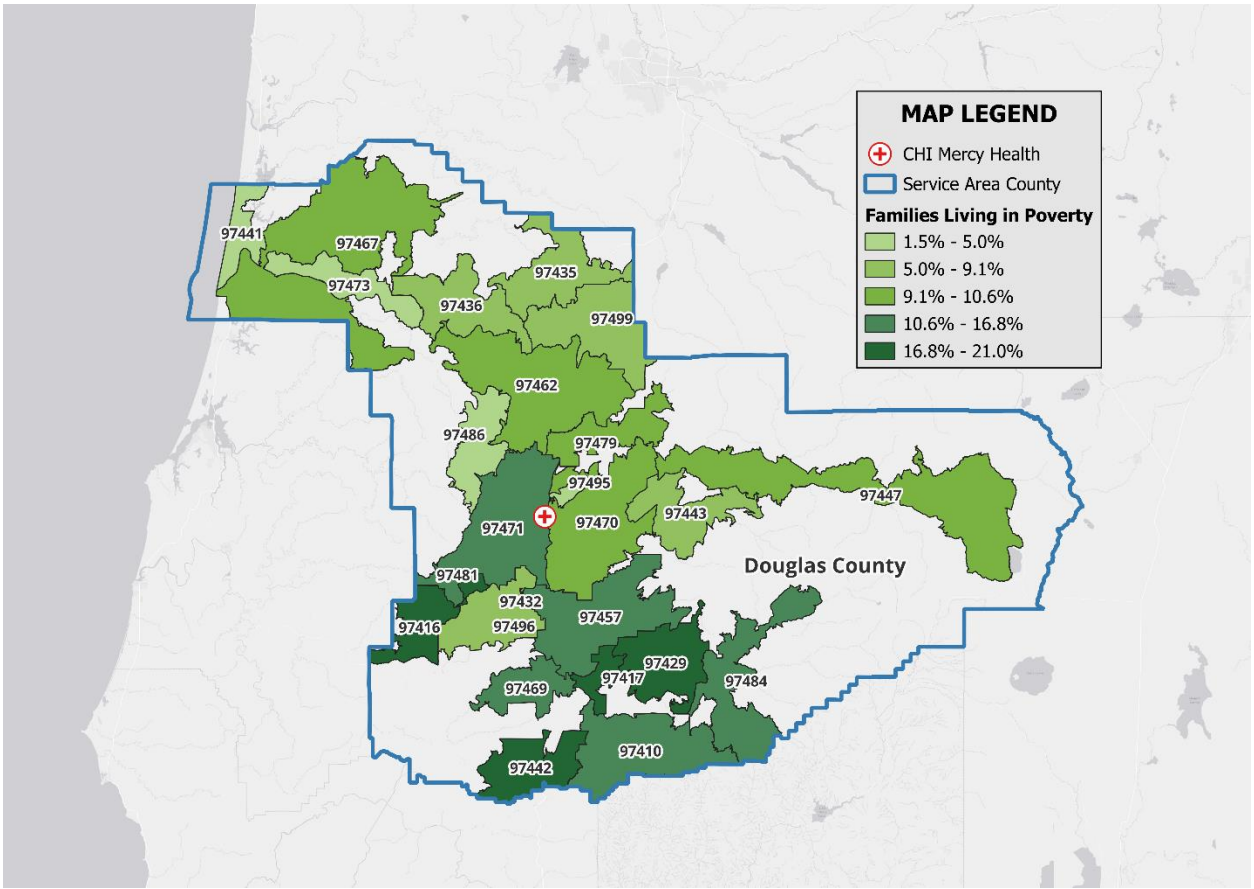
U.S. value taken from American Community Survey (2019-2023)

Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to health care, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[1]

Overall, 10.0% of families in the CHI Mercy Health primary service area live below the poverty level, which is higher than the state value of 7.5% and the national value of 8.7%. The map in Figure 10 shows the percentage of families living below the poverty level by zip code. The darker green colors represent a higher percentage of families living below the poverty level.

FIGURE 10. PERCENT OF FAMILIES LIVING BELOW POVERTY LEVEL BY ZIP CODE



[1] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

The percentage of families living below poverty for each zip code in the service area is provided in Table 1. The zip code in the service area with the highest concentration of poverty is 97441 (23.3%) and the zip code with the lowest concentration of poverty is 97486 (2.2%).

TABLE 1. FAMILIES LIVING IN POVERTY: CHI MERCY HEALTH PRIMARY SERVICE AREA

Zip Code	% Families in Poverty	Zip Code	% Families in Poverty
97441	23.3%	97496	10.2%
97481	20.6%	97479	9.7%
97416	20.5%	97499	9.2%
97473	20.0%	97471	9.1%
97429	16.0%	97457	8.8%
97484	15.6%	97436	8.7%
97432	15.2%	97462	7.7%
97417	13.7%	97495	7.0%
97467	12.9%	97443	6.0%
97469	12.6%	97435	5.3%
97442	11.8%	97410	4.7%
97447	11.6%	97486	2.2%
97470	11.4%		

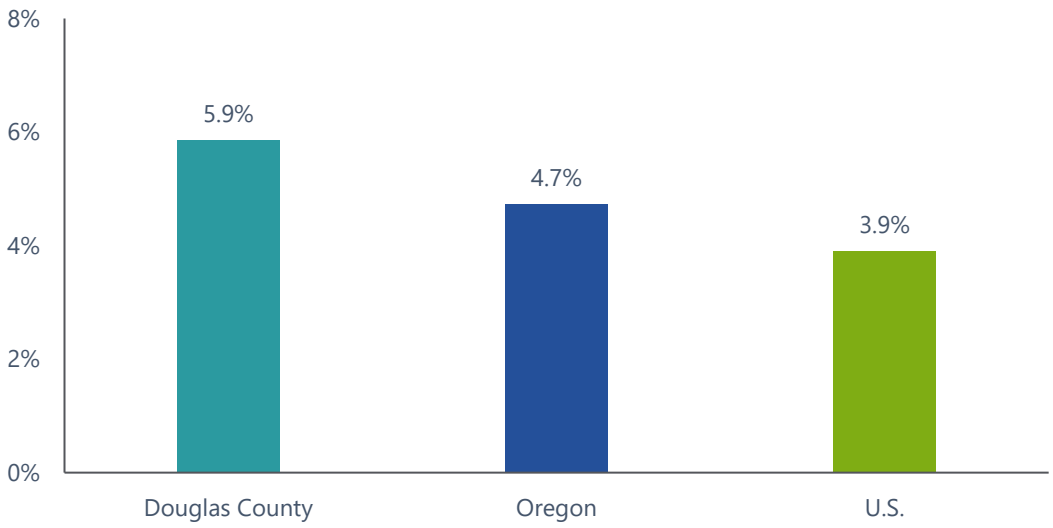
Employment

A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to health care, work environment, health behaviors and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[2]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[2] Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[2]

Figure 11 shows the population aged 16 and over who are unemployed. The unemployment rate for the CHI Mercy Health primary service area is 5.9%, which is higher than both the state-wide and nation-wide unemployment rates (4.7% and 3.9%, respectively).

FIGURE 11. POPULATION 16+ UNEMPLOYED: COUNTY, STATE, AND U.S.



U.S. value taken from U.S. Bureau of Labor Statistics (2024)

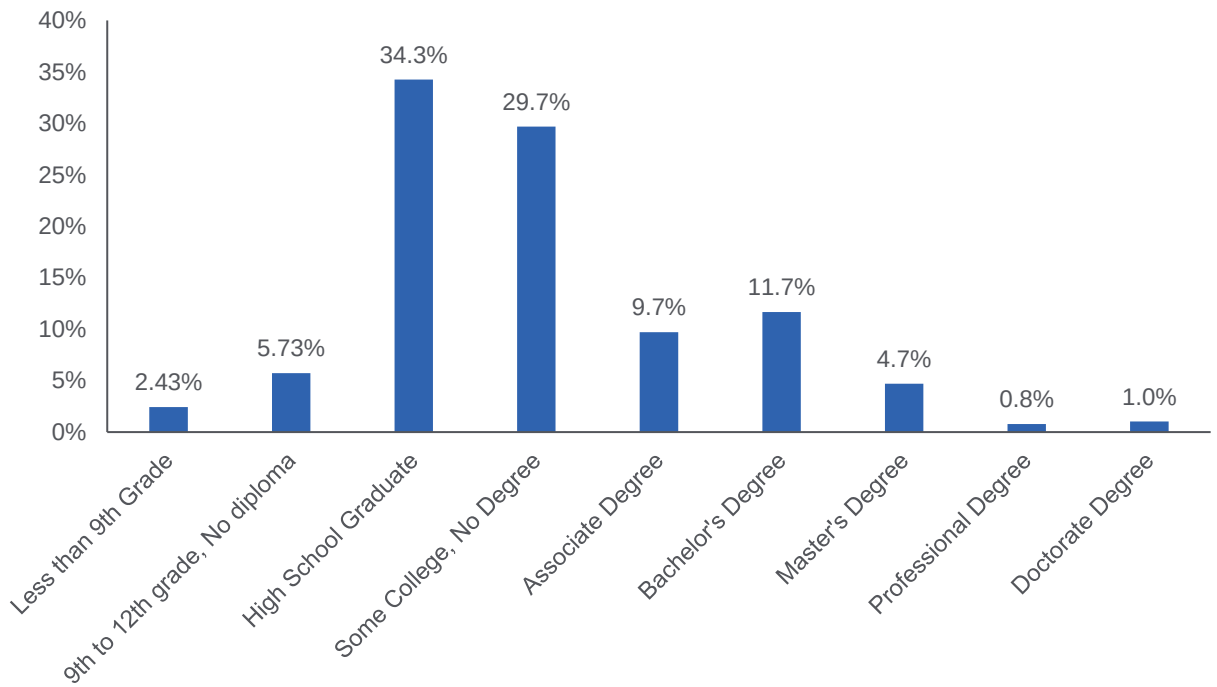
[2] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-anddata/social-determinants-health/literature-summaries/employment

Education

Education is an important indicator for health and wellbeing across the lifespan. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. A high school diploma in particular is a requirement for many employment opportunities, and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[3] Further, people with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[4]

Figure 12 shows the detailed breakdown of the CHI Mercy Health primary service area by educational attainment, among those aged 25 and up. As shown in Figure 13, most of the Douglas County population has a high school diploma or higher (91.8%), which is similar to the state-wide rate (91.6%), and slightly higher than the nation-wide rate (89.4%). Conversely, people 25 and older are less likely to have a Bachelor's Degree in Douglas County when compared to the state and nation (18.2% vs. 36.1% and 35.0%, respectively).

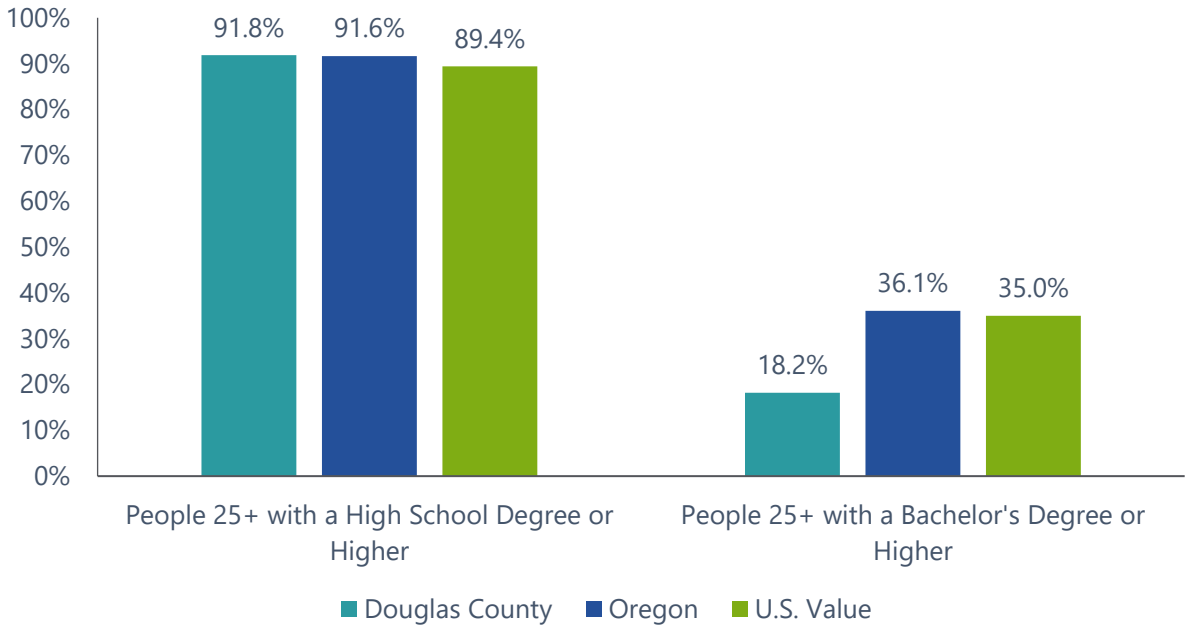
FIGURE 12. CHI MERCY HEALTH PRIMARY SERVICE AREA POPULATION BY EDUCATIONAL ATTAINMENT, AGE 25+



[3] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/priority-areas/social-determinants-health

[4] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/educationmatters-for-health.html

FIGURE 13. POPULATION 25+ BY EDUCATIONAL ATTAINMENT



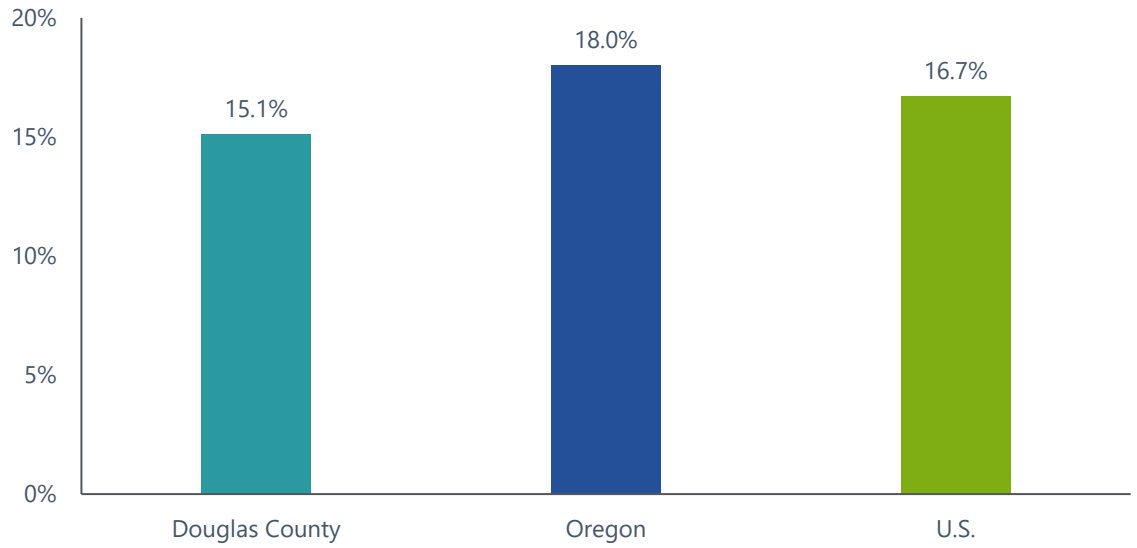
U.S. value taken from American Community Survey (2019-2023)

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[5]

As shown in Figure 14, 15.1% of households in Douglas County have severe housing problems, indicating that they have at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. This is lower than both the state-wide and nation-wide rates (18.0% and 16.7%, respectively).

FIGURE 14. HOUSEHOLDS WITH SEVERE HOUSING PROBLEMS



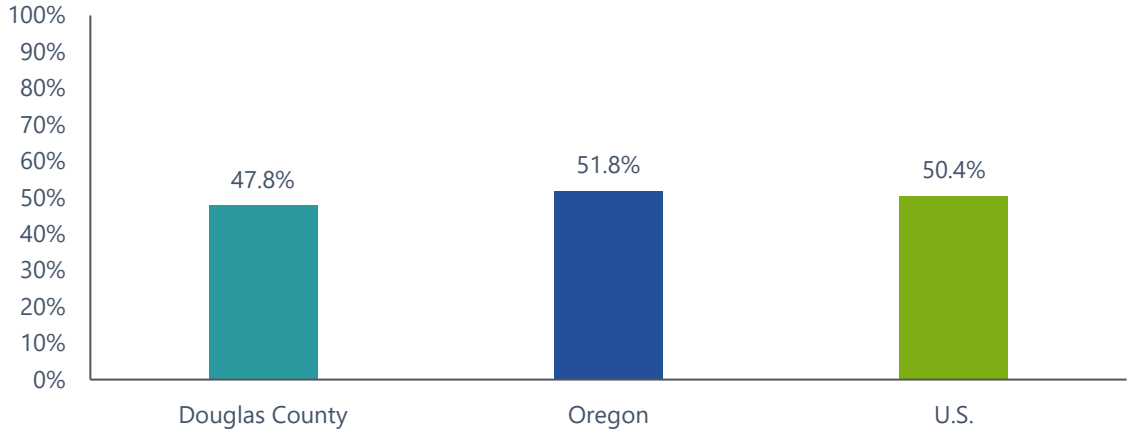
County, State, and U.S. values taken from County Health Rankings (2016-2020)

[5] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or health care. This is linked to increased stress, mental health problems, and an increased risk of disease.[6]

Figure 15 shows the percentage of renters who are spending 30% or more of their household income on rent. The value in Douglas County (47.8%) is lower than both the state value (51.8%) and the national value (50.4%).

FIGURE 15. RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT



County, State, and U.S. values taken from American Community Survey (2019-2023)

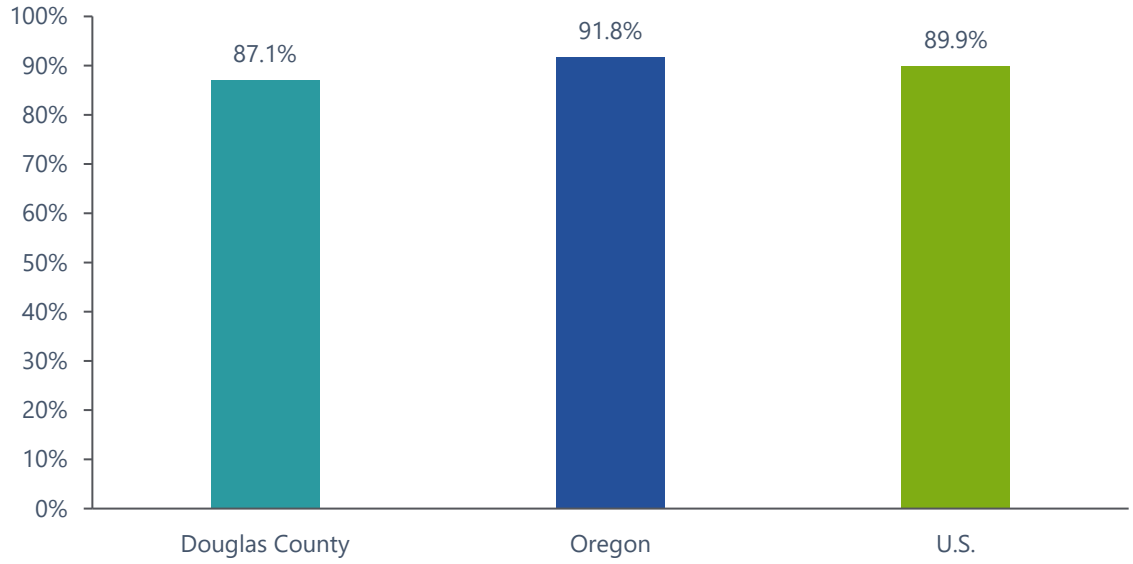
[6] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Neighborhood and Built Environment

Internet access is essential for basic health care access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet also helps expand healthcare access through home-based telemedicine services, which has been particularly critical during the COVID-19 pandemic.[7]Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[7]

Figure 16 shows the percentage of households that have an internet subscription. The rate in Douglas County (87.1%) is lower than the state value (91.8%) and slightly lower than the national value (89.9%).

FIGURE 16. HOUSEHOLDS WITH AN INTERNET SUBSCRIPTION



County, State, and U.S. values taken from American Community Survey (2019-2023)

[7] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Primary and Secondary Data Methodology and Key Findings

CHI Mercy Health utilized a combination of quantitative (secondary) data and qualitative (primary) input to create a comprehensive picture of health needs, disparities, and opportunities for community improvement. This approach ensures that health priorities are informed not only by statistical trends but also by the lived experiences and perspectives of the community.

Quantitative Data: Secondary Sources

Secondary data analysis provided significant insights into health status, social factors of health, and the health care system performance throughout the community. Sources included national, state, and local public health databases, as well as internal hospital data. The Healthy Communities Institute database was leveraged with over 200 indicators in both health and quality of life topic areas for the Secondary Data Analysis of the Health Service Area. Key Indicators analyzed include:

 **Quality of Life**	 **Health**	
Community	Adolescent Health	Men's Health
Economy	Alcohol & Drug Use	Mental Health & Mental Disorders
Education	Cancer	Older Adults
Environment	Children's Health	Oral Health
Transportation	Diabetes	Prevention & Safety
	Disabilities	Physical Activity
	Environmental Health	Respiratory Diseases
	Family Planning	Tobacco Use
	Health Care Access and Quality	Women's Health
	Heart Disease & Stroke	Wellness & Lifestyle
	Immunizations and Infectious Diseases	Weight Status
	Maternal, Fetal & Infant Health	

**All data were scored using a standardized index to assess severity and disparities across zip codes.*

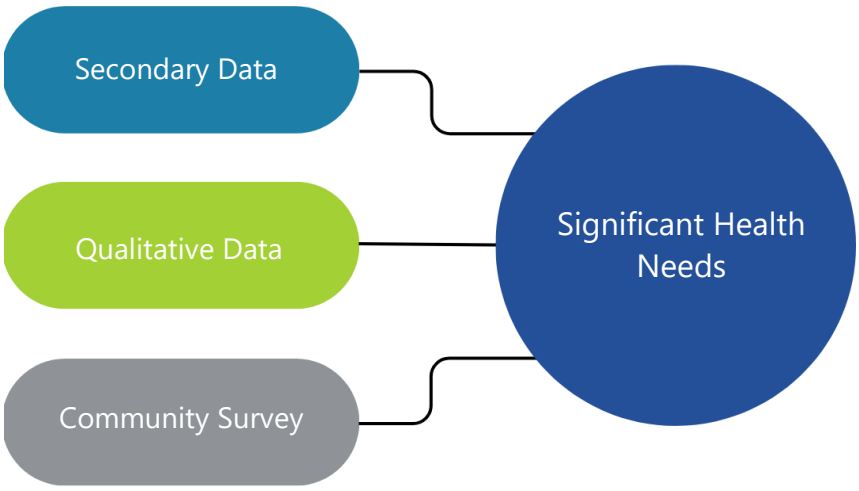
Qualitative Data: Primary Sources
Primary data were collected through community engagement activities designed to elevate voices from across the hospital's defined service area. These activities included:

Community Survey
An online survey was conducted in Douglas County in English and Spanish over six weeks, during the data collection period. The survey uncovered perspectives on health priorities, gaps in care, barriers to service delivery, and populations most affected by health inequities.

Key Informant Interviews and Listening Sessions
Conducted with dozens of individuals from various sectors, including public health, healthcare, housing, education, behavioral health, and community-based organizations. These participants included:

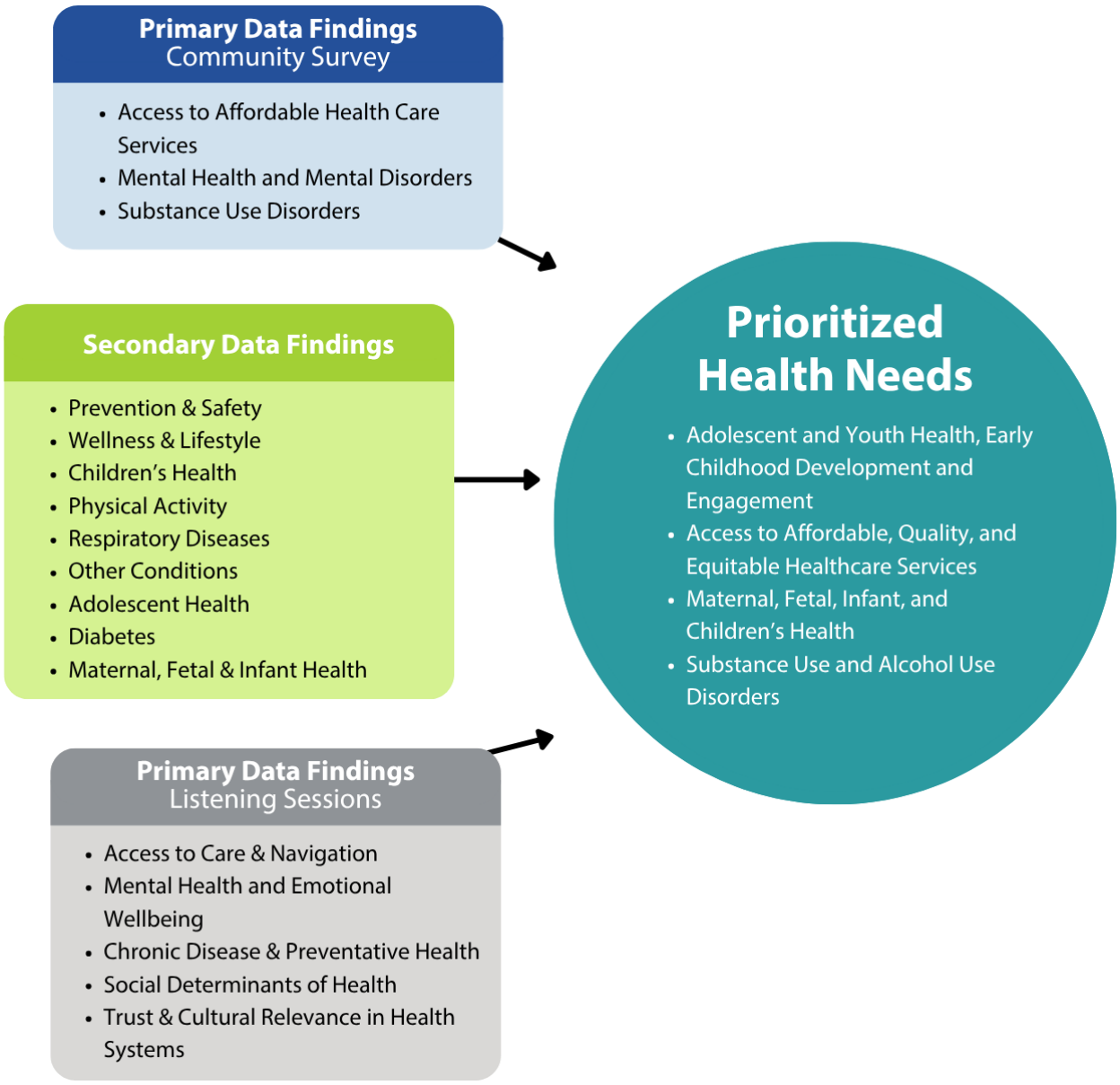
- Representatives of medically underserved, low-income, and minority populations
- Public health experts from local and regional agencies
- Community advocates and service providers with direct knowledge of vulnerable and marginalized groups.

Participants were asked to share their views on community strengths, emerging challenges, and opportunities for collaboration. Themes were identified in relation to the access to care, behavioral health, transportation, and the lingering effects of COVID-19 and natural disasters. A detailed summary of participating organizations, and input themes is available in Appendix [X].



By combining data-driven analysis with community perspectives, the process ensures a comprehensive understanding of health needs and identifies priority areas for future intervention, collaboration, and investment.

Data Synthesis



Identification of Significant Health Needs

As part of the CHNA process, CHI Mercy Health and community partners utilized a prioritization scoring framework to rank the most pressing health needs in Douglas County. These priorities were determined using a combination of primary data from community listening sessions, qualitative interviews, health and socioeconomic data analysis, and community survey results. The scoring criteria included magnitude/severity of the issue, disparities, trends, and feasibility of impact.

Adolescent and Youth Health, Early Childhood Development and Engagement

Access to Affordable, Quality, and Equitable Healthcare Services

Maternal, Fetal, Infant, and Children's Health

Substance Use and Alcohol Use Disorders

Significant Health Needs

Adolescent and Youth Health, Early Childhood Development and Engagement

From the secondary data scoring results, Adolescent Health ranked 7th in the data scoring of all topic areas with a score of 1.63. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 2 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 2. DOUGLAS COUNTY DATA SCORING RESULTS: ADOLESCENT HEALTH

Score	Adolescent Health Indicator	Units	Douglas County	HP2030	OR	U.S.	OR Counties	U.S. Counties	Trend
2.03	HPV Immunization Completion (13-to 17-year-olds)	*percent*	44.0	--	57.0	--	--	--	--
2.03	HPV Immunization	*percent*	64.0	--	74.0	--	--	--	--

	Initiation (13-to 17-year-olds)								
2.03	Students with Less Than 3 Days of Physical Activity: 8th Graders	*percent*	9.9	--	15.0	--		--	--
2.00	Positive Youth Development Benchmark: 8th Graders	*percent*	52.1	--	53.8	--		--	--
2.00	Teen Pregnancy Rate: 15-17-year-old	*pregnancies/ 1,000 females aged 15-17*	11.3	--	7.2	--		--	
1.85	HPV Immunization Completion (13-year-olds)	*percent*	31.0	--	37.0	--	--	--	--
1.85	HPV Immunization Initiation (13-year-olds)	*percent*	57.0	--	64.0	--	--	--	--
1.85	Students who have had a Cavity: 11th Graders	*percent*	75.0	--	68.2	--		--	--
1.76	8th Grade Students Who Report Vaping or Using E-Cigarettes	*percent*	14.2	--	--	--			--
1.71	Students who Binge Drink: 11th Graders	*percent*	14.4	--	12.8	--		--	--
1.71	Students who Visited Dentist or	*percent*	67.3	--	74.3	--		--	--

	Dental Hygienist in Past Year: 8th Graders								
1.68	Students who have had a Cavity: 8th Graders	*percent*	62.5	--	59.4	--		--	--
1.53	Students who Visited Dentist or Dental Hygienist in Past Year: 11th Graders	*percent*	70.2	--	75.3	--		--	--

HPV vaccine compliance is below ideal levels for adolescents 13-17 years old. The poorest scoring indicators for Adolescent Health were the percentage of 13- to 17-year-olds who were immunized with two-three doses of the HPV vaccine and the percentage of 13- to 17-year-olds who have received one dose of the HPV vaccine. Only 64% of 13-17 year olds in Douglas County initiated the HPV vaccine and only 44% completed it, these percentages are lower than the state-wide rate of 57% and 74%, respectively.

The teen pregnancy rate in Douglas County is in the 2nd worst quartile of all Oregon counties at 11.3 pregnancies per 1,000 females aged 15-17 years old. Secondary data shows that 8th grade students have poor health indicators with regards to physical activity, positive youth development, vaping, and oral health. There are four oral health indicators above the 1.50 threshold: *Students who have had a Cavity: 11th Graders, Students who Visited Dentist or Dental Hygienist in Past Year: 8th Graders, Students who have had a Cavity: 8th Graders,* and *Students who Visited Dentist or Dental Hygienist in Past Year: 11th Graders*. These poor health indicators related to oral hygiene could be correlated to the use of vaping or e-cigarettes, as well as poor positive youth development scores, which is a measure of the number of youth who have the physical, emotional and social supports to succeed in school and live happy, healthy and productive lives.

This category emerged as the top health priority, reflecting widespread concern for the well-being of children and youth in Douglas County. Key themes from community conversations and qualitative data included youth disengagement, chronic absenteeism, and a lack of structured opportunities for development.

> Our biggest issue is with engagement of our children… they don't see this as a place for their future. **–Listening Session Participant**

Leaders in education and child welfare emphasized the critical need for early interventions, parenting support, and school-based behavioral health services. Listening session participants also pointed to the lack of prosocial activities and youth-centered community infrastructure as significant gaps.

Community survey responses affirmed this priority, with many highlighting concerns around early childhood education, parenting challenges, and youth mental health. Stakeholders also emphasized the importance of prevention-focused investment in the first 1,000 days of a child's life.

Access to Affordable, Quality, and Equitable Healthcare Services

Access to care remains a significant concern across Douglas County, particularly for residents in outlying rural areas. Residents reported difficulty accessing primary care, specialty care, dental, and behavioral health services.

> It's not just primary care. It's dental. It's mental health. We don't have enough of any of it. **– Listening Session Participant**

Transportation challenges, clinician shortages, and long wait times were commonly cited barriers, especially for individuals with Medicaid or without insurance. Residents in more remote areas must travel long distances for care, often without reliable transportation or internet access.

Survey respondents also noted that cost and appointment availability were frequent challenges. Many shared the need for walk-in and mobile care models, with more culturally and linguistically appropriate services for the growing Hispanic population.

From the secondary data scoring results, Health Care Access & Quality ranked 21st in the data scoring of all topic areas with a score of 1.06. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 3 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 3. DOUGLAS COUNTY DATA SCORING RESULTS: HEALTH CARE ACCESS & QUALITY

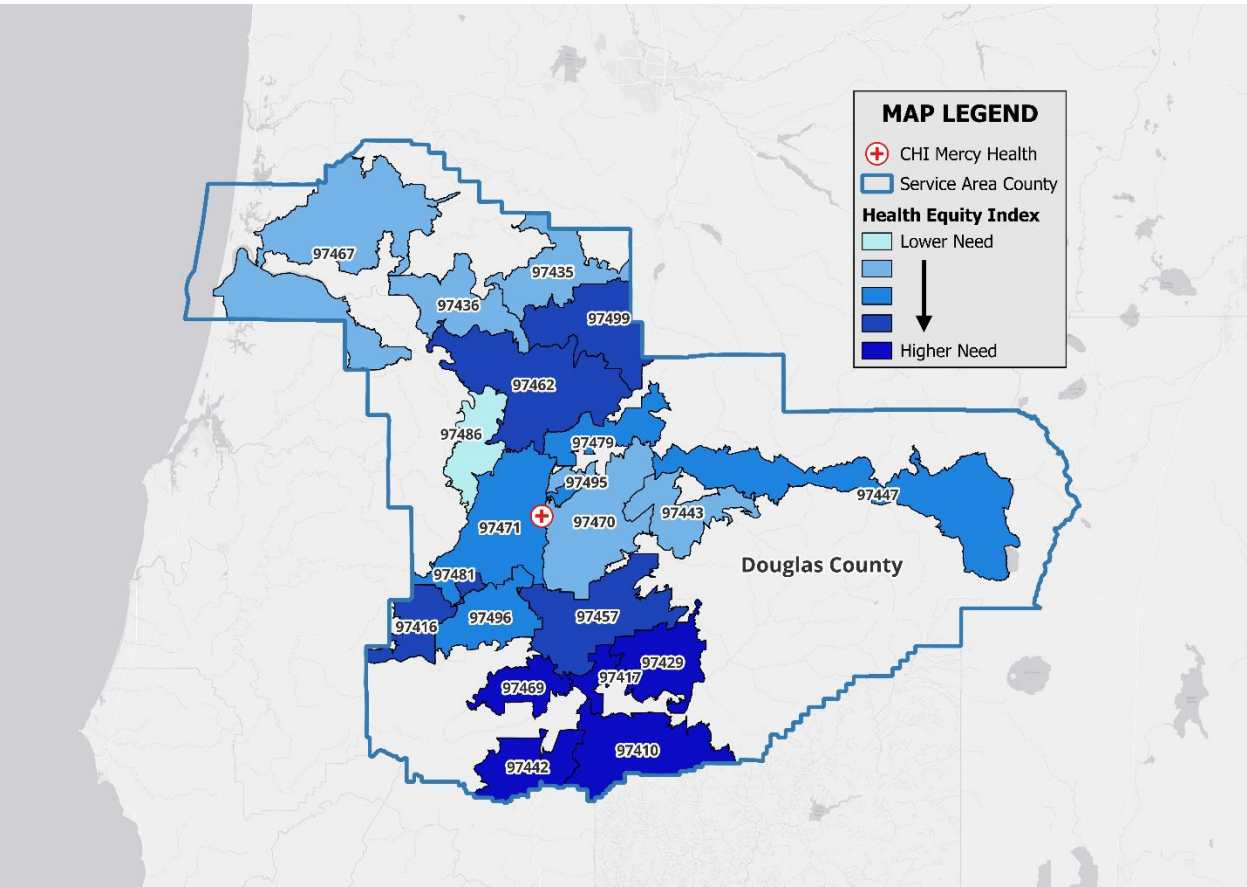
Score	Healthcare Access Indicator	Units	Douglas County	HP2030	OR	U.S.	OR Counties	U.S. Counties	Trend
2.18	Primary Care Provider Rate	*providers/ 100,000 population*	64.3	--	93.9	74.9			
1.59	Adults who have had a Routine Checkup	*percent*	74.6	--	--	76.1			--
1.59	Adults who Visited a Dentist	*percent*	60.1	--	--	63.9			--

One of the most concerning indicators in Douglas County with regards to healthcare access is the P*rimary Care Provider Rate*. There are 64.3 providers per 100,000 people, while the state has 93.9 providers per 100,000. Access to primary care providers increases the likelihood that community members will have routine checkups and screenings. Moreover, those with access to primary care are more likely to know where to go for treatment in acute situations. However, Douglas County is in the best 50% of all U.S. counties for primary care provider rate.

Other concerning indicators regard routine care. Only 74.6% of adults have had a routine checkup, and only 60.1% visited a dentist. The lower rate of primary care providers could contribute to lower rates of routine check-ups.

Conduent's Community Health Index (CHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor health outcomes, such as preventable hospitalization or premature death. Each zip code is ranked based on its index value to identify relative levels of need. The map in Figure 17 illustrates the zip codes with the highest level of socioeconomic need (as indicated by the darkest shade of blue).

FIGURE 17. COMMUNITY HEALTH INDEX: CHI MERCY HEALTH PRIMARY SERVICE AREA



Maternal, Fetal, Infant, and Children's Health

Maternal and child health was consistently identified as a key concern, particularly as it relates to early screenings, prenatal care, parenting support, and wraparound services for vulnerable families. Several respondents mentioned difficulty navigating services following birth and highlighted gaps in pediatric specialty care.

> We are missing out on early screening and connection with families right after birth. If we could strengthen those handoffs, we'd prevent so much later down the road. **– Listening Session Participant**

Providers and community-based organizations emphasized the importance of collaboration between Mercy's birthing center, pediatricians, and early learning systems to improve care continuity for young children.

From the secondary data scoring results, Maternal, Fetal and Infant Health ranked 9th in the data scoring of all topic areas with a score of 1.62. Children's Health ranked 3rd with a score of 1.70. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 4 below. See Appendix A for the full list of indicators categorized within these topics.

TABLE 4. DOUGLAS COUNTY DATA SCORING RESULTS: MATERNAL, FETAL, INFANT, AND CHILDREN'S HEALTH

Score	Maternal, Fetal, Infant and Children's Health Indicator	Units	Douglas County	HP2030	OR	U.S.	OR Counties	U.S. Counties	Trend
2.56	Child Food Insecurity Rate	*percent*	23.3	--	17.3	18.5			
2.29	Child Care Centers	*per 1,000 population under age 5*	5.9	--	8.5	7.0		--	--
2.00	Teen Pregnancy Rate: 15-17-year-old	*pregnancies/ 1,000 females aged 15-17*	11.3	--	7.2	--		--	
1.97	Substantiated Child Abuse Rate	*cases/ 1,000 children*	19.4	8.7	12.4	7.7		--	
1.91	Babies with Low Birthweight	*percent*	8.0	--	7.1	8.6		--	
1.85	Mothers who Smoked During Pregnancy	*percent*	10.8	4.3	4.5	3.7		--	
1.82	Children Up-to-Date on Immunizations: 2 Years	*percent*	64.7	--	68.3	--	--	--	

Maternal and child health resources appear to be an issue contributing to poor health indicators. The most concerning indicator for Maternal, Fetal and Infant Health is the *Child Food Insecurity Rate*. Compared to all other Oregon and U.S. counties, the child food insecurity rate is in the worst 25%. Douglas County also has lower rates of child-care centers with 5.9 centers per 1,000 population under age 5 compared to the state (8.5 per 1,000).

The county's teen pregnancy rate among 15-17 year olds is higher than the state value and trending upwards. Compared to the U.S. value, child abuse is also considerably more common (19.4 vs. 7.7 cases per 1,000 children).

In Douglas County, 8% of babies are born with low birthweight (born under 5lbs, 8oz). Smoking, drinking alcohol, and substance misuse during pregnancy can increase the risk for having an infant with low birthweight. Correspondingly, 10.8% of mothers in Douglas County smoked during pregnancy, which is more than double the state and national rates.

Finally, only 64.7 percent of children under the age of two are up to date on their immunizations. This value has been decreasing significantly since 2021.

Substance Use and Alcohol Use Disorders

Substance use, particularly methamphetamine and opioid misuse, continues to be a prominent issue affecting families, community safety, and emergency medical services. The problem is compounded by trauma, poverty, and gaps in recovery resources.

Stakeholders spoke to the need for more detox beds, longer-term residential treatment, and recovery supports that include family services. The trauma-to-addiction pipeline was referenced frequently. Survey data reinforced the concern, with many noting the impact of substance use on family stability, crime, and youth outcomes.

> We've spent a lot of money reacting to the houseless crisis. But we need to start investing upstream—preventing kids from going down that road.

From the secondary data scoring results, Alcohol and Drug Use ranked 15th in the data scoring of all topic areas with a score of 1.54. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 5 below. See Appendix A for the full list of indicators categorized within this topic.

TABLE 5. DOUGLAS COUNTY DATA SCORING RESULTS: SUBSTANCE USE AND ALCOHOL USE

Score	Alcohol and Drug Use Indicator	Units	Douglas County	HP2030	OR	U.S.	OR Counties	U.S. Counties	Trend
3.00	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	35.4	--	27.4	18.5			
2.03	Age-Adjusted Death Rate due to Alcohol Consumption	*deaths/ 100,000 population*	77.4	--	52.9	7.0		--	--
1.88	Students who Binge Drink: 8th Graders	*percent*	9.4	--	4.7	--		--	--
1.88	Students who Use Alcohol: 8th Graders	*percent*	18.6	--	11.3	7.7		--	--
1.85	Mothers who Smoked During Pregnancy	*percent*	10.8	4.3	4.5	8.6		--	
1.76	Students who Use Marijuana: 8th Graders	*percent*	12.2	--	--	3.7		--	--
1.71	Students who Binge Drink: 11th Graders	*percent*	14.4	--	12.8	--		--	--
1.50	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	18.9	--	15.1	--		--	--
1.50	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	23.0	20.7	20.4	--			--

The most concerning indicator for Douglas County is *Alcohol-Impaired Driving Deaths*. In Douglas County, 35.4% of driving deaths involve alcohol involvement, which is in the worst 25% of Oregon and U.S. counties. The secondary data indicate that Douglas County has higher rates of death related to substance use compared to the state and nation. Age-adjusted death rate due to alcohol consumption is also higher than the state value (77.4% vs. 52.9% per 100,000). Additionally, *Age-Adjusted Drug and Opioid-Involved Overdose Death Rate* and *Death Rate due to Drug Poisoning* have more deaths per 100,000 than the state values.

Other poor indicators involve substance use among students. 18.6% of 8th graders consume alcohol in Douglas County, which is more than 10% higher than the national value. Additionally, 9.4% of 8th graders reported binge drinking, which is higher than the state value (4.7%). Compared to the nation, the percentage of 8th grade students in Douglas County using marijuana is much higher (12.2% vs 3.7%).

Finally, the percentage of mothers who smoked during pregnancy is 6.5% higher than the Healthy People 2030 goal (10.8% vs. 4.3%).

Other Health Needs of Concern

Community Infrastructure and Social Determinants of Health

A lack of affordable housing, reliable transportation, and accessible childcare were common and recurring barriers affecting all populations. The housing crisis in Douglas County was referred to as "compounding everything," including health outcomes, workforce shortages, and the retention of medical providers.

> We need housing that's affordable and sustainable. Without it, everything else falls apart. **– Listening Session Participants**

Access to childcare was a critical theme, with several leaders identifying the shortage as a workforce and health equity issue. Many respondents also expressed concern over neighborhood safety, lack of sidewalks or lighting, and few free or low-cost recreation options.

Chronic Diseases

From the secondary data scoring results, Chronic Disease indicators are present under several topics such as **Respiratory Disease** (*Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases,*
Death Rate due to Chronic Lower Respiratory Diseases, Adults with Current Asthma

Adults with COPD, Age-Adjusted Death Rate due to Lung Cancer, Lung and Bronchus Cancer Incidence Rate), **Older Adults** (*COPD: Medicare Population, Death Rate due to Alzheimer's Disease, Chronic Kidney Disease: Medicare Population, Hypertension: Medicare Population)*, **Heart Disease and Stroke** (*Death Rate due to Heart Disease, Adults who Experienced Coronary Heart Disease, Hypertension: Medicare Population, Hyperlipidemia: Medicare Population*), Diabetes (*Age-Adjusted Death Rate due to Diabetes, Death Rate due to Diabetes*), **Cancer** (*Age-Adjusted Death Rate due to Breast Cancer, Age-Adjusted Death Rate due to Cancer, Adults with Cancer (Non-Skin) or Melanoma, Cervical Cancer Incidence Rate, Colon Cancer Screening: USPSTF Recommendation, Age-Adjusted Death Rate due to Colorectal Cancer, Oral Cavity and Pharynx Cancer Incidence Rate*), and **Immunizations and Infectious Disease** (*Chronic Hep B Cases*).

> The biggest issues we see with chronic disease management are tied to lack of primary care and health literacy. **– Health Provider**

Wellness, Lifestyle and Physical Activity

Listening sessions surfaced a strong desire for more wellness education and accessible opportunities for physical activity especially for older adults and working families. There were calls for community-wide health promotion, walking clubs, and group fitness.

"We need to make being healthy a community thing–not just a gym membership."
"I'd love to walk more, but there aren't safe sidewalks near my home."

From the secondary data scoring results, Wellness and Lifestyle ranked 2nd in the data scoring of all topic areas with a score of 1.75. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) included:

- *Life Expectancy (75.3 years)*
- *Poor Physical Health: 14+ Days (15.9%)*
- *Self-Reported General Health Assessment: Poor or Fair (22.3%)*
- *Poor Physical Health: Average Number of Days (3.7 days)*

See Appendix A for the full list of indicators categorized within this topic.

Diabetes and Weight Status

Residents shared concern about rising rates of diabetes and obesity, particularly among families with limited access to fresh food and consistent healthcare. Many described challenges in understanding nutritional guidelines or affording healthy options.

"The cheap food is what's hurting us. Its easier to grab fast food than figure out how to cook on a budget."

"I was told I was pre-diabetic but no one really explained what that meant or what to do next."

From the secondary data scoring results, Diabetes ranked 8th in the data scoring of all topic areas with a score of 1.62. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) included:

- *Age-Adjusted Death Rate due to Diabetes (34.0 deaths per 100,000)*
- *Death Rate due to Diabetes (54.3 deaths per 100,000)*

See Appendix A for the full list of indicators categorized within this topic.

> We need more education and support for people living with diabetes. It's not just about medicine… it's about food access, exercise, and stress too.

Mental Health, Mental Disorders, and Generational Trauma

From the qualitative data and community voices there was deep and repeated mention of unaddressed mental health needs particularly stress, depression, and trauma that spans generations. Stigma, provider shortages, and lack of culturally competent care were dominant barriers.

"We've all got trauma in some form, and no one's talking about how that affects our bodies and minds."

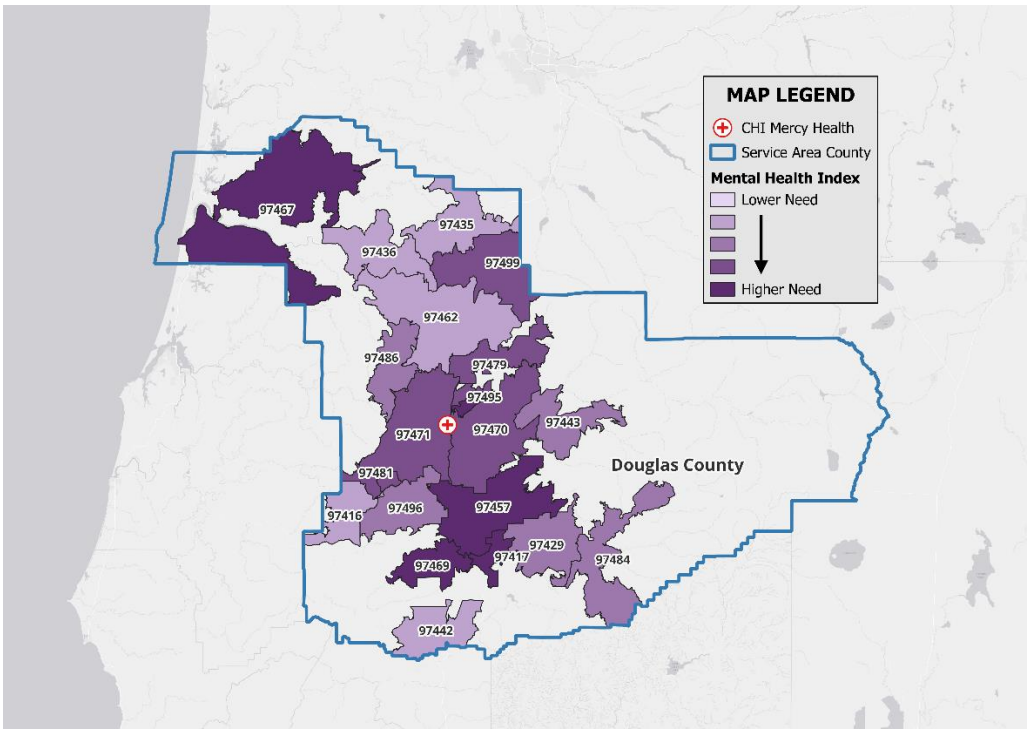
From the secondary data scoring results, Mental Health and Mental Disorders ranked 18th in the data scoring of all topic areas with a score of 1.48. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) included:

- *Age-Adjusted Death Rate due to Suicide (31.3 deaths per 100,000)*
- *Adults Ever Diagnosed with Depression (27.4%)*
- *Poor Mental Health: 14+ Days (19.3%)*
- *Death Rate due to Suicide (37.4 deaths per 100,000)*

See Appendix A for the full list of indicators categorized within this topic.

Conduent's Mental Health Index (MHI) uses socioeconomic data to estimate which zip codes are at greatest risk for poor mental health. Each zip code is ranked based on its index value to identify relative levels of need. The map in Figure 18 illustrates the zip codes with the highest risk for poor mental health (as indicated by the darkest shade of purple).

FIGURE 18. MENTAL HEALTH INDEX: CHI MERCY HEALTH PRIMARY SERVICE AREA



Prevention, Safety and Injury Reduction

From the secondary data scoring results, Prevention and Safety ranked 1st in the data scoring of all topic areas with a score of 1.75. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) included:

- *Age-Adjusted Death Rate due to Motor Vehicle Collisions (11.7 deaths per 100,000)*
- *Age-Adjusted Death Rate due to Firearms (17.9 deaths per 100,000)*
- *Age-Adjusted Death Rate due to Unintentional Injuries (59.6 deaths per 100,000)*
- *Death Rate due to Injuries (93.5 deaths per 100,000)*
- *Age-Adjusted Death Rate due to Unintentional Poisonings (18.9 deaths per 100,000)*
- *Death Rate due to Drug Poisoning (23.0 deaths per 100,000)*

See Appendix A for the full list of indicators categorized within this topic.

Barriers to Care

Residents of Douglas County experience a range of barriers to accessing healthcare, many of which are deeply rooted in the county's rural geography, limited resources, and systemic workforce challenges. These barriers are consistent across multiple data sources, including community listening sessions, survey responses, key informant interviews, and secondary data indicators.

Geographic Isolation and Transportation

Residents in rural and remote areas outside of Roseburg frequently face long travel times to reach medical, dental, and behavioral health services. A lack of affordable and reliable transportation options compounds the challenge, particularly for older adults, people with disabilities, and families without access to a personal vehicle.

Workforce Shortages and Provider Availability

There is a critical shortage of primary care providers, specialists, dentists, and mental health professionals across the county. Wait times for services, even for urgent needs, are long, and continuity of care is disrupted by workforce turnover and recruitment challenges.

Affordability and Insurance Navigation

Many residents, particularly those on Medicaid or without insurance, report difficulty accessing care due to cost. Navigating eligibility, coverage, and out-of-pocket expenses for services like dental care, mental health treatment, or specialty care is complex and often discouraging.

Limited Childcare and Competing Priorities

Lack of affordable childcare prevents many caregivers particularly women from seeking medical appointments or employment that offers insurance. The burden of managing basic needs, including food and housing insecurity, often pushes health care to a lower priority.

System Navigation and Care Coordination Gaps

Families and individuals with complex needs often struggle to navigate between health care, behavioral health, and social services. Lack of integration and communication across providers leads to care gaps, duplication, and missed opportunities for early intervention.

Conclusion

Douglas County is a geographically diverse region characterized by its natural landscapes, close-knit communities, and a longstanding culture of collaboration. Despite these strengths, the area continues to face significant health challenges influenced by geographic isolation, economic hardship, and limited access to essential services. The 2025 Community Health Needs Assessment (CHNA) for CHI Mercy Health acknowledges these challenges while also underscoring the community's resilience, existing assets, and strong potential for driving collaborative, community-based health improvements.

This CHNA process was rooted in a commitment to transparency and deep community engagement. It combined robust quantitative data including health indicators and community survey responses with extensive qualitative insights drawn from listening sessions and stakeholder interviews. This mixed-methods approach ensured that both statistical trends and lived experiences informed the identification of key health needs.

> There are so many people struggling silently, especially with mental health. It's not just about access to services; it's about having people who listen and understand. **— Community Listening Session**

To support an open and objective data collection process, CHI Mercy Health partnered with a third-party facilitator to lead community engagement activities. The use of an external partner allowed participants to speak freely and candidly, ensuring a safe space for honest dialogue. This approach was instrumental in uncovering the deeper stories and themes that might otherwise go unspoken, especially around sensitive issues like mental health, generational trauma, and access to care.

The CHNA findings reflect the strength of local resilience throughout Douglas County. The region benefits from dedicated leaders, community organizations, and residents who are actively engaged in advancing health through cross-sector collaboration, preventive strategies, and workforce development initiatives. Ongoing efforts such as the expansion of school-based health services and the growth of local medical residency programs demonstrate a shared commitment to improving health outcomes and building a more integrated and coordinated system of care.

Appendices Summary

The following appendices provide supplemental data, documentation, and references supporting the findings and processes detailed in this Community Health Needs Assessment:

Community Definition Materials

Includes the complete list of the zip codes that define the service area, along with a Social Vulnerability Index (SVI) map illustrating high-need areas across the region and identification of federally designated Health Professional Shortage Areas (HPSAs).

Stakeholder and Community Engagement Summary

Lists all organizations that contributed input through interviews, surveys, or listening sessions, including representatives of public health agencies, medically underserved, low-income, and minority populations. Also includes data collection tools such as survey instruments and discussion guides used during community engagement.

Data Sources and Methodology Details

Includes methodology overview, data scoring criteria and tables, and a summary of how qualitative and quantitative data were collected and analyzed. This section also includes any supplemental information from the previous CHNA to support comparison and context.

Community Resources by Health Need

Provides a structured list or table of community-based organizations, coalitions, and programs available to address each prioritized health need identified in the report.

References and Citations

A complete list of all data sources, literature, and tools used throughout the CHNA.