Governor's Health Care Safety Net Policy Team:

Enhancing the Safety Net Through Data Driven Policy

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Office for Oregon Health Policy and Research

Department of Human Services, Health Systems Planning

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Introduction

As more businesses struggle to offer employer-sponsored insurance, the number of uninsured Oregonians increases. As more people lose employment, the number of uninsured Oregonians increases. As the State reduces OHP availability to meet monumental budget constraints, the number of uninsured Oregonians increases and more people remain uninsured for longer periods of time.

Lack of health insurance leads to limited access to needed health services. Many uninsured have a fear of high medical bills, and consequently forego needed treatment. The uninsured are more likely than those with insurance to be hospitalized for conditions that could be avoided. Delaying or not receiving treatment can lead to more serious illness and avoidable health problems, which ultimately makes a difference in the health and productivity of the uninsured. Furthermore, lack of insurance has a substantial financial impact and often leads to serious problems paying medical bills.[1]

Some of these challenges could be addressed effectively by establishing state health care safety net policies and support. This document provides recommendations developed by Oregon's Health Care Safety Net Policy Team. These policy recommendations, if applied, will help ensure that vulnerable Oregonians receive needed health services and are able to contribute at work and in school. These recommendations, if applied, will allow health care safety net providers to continue to be an essential and integral component of the State's health and economic infrastructure.

Background and Process

Each year, Oregon's health care safety net providers offer access to health services to hundreds of thousands of Oregonians who have limited resources and often experience barriers to receiving needed services elsewhere. With one of the highest rates of unemployment in the country; the changes, challenges, and reductions of the Oregon Health Plan; and a rapidly growing number of uninsured, there is a growing demand for safety net services in Oregon. Consequently, Oregon recognizes the need to ensure an adequate supply and distribution of health care safety net services.

Getting an accurate picture of safety net services, however, is challenging and complex given the varying data collection and reporting strategies of health care safety net providers - both nationally and locally. The Institute of Medicine (IOM) declared in its report, "America's Health Care Safety Net: Intact But Endangered," that the safety net is a vital part of the health care delivery system and yet highly fragmented.[2] Furthermore, the report cited the "inability to find a single source" where safety net data is collected and analyzed. The report goes on to say that "information on the safety net takes years to assemble and important data is often missing or only describing the situation in a few communities." Consequently, the IOM report recommended that intensive efforts be

[1] Kaiser Commission on Medicaid and the Uninsured, January 2003. *The uninsured and their access to health care*. http://www.kff.org.

[2] Lewin, M.E and Altman, S. Eds. Institute of Medicine, 2000. America's Health Care Safety Net: Intact But Endangered. Committee on the Changing Market, Managed Care, and the Future Viability of Safety Net Providers. National Academy Press, Washington D.C.

directed to improving the ability to monitor and track the structure, capacity, and financial stability of the safety net in order to meet the needs of vulnerable populations.

Because of a lack of comprehensive data, Oregon has been unable to adequately describe or specifically delineate the supply, demand, strengths and challenges of its safety net system. Inadequate data and information have hindered the development of state policy and financial support for Oregon's safety net. Although a commitment to support the safety net is shared by many in both Oregon's public and private sectors, including the Governor and Legislators, without necessary and meaningful data and policies, Oregon's health care safety net is "endangered."

Recognizing the undeniable need for a health care safety net, and in order to better understand and support it, the National Governors Association (NGA) Center for Best Practices sponsored the *Enhancing the Safety Net Through Data-Driven Policy: Demonstration Project.* The NGA demonstration project was a partnership with the Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) of the United States Department of Health and Human Services.

Acknowledging the vital and growing role of the safety net as well as the lack of state health care safety net policy, Oregon applied and was selected as one of only four states to participate in the NGA demonstration project (Appendix A). The project provided Oregon stakeholders the opportunity to better understand the health care safety net by applying several new data tools containing previously unavailable information about the strengths, structure, and stability of state and local safety net systems. Furthermore, Oregon's participation in the NGA project resulted in data driven policy recommendations for the Governor and Legislative Assembly.

Process

The Office for Oregon Health Policy and Research and the Department of Human Services, Health Systems Planning convened a diverse group of stakeholders to form *Oregon's Health Care Safety Net Policy Team*. The *Policy Team* included representation from the Governor's Office, members of Oregon's Legislative Assembly, health care safety net providers, and other stakeholders (Appendix B). This *Policy Team* took a broad and inclusive approach while defining, examining, analyzing, and creating health care safety net policy options (Appendix C). More specifically, the *Policy Team* focused on three goals:

- **Evaluate the strengths and weaknesses of Oregon's current health care safety net;**
- **Identify gaps in Oregon's safety net, evaluate the underlying causes for those gaps, and explore innovative practices other states have employed to organize, manage, and finance safety net services; and**
- **Develop a series of data-driven policy options that can be used to bolster safety net services capacity at the State and local levels.**

Definition

In early 2004, the *Oregon's Health Care Safety Net Policy Team* discussed and reached consensus on how best to define Oregon's health care safety net. After much deliberation, the *Policy Team* defined health care safety net providers as well as patients. The group concluded:

- The **health care safety net** is a community's response to meeting the needs of people who experience barriers that prevent them from having access to appropriate, timely, affordable and continuous health services.
- **Health care safety net patients** often experience barriers to accessing services from other health care providers due to cultural, linguistic, geographic and financial issues. Safety net patients tend to be uninsured, underserved, Medicaid/Medicare enrollees, and other vulnerable/special populations.
- **Health care safety net providers** deliver services to persons experiencing barriers to accessing the services they need. These providers include a broad range of local non-profit organizations, government agencies, and individual providers.
- **Core health care safety net providers** are especially adept at serving people regardless of their ability to pay. They have a mission or mandate to deliver services to persons who experience barriers to accessing the services they need, and serve a substantial share of Medicaid/Medicare enrollees, people who have no health insurance, as well as other vulnerable/special populations.

Values and Principles

The *Policy Team* determined that in order to develop and gain consensus for policy options that strengthen and stabilize Oregon's health care safety net, it was necessary to agree to values and principles. Consequently, the *Policy Team* determined:

- The health care safety net system is **an essential and integral component of Oregon's health and economic infrastructure**. Consequently, anything affecting the health of Oregonians and their communities has an impact on the safety net and is in turn impacted by the effectiveness of the safety net.
- Health care safety net policies shall **build upon existing access policies** in Oregon.
- The Governor's Office, Oregon's Legislative Assembly, and other policy makers shall have access to **current and meaningful safety net data and information**.
- **Statewide infrastructure, tools and policies** are needed and should involve public and private organizations**,** in order to better understand, monitor, adequately fund, and support the health care safety net.
- Public and private entities must consider all opportunities that **leverage funding** to support safety net providers and patients.

- All opportunities to **ensure the effective and efficient delivery of essential services** must be considered by health care safety net and other stakeholders.
- The State and other health care stakeholders, including safety net providers and their patients, have an **obligation to effectively collaborate** in order to improve access to needed health services.
- **Integration of behavioral health in primary care** results in effective and less costly treatment of conditions that otherwise might undermine the ability of Oregonians to remain self-reliant and productive members of their communities.

Findings

Building from data gathered nationally by AHRQ, the *Policy Team* spent several months gathering and analyzing Oregon safety net data. Baseline information on Oregon's health care safety net was collected from multiple sources including federal databases, state agency administrative databases, statewide surveys, and the Oregon Community Health Information Network (OCHIN) - a statewide data infrastructure collaborative offering a data base that measures OHP and uninsured utilization at participating safety net clinics (Appendix D). Three data objectives were pursued during Oregon's NGA project:

- Gather available information about **demand** for safety net health care services**,** defining particular indicators, community characteristics, and measures of outcomes.
- Compile available data about safety net **capacity,** by taking an inventory of safety net providers, services provided, hours of operation, organizational structure, and other information.
- Identify **gaps** in available information.

Since available data offers an incomplete picture of the safety net, rather than report findings in a traditional statistical manner, general findings about the quality and availability of health care safety net demand and capacity data is outlined below (Appendix D).

Demand data items specifically collected, as indicators of need for safety net services are generally more readily available than capacity measures requiring clinic-level data. Sources for demand data include both state and federal databases. Based on the available demand data, the *Policy Team* concluded:

- Data lag has been a major barrier to assessing demand for the health care safety net. A two or three year lag between data collection and publishing is not uncommon.
- Data related to the health care safety net is multifaceted and involves many organizations, sources, and variables. Tracking demand on an ongoing basis requires inter-agency coordination and regular reporting from a variety of sources and agencies.

- Data tends to provide statewide information. The health care safety net, however, is a local effort designed to meet the needs of members of a community who otherwise experience barriers to needed health services. Local data are usually not available. This hinders not only the ability to adequately measure demand at a local level, but also the ability to measure health outcomes of a community.
- Using sources that collect de-identified individual-level data, such as vital statistics or hospital discharge data, a small group of outcomes measures should be calculated annually at the county level.

Capacity data pertaining to Oregon's health care safety net, as mentioned, tends to be limited in scope and not readily available. Based on existing capacity data, the *Policy Team* concluded:

- Most data elements require an inventory of health care safety net providers. In Oregon, the only data currently compiled at the State level and across all safety net facilities is name and address.
- There is no comprehensive source for data about the financial stability of safety net providers in the state.
- The Oregon Primary Care Association compiles extensive data for Federally Qualified Health Centers, but does not collect information regarding referral networks, physical plant capacity, or measures of financial health.
- Oregon's Department of Human Services, Office of Family Health maintains data on several key School Based Health Clinic data elements. It does not, however, collect data on referral networks, enabling services, or appointment capacity measures.
- There is no central data collection entity for Rural Health Clinics or Local Health Authorities/Departments.
- Although practice management software exists that assesses provider capacity, not all health care safety net providers have access to such sophisticated practice management software.
- Connectivity is a significant barrier to Oregon's rural safety net providers' ability to participate in advanced data reporting systems.
- There are no statewide reporting requirements regarding Oregon's health care workforce. Such data would allow for more reliable estimates about the primary care capacity to serve vulnerable populations.

Gaps in data are evident, and not surprising, given the complexity and diversity of the health care safety net, no standard and on-going data-reporting tool, and no central data warehouse. Following the analysis of available safety net data, the *Policy Team* agreed with the IOM's 2000 report "*America's Health Care Safety Net: Intact But Endangered.*" That is, available health care safety net data offers an incomplete and fragmented picture of the vital role it plays in providing care for underserved and vulnerable Oregonians.

Policy Recommendations

Oregon's Health Care Safety Net Policy Team explored, developed, and prioritized policy options that reflect the values and principles identified above and findings from the data analysis. It is important to note, while developing health care safety net policy options, the *Policy Team* focused on the needs of low-income Oregonians, the viability of the system that serves them, and the State's current fiscal challenges. The *Policy Team* respectfully proposes that the State of Oregon adopt the below policy recommendations to ensure quality and effective health care safety net services for vulnerable Oregonians.

(1) Safety Net Advisory Council

Given the increasing numbers of uninsured Oregonians and those living at or near poverty, there is a growing need for health care safety net services. Health care safety net providers and patients need the continued support of the Governor's Office, Legislative Assembly, and public and private stakeholders. In order to promote understanding and support for safety net patients and providers in Oregon, the *Policy Team* recommends that the Governor's Office instruct the Office for Oregon Health Plan Policy and Research in conjunction with the Department of Human Services, Health Systems Planning to immediately convene and staff the *Health Care Safety Net Advisory Council* (*SNAC*). The *SNAC* will reflect the diversity of Oregon's health care safety net and meet at least quarterly. The *SNAC* will provide policy makers and the Oregon Health Policy Commission with specific policy recommendations for safety net providers in order to ensure the provision of needed services to vulnerable Oregonians.

(2) Statement of Support

The *Policy Team* recommends that the 2005 Legislative Assembly support the health care safety net by revising Chapter 442 of the Oregon Revised Statutes (ORS), which contains the Health Planning laws of Oregon, http://landru.leg.state.or.us/ors/442.html. More specifically, it is recommended that the 2005 Legislative Assembly create a statement indicating:

> *Oregon acknowledges that the health care safety net provides access to needed services for people who have difficulty obtaining care elsewhere due to financial, geographic, and cultural barriers. Furthermore, Oregon acknowledges a strong, resilient, and adequately supported safety net is vital to the health of Oregonians and local economies.*
>
> *The safety net recruits and retains practitioners; maintains quality of care; provides preventive services and diagnoses; treats chronic and urgent conditions; and gathers data needed to inform public policy.*
>
> *The role of the health care safety net is even more significant during downturns in the economy. The health care safety net absorbs the care and cost-shift burden as fewer Oregonians are covered by public and private insurance.*
>
> *The Legislative Assembly recognizes an obligation to Oregonians and acts to assure the continued viability of the health care safety net.*

(3) Data Collection and Analysis Uniformity

Oregon's Health Care Safety Net Policy Team recognizes wisdom in the adage, "if you can't measure it, you can't manage it.[*]" Consequently, the *Policy Team* recommends that the Governor's Office direct the Office for Oregon Health Policy and Research to begin work immediately with public and private stakeholders, including representatives of the *Health Care Safety Net Advisory Council, SNAC* (see recommendation #1), to design and implement a process for statewide assessments of health services and resources. Statewide assessments will include:

- The development of a standard and on-going data-reporting tool for health care safety net providers to measure capacity, financial performance, visits, and other relevant information.
- Centralized health care safety net data collection and reporting.
- Workforce data that captures personnel available at each health care safety net site.
- An analysis of the supply of and demand for health services.

(4) Financial Stability

The Policy Team recommends that the Governor's Office direct the Health Care Safety Net Advisory Council, SNAC (see recommendation #1) to develop recommendations designed to stabilize resources devoted to safety net services. By May 2005, the SNAC will develop and report recommendations to policy makers and the Oregon Health Policy Commission. These financial stability recommendations will address how to:

- Fund and develop infrastructure to maintain sufficient health care safety net capacity throughout Oregon and during all economic times, including, downturns.
- Ensure funding devoted to OHP and other health care safety net services is managed efficiently.
- Further and better maximize revenue sources eligible for matching federal dollars and that support health care safety net providers and patients.
- Offer adequate incentives to providers that ensure the effective and efficient delivery of health services to safety net populations.
- Assure that the payment structure supports the ability to achieve positive and identified outcomes.

(5) Federal Financial Participation

Oregon's Health Care Safety Net Policy Team believes additional federal dollars can be carefully and successfully generated, and then invested in safety net infrastructure and capacity. Additionally, the Policy Team appreciates the need for the State to exercise caution and focus efforts on low risk leveraging areas. Consequently, the Policy Team requests that the Department of Human Services (DHS) conduct a thorough analysis

[*] Peter Drucker

of opportunities to further leverage federal dollars that benefit the health care safety net. The analysis will be reported to policy makers, the Oregon Health Policy Commission, and the Health Care Safety Net Advisory Council, SNAC (see recommendation #1) by July 2005. Such an analysis will describe how state and local government contributions can generate additional federal money and include information specific to the health care safety net. Lastly, the Policy Team requests that DHS prioritize additional and on-going staffing assigned to focus on maximizing federal financial participation.

(6) Support Local Innovations – Planning

The *Policy Team* recommends that the Governor's Office direct the Department of Human Services, Health Systems Planning to develop a work plan regarding support for community innovations that improve access and health outcomes of safety net patients in a community or region. This work plan will be developed with the *Health Care Safety Net Advisory Council, SNAC* (see recommendation #1) and other community-based stakeholders and be completed by April 2005. The work plan will be shared with policy makers and the Oregon Health Policy Commission. Although local innovations will vary, and be based on the needs and strengths of individual communities/regions, key elements of the work plan include:

- Identification of public and/or private organizations/departments most appropriate and able to support local innovations that improve access to a community's safety net population.
- Identification of funding sources.
- A process to identify and prioritize interested communities/regions/local initiatives and their readiness to improve access to safety net populations.
- Strategies to effectively support and evaluate local innovations designed to improve access to a community's safety net population.
- Performance benchmarks and outcome measures.
- A process to align payment with performance benchmarks and desired outcomes.
- A process to document and communicate the return on investment of local access innovations to policy makers, the Oregon Health Policy Commission, and others.

(7) Support Local Innovations – Implementing

Upon completion of the work plan addressing state support for community innovations that improve access and health outcomes of safety net patients, (see recommendation #6) the *Policy Team* recommends that the Governor's Office direct the appropriate State offices to implement the plan with other public and private partners. It is recommended that State support to local innovations begin by December 2005 and include:

- Partnering with local hospitals, health systems, private practitioners, public health authorities/departments, charitable foundations, insurers, government, business, health care safety net providers, and others.
- Convening diverse stakeholders.

- Matching local government dollars for the planning and implementation of local collaborative efforts.
- Leveraging federal dollars, as appropriate, to support innovations.
- Documenting and communicating the return on investment of local access innovations to policy makers, the Oregon Health Policy Commission, *Health Care Safety Net Advisory Council, SNAC* (see recommendation #1), and others.

(8) Behavioral Health Primary Care Integration

The *Policy Team* recommends that the Governor's Office direct the Department of Human Services (DHS) to better integrate primary care and behavioral health. DHS will work with the *Health Care Safety Net Advisory Council*, *SNAC* (see recommendation #1) and other behavioral health providers to explore and support feasible and effective approaches that coordinate, fund, and integrate behavioral health care provided in primary care settings. A report that includes information regarding feasible and effective approaches to integrate behavioral health and primary care will be completed by April 2005. This report will be shared with policy makers and the Oregon Health Policy Commission. Based on identified feasible and effective approaches, the DHS will provide assistance to local initiatives, communities, and regions beginning October 2005. Such DHS assistance will include:

- Technical support, funding, and incentives to health care safety net providers who design and implement programs that achieve community-based integrated "Systems of Care," as described in the Report to The Governor and Legislature: A Blueprint For Action by the Governor's Mental Health Task Force, September 2004.
- Disseminating evidence-based practices to health care safety net providers.
- Data sharing/monitoring of health care providers, including safety net, primary care, and mental health.
- Developing feasible approaches to fund and reimburse direct and consultative behavioral health care provided in primary care settings.
- Documenting and communicating the return on investment of behavioral health integration to policy makers, the Oregon Health Policy Commission, and others.

(9) Primary Care and Prevention Pilot

The Policy Team recommends that the Governor's Office direct the Department of Human Services (DHS) to begin work with the Health Care Safety Net Advisory Council, SNAC (see recommendation #1) and others by January 2005 to develop a preliminary proposal to pilot a basic benefit package for uninsured pregnant women, children, and those Oregonians most in need of medical services. The basic benefit pilot proposal will:

- Base eligibility on medical conditions and poverty level; thus moving away from eligibility based on federal poverty level alone.

- Focus Medicaid resources on controlling health costs that are unavoidable to a community.
- Include appropriate performance benchmarks and document return on investment.
- Be designed to reduce avoidable emergency department visits and unnecessary hospitalizations and improve the health of targeted population.
- Document and communicate the return on investment to policy makers, the Oregon Health Policy Commission, *Health Care Safety Net Advisory Council, SNAC* (see recommendation #1), and others.

Such a proposal will require the DHS work with the Center for Medicare and Medicaid Services (CMS) to investigate the feasibility of a basic benefit pilot program focused on primary care and preventive services provided by Oregon's health care safety net providers. This investigation will include an analysis of federal requirements, program costs, and general policy as well as operational requirements. The results of the feasibility analysis will be reported to policy makers, the Oregon Health Policy Commission, and the *SNAC* by May 2005.

Conclusion

Acknowledging the vital and growing role of the health care safety net, the need to better understand and support it, and the lack of state health care safety net policy, Oregon applied and was selected as one of only four states to participate in the National Governors Association (NGA) Center for Best Practices *Enhancing the Safety Net Through Data-Driven Policy: Demonstration Project*. Consequently, stakeholders – including representatives from the Governor's Office, Legislative Assembly, health care safety net providers, and others – evaluated Oregon's current health care safety net system and created policy recommendations that will support and strengthen services, providers and patients.

Please contact the Office for Oregon Health Policy and Research for additional information and details regarding the Health Care Safety Net Policy Team process and recommendations.

Appendices

Appendix A

Oregon's Application

Enhancing Oregon's Safety Net Through Data-Driven Policy

Introduction

Oregon's health care safety net providers offer access to needed health services to hundreds of thousands of Oregonians who have limited means and often experience barriers to receiving needed health services elsewhere. Consequently, Oregon would like to ensure an adequate supply and distribution of health care safety net resources. Yet presently Oregon lacks sufficient data to create State policy and financial support for the health care safety net. Furthermore, because of the lack of comprehensive safety net data, Oregon is unable to adequately identify or understand the strengths and challenges in the current safety net system. Additionally, the State is unable to satisfactorily monitor the impact of recent and significant Medicaid changes on safety net providers and the populations they serve. And yet with the highest rate of unemployment in the country and a rapidly growing number of uninsured Oregonians, safety net services are in enormous demand. Although a commitment to support the safety net is shared by many in both Oregon's public and private sectors, including the Governor and legislators, without necessary and meaningful data, Oregon's health care safety net is "endangered." *Enhancing the Safety Net Through Data-Driven Policy: Demonstration Project* will not only help Oregon's safety net remain "intact" but it will strengthen this crucial health care system. Expertise and assistance from the National Governors Association (NGA) Center for Best Practices coupled with the comprehensive data tools from the Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) will provide Oregon with the greatly needed support to develop data-driven safety net policy options.

Demonstrated Need

There is no established health care safety net policy in Oregon. This, in part, is due to limited and inconsistent data. Oregon has an incomplete picture of the safety net's present or evolving structure, capacity, and financial stability. The lack of data, analysis and understanding, to some extent, is the result of the diversity of the health care safety net as well as varying data collection strategies among providers. Consequently, the data gleaned to offer a picture of the safety net is often "patch worked" together and offers less than a clear depiction of the safety net's strengths, challenges, and reality. Complicating matters, the safety net often is viewed as a separate part or parts of the health care system by policymakers, advocates, providers, and others concerned about health care in Oregon. Nonetheless, there is a demonstrated desire and commitment to better support safety net providers and those they serve by stakeholders throughout Oregon.

States across the nation are facing tough health policy decisions due to the worst budget shortfalls since World War II.[1]Oregon is no exception to such challenges with a budget shortfall of an estimated $2 billion, and its Medicaid program, the Oregon Health Plan (OHP), at serious risk. Since OHP was launched, it has provided access to quality health care services for more than one million uninsured people and decreased uninsurance rates

[1] "Medicaid 101: The Basics of America's Biggest Health Program," Kaiser Commission on Medicaid and the Uninsured. http://www.kaisernetwork.org/health_cast/

in from 18 percent in 1994 to as low as 10 percent in 1998.[2] But recently, the State was forced to make benefit cuts to OHP, and with the highest unemployment rate in the country, more than fourteen percent of Oregonians presently are uninsured.[3] Consequently, Oregon's safety net services are in even greater demand. And yet the State is unable to satisfactorily monitor the impact of all these changes on safety net providers and the populations they serve and therefore not effectively and efficiently supporting the health care safety net.

Oregon's safety net is comprised of a broad range of local non-profit organizations, government agencies, and individual providers who share the common mission of delivering health care to persons who experience barriers to accessing the health care they need. In addition, safety net providers have a substantial share of patients who are uninsured, enrolled in Medicaid, and other vulnerable Oregonians.[4] These provider organizations vary in terms of size, number and types of professionals, client need, service area population density and demographics, diversity and stability of revenue sources, and sophistication in business management practices. Oregon's health care safety net includes:

- Federally qualified health centers
- School-based health centers
- Indian/tribal clinics
- County health departments
- Community health clinics
- Rural health clinics
- Hospitals
- Other providers committed to serving the underserved

A variety of public-private efforts exist to monitor and support the safety net in Oregon and are willing and enthusiastic partners in this *Demonstration Project*. In order to examine and strengthen the health care safety net, organizations throughout Oregon have collaborative efforts underway. For example, the statewide **Health Care Safety Net Coalition** strives to advocate as a unified voice that impacts state policy supporting *all* health care safety net providers in Oregon. Another statewide effort designed to support and strengthen the safety net is the **Oregon Community Health Information Network (OCHIN). OCHIN** is a collaborative project of health care safety net providers, the Oregon Primary Care Association, and Oregon's primary care office. OCHIN collaborators work at stabilizing Oregon's health care safety net system infrastructure so that all residents – regardless of their insurance, income or social status – have equal access to quality health care services. Furthermore, the **Community Site Development Team** is committed to ensuring that Oregon benefits from the federal government's efforts to increase support to the health care safety net. CareOregon, Oregon's largest

[2] Office for Oregon Health Policy and Research Oregon's Uninsured: Summary of Findings from the 2002 Oregon Population Survey. http://www.ohppr.state.or.us/data/
[3] Office for Oregon Health Policy and Research Oregon's Uninsured: Summary of Findings from the 2002 Oregon Population Survey. http://www.ohppr.state.or.us/data/
[4] Office for Oregon Health Policy & Research: HRSA State Planning Grant: Universal Health Care (June, 1999). *Role of the Health Care Safety Net.*
http://www.ohpr.state.or.us/docs/pdf/techSafety%20Net%20TAG.pdf

Medicaid managed care organization, Oregon Primary Care Association, Office of Rural Health, Oregon Community Health Information Network, and Oregon's primary care office meet monthly to strategize on how best to close the gaps in Oregon's health care delivery system. In addition, the **Conference of Local Health Officials** consists of the health administrator, health officer, supervising nurse, and supervising sanitarian from each of the 34 Oregon county health departments. The Conference provides the Department of Human Services with recommendations on rules, standards, and activities of public health, including primary care, in Oregon. Yet another health care safety net effort is "**5 O"**. The **5 0**s include Oregon's Area Health Education Centers, Oregon Primary Care Association, Primary Care Office (within the Department of Human Services, Health Services, Health Systems Planning), Office or Rural Health, and OCHIN. These five organizations meet regularly to ensure they are aware of each other's efforts and to coordinate support for the health care safety net.

Each of these as well as local or regional efforts exists to enhance the capacity, stability, and performance of Oregon's health care safety net. Despite these earnest and significant efforts, however, the struggle remains to gather the meaningful and comprehensive data needed to formulate solid recommendations to Oregon's policy makers. This *Demonstration Project* provides the opportunity to bring representatives from these efforts together with the Governor's staff and legislators to coordinate activities and craft State policy that will strengthen the safety net.

In addition to the above-mentioned efforts examining and supporting the health care safety net, a body of written work attempts to analyze Oregon's safety net.[5, 6, 7] These and other reports offer valuable insight on Oregon's health care safety net - or some component of the safety net. They indicate that Oregon's safety net providers play a valuable and needed role in Oregon's delivery system. Furthermore, the reports indicate that the strength and stability of the safety net is at risk in many areas. However no report exists that comprehensively measures the demand for Oregon's safety net services and identifies gaps in the supply and distribution of safety net resources. Again, this is due to, in large part, a lack of sound data. As stated in *American's Health Care Safety Net: Intact But Endangered*, there is an "inability to find a single source" where safety net data is collected and analyzed. Furthermore, "information on the safety net takes years to assemble and important data is often missing or only describing the situation in a few communities."[8] Unfortunately, Oregon is no exception to these statements. Researchers, policy makers, providers and advocates in Oregon acknowledge these limitations and want to work toward better analyzing and supporting the safety net.

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[5] Center for Policy and Research in Emergency Medicine, (2003). *Changes in Access to Primary Care for Oregon Health Plan Beneficiaries and the Uninsured: A Preliminary Report Based on Oregon Health & Science University Emergency Department Data*. Oregon Health & Science University. http://www.ohsu.edu/som-EmergMed/research/

[6] City Club of Portland, Health Care Issues Committee, (October 6, 2003). *The Health Care Safety Net in Portland.* http://www.orrc.net/CityClub/HC.htm

[7] Office for Oregon Health Policy & Research: HRSA State Planning Grant: Universal Health Care, (June, 1999). *Role of the Health Care Safety Net.* http://www.ohpr.state.or.us/docs/pdf/techSafety%20Net%20TAG.pdf

[8] Lewin, M.E. & Altman, S., (2000) *American's Health Care Safety Net: Intact But Endangered.* Institute of Medicine, National Academy Press, Washington D.C., p. 211.

Both public and private stakeholders and decision makers throughout Oregon recognize the valuable opportunity NGA is offering and agree to participate as members of the *Demonstration Project* Advisory Team (*see Team Member list*). They are committed to being engaged in the *Demonstration Project* and process. They agree that there is a need to better gather and organize data to enhance understanding of the current health care safety net strengths and challenges, and evaluate their underlying causes. They appreciate the opportunity to further explore innovative practices employed by other States to organize, manage, and finance safety net services. Furthermore, Oregon stakeholders and decision makers value the possibility to develop a series of data driven policy options that can be used to strengthen safety net service capacity.

High Level Commitment

Governor Kulongoski is committed to the *Enhancing the Safety Net Through Data-Driven Policy: Demonstration Project*. As the former Insurance Commissioner, Governor Kulongoski recognizes that the health care safety net is an integral part of Oregon's health care delivery system. Further demonstrating Oregon's dedication to the safety net and the *Demonstration Project*, Governor Kulongoski has committed Erinn Kelley-Siel, his Health and Human Services Policy Advisor to be involved on the Advisory Team (*see Long Term Feasibility*). This direct involvement will be especially beneficial when creating policy options and a formal policy proposal for the Governor to consider.

Bruce Goldberg, MD, Administrator of the Office for Oregon Health Policy & Research (OHPR) and appointed by Governor Kulongoski, will be the "project lead" responsible for Oregon's *Demonstration Project* and its "policy level person". Dr. Goldberg will manage the *Demonstration Project* and ensure that data-driven concerns are translated into policy recommendations and initiatives. Dr. Goldberg and OHPR are committed and able to provide the necessary technical and policy support to ensure the success of the *Demonstration Project*. OHPR's key function is to provide health policy direction and information to the Governor and Legislature. As OHPR's administrator, Dr. Goldberg has direct and regular communication with key stakeholders and policymakers (including both the Governor and Legislative Assembly). Already OHPR provides research, technical and support staff to Oregon's key health policy advisory bodies, i.e. the Health Resources Commission, Health Services Commission, Oregon Health Research & Evaluation Collaborative, and Oregon Health Policy Commission. These bodies consist of public and private stakeholders from throughout Oregon and, with the support of OHPR, translate data driven concerns into policy recommendations as well as report to the Governor, Legislative Assembly, and the public at large. OHPR will ensure that communication and involvement occurs between these advisory bodies and stakeholders involved with the *Demonstration Project*. Consequently, Dr. Goldberg and OHPR are well positioned to help move forward a formal health care safety net policy proposal to the Governor and others for their consideration.[*]

Laura Brennan, MSW will be the designated "program level person" responsible for using the data books established jointly by the Agency for Healthcare Research and Quality (AHRQ) and Health Resource and Services Administration (HRSA). Ms. Brennan currently works for Oregon's Department of Human Services (DHS), Health

[*] For more information on OHPR log on to, http://www.ohpr.state.or.us/

Systems Planning (HSP) - the designated "primary care office" in Oregon. HSP aims to strengthen the ability of Oregon's health system by improving access to primary care, reducing disparities in health care services, and improving quality of care. HSP commits to providing additional technical staff to the *Demonstration Project* as needed. As the Access Policy Lead for DHS, some of Ms. Brennan's present responsibilities include convening state policy makers and community partners on Oregon's Robert Wood Johnson Foundation's *Covering Kids and Families* grant, coordinating/staffing the Access Committee of the Oregon Health Council, and contributing to the development community based delivery systems. Furthermore, Ms. Brennan is the immediate past president of the Oregon Public Health Association. Ms. Brennan, with the support of HSP and OHPR, will ensure that the State along with diverse stakeholders *(see Long Term Feasibility)* from throughout Oregon use the data books to monitor and evaluate the viability of Oregon's health care safety net.[**]

The State is dedicated to providing the staff time and necessary resources to fully participate in and benefit from *Enhancing the Safety Net Through Data-Driven Policy: Demonstration Project*. OHPR and HSP are committed to offering additional technical and support staff as needed. With the support of OHPR and HSP, Dr. Goldberg and Ms. Brennan will ensure full participation of team members in site-visits, meetings, conference calls, and other project-related activities.

Long Term Feasibility

Oregon has a long and successful history of stakeholder and citizen involvement in health policy. As mentioned above, OHPR already is responsible for the key health policy advisory bodies in Oregon. This *Demonstration Project* will benefit from this history and leadership and is ensured a team of public and private sector decision makers with the appropriate levels of technical knowledge, influence and authority to advance efforts from a series of raw data measures about the safety net to a full-scale policy proposal.

In order to ensure that the necessary support and expertise is involved with the *Demonstration Project*, we have created a comprehensive list of public and private sector decision makers able to create and move forward a safety net policy proposal *(see Safety Net Policy Team Members list)*. These decision makers have agreed to participate as members of the "Oregon Safety Net Policy Team". This team will be responsible for crafting policy initiatives to strengthen and sustain the health care safety net using HRSA/AHRQ data tools as the primary technical assistance resource. These stakeholders recognize that "state and local policies and programs that support care for vulnerable populations have proved to be critically important to the ability of community safety net systems to remain viable while maintaining their missions to provide care for uninsured populations."[9] And yet they also are acutely aware that Oregon has not created such policies and programs for the safety net and the growing number of uninsured.
The "Oregon Safety Net Policy Team" members represent both health policy makers and the diversity of Oregon's health care safety net. The team includes a bipartisan group of legislators representing both urban and rural Oregon, the Governor's Health and Human

[**] For more information on HSP log on to, http://www.dhs.state.or.us/publichealth/hsp/index.cfm
[9] Lewin, M.E. & Altman, S., (2000). *American's Health Care Safety Net: Intact But Endangered.* Institute of Medicine, National Academy Press, Washington D.C., p. 211.

Service Policy Advisor, Oregon's hospital and medical associations, local safety net providers and their associations, academic institutions, and others. All of these individuals have agreed to be actively engaged in this project to ensure that Oregon:

- Evaluates the strengths and weaknesses of Oregon's current health care safety net;
- Identifies gaps in Oregon's safety net, evaluates the underlying causes for those gaps, and explores innovative practices other states have employed to organize, manage, and finance safety net services; as well as
- Develops a series of data-driven policy options that can be used to bolster safety net services capacity at the state and local levels.

The "Oregon Safety Net Policy Team" will use the AHRQ/HRSA data tools to create data driven policy options that will be brought to Governor Kulongoski for his consideration. Individuals from both the Office for Oregon Health Policy and Research and Health Systems Planning will staff this policy team (see team list).

The NGA Center's technical assistance and the AHRQ/HRSA data tools will provide Oregon with the ability to create a valid and reliable picture of the safety net. This support will allow Oregon stakeholders to look at the supply and demand of the safety net and provides the opportunity to monitor it overtime. Stakeholders and decision makers, consequently, will be able to encourage policy that supports the entire health care safety net and then share their experiences with others. Oregon welcomes, requests, and needs your support.

Appendix B

Oregon's Health Care Safety Net Policy Team
Roster

Oregon Health Care Safety Net Policy Team
Master Roster

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Appendix C

Timeline

Enhancing Oregon's Health Care Safety Net
Through Data Driven Policy
2004 Timeline

The NGA process that will enable Oregon health care safety net stakeholders to:

- *Identify the strengths and weaknesses in the current safety net system(s), and evaluate the underlying causes;*
- *Explore innovative practices states have employed to organize, manage, and finance safety net services; and*
- *Develop a series of data-driven policy options that can be used to bolster safety net service capacity at the state and local levels.*

February	NGA, AHRQ, HRSA site visit and introduction
March	Defining the health care safety net Overview of Oregon's safety net
April	Defining health care safety net Determine availability of Oregon data
May	Review compiled data
June	Review policies and proposals in other states Brainstorm potential Oregon policy options
July	Review policy options using Oregon data/evidence
August	Review and refine policy options Policy work groups convene
September	Policy work groups report Refine policy options for Oregon
October	Finalize and prioritize policy options
November	Finalize report
December	Submit report to Governor's Office

Appendix D

Demand and Capacity Data

Monitoring Oregon's Healthcare Safety Net

Objective

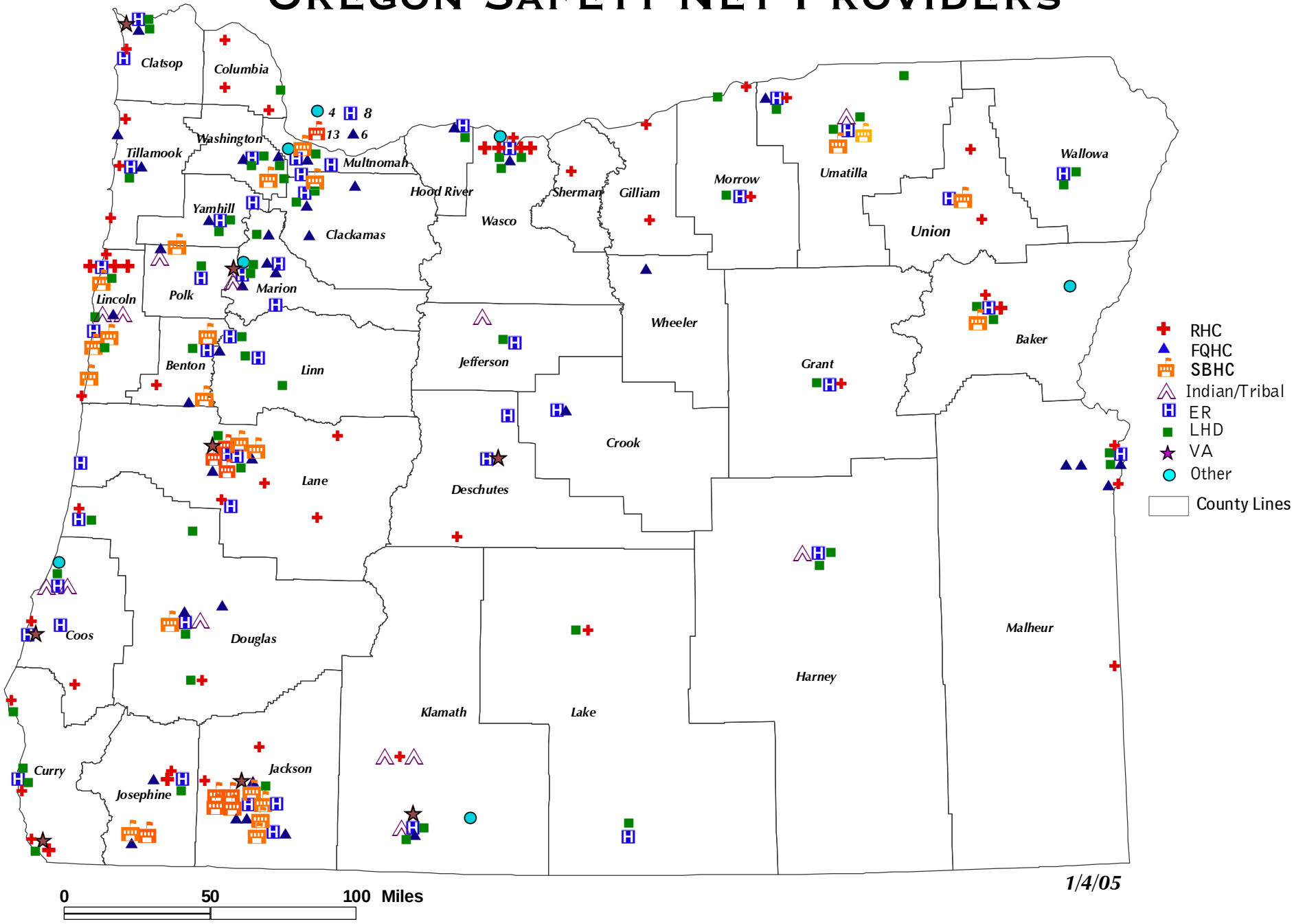
- To gather information about demand for safety net healthcare services in Oregon
- To compile available data about safety net capacity in Oregon
- To identify gaps in available information

There is an "inability to find a single source" where safety net data is collected and analyzed. Furthermore, "information on the safety net takes years to assemble and important data is often missing or only describing the situation in a few communities."

- *"America's Health Care Safety Net: Intact But Endangered"*

Unfortunately, Oregon is no exception to these statements. But this is a beginning.

Oregon Safety Net Providers

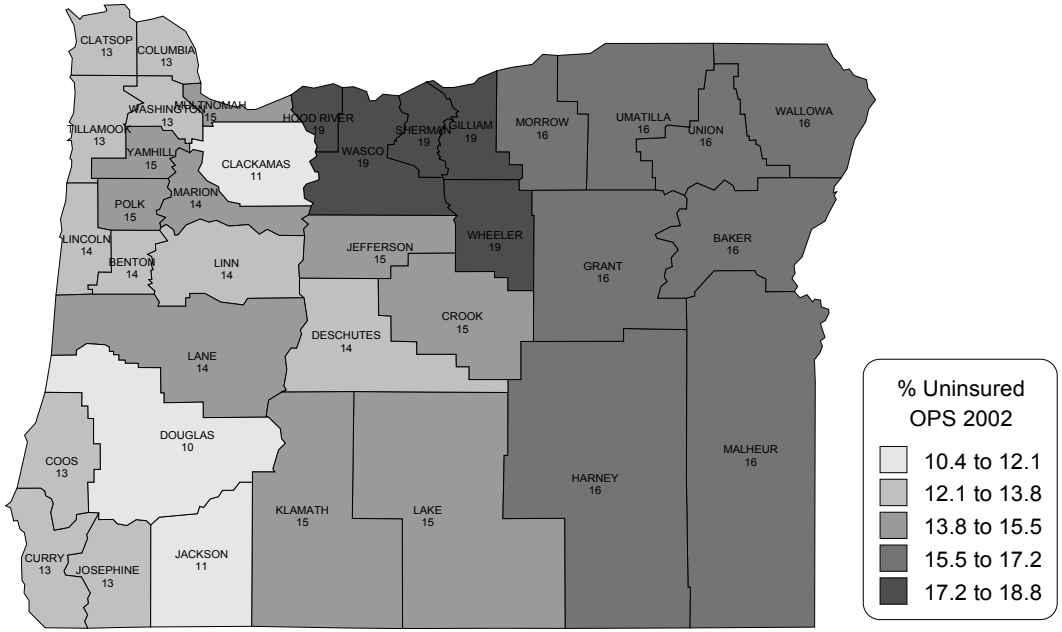


Health Systems Planning Office
map prepared by Oregon Office of Rural Health, OHSU

Appendix D

We know where the demand is…uninsured, low-income, geographically isolated, racial and ethnic minorities, homeless and migrant populations.

Uninsured: According to the 2002 OPS, the overall uninsurance rate is 14%, but there are regional and population variations.

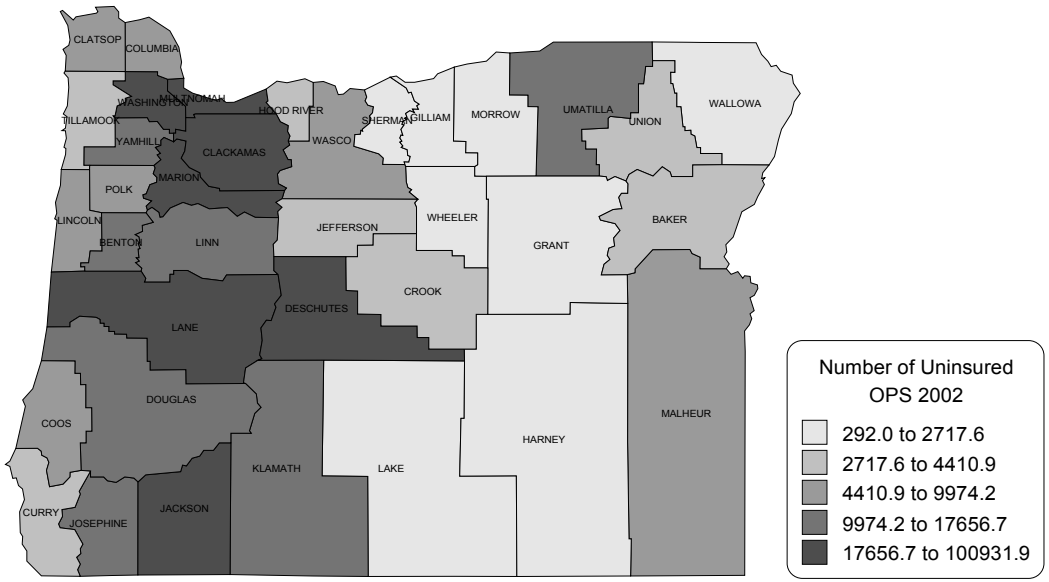


Uninsurance ranged from a low of 10.8% in Clackamas County to a high of 18.9% in the Columbia Gorge Region. There are also racial and ethnic disparities:

- 30.7% uninsured for the Hispanic population
- 13.9% uninsured for the African-American population
- 17.8% uninsured for the Native American population

And proportions only tell part of the story.

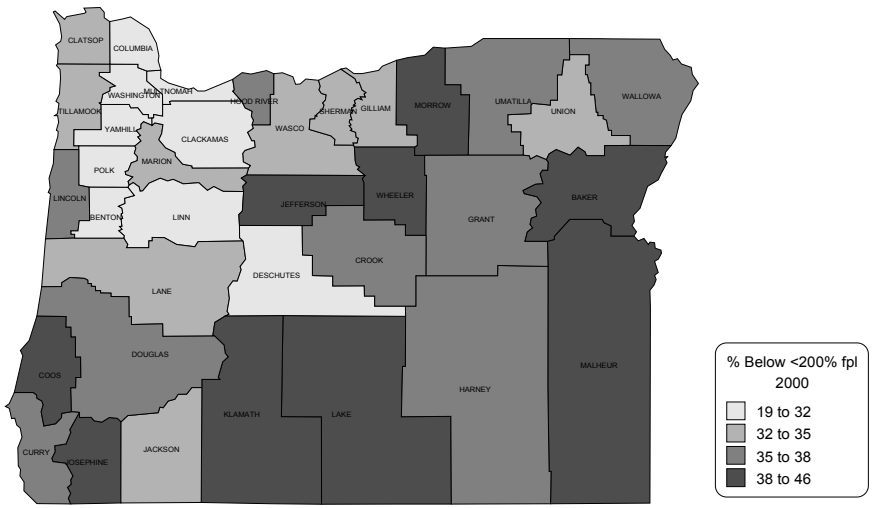
Number of Uninsured by County, 2002



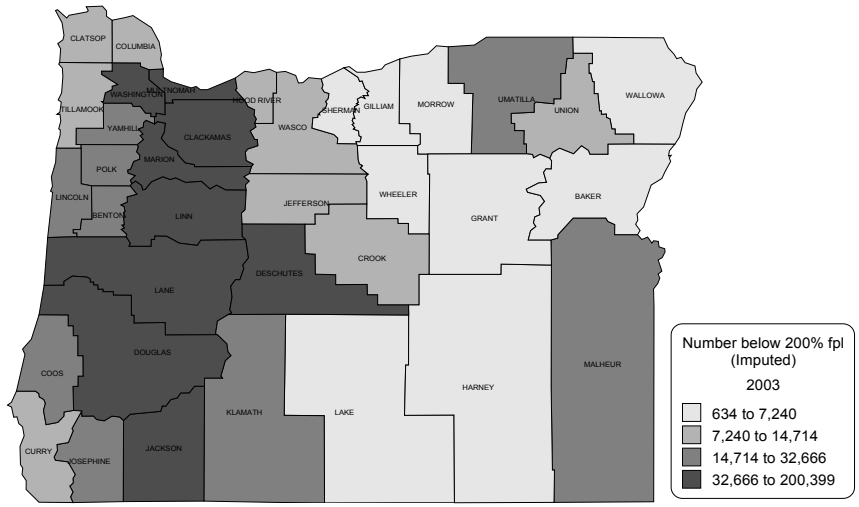
The I-5 Corridor carries less of the relative burden of the uninsured, but more in absolute numbers.

Understanding the numbers: Distribution of low-income population

Low-income (<200% fpl) as a percentage of population:

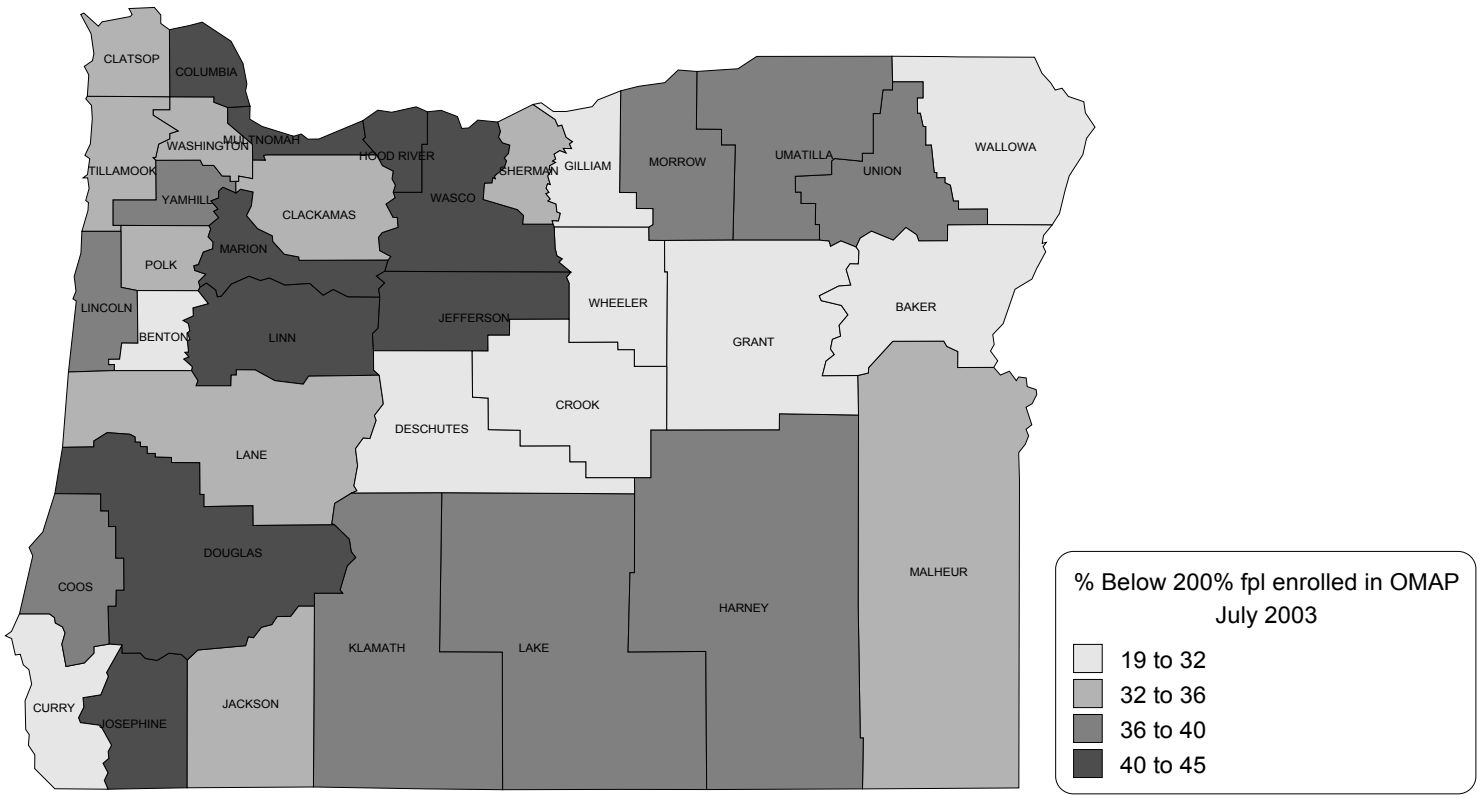


Low-income (<200% fpl) as a raw number:



Understanding the numbers: Distribution of low-income and Medicaid coverage…

Percent of low-income population enrolled in the Oregon Health Plan



The Data: Demand

DEMAND: Population

Area	Population (Est. 2003)	Square Miles	Population Density	% Population			% Population Change 1990-2000			
				Ages 0-17	Ages 18-64	Ages 65+	Total	Ages 0-17	Ages 18-64	Ages 65+
Oregon	3,541,500	96,545	37	24.7	62.5	12.8	20.4	16.9	23.7	12.0
Baker County	16,500	2,990	6	23.6	57.4	19.0	9.3	-1.7	14.2	10.4
Benton County	80,500	656	123	23.4	66.4	10.3	10.4	15.8	7.6	17.5
Clackamas County	353,450	1,814	195	25.8	63.1	11.1	21.4	17.5	23.8	17.0
Clatsop County	36,300	714	51	23.7	60.8	15.6	7.0	-1.5	12.0	2.6
Columbia County	45,000	779	58	26.7	61.6	11.6	16.0	7.9	21.8	7.3
Coos County	63,000	1,611	39	21.7	59.1	19.1	4.2	-9.8	6.9	15.4
Crook County	20,300	2,963	7	25.9	59.4	14.7	35.9	28.5	42.4	25.6
Curry County	21,100	1,636	13	18.7	54.6	26.6	9.4	-0.7	8.8	19.2
Deschutes County	130,500	3,460	38	24.5	62.4	13.1	53.9	46.3	59.2	45.1
Douglas County	101,800	5,034	20	23.7	58.5	17.8	6.1	-6.6	7.5	22.8
Gilliam County	1,900	1,201	2	22.4	58.6	19.1	11.5	-7.1	21.4	9.9
Grant County	7,650	4,494	2	25.0	58.3	16.8	1.0	-7.0	0.9	16.7
Harney County	7,300	5,434	1	25.5	59.5	15.0	7.8	-1.6	10.3	16.1
Hood River County	20,500	548	37	27.6	59.6	12.9	20.8	21.7	22.6	10.9
Jackson County	189,100	2,789	68	24.3	59.7	16.0	23.8	19.8	26.0	22.3
Jefferson County	19,900	1,767	11	29.2	58.3	12.4	39.0	29.8	44.1	38.9
Josephine County	78,350	1,651	47	22.8	57.1	20.1	20.9	13.4	25.0	18.7
Klamath County	64,600	6,033	11	25.7	59.4	14.9	10.5	6.5	11.1	15.6
Lake County	7,400	12,650	1	23.7	58.6	17.7	3.3	-12.9	5.2	27.2
Lane County	329,400	4,631	71	23.2	63.5	13.3	14.2	8.5	16.0	15.8
Lincoln County	45,000	1,027	44	21.0	59.4	19.5	14.4	3.0	20.1	11.4
Linn County	104,900	2,355	45	25.8	59.7	14.5	13.0	9.2	15.3	10.6
Malheur County	32,000	9,944	3	27.7	58.7	13.7	21.4	9.9	32.3	6.5
Marion County	295,900	1,202	246	27.4	60.3	12.4	24.7	29.3	26.8	7.5
Morrow County	11,750	2,026	6	30.5	58.9	10.6	44.2	45.1	46.5	30.6
Multnomah County	677,850	423	1,601	22.5	66.4	11.1	13.1	10.1	18.6	-7.3
Polk County	64,000	620	103	25.8	59.4	14.8	25.9	22.7	27.7	24.8
Sherman County	1,900	826	2	25.7	56.1	18.3	0.8	-6.9	2.1	9.3
Tillamook County	24,900	1,079	23	21.8	58.5	19.8	12.5	4.0	18.3	6.6
Umatilla County	71,100	3,217	22	27.6	60.1	12.3	19.1	17.9	22.8	5.7
Union County	24,650	2,117	12	25.1	60.2	14.7	3.9	-6.1	7.7	8.4
Wallowa County	7,150	3,147	2	23.4	57.8	18.9	4.6	-8.4	9.0	10.3
Wasco County	23,550	2,388	10	24.9	58.4	16.7	9.7	1.3	15.4	4.7
Washington County	472,600	782	604	26.7	64.5	8.8	42.9	42.2	46.2	24.7
Wheeler County	1,550	1,719	1	21.1	55.6	23.3	10.8	5.6	9.2	20.4
Yamhill County	88,150	816	108	27.2	61.0	11.7	29.7	24.6	35.4	15.4

DEMAND: Economy

Area	Median Household Income ($)	% Households Income Under $15,000	% Households Income Over $75,000	% Households Under $15,000 on Public Assistance	Mean Public Assistance Amount ($)	% Ages 16+ Not In Labor Force	% Ages 16+ Unemployed
Oregon	40,916	15.1	19.7	23.5	2,697	34.8	6.5
Baker County	30,367	22.2	8.6	18.5	1,748	44.4	8.3
Benton County	41,897	17.6	23.3	11.5	2,333	36.4	4.9
Clackamas County	52,080	8.9	30.9	24.6	2,948	31.4	5.0
Clatsop County	36,301	18.4	14.1	19.4	2,000	36.4	6.6
Columbia County	45,797	13.8	19.5	24.3	2,205	35.2	6.3
Coos County	31,542	22.6	10.7	23.4	2,590	45.7	8.5
Crook County	35,186	17.8	10.6	25.6	3,303	40.6	7.7
Curry County	30,117	23.0	9.6	16.5	3,111	50.7	7.3
Deschutes County	41,847	13.0	19.9	21.7	2,301	34.7	5.2
Douglas County	33,223	19.6	11.1	22.2	2,770	43.1	7.6
Gilliam County	33,611	17.8	11.7	12.8	5,168	34.1	6.8
Grant County	32,560	19.1	9.9	15.5	2,431	38.6	11.9
Harney County	30,957	19.8	12.7	16.1	5,650	36.2	9.4
Hood River County	38,326	14.1	14.4	22.6	2,595	33.5	6.6
Jackson County	36,461	17.3	16.4	21.8	2,453	38.7	7.3
Jefferson County	35,853	14.8	12.1	36.9	2,754	36.1	8.6
Josephine County	31,229	22.6	11.5	23.1	2,459	47.9	9.8
Klamath County	31,537	21.3	11.3	22.0	2,579	40.3	10.0
Lake County	29,506	24.1	9.2	15.5	1,809	42.2	8.5
Lane County	36,942	18.3	15.9	19.3	2,752	35.7	6.4
Lincoln County	32,769	19.0	12.4	22.3	2,664	41.7	8.4
Linn County	37,518	16.4	14.3	23.7	3,520	37.0	7.9
Malheur County	30,241	21.9	10.0	22.6	2,363	46.7	11.1
Marion County	40,314	14.7	17.1	29.5	2,965	36.3	7.7
Morrow County	37,521	13.6	12.6	39.7	2,477	34.9	10.7
Multnomah County	41,278	15.3	20.4	27.5	2,624	31.0	6.4
Polk County	42,311	15.9	19.3	19.5	2,580	35.9	6.2
Sherman County	35,142	21.3	12.0	7.0	2,542	40.1	7.3
Tillamook County	34,269	18.7	11.2	17.1	2,322	41.3	4.4
Umatilla County	36,249	16.8	13.8	20.3	2,184	36.8	7.5
Union County	33,738	21.8	13.1	19.3	2,863	38.6	7.9
Wallowa County	32,129	22.2	11.6	12.1	2,566	39.3	11.8
Wasco County	35,959	19.6	13.4	21.5	2,441	39.5	7.9
Washington County	52,122	8.6	29.7	26.2	2,947	27.7	4.6
Wheeler County	28,750	21.9	8.3	12.7	1,406	47.5	7.3
Yamhill County	44,111	12.6	19.3	24.1	2,416	35.5	6.4

DEMAND: Poverty and Disability

Area	Population (2003)	% Uninsured OPS 2002	% Below Poverty (2000 Census)				% Below 200% Poverty (2000 Census)				SSI (2003)		
			Total	Ages 0-17	Ages 18-64	Ages 65+	Total	Ages 0-17	Ages 18-64	Ages 65+	Aged	Blind & Disabled	Total
Oregon	3,541,500	14.0%	11.6	14.0	11.2	7.6	29.6	37.2	26.7	29.2	7,587	49,919	57,506
Baker County	16,500	16.5%	14.7	18.8	13.5	12.4	42.1	55.6	37.8	38.0	42	307	349
Benton County	80,500	13.5%	14.6	10.6	17.1	4.9	30.4	29.5	32.5	19.5	71	556	627
Clackamas County	353,450	10.8%	6.6	7.6	6.2	5.1	18.7	23.7	16.1	22.1	524	2,570	3,094
Clatsop County	36,300	12.9%	13.2	16.8	12.5	8.0	31.9	40.3	29.1	30.4	74	644	718
Columbia County	45,000	12.9%	9.1	11.6	8.1	7.0	23.5	29.2	19.7	30.1	28	393	421
Coos County	63,000	13.3%	15.0	19.9	14.8	9.4	39.2	51.1	35.1	38.3	153	1,661	1,814
Crook County	20,300	14.5%	11.3	13.9	10.6	8.1	35.7	46.8	29.5	41.2	32	202	234
Curry County	21,100	13.3%	12.2	13.6	12.4	10.6	37.1	48.6	33.8	35.9	48	358	406
Deschutes County	130,500	13.5%	9.3	10.4	9.2	6.1	27.2	34.3	24.5	26.6	118	1,248	1,366
Douglas County	101,800	10.4%	13.1	16.6	12.6	9.2	35.4	44.1	31.1	38.5	169	1,844	2,013
Gilliam County	1,900	18.8%	9.1	11.0	9.0	6.6	34.7	45.9	32.4	28.0	7	27	34
Grant County	7,650	16.5%	13.7	16.6	13.1	10.2	37.6	48.7	33.6	34.3	12	125	137
Harney County	7,300	16.5%	11.8	12.7	10.8	13.9	36.7	49.7	31.5	35.2	14	128	142
Hood River County	20,500	18.8%	14.2	17.3	13.5	7.8	37.7	49.7	33.7	30.4	31	176	207
Jackson County	189,100	11.3%	12.5	16.3	12.2	6.9	33.4	43.8	30.6	28.4	311	2,789	3,100
Jefferson County	19,900	14.5%	14.6	22.2	12.7	5.9	38.1	53.8	31.9	30.1	36	279	315
Josephine County	78,350	13.3%	15.0	21.1	15.1	6.8	40.1	52.8	37.2	33.7	157	1,575	1,732
Klamath County	64,600	15.4%	16.8	22.4	16.4	7.7	40.5	52.5	36.8	35.0	151	1,310	1,461
Lake County	7,400	14.8%	16.1	20.4	16.0	9.5	41.0	50.4	37.6	39.0	12	113	125
Lane County	329,400	14.1%	14.4	16.1	14.9	7.5	33.0	39.2	31.5	29.4	442	5,169	5,611
Lincoln County	45,000	13.5%	13.9	19.5	13.6	7.2	36.1	49.2	33.6	29.4	76	687	763
Linn County	104,900	13.5%	11.4	14.8	10.6	7.1	31.1	40.0	26.8	33.2	194	2,044	2,238
Malheur County	32,000	16.5%	18.6	25.8	16.5	11.6	46.0	58.7	41.4	37.3	109	600	709
Marion County	295,900	14.3%	13.5	18.1	12.3	7.4	33.8	44.2	30.2	27.7	624	4,352	4,976
Morrow County	11,750	16.5%	14.8	21.6	11.9	10.1	38.6	53.1	31.6	36.1	8	103	111
Multnomah County	677,850	14.9%	12.7	15.4	12.0	9.8	29.6	37.6	26.9	29.4	2,606	13,110	15,716
Polk County	64,000	14.6%	11.5	12.5	12.2	5.5	29.2	35.1	27.0	28.0	110	981	1,091
Sherman County	1,900	18.8%	14.6	20.2	14.1	7.7	33.4	42.1	30.6	29.4	**	**	22
Tillamook County	24,900	12.9%	11.4	13.4	11.1	8.1	34.5	45.4	30.9	33.1	48	343	391
Umatilla County	71,100	16.3%	12.7	16.2	11.4	8.7	36.4	46.7	31.3	36.6	137	1,125	1,262
Union County	24,650	16.5%	13.8	13.6	14.6	9.5	35.0	39.8	32.8	36.3	51	446	497
Wallowa County	7,150	16.5%	14.0	18.3	12.5	11.4	37.9	50.2	32.7	38.2	18	99	117
Wasco County	23,550	18.7%	12.9	17.7	12.4	7.3	33.5	43.0	29.5	33.0	50	460	510
Washington County	472,600	12.8%	7.4	8.3	7.1	5.3	20.6	25.6	18.6	20.8	1,008	3,241	4,249
Wheeler County	1,550	18.8%	15.6	22.2	16.7	4.2	45.3	66.8	40.6	36.0	**	**	12
Yamhill County	88,150	16.2%	9.2	10.1	8.8	7.5	26.6	31.9	23.7	29.2	106	766	872

DEMAND: Disability

Area	Population (Est. 2003)	% With a Disability (2000 Census)			SSI (SSA: 2003)			Need for Mental Health Services (SMI) (Adults 18+: HH, Inst. & Group)*			Need for Mental Health Services (SMI) (Adults 18+: HH < 200% fpl)*			Need for Mental Health Services (SMI) (Youth 0 to 17: HH, Inst. & Group)*		
		Ages 5-20	Ages 21-64	Ages 65+	Aged	Blind & Disabled	Total	Cases	Population	Percent	Cases	Population	Percent	Cases	Population	Percent
Oregon	3,541,500	8.2	18.0	41.5	7,587	49,919	57,506	163,361	2,574,873	6.3	61,294	666,239	9.2	62,350	846,526	7.4
Baker County	16,500	7.7	21.9	49.4	42	307	349	828	12,688	6.5	356	3,796	9.4	309	4,054	7.6
Benton County	80,500	6.9	11.7	35.6	71	556	627	3,802	61,495	6.2	1,565	17,216	9.1	1,225	16,659	7.4
Clackamas County	353,450	7.5	15.1	38.8	524	2,570	3,094	14,512	249,871	5.8	3,999	44,038	9.1	6,210	88,520	7.0
Clatsop County	36,300	8.9	19.7	41.4	74	644	718	1,795	27,197	6.6	698	7,477	9.3	639	8,434	7.6
Columbia County	45,000	8.2	18.9	44.7	28	393	421	1,945	31,661	6.1	730	7,955	9.2	875	11,902	7.4
Coos County	63,000	10.9	25.5	45.8	153	1,661	1,814	3,266	49,010	6.7	1,482	15,884	9.3	1,056	13,769	7.7
Crook County	20,300	8.3	21.7	51.6	32	202	234	889	14,083	6.3	373	4,072	9.2	390	5,100	7.6
Curry County	21,100	10.8	27.7	39.9	48	358	406	1,008	17,073	5.9	461	5,374	8.6	308	4,065	7.6
Deschutes County	130,500	7.4	16.5	37.2	118	1,248	1,366	5,166	86,784	6.0	2,011	22,064	9.1	2,083	28,583	7.3
Douglas County	101,800	8.0	22.7	42.9	169	1,844	2,013	5,067	76,321	6.6	2,244	24,364	9.2	1,817	24,079	7.6
Gilliam County	1,900	4.8	17.6	42.9	7	27	34	85	1,470	5.8	34	393	8.6	33	445	7.3
Grant County	7,650	5.2	16.7	40.5	12	125	137	372	5,890	6.3	155	1,690	9.2	153	2,045	7.5
Harney County	7,300	6.2	20.8	44.9	14	128	142	379	5,635	6.7	153	1,704	9.0	154	1,975	7.8
Hood River County	20,500	6.1	16.4	40.5	31	176	207	980	14,702	6.7	401	4,554	8.8	448	5,709	7.9
Jackson County	189,100	8.2	19.1	41.0	311	2,789	3,100	8,880	137,009	6.5	3,811	41,374	9.2	3,347	44,260	7.6
Jefferson County	19,900	6.2	22.0	39.1	36	279	315	803	13,344	6.0	379	4,573	8.3	443	5,666	7.8
Josephine County	78,350	8.5	23.1	41.0	157	1,575	1,732	3,863	58,254	6.6	1,755	18,960	9.3	1,349	17,472	7.7
Klamath County	64,600	8.7	22.7	43.3	151	1,310	1,461	3,106	47,305	6.6	1,489	15,593	9.6	1,275	16,470	7.7
Lake County	7,400	5.5	21.1	44.6	12	113	125	349	5,576	6.3	171	1,789	9.5	143	1,847	7.7
Lane County	329,400	8.3	17.9	42.7	442	5,169	5,611	16,051	249,145	6.4	6,977	74,257	9.4	5,523	73,814	7.5
Lincoln County	45,000	11.8	21.7	39.3	76	687	763	2,172	34,945	6.2	930	10,096	9.2	732	9,536	7.7
Linn County	104,900	9.6	21.3	45.6	194	2,044	2,238	4,950	76,239	6.5	2,009	21,404	9.4	1,998	26,830	7.5
Malheur County	32,000	7.7	20.5	43.3	109	600	709	1,805	22,881	7.9	676	7,438	9.1	698	8,734	8.0
Marion County	295,900	8.7	19.6	42.1	624	4,352	4,976	14,579	206,871	7.1	5,458	57,955	9.4	5,970	77,963	7.7
Morrow County	11,750	5.9	19.5	44.7	8	103	111	487	7,611	6.4	234	2,552	9.2	263	3,385	7.8
Multnomah County	677,850	9.0	17.9	42.1	2,606	13,110	15,716	32,845	513,236	6.4	12,285	132,469	9.3	10,921	147,250	7.4
Polk County	64,000	7.3	18.2	43.0	110	981	1,091	2,986	46,565	6.4	1,082	11,550	9.4	1,155	15,815	7.3
Sherman County	1,900	5.7	16.4	32.6	**	**	22	84	1,423	5.9	39	423	9.2	39	511	7.7
Tillamook County	24,900	9.1	24.4	40.6	48	343	391	1,165	18,867	6.2	446	5,050	8.8	403	5,396	7.5
Umatilla County	71,100	7.9	19.4	44.1	137	1,125	1,262	3,585	50,956	7.0	1,424	15,531	9.2	1,495	19,592	7.6
Union County	24,650	7.5	18.9	45.1	51	446	497	1,197	18,484	6.5	520	5,427	9.6	452	6,046	7.5
Wallowa County	7,150	6.4	16.9	42.1	18	99	117	332	5,471	6.1	135	1,498	9.0	134	1,755	7.6
Wasco County	23,550	6.5	18.6	41.3	50	460	510	1,152	17,756	6.5	490	5,348	9.2	459	6,035	7.6
Washington County	472,600	7.4	14.0	39.3	1,008	3,241	4,249	18,206	325,724	5.6	4,908	55,712	8.8	8,293	119,618	6.9
Wheeler County	1,550	2.5	18.9	34.3	**	**	12	69	1,196	5.8	32	363	8.7	27	351	7.8
Yamhill County	88,150	8.2	19.6	39.4	106	766	872	4,261	62,149	6.9	1,309	14,408	9.1	1,653	22,843	7.2

Holzer, CE, "Estimation of Need for Mental Health Services," 2000. http://psy.utmb.edu/estimation/estimation.htm (May 2004).

DEMAND: Increasing diversity

Oregon is becoming more diverse; minority population is growing especially among younger ages.

- Some rural counties are in a process of demographic replacement. An aging white, non-Hispanic population is diminishing and minority population is growing, especially Latino populations.
- The Hispanic/Latino population is growing and is forecast to continue growing, based on in-migration and fertility.
- The Hispanic/Latino population is not dispersed throughout rural areas. Populations are concentrated in small cities in rural counties, e.g., Hood River, Morrow and Malheur.

--Population Research Center, Portland State University, 2004.

	Hispanic/Latino (of any race) April 1, 1990 and 2000						Total Population	
Area	1990	2000	Change 1990-2000	Percent Change 1990-2000	Total Population (%) 1990	Total Population (%) 2000	% Speak Non-English at Home	% Speak English Less than Very Well
Oregon	112,708	275,314	162,606	144%	0.2	4.0%	12.1	5.9
Clatsop County	648	1,597	949	146%	0.2	1.9%	7.1	3.3
Crook County	388	1,082	694	179%	0.0	2.7%	6.3	2.8
Curry County	354	761	407	115%	0.1	1.8%	5.4	1.1
Deschutes County	1,526	4,304	2,778	182%	0.1	2.0%	5.4	1.9
Hood River County	2,752	5,107	2,355	86%	0.1	16.3%	24.7	15.4
Jefferson County	1,448	3,372	1,924	133%	0.2	10.6%	19.0	9.3
Josephine County	1,749	3,229	1,480	85%	0.1	2.8%	4.8	1.4
Klamath County	2,984	4,961	1,977	66%	0.1	5.2%	8.1	3.4
Lincoln County	598	2,119	1,521	254%	0.2	1.5%	5.7	2.8
Malheur County	5,155	8,099	2,944	57%	0.1	19.8%	21.1	8.8
Morrow County	825	2,686	1,861	226%	0.1	10.8%	23.3	13.6
Tillamook County	374	1,244	870	233%	0.2	1.7%	6.3	2.7
Wasco County	1,065	2,214	1,149	108%	0.5	4.9%	10.5	5.2
Wheeler County	12	79	67	558%	0.1	0.9%	4.2	1.9

Source: 1990 and 2000 US Census of Population

Prepared by Population Research Center, Portland State University.

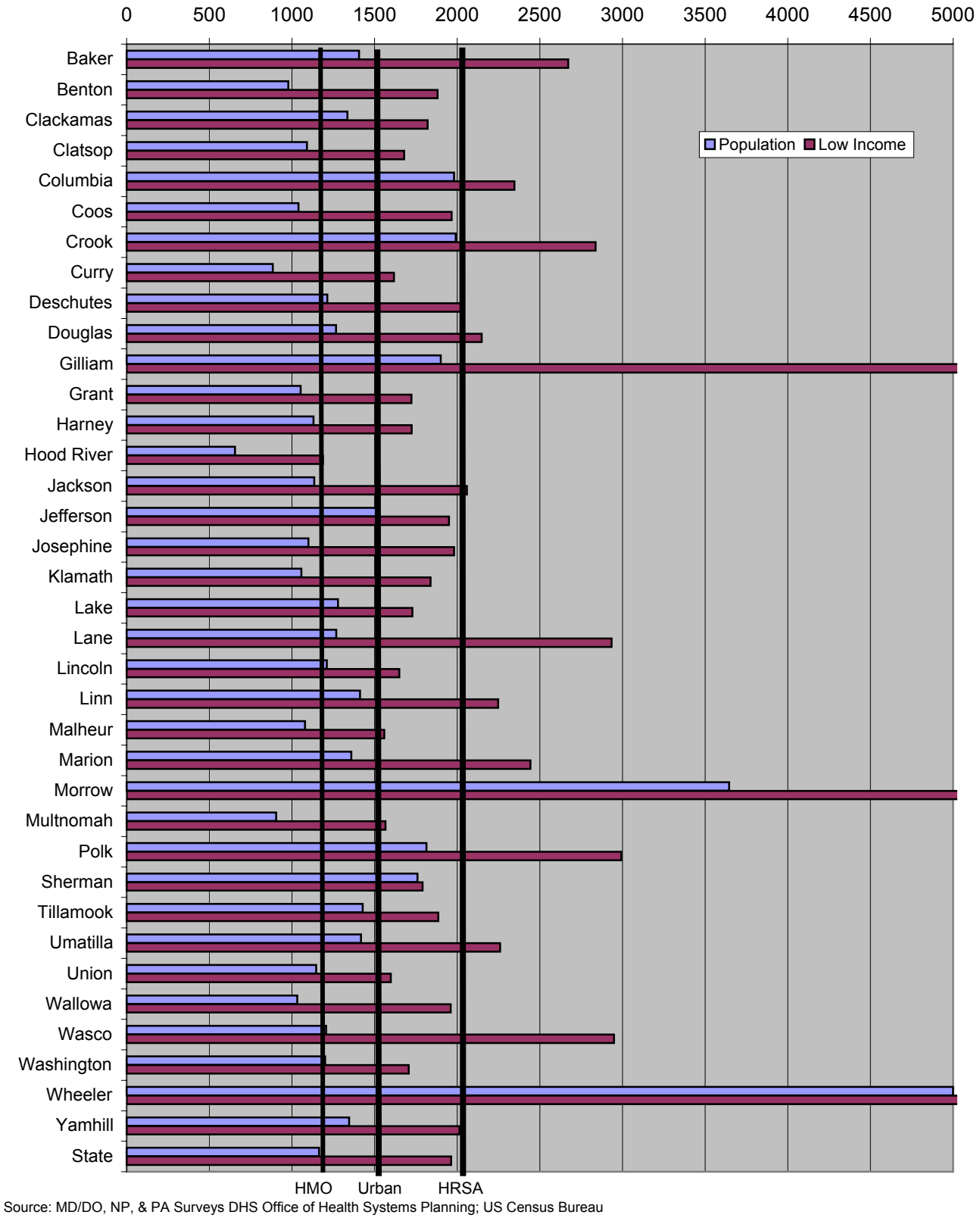
DEMAND: Diversity

Area	% Population							% Population Hispanic (Any Race)				
	Single Race						2+ Races	All Hispanic	Mexican	Puerto Rican	Cuban	Other
	White	Black	Asian	Native American	Hawaiian/ Pacific Island	Other						
Oregon	86.6	1.6	3.0	1.3	0.2	4.2	3.1	8.0	6.3	0.1	0.1	1.5
Baker County	95.7	0.2	0.4	1.1	0.0	0.9	1.7	2.3	1.7	0.1	0.0	0.5
Benton County	89.2	0.8	4.5	0.8	0.2	1.9	2.6	4.7	3.2	0.2	0.1	1.2
Clackamas County	91.3	0.7	2.5	0.7	0.2	2.3	2.5	4.9	3.7	0.1	0.1	1.1
Clatsop County	93.1	0.5	1.2	1.0	0.2	1.6	2.3	4.5	3.5	0.2	0.0	0.8
Columbia County	94.4	0.2	0.6	1.3	0.1	0.8	2.5	2.5	1.6	0.1	0.1	0.8
Coos County	92.0	0.3	0.9	2.4	0.2	1.1	3.2	3.4	2.4	0.1	0.0	0.9
Crook County	93.0	0.0	0.4	1.3	0.0	3.8	1.4	5.6	4.6	0.0	0.0	1.0
Curry County	92.9	0.2	0.7	2.1	0.1	1.1	2.9	3.6	2.7	0.1	0.0	0.8
Deschutes County	94.8	0.2	0.7	0.8	0.1	1.4	2.0	3.7	2.7	0.1	0.0	0.9
Douglas County	93.9	0.2	0.6	1.5	0.1	1.0	2.7	3.3	2.3	0.1	0.0	0.8
Gilliam County	96.8	0.2	0.2	0.8	0.0	1.1	0.9	1.8	1.7	0.0	0.1	0.1
Grant County	95.7	0.1	0.2	1.6	0.0	0.7	1.7	2.1	1.2	0.1	0.0	0.7
Harney County	91.9	0.1	0.5	4.0	0.1	1.3	2.1	4.2	3.0	0.1	0.1	1.0
Hood River County	78.9	0.6	1.5	1.1	0.1	15.4	2.5	25.0	22.4	0.1	0.1	2.4
Jackson County	91.6	0.4	0.9	1.1	0.2	2.9	2.9	6.7	5.3	0.1	0.1	1.2
Jefferson County	69.0	0.3	0.3	15.7	0.2	11.3	3.2	17.7	14.4	0.2	0.0	3.2
Josephine County	93.9	0.3	0.6	1.3	0.1	1.2	2.7	4.3	3.0	0.2	0.1	1.0
Klamath County	87.3	0.6	0.8	4.2	0.1	3.4	3.5	7.8	6.2	0.2	0.1	1.3
Lake County	91.0	0.1	0.7	2.4	0.1	3.2	2.5	5.4	4.8	0.0	0.0	0.6
Lane County	90.6	0.8	2.0	1.1	0.2	1.9	3.3	4.6	3.3	0.2	0.0	1.1
Lincoln County	90.6	0.3	0.9	3.1	0.2	1.7	3.2	4.8	3.8	0.1	0.1	0.8
Linn County	93.2	0.3	0.8	1.3	0.1	1.8	2.5	4.4	3.3	0.1	0.0	0.9
Malheur County	75.8	1.2	2.0	1.0	0.1	17.4	2.6	25.6	19.8	0.1	0.0	5.7
Marion County	81.6	0.9	1.8	1.4	0.4	10.6	3.4	17.1	14.5	0.1	0.1	2.4
Morrow County	76.3	0.1	0.4	1.4	0.1	19.5	2.1	24.4	20.6	0.1	0.0	3.8
Multnomah County	79.2	5.7	5.7	1.0	0.4	4.0	4.1	7.5	5.5	0.2	0.2	1.6
Polk County	89.2	0.4	1.1	1.8	0.2	4.5	2.7	8.8	7.4	0.2	0.1	1.2
Sherman County	93.6	0.2	0.5	1.4	0.0	2.8	1.6	4.9	3.6	0.0	0.1	1.2
Tillamook County	93.9	0.2	0.6	1.2	0.2	1.9	2.0	5.1	4.1	0.1	0.1	0.8
Umatilla County	82.0	0.8	0.8	3.4	0.2	10.7	2.2	16.1	13.7	0.1	0.0	2.2
Union County	94.3	0.5	0.9	0.8	0.6	1.2	1.7	2.4	1.7	0.1	0.0	0.7
Wallowa County	96.5	0.0	0.2	0.7	0.0	1.0	1.5	1.7	1.3	0.1	0.0	0.3
Wasco County	86.6	0.3	0.8	3.8	0.5	5.6	2.4	9.3	8.1	0.1	0.0	1.1
Washington County	82.2	1.1	6.7	0.7	0.3	5.9	3.2	11.2	8.6	0.2	0.1	2.2
Wheeler County	93.3	0.1	0.3	0.8	0.1	3.5	1.9	5.1	3.2	0.1	0.1	1.7
Yamhill County	89.0	0.8	1.1	1.5	0.1	5.1	2.4	10.6	8.6	0.1	0.1	1.8

DEMAND: Immigration

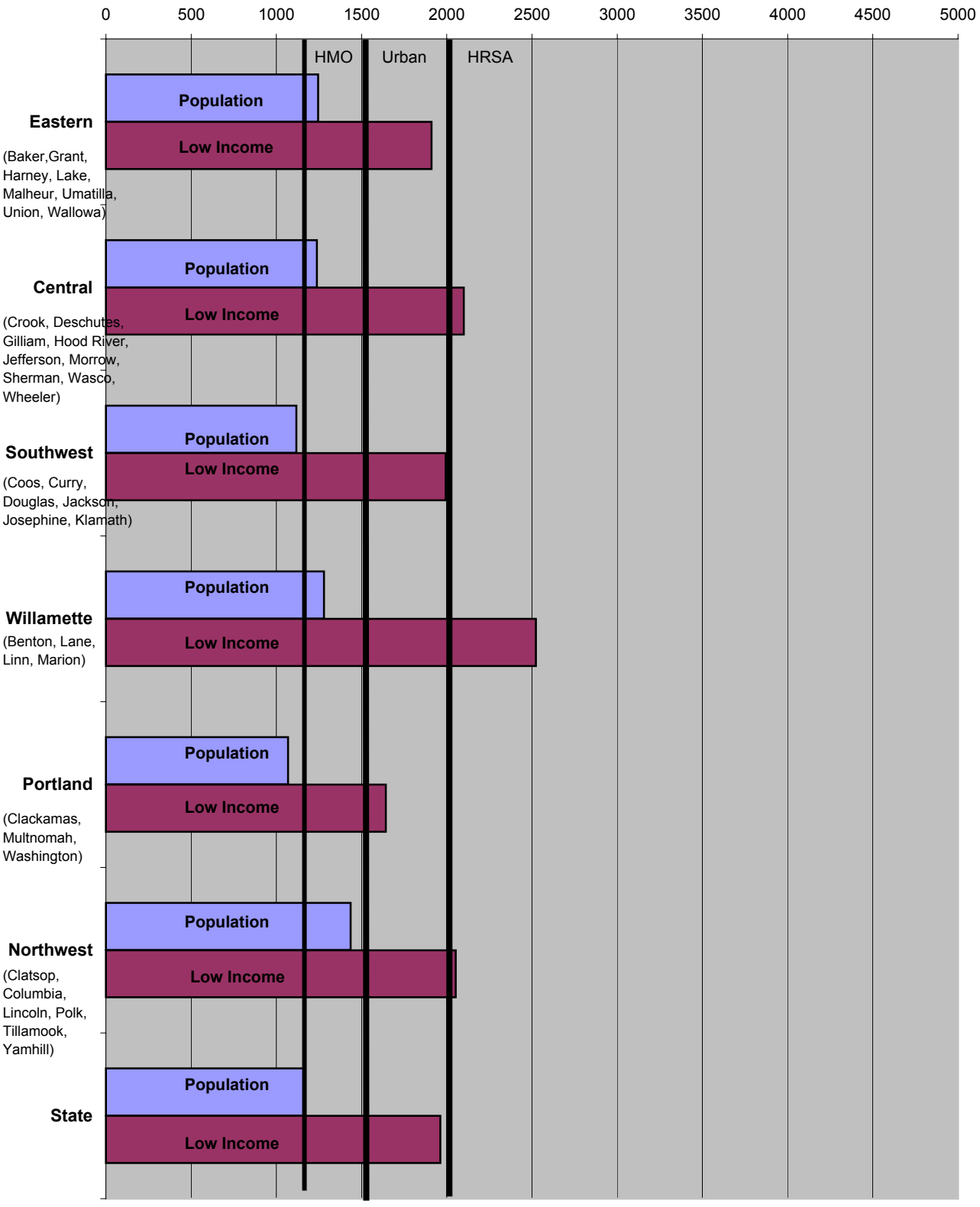
Area	% Population Foreign Born	Foreign Born		Place of Foreign Birth						% Speak Non-English at Home	% Speak English Less than Very Well
		% Lived in U.S. 10 Years or Less	% Naturalized Citizen	% Latin America	% Asia	% Africa	% Europe	% North America	% Oceania		
Oregon	8.5	50.0	33.6	44.6	27.3	1.7	18.8	5.9	1.6	12.1	5.9
Baker County	1.8	42.8	48.4	44.1	22.7	0.0	23.0	10.2	0.0	4.0	1.7
Benton County	7.6	54.9	35.4	22.4	42.3	2.8	25.6	5.2	1.8	10.0	4.0
Clackamas County	7.1	43.3	38.6	33.9	28.3	1.9	26.8	7.8	1.3	9.6	4.1
Clatsop County	4.2	44.3	32.5	51.0	16.6	2.4	16.6	12.0	1.5	7.1	3.3
Columbia County	1.8	17.9	47.4	18.7	21.9	0.1	37.2	21.4	0.6	3.9	1.3
Coos County	2.7	26.3	47.4	30.0	18.8	2.8	33.1	13.2	2.2	4.5	1.3
Crook County	3.3	51.3	25.9	80.7	3.1	0.0	11.5	3.9	0.8	6.3	2.8
Curry County	3.7	17.1	61.4	16.1	12.5	0.6	47.7	17.4	5.8	5.4	1.1
Deschutes County	2.8	37.5	45.2	37.6	16.6	0.8	27.6	14.8	2.6	5.4	1.9
Douglas County	2.1	21.7	63.8	25.6	19.5	1.1	29.2	22.6	2.1	3.9	1.2
Gilliam County	1.7	9.4	56.3	40.6	12.5	0.0	15.6	21.9	9.4	3.2	0.9
Grant County	1.4	36.0	47.4	51.8	8.8	0.0	23.7	15.8	0.0	2.8	1.0
Harney County	2.1	10.9	44.2	35.3	19.9	0.0	30.8	14.1	0.0	6.0	1.5
Hood River County	16.4	46.1	18.4	86.4	4.7	0.2	4.9	3.5	0.3	24.7	15.4
Jackson County	4.9	36.4	38.8	56.5	12.7	0.5	20.5	8.5	1.3	7.7	3.2
Jefferson County	9.9	41.0	21.5	86.5	6.4	0.7	3.7	2.3	0.4	19.0	9.3
Josephine County	3.1	20.1	57.8	27.3	13.8	0.6	38.4	18.9	0.9	4.8	1.4
Klamath County	4.8	38.1	40.8	60.0	11.6	1.0	18.0	8.4	1.0	8.1	3.4
Lake County	3.4	42.8	38.4	50.0	21.2	0.0	22.8	5.2	0.8	4.8	2.9
Lane County	4.9	47.3	38.1	32.5	31.4	1.6	21.3	10.9	2.2	7.9	2.9
Lincoln County	4.2	46.7	35.5	49.4	12.6	1.8	22.7	10.2	3.2	5.7	2.8
Linn County	3.5	39.9	43.7	46.1	16.8	0.7	25.3	9.9	1.3	5.9	2.5
Malheur County	8.2	44.8	28.5	86.8	4.5	0.0	5.1	3.3	0.3	21.1	8.8
Marion County	12.6	53.0	25.5	69.4	13.0	0.6	12.2	3.5	1.3	19.5	11.1
Morrow County	14.5	51.6	17.1	93.0	3.6	0.0	2.1	1.1	0.2	23.3	13.6
Multnomah County	12.7	55.1	34.5	30.6	34.9	3.1	24.1	4.8	2.4	16.6	8.9
Polk County	6.5	47.0	30.5	60.5	13.2	1.1	16.6	7.7	0.9	10.0	5.0
Sherman County	2.5	52.1	14.6	77.1	12.5	0.0	10.4	0.0	0.0	8.0	2.9
Tillamook County	4.2	49.7	34.0	54.9	11.7	1.1	17.4	12.3	2.6	6.3	2.7
Umatilla County	8.4	43.6	26.9	84.8	6.8	0.2	4.2	3.6	0.4	16.2	7.8
Union County	2.7	49.8	35.9	28.1	26.0	2.1	16.5	13.9	13.4	4.5	1.6
Wallowa County	0.8	11.5	50.8	18.0	8.2	0.0	37.7	34.4	1.6	2.5	0.8
Wasco County	6.2	37.1	37.2	72.1	10.2	1.0	10.1	5.1	1.6	10.5	5.2
Washington County	14.2	53.1	32.1	42.9	37.6	1.4	12.9	4.3	0.9	18.6	9.2
Wheeler County	2.1	37.5	18.8	46.9	0.0	0.0	46.9	6.3	0.0	4.2	1.9
Yamhill County	7.6	54.7	26.2	76.2	7.9	0.1	9.7	5.6	0.4	11.2	5.6

2004 Ratio of Primary Care Providers (MD/DO & NP & PA) to the Population



Source: MD/DO, NP, & PA Surveys DHS Office of Health Systems Planning; US Census Bureau

2004 Ratio of Primary Care Providers (MD/DO & NP & PA) to the Population



Data Source: MD/DO, NP, &PA survey DHS Office of Health Systems Planning; US Census Bureau

But do we know how much capacity we have?

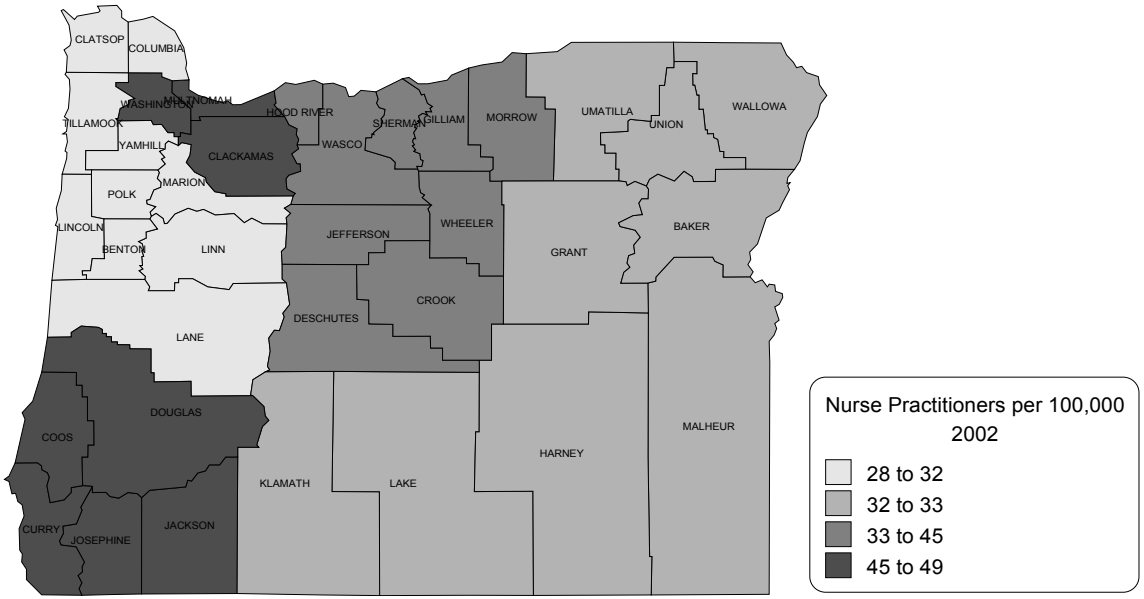
The descriptive data:

- Population to Primary Care Physician Ratio
- Population to Nurse Practitioner Ratios

Crude proxy for capacity.

Using survey data, the Office for Health Systems Planning develops estimates of primary care FTE for the general population and the low-income population. Based on imputation of self-reported time spent on direct patient care for both general population and low-income population.

Nurse Practitioners per 100,000*



Estimates less well defined for nurse practitioners. Do not know to what extent the available work force provides access to low-income and/or uninsured. Data show 19% with public or community clinic as their primary setting.

- Estimated number of practicing NPs per 100,000 Oregonians: 39.9
- Estimated number of practicing NPs per 100,000 Oregon residents living in urban areas: 43.1
- Estimated number of practicing NPs per 100,000 Oregon residents living in rural areas: 30.8

*Nurse Practitioner Workforce 2002: A Sourcebook, Oregon Health & Science University, Area Health Education Centers Program, Oregon Health Workforce Project.

Capacity: The Data

Capacity: Health Care Delivery System

Area	Medicare Managed Care Pene-tration (%)	Primary Care Provider Supply per 100,000				Supply/Utilzation per 1,000		
		Primary Care Physician* FTE per 100,000 population 2004	Primary Care Physician FTE per 100,000 Low-Income (<200% fpl) population 2004	Population to PCP ratio for low-income population (<200% fpl) 2004	Nurse Practitioners per 100,000 2002	Inpatient Beds	Admissions	Emergency Department Visits
Oregon	36.2	74.2	40.0	460.2	39.9	1.86	95	280
Baker County	1.1	62.1	30.2	3305.2	32.7	2.15	90	314
Benton County	42.3	86.6	39.3	2546.3	28.7	1.90	95	231
Clackamas County	55.3	65.5	46.0	2173.1	48.5	1.33	93	294
Clatsop County	22.7	81.7	54.8	1825.1	27.7	1.75	99	559
Columbia County	51.1	24.7	16.4	6115.4	27.7	No Hosp	No Hosp	No Hosp
Coos County	0.8	81.7	37.3	2683.6	44.8	2.40	133	219
Crook County	17.5	33.7	14.6	6875.5	33.2	1.68	55	320
Curry County	5.5	75.5	38.7	2585.3	44.8	1.16	26	89
Deschutes County	16.0	71.8	38.2	2617.8	33.2	2.00	109	276
Douglas County	16.5	67.9	31.6	3159.6	44.8	2.69	95	297
Gilliam County	1.4	0.0	0.0	10001	37.5	No Hosp	No Hosp	No Hosp
Grant County	8.7	63.7	39.0	2574.7	32.7	2.73	61	410
Harney County	11.2	68.5	41.7	2399.7	32.7	5.75	86	287
Hood River County	2.0	119.7	56.0	1784.6	37.5	1.52	74	368
Jackson County	31.6	72.8	34.3	2912.9	44.8	2.44	110	297
Jefferson County	15.7	42.7	29.7	3364.5	33.2	2.02	47	343
Josephine County	27.8	76.4	40.9	2445	44.8	0.95	89	379
Klamath County	1.3	78.5	41.3	2418.8	31.7	2.15	108	248
Lake County	2.8	63.1	41.9	2386.6	31.7	2.72	47	305
Lane County	43.0	69.2	29.0	3445.2	28.7	1.67	87	256
Lincoln County	3.1	68.4	43.6	2295.4	28.7	1.67	76	464
Linn County	40.7	66.4	39.8	2514.5	28.7	1.09	59	324
Malheur County	0.7	68.7	40.0	2500.2	32.7	2.42	122	606
Marion County	46.2	65.9	33.9	2952.8	28.7	1.71	74	273
Morrow County	1.5	20.6	8.5	11871.1	33.2	1.12	10	73
Multnomah County	53.0	97.9	50.4	1985.7	48.5	2.90	144	315
Polk County	43.5	42.6	23.3	4288.3	28.7	0.62	20	135
Sherman County	1.9	52.6	31.6	3168.3	37.5	No Hosp	No Hosp	No Hosp
Tillamook County	16.0	55.5	30.7	3255.4	27.7	1.25	57	372
Umatilla County	2.7	63.7	41.0	2435.8	32.7	1.36	67	364
Union County	4.6	71.1	48.7	2052.9	32.7	1.99	74	360
Wallowa County	0.4	73.7	25.5	3950.2	32.7	3.26	88	319
Wasco County	2.7	73.5	28.0	3568.9	37.5	2.14	123	586
Washington County	51.6	72.6	49.9	2002.9	48.5	1.17	78	171
Wheeler County	6.8	9.7	4.3	25626.9	37.5	No Hosp	No Hosp	No Hosp
Yamhill County	44.8	68.8	42.3	2366.5	28.7	1.22	62	301

*Primary care physicians include family practice, general practice, internal medicine, ob/gyn, and pediatrics.

Utilization and Capacity Data – The Gaps

Oregon Community Health Information Network (OCHIN) data: Unduplicated utilization and population demographics representing 70% FQHCs; 50% School based health clinics. Ability to determine appointment capacity and booking utilization for partner organizations.

Oregon Primary Care Association (OPCA): Comprehensive data for FQHCs. UDS data for utilization.

Department of Human Services School Based Health Clinic Program Office: Information about SBHC population and services offered.

Local Health Departments: Utilization data available at individual health departments.

Community Mental Health Centers: Comprehensive utilization data available through Oregon Mental Health and Addiction Services.

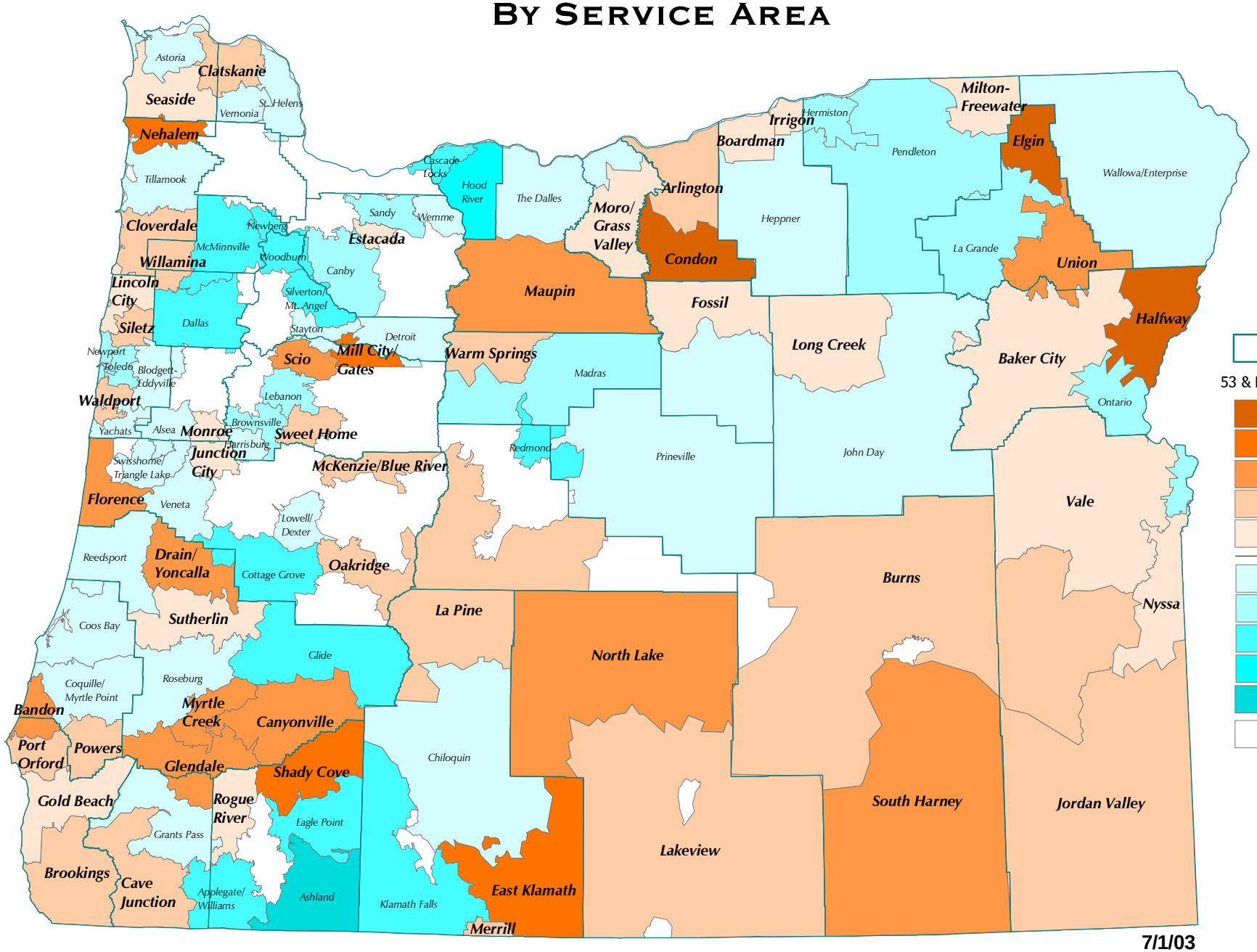
Inconsistent data about utilization of enabling services.

Very little data for Rural Health Clinics

No comprehensive source for data regarding financial stability of the safety net.

Office of Rural Health
Primary Care Service Areas

2003-2004 Oregon Rural Unmet Healthcare Need By Service Area



OREGON OFFICE OF RURAL HEALTH

Appendix D

OREGON OFFICE OF RURAL HEALTH

GEOGRAPHY

County: Tillamook

Major Town: Tillamook

Zip Codes: 97107, 97118, 97134, 97136, 97141, 97143

Major Geographic Features: Mountains: 1,600 feet; Bay; Ocean; Five rivers

Elevation: 22

TRANSPORTATION

Miles from Tillamook	to:	TYPE OF ROAD
Nearest Larger Town:	Lincoln City	39 — Primary
County Seat:	Tillamook	0 — n/a
Nearest Hospital:	Tillamook	0 — n/a

Special Transportation Barriers: Mountains, Traffic congestion due to tourists

Systems: Tillamook County Transportation; Dial-a-ride for seniors and disabled

WEATHER

Climate Zone: The Coast, Coastal Range

Average Temperature (Winter): 42

Average Temperature (Summer): 58

DEMOGRAPHY (Claritas)

	Population	% Change
1980	15,463	n/a
1990	15,389	-0.5%
2003	17,794	15.6%
2008	18,627	4.7%

CHANGE FROM 1990 TO 2003

Age	1990 Pop.	2003 Pop.	% Change
0-14	3,145	3,146	0.0%
15-44	5,794	6,419	10.8%
45-64	3,419	4,881	42.8%
65+	3,031	3,348	10.5%
Total	15,389	17,794	15.6%

DEMOGRAPHY (continued)

2003 POPULATION BREAKDOWN BY AGE

Age	Service Area				OREGON			
	Male	Female	Total	Percent	Male	Female	Total	Percent
0-14	1,667	1,479	3,146	17.7%	363,040	348,843	711,883	20.0%
15-20	812	718	1,530	8.6%	153,386	144,820	298,206	8.4%
21-24	431	312	743	4.2%	101,666	93,896	195,562	5.5%
25-34	999	830	1,829	10.3%	244,262	228,094	472,356	13.3%
35-44	1,211	1,106	2,317	13.0%	257,420	253,150	510,570	14.4%
45-64	2,425	2,456	4,881	27.4%	446,250	458,783	905,033	25.5%
65-74	837	887	1,724	9.7%	103,199	118,661	221,860	6.2%
75-84	545	648	1,193	6.7%	69,188	98,915	168,103	4.7%
85+	136	295	431	2.4%	22,871	48,565	71,436	2.0%
Total	9,063	8,731	17,794	100.0%	1,761,282	1,793,727	3,555,009	100.0%

OTHER POPULATION CHARACTERISTICS (2003)

	Service Area	Oregon
Hispanic (all, including other and 2 or more, races)	6.7%	8.6%
Asian/Pacific Islander only (non-Hispanic)	0.9%	3.3%
African-American only (non-Hispanic)	0.3%	1.6%
Native American only (non-Hispanic)	1.3%	1.2%
Other, including 2 or more races (non-Hispanic)	1.8%	2.6%
Average Household Size	2.3	2.5
Median Age	44.8	40.0

SOCIOECONOMICS (2000 Census)

	Service Area	County	Oregon
Percent of Population below Poverty Level ($14,675 per year for family of 3 in 2003)	12.0%	11.4%	11.6%
Percent of Population below 200% of Poverty Level	35.6%	34.5%	29.6%
Single Moms w/Children as Percent of Families:	7.7%	6.7%	9.0%
Percent Renter-Occupied Units	31.8%	28.1%	35.7%
Percent of Population 16-64 with Disability and:	21.9%	23.2%	17.4%
Unable to Work	39.5%	40.3%	42.7%
Percent of Households receiving Public Assistance:	3.4%	7.5%	3.6%
Percent of Population 25 and Over without High School Diploma	15.9%	15.9%	14.9%
Percent Population Over 5 who Speak English Less than "very well"	2.8%	2.7%	5.9%
Median Household Income in 1999	$30,405	$34,269	$37,938

SOCIOECONOMICS (various)

	County	Oregon
Receiving Temporary Assistance for Needy Families (4/03)	1.0%	1.2%
Medicaid Eligibles (5/03)	11.4%	11.8%
Children Eligible for Free/Reduced Lunch (03-04 School Yr)	47.5%	40.6%
Receiving Food Stamps (4/03)	10.2%	11.7%
Government Employees as % of Total Employment (4/03)	23.9%	17.8%
Without Health Insurance (2002)	12.9%	14.0%

County Per Capita Income, 2002	$25,734
Rank Among All Oregon Counties	10 of 36
County Median Family Income, 2004	$48,500
Rank Among All Oregon Counties	20 of 36

AVERAGE ANNUAL UNEMPLOYMENT RATES

	County	Oregon	U.S.
1990	5.9 %	5.5 %	5.6 %
2000	4.4 %	4.9 %	4 %
2003	6.6 %	8.2 %	6 %

VITAL STATISTICS (Health Division)

Maternity Characteristics		1998-2002 (Average per year--rates are per 1000 births)						
		TOTAL	Race					Ethnicity
			White	Black	NatAm	Asian	Other	Hispanic
SERVICE AREA	Total Average Births	175	169	1	3	2	0	27
	Low Birth Weight Rate	55.9	56.7	0.0	0.0	90.9	0.0	30.1
	Inadequate Prenatal Care Rate	38.8	36.6	0.0	133.3	90.9		60.2
	Infant Mortality Rate	8.0	8.3	0.0	0.0	0.0	0	0.0
	Teen Birth Rate	146.0	146	0	200	91		180
OREGON	Total Average Births	45,343	41268	948	755	2225	21	7350
	Low Birth Weight Rate	55.6	53.8	102.5	67.6	61.3		55.4
	Inadequate Prenatal Care Rate	53.1	51.4	63.9	113.4	54.8		91.2
	Infant Mortality Rate	5.6	5.5	11.8	8.7	2.5		6.0
	Teen Birth Rate	112	111	189	202	30		162

VITAL STATISTICS (Health Division--continued)

MORTALITY FIGURES (rates are per 100,000 persons)

CAUSE-SPECIFIC DEATH RATES (Average per year 99-02):

	Service Area	OR
Heart Disease:	276.8	201.7
Cancer:	247.3	198.4
Cerebrovascular Disease	91.3	74.7
Chronic Lower Respiratory Disease	102.6	49.5
Unintended Injuries:	47.8	35.1
Alzheimer's:	22.5	27.7
Diabetes:	37.9	26.5
Flu and Pneumonia:	19.7	18.0
Suicide:	16.9	14.4
Alcohol Induced:	22.5	11.0

TOP 10 CAUSES OF DEATH IN COUNTY (2002):

1. Heart Disease
2. Cancer
3. Chronic Lower Respiratory Disease
4. Unintended Injuries
5. Cerebrovascular Disease
6. Diabetes Mellitus
7. Alzheimer's Disease
8. Alcohol Induced
9. Hypertension
10. Flu and Pneumonia

	Service Area	County	Oregon
Age-adjusted Death Rate, (Average per year 99-01)	866.4	839.5	834.7
Comparative Mortality Figure, (Average per year 99-01)	1.3	1.4	1.0
Years of Life Lost Index, (Average per year 99-01)	1.2	1.2	1.0
Percent of Preventable Hospitalizations (00-02): (COMPdata)	7.24%		4.82%

HEALTH RISK FACTORS (1997, 2000-2001 BRFSS)

	County 97	County 01	Oregon 01
% of Adults who Currently Smoke Cigarettes	20%	23%	21%
% of Adults who Meet Recommended Activity Levels	42%	50%	40%
% of Adults Overweight		40%	37%
% of Adults Obese	20%	20%	20%
% of Adults who Eat 5 Fruits and Vegetables Daily	34%	27%	25%
Had Cholesterol Check Within 5 Yrs (18+ yrs old)	75%	92%	92%
Had Mammogram Within Past 2 Yrs (F 40+ only)	70%	75%	85%
Had PAP Test Within Past 3 Yrs (F 18+ only)	73%	73%	85%

HEALTH CARE RESOURCES

PRACTITIONERS IN SERVICE AREA

Primary Care Practitioners	Licensed
Family Practitioners	6
General Practitioners	0
Obstetricians/Gynecologists	2
General Internists	5
Pediatricians	0
Specialists	
General Surgeons	3
Other Surgeons	0
Other Practitioners	
Certified Nurse Midwives	0
Nurse Practitioners	5
Dentists	10
Physician Assistants	0
Registered Nurses	119
Pharmacists	9
Dental Hygenists	7
Chiropractors	4
Naturopaths	0
Direct Entry Midwife	0
Optometrists	7
Nurse Anesthetists	1
School Guidance Counselors	5
Psychiatrists	1
Psychologists	3
Licensed Social Worker	9
Family Counselor	3
Drug/Alcohol Counselor	7
Total Practitioners	206

SUPPLY AND DEMAND FOR PRIMARY CARE VISITS IN SERVICE AREA

Number of Persons Per Primary Care Provider: 1,369

Number of Visits Accommodated by:

Primary Care Physicians:	53,450
PA/NP:	12,750
Total:	66,200

Number of Primary Care Visits Needed by 2003 Population: 49,727

HEALTH CARE RESOURCES (continued)

CLINICS IN SERVICE AREA

	Number
Rural Health Clinics (RHC):	1
Federally Qualified Health Clinics (FQHC):	2
School-Based Clinics:	0

HOSPITALS IN SERVICE AREA (2001)

Name:	Tillamook County General Hospital
# of Staffed Beds:	30
Type:	A
Trauma Designation:	Level III
Other Designation:	
% Medicare Discharges:	51.6
% Medicaid Discharges:	8.2
Net Patient Revenue:	$24,814,865
# of Employees :	227

DESIGNATIONS OF SHORTAGE BY SERVICE AREA

Health Professional Shortage Area (HPSA)	
1. Geographic	No
2. Population	Yes
3. Mental Health	Yes
4. Dental	Yes
Medically Underserved Area (MUA)	Yes
Population (MUP)	No
Office of Rural Health Unmet Need Area	No

This report has been prepared by the Oregon Office of Rural Health at Oregon Health and Science University.

Printed on 6/7/2004

Additional information, maps, and lists are available at:
www.ohsu.edu/oregonruralhealth/what is rural.html

For questions, comments, or sources, please contact Emerson Ong at: onge@ohsu.edu

OREGON OFFICE OF RURAL HEALTH

GEOGRAPHY

County: Crook

Major Town: Prineville

Zip Codes: 97750, 97751, 97752, 97754

Major Geographic Features: Mountains: 6,900 feet; Two rivers; Lake; Two reservoirs

Elevation: 2952

TRANSPORTATION

Miles from Prineville to:		TYPE OF ROAD
Nearest Larger Town:	Redmond	19 — Primary
County Seat:	Prineville	0 — n/a
Nearest Hospital:	Prineville	0 — n/a

Special Transportation Barriers: Mountains, Gravel Roads, Unimproved Roads

Systems: Amtrak; Greyhound; dial-a-ride for seniors and disabled and fixed bus route to Bend

WEATHER

Climate Zone: The Cascades, The Northeastern Highlands

Average Temperature (Winter): 32

Average Temperature (Summer): 65

DEMOGRAPHY (Claritas)

	Population	% Change
1980	11,742	n/a
1990	13,388	14.0%
2003	19,129	42.9%
2008	21,316	11.4%

CHANGE FROM 1990 TO 2003

Age	1990 Pop.	2003 Pop.	% Change
0-14	3,052	4,020	31.7%
15-44	5,453	7,209	32.2%
45-64	2,700	4,902	81.6%
65+	2,183	2,998	37.3%
Total	13,388	19,129	42.9%

DEMOGRAPHY (continued)

2003 POPULATION BREAKDOWN BY AGE

Age	Service Area				OREGON			
	Male	Female	Total	Percent	Male	Female	Total	Percent
0-14	2,042	1,978	4,020	21.0%	363,040	348,843	711,883	20.0%
15-20	1,002	791	1,793	9.4%	153,386	144,820	298,206	8.4%
21-24	455	403	858	4.5%	101,666	93,896	195,562	5.5%
25-34	1,056	1,053	2,109	11.0%	244,262	228,094	472,356	13.3%
35-44	1,199	1,250	2,449	12.8%	257,420	253,150	510,570	14.4%
45-64	2,480	2,422	4,902	25.6%	446,250	458,783	905,033	25.5%
65-74	752	846	1,598	8.4%	103,199	118,661	221,860	6.2%
75-84	443	553	996	5.2%	69,188	98,915	168,103	4.7%
85+	143	261	404	2.1%	22,871	48,565	71,436	2.0%
Total	9,572	9,557	19,129	100.0%	1,761,282	1,793,727	3,555,009	100.0%

OTHER POPULATION CHARACTERISTICS (2003)

	Service Area	Oregon
Hispanic (all, including other and 2 or more, races)	6.2%	8.6%
Asian/Pacific Islander only (non-Hispanic)	0.5%	3.3%
African-American only (non-Hispanic)	0.1%	1.6%
Native American only (non-Hispanic)	1.2%	1.2%
Other, including 2 or more races (non-Hispanic)	1.3%	2.6%
Average Household Size	2.6	2.5
Median Age	40.8	40.0

SOCIOECONOMICS (2000 Census)

	Service Area	County	Oregon
Percent of Population below Poverty Level ($14,675 per year for family of 3 in 2003)	12.1%	11.3%	11.6%
Percent of Population below 200% of Poverty Level	38.6%	35.7%	29.6%
Single Moms w/Children as Percent of Families:	7.4%	6.9%	9.0%
Percent Renter-Occupied Units	27.5%	25.8%	35.7%
Percent of Population 16-64 with Disability and:	21.7%	21.0%	17.4%
Unable to Work	47.0%	45.6%	42.7%
Percent of Households receiving Public Assistance:	4.9%	15.0%	3.6%
Percent of Population 25 and Over without High School Diploma	21.1%	19.5%	14.9%
Percent Population Over 5 who Speak English Less than "very well"	2.9%	2.8%	5.9%
Median Household Income in 1999	$32,297	$35,186	$37,938

SOCIOECONOMICS (various)

	County	Oregon
Receiving Temporary Assistance for Needy Families (4/03)	0.7%	1.2%
Medicaid Eligibles (5/03)	13.2%	11.8%
Children Eligible for Free/Reduced Lunch (03-04 School Yr)	48.4%	40.6%
Receiving Food Stamps (4/03)	12.9%	11.7%
Government Employees as % of Total Employment (4/03)	20.1%	17.8%
Without Health Insurance (2002)	14.5%	14.0%

County Per Capita Income, 2002	$21,859
Rank Among All Oregon Counties	28 of 36
County Median Family Income, 2004	$47,900
Rank Among All Oregon Counties	21 of 36

AVERAGE ANNUAL UNEMPLOYMENT RATES

	County	Oregon	U.S.
1990	7 %	5.5 %	5.6 %
2000	8.4 %	4.9 %	4 %
2003	10.8 %	8.2 %	6 %

VITAL STATISTICS (Health Division)

Maternity Characteristics		1998-2002 (Average per year--rates are per 1000 births)						
		TOTAL	Race					Ethnicity
			White	Black	NatAm	Asian	Other	Hispanic
SERVICE AREA	Total Average Births	213	206	0	6	1	0	20
	Low Birth Weight Rate	63.9	64.2	0.0	66.7	0.0	0.0	81.6
	Inadequate Prenatal Care Rate	25.4	26.3	0.0	0.0	0.0		40.8
	Infant Mortality Rate	11.3	11.7	0.0	0.0	0.0	0	20.4
	Teen Birth Rate	151.3	151	0	200	0		184
OREGON	Total Average Births	45,343	41268	948	755	2225	21	7350
	Low Birth Weight Rate	55.6	53.8	102.5	67.6	61.3		55.4
	Inadequate Prenatal Care Rate	53.1	51.4	63.9	113.4	54.8		91.2
	Infant Mortality Rate	5.6	5.5	11.8	8.7	2.5		6.0
	Teen Birth Rate	112	111	189	202	30		162

VITAL STATISTICS (Health Division--continued)

MORTALITY FIGURES (rates are per 100,000 persons)

CAUSE-SPECIFIC DEATH RATES (Average per year 99-02):

	Service Area	OR
Heart Disease:	241.8	201.7
Cancer:	205.2	198.4
Cerebrovascular Disease	54.9	74.7
Chronic Lower Respiratory Disease	70.6	49.5
Unintended Injuries:	36.6	35.1
Alzheimer's:	20.9	27.7
Diabetes:	24.8	26.5
Flu and Pneumonia:	9.1	18.0
Suicide:	13.1	14.4
Alcohol Induced:	6.5	11.0

TOP 10 CAUSES OF DEATH IN COUNTY (2002):

1. Heart Disease
2. Cancer
3. Arteriosclerosis
4. Chronic Lower Respiratory Disease
5. Cerebrovascular Disease
6. Unintended Injuries
7. Congenital Anomalies
8. Diabetes Mellitus
9. Hypertension
10. Alzheimer's

	Service Area	County	Oregon
Age-adjusted Death Rate, (Average per year 99-01)	863.5	863.2	834.7
Comparative Mortality Figure, (Average per year 99-01)	1.1	1.1	1.0
Years of Life Lost Index, (Average per year 99-01)	1.2	1.2	1.0
Percent of Preventable Hospitalizations (00-02): (COMPdata)	6.73%		4.82%

HEALTH RISK FACTORS (1997, 2000-2001 BRFSS)

	County 97	County 01	Oregon 01
% of Adults who Currently Smoke Cigarettes	29%	23%	21%
% of Adults who Meet Recommended Activity Levels	26%	46%	40%
% of Adults Overweight		41%	37%
% of Adults Obese	14%	20%	20%
% of Adults who Eat 5 Fruits and Vegetables Daily	24%	23%	25%
Had Cholesterol Check Within 5 Yrs (18+ yrs old)	64%	88%	92%
Had Mammogram Within Past 2 Yrs (F 40+ only)	62%	78%	85%
Had PAP Test Within Past 3 Yrs (F 18+ only)	68%	79%	85%

HEALTH CARE RESOURCES

PRACTITIONERS IN SERVICE AREA

Primary Care Practitioners	Licensed
Family Practitioners	9
General Practitioners	0
Obstetricians/Gynecologists	0
General Internists	1
Pediatricians	0
Specialists	
General Surgeons	2
Other Surgeons	0
Other Practitioners	
Certified Nurse Midwives	0
Nurse Practitioners	1
Dentists	6
Physician Assistants	3
Registered Nurses	81
Pharmacists	9
Dental Hygenists	6
Chiropractors	4
Naturopaths	0
Direct Entry Midwife	0
Optometrists	0
Nurse Anesthetists	3
School Guidance Counselors	5
Psychiatrists	0
Psychologists	0
Licensed Social Worker	1
Family Counselor	0
Drug/Alcohol Counselor	7
Total Practitioners	138

SUPPLY AND DEMAND FOR PRIMARY CARE VISITS IN SERVICE AREA

Number of Persons Per Primary Care Provider: 1,913

Number of Visits Accommodated by:

Primary Care Physicians:	47,350
PA/NP:	10,200
Total:	57,550

Number of Primary Care Visits Needed by 2003 Population: 50,968

HEALTH CARE RESOURCES (continued)

CLINICS IN SERVICE AREA

	Number
Rural Health Clinics (RHC):	
Federally Qualified Health Clinics (FQHC):	1
School-Based Clinics:	0

HOSPITALS IN SERVICE AREA (2001)

Name:	Pioneer Memorial Hospital Prineville
# of Staffed Beds:	35
Type:	CAH
Trauma Designation:	Level IV
Other Designation:	
% Medicare Discharges:	33.4
% Medicaid Discharges:	17.4
Net Patient Revenue:	$11,742,183
# of Employees :	117

DESIGNATIONS OF SHORTAGE BY SERVICE AREA

Health Professional Shortage Area (HPSA)	
1. Geographic	No
2. Population	Yes
3. Mental Health	Yes
4. Dental	No
Medically Underserved Area (MUA)	Yes
Population (MUP)	No
Office of Rural Health Unmet Need Area	No

This report has been prepared by the Oregon Office of Rural Health at Oregon Health and Science University.

Printed on 6/7/2004

Additional information, maps, and lists are available at:
www.ohsu.edu/oregonruralhealth/what is rural.html

For questions, comments, or sources, please contact Emerson Ong at: onge@ohsu.edu

OREGON OFFICE OF RURAL HEALTH

GEOGRAPHY

County: Baker

Major Town: Halfway

Zip Codes: 97834, 97840, 97870

Major Geographic Features: Mountains: 6,300 feet; Two Rivers; Lake; Flats

Elevation: 2660

TRANSPORTATION

Miles from Halfway	to:	TYPE OF ROAD
Nearest Larger Town:	Baker City	56 – Primary
County Seat:	Baker City	56 – Primary
Nearest Hospital:	Baker City	56 – Primary

Special Transportation Barriers: Mountains, Gravel Roads, Snow & Ice

Systems: Limited to fixed bus route between Halfway and Baker City for seniors only

WEATHER

Climate Zone: The Northeastern Highlands

Average Temperature (Winter): 25

Average Temperature (Summer): 67

DEMOGRAPHY (Claritas)

	Population	% Change
1980	1,855	n/a
1990	1,769	-4.6%
2003	1,859	5.1%
2008	1,866	0.4%

CHANGE FROM 1990 TO 2003

Age	1990 Pop.	2003 Pop.	% Change
0-14	387	270	-30.2%
15-44	577	530	-8.1%
45-64	445	637	43.1%
65+	360	422	17.2%
Total	1,769	1,859	5.1%

DEMOGRAPHY (continued)

2003 POPULATION BREAKDOWN BY AGE

Age	Service Area				OREGON			
	Male	Female	Total	Percent	Male	Female	Total	Percent
0-14	138	132	270	14.5%	363,040	348,843	711,883	20.0%
15-20	106	88	194	10.4%	153,386	144,820	298,206	8.4%
21-24	29	24	53	2.9%	101,666	93,896	195,562	5.5%
25-34	45	44	89	4.8%	244,262	228,094	472,356	13.3%
35-44	90	104	194	10.4%	257,420	253,150	510,570	14.4%
45-64	315	322	637	34.3%	446,250	458,783	905,033	25.5%
65-74	110	95	205	11.0%	103,199	118,661	221,860	6.2%
75-84	69	88	157	8.4%	69,188	98,915	168,103	4.7%
85+	21	39	60	3.2%	22,871	48,565	71,436	2.0%
Total	923	936	1,859	100.0%	1,761,282	1,793,727	3,555,009	100.0%

OTHER POPULATION CHARACTERISTICS (2003)

	Service Area	Oregon
Hispanic (all, including other and 2 or more, races)	1.7%	8.6%
Asian/Pacific Islander only (non-Hispanic)	0.2%	3.3%
African-American only (non-Hispanic)	0.1%	1.6%
Native American only (non-Hispanic)	1.6%	1.2%
Other, including 2 or more races (non-Hispanic)	1.2%	2.6%
Average Household Size	2.2	2.5
Median Age	49.1	40.0

SOCIOECONOMICS (2000 Census)

	Service Area	County	Oregon
Percent of Population below Poverty Level ($14,675 per year for family of 3 in 2003)	15.8%	14.7%	11.6%
Percent of Population below 200% of Poverty Level	43.2%	42.1%	29.6%
Single Moms w/Children as Percent of Families:	6.5%	7.2%	9.0%
Percent Renter-Occupied Units	28.6%	30.0%	35.7%
Percent of Population 16-64 with Disability and:	18.0%	20.6%	17.4%
Unable to Work	52.1%	52.8%	42.7%
Percent of Households receiving Public Assistance:	4.0%	7.2%	3.6%
Percent of Population 25 and Over without High School Diploma	16.3%	19.7%	14.9%
Percent Population Over 5 who Speak English Less than "very well"	0.4%	1.7%	5.9%
Median Household Income in 1999	$26,945	$30,367	$37,938

SOCIOECONOMICS (various)

	County	Oregon
Receiving Temporary Assistance for Needy Families (4/03)	1.4%	1.2%
Medicaid Eligibles (5/03)	13.2%	11.8%
Children Eligible for Free/Reduced Lunch (03-04 School Yr)	46.6%	40.6%
Receiving Food Stamps (4/03)	13.5%	11.7%
Government Employees as % of Total Employment (4/03)	25.3%	17.8%
Without Health Insurance (2002)	16.5%	14.0%

County Per Capita Income, 2002	$21,424
Rank Among All Oregon Counties	30 of 36
County Median Family Income, 2004	$43,300
Rank Among All Oregon Counties	29 of 36

AVERAGE ANNUAL UNEMPLOYMENT RATES

	County	Oregon	U.S.
1990	7.4 %	5.5 %	5.6 %
2000	7.3 %	4.9 %	4 %
2003	9.5 %	8.2 %	6 %

VITAL STATISTICS (Health Division)

Maternity Characteristics		1998-2002 (Average per year--rates are per 1000 births)						
		TOTAL	Race					Ethnicity
			White	Black	NatAm	Asian	Other	Hispanic
SERVICE AREA	Total Average Births	9	9	0	0	0	0	0
	Low Birth Weight Rate	23.3	23.3	0.0	0.0	0.0	0.0	0.0
	Inadequate Prenatal Care Rate	23.3	23.3	0.0	0.0	0.0		0.0
	Infant Mortality Rate	0.0	0.0	0.0	0.0	0.0	0	0.0
	Teen Birth Rate	162.8	163	0	0	0		0
OREGON	Total Average Births	45,343	41268	948	755	2225	21	7350
	Low Birth Weight Rate	55.6	53.8	102.5	67.6	61.3		55.4
	Inadequate Prenatal Care Rate	53.1	51.4	63.9	113.4	54.8		91.2
	Infant Mortality Rate	5.6	5.5	11.8	8.7	2.5		6.0
	Teen Birth Rate	112	111	189	202	30		162

VITAL STATISTICS (Health Division--continued)

MORTALITY FIGURES (rates are per 100,000 persons)

CAUSE-SPECIFIC DEATH RATES (Average per year 99-02):

	Service Area	OR
Heart Disease:	363.1	201.7
Cancer:	242.1	198.4
Cerebrovascular Disease	107.6	74.7
Chronic Lower Respiratory Disease	40.3	49.5
Unintended Injuries:	40.3	35.1
Alzheimer's:	13.4	27.7
Diabetes:	40.3	26.5
Flu and Pneumonia:	26.9	18.0
Suicide:	53.8	14.4
Alcohol Induced:	26.9	11.0

TOP 10 CAUSES OF DEATH IN COUNTY (2002):

1. Cancer
2. Heart Disease
3. Cerebrovascular Disease
4. Chronic Lower Respiratory Disease
5. Unintended Injuries
6. Influenza and Pneumonia
7. Diabetes Mellitus
8. Alzheimer's Disease
9. Alcohol Induced
10. Suicide

	Service Area	County	Oregon
Age-adjusted Death Rate, (Average per year 99-01)	808.5	859.0	834.7
Comparative Mortality Figure, (Average per year 99-01)	1.5	1.5	1.0
Years of Life Lost Index, (Average per year 99-01)	0.8	1.4	1.0
Percent of Preventable Hospitalizations (00-02): (COMPdata)	9.70%		4.82%

HEALTH RISK FACTORS (1997, 2000-2001 BRFSS)

	County 97	County 01	Oregon 01
% of Adults who Currently Smoke Cigarettes	15%	22%	21%
% of Adults who Meet Recommended Activity Levels	18%	53%	40%
% of Adults Overweight		40%	37%
% of Adults Obese	16%	20%	20%
% of Adults who Eat 5 Fruits and Vegetables Daily	20%	18%	25%
Had Cholesterol Check Within 5 Yrs (18+ yrs old)		90%	92%
Had Mammogram Within Past 2 Yrs (F 40+ only)	73%	84%	85%
Had PAP Test Within Past 3 Yrs (F 18+ only)	71%	71%	85%

HEALTH CARE RESOURCES

PRACTITIONERS IN SERVICE AREA

Primary Care Practitioners	Licensed
Family Practitioners	0
General Practitioners	0
Obstetricians/Gynecologists	0
General Internists	0
Pediatricians	0
Specialists	
General Surgeons	0
Other Surgeons	0
Other Practitioners	
Certified Nurse Midwives	0
Nurse Practitioners	2
Dentists	0
Physician Assistants	1
Registered Nurses	9
Pharmacists	0
Dental Hygenists	0
Chiropractors	1
Naturopaths	0
Direct Entry Midwife	0
Optometrists	0
Nurse Anesthetists	0
School Guidance Counselors	1
Psychiatrists	0
Psychologists	0
Licensed Social Worker	1
Family Counselor	0
Drug/Alcohol Counselor	0
Total Practitioners	15

SUPPLY AND DEMAND FOR PRIMARY CARE VISITS IN SERVICE AREA

Number of Persons Per Primary Care Provider: 0

Number of Visits Accommodated by:

Primary Care Physicians:	0
PA/NP:	7,650
Total:	7,650

Number of Primary Care Visits Needed by 2003 Population: 5,607

HEALTH CARE RESOURCES (continued)

CLINICS IN SERVICE AREA

	Number
Rural Health Clinics (RHC):	
Federally Qualified Health Clinics (FQHC):	1
School-Based Clinics:	0

HOSPITALS IN SERVICE AREA (2001)

Name:
# of Staffed Beds:
Type:
Trauma Designation:
Other Designation:
% Medicare Discharges:
% Medicaid Discharges:
Net Patient Revenue:
# of Employees :

DESIGNATIONS OF SHORTAGE BY SERVICE AREA

Health Professional Shortage Area (HPSA)	
1. Geographic	Yes
2. Population	No
3. Mental Health	Yes
4. Dental	No
Medically Underserved Area (MUA)	Yes
Population (MUP)	No
Office of Rural Health Unmet Need Area	Yes

This report has been prepared by the Oregon Office of Rural Health at Oregon Health and Science University.

Printed on 6/7/2004

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For questions, comments, or sources, please contact Emerson Ong at: onge@ohsu.edu

OREGON OFFICE OF RURAL HEALTH

GEOGRAPHY

County: Curry

Major Town: Brookings

Zip Codes: 97415

Major Geographic Features: Mountains: 4,700 feet; Three rivers; Ocean

Elevation: 129

TRANSPORTATION

Miles from Brookings	to:	TYPE OF ROAD
Nearest Larger Town:	Gold Beach	29 — Primary
County Seat:	Gold Beach	29 — Primary
Nearest Hospital:	Gold Beach	29 — Primary

Special Transportation Barriers: Mountains, Fog, Gravel Roads

Systems: Greyhound; Limited to dial-a-ride for general public

WEATHER

Climate Zone: The Coast, Coastal Range

Average Temperature (Winter): 47

Average Temperature (Summer): 59

DEMOGRAPHY (Claritas)

	Population	% Change
1980	9,038	n/a
1990	11,665	29.1%
2003	13,930	19.4%
2008	14,880	6.8%

CHANGE FROM 1990 TO 2003

Age	1990 Pop.	2003 Pop.	% Change
0-14	2,044	2,091	2.3%
15-44	3,816	3,925	2.9%
45-64	2,715	3,851	41.8%
65+	3,090	4,063	31.5%
Total	11,665	13,930	19.4%

DEMOGRAPHY (continued)

2003 POPULATION BREAKDOWN BY AGE

Age	Service Area				OREGON			
	Male	Female	Total	Percent	Male	Female	Total	Percent
0-14	1,091	1,000	2,091	15.0%	363,040	348,843	711,883	20.0%
15-20	448	436	884	6.3%	153,386	144,820	298,206	8.4%
21-24	245	233	478	3.4%	101,666	93,896	195,562	5.5%
25-34	521	536	1,057	7.6%	244,262	228,094	472,356	13.3%
35-44	760	746	1,506	10.8%	257,420	253,150	510,570	14.4%
45-64	1,804	2,047	3,851	27.6%	446,250	458,783	905,033	25.5%
65-74	1,011	1,005	2,016	14.5%	103,199	118,661	221,860	6.2%
75-84	706	829	1,535	11.0%	69,188	98,915	168,103	4.7%
85+	206	306	512	3.7%	22,871	48,565	71,436	2.0%
Total	6,792	7,138	13,930	100.0%	1,761,282	1,793,727	3,555,009	100.0%

OTHER POPULATION CHARACTERISTICS (2003)

	Service Area	Oregon
Hispanic (all, including other and 2 or more, races)	4.2%	8.6%
Asian/Pacific Islander only (non-Hispanic)	0.9%	3.3%
African-American only (non-Hispanic)	0.2%	1.6%
Native American only (non-Hispanic)	2.2%	1.2%
Other, including 2 or more races (non-Hispanic)	2.8%	2.6%
Average Household Size	2.2	2.5
Median Age	49.7	40.0

SOCIOECONOMICS (2000 Census)

	Service Area	County	Oregon
Percent of Population below Poverty Level ($14,675 per year for family of 3 in 2003)	11.6%	12.2%	11.6%
Percent of Population below 200% of Poverty Level	36.1%	37.1%	29.6%
Single Moms w/Children as Percent of Families:	5.6%	6.4%	9.0%
Percent Renter-Occupied Units	28.5%	27.1%	35.7%
Percent of Population 16-64 with Disability and:	26.6%	26.8%	17.4%
Unable to Work	40.8%	42.7%	42.7%
Percent of Households receiving Public Assistance:	2.9%	11.8%	3.6%
Percent of Population 25 and Over without High School Diploma	19.7%	18.3%	14.9%
Percent Population Over 5 who Speak English Less than "very well"	0.8%	1.1%	5.9%
Median Household Income in 1999	$30,199	$30,117	$37,938

SOCIOECONOMICS (various)

	County	Oregon
Receiving Temporary Assistance for Needy Families (4/03)	1.2%	1.2%
Medicaid Eligibles (5/03)	12.2%	11.8%
Children Eligible for Free/Reduced Lunch (03-04 School Yr)	56.7%	40.6%
Receiving Food Stamps (4/03)	11.0%	11.7%
Government Employees as % of Total Employment (4/03)	20.5%	17.8%
Without Health Insurance (2002)	13.3%	14.0%

County Per Capita Income, 2002	$24,679
Rank Among All Oregon Counties	17 of 36
County Median Family Income, 2004	$42,300
Rank Among All Oregon Counties	34 of 36

AVERAGE ANNUAL UNEMPLOYMENT RATES

	County	Oregon	U.S.
1990	6.4 %	5.5 %	5.6 %
2000	6.3 %	4.9 %	4 %
2003	7.3 %	8.2 %	6 %

VITAL STATISTICS (Health Division)

Maternity Characteristics		1998-2002 (Average per year--rates are per 1000 births)						
		TOTAL	Race					Ethnicity
			White	Black	NatAm	Asian	Other	Hispanic
SERVICE AREA	Total Average Births	104	99	0	3	2	0	10
	Low Birth Weight Rate	48.1	48.6	0.0	0.0	125.0	0.0	20.8
	Inadequate Prenatal Care Rate	92.3	89.1	0.0	235.3	0.0		62.5
	Infant Mortality Rate	7.7	8.1	0.0	0.0	0.0	0	20.8
	Teen Birth Rate	146.2	140	0	353	125		146
OREGON	Total Average Births	45,343	41268	948	755	2225	21	7350
	Low Birth Weight Rate	55.6	53.8	102.5	67.6	61.3		55.4
	Inadequate Prenatal Care Rate	53.1	51.4	63.9	113.4	54.8		91.2
	Infant Mortality Rate	5.6	5.5	11.8	8.7	2.5		6.0
	Teen Birth Rate	112	111	189	202	30		162

VITAL STATISTICS (Health Division--continued)

MORTALITY FIGURES (rates are per 100,000 persons)

CAUSE-SPECIFIC DEATH RATES (Average per year 99-02):

	Service Area	OR
Heart Disease:	428.9	201.7
Cancer:	384.1	198.4
Cerebrovascular Disease	134.6	74.7
Chronic Lower Respiratory Disease	82.6	49.5
Unintended Injuries:	32.3	35.1
Alzheimer's:	66.4	27.7
Diabetes:	50.3	26.5
Flu and Pneumonia:	30.5	18.0
Suicide:	32.3	14.4
Alcohol Induced:	12.6	11.0

TOP 10 CAUSES OF DEATH IN COUNTY (2002):

1. Cancer
2. Heart Disease
3. Cerebrovascular Disease
4. Chronic Lower Respiratory Disease
5. Alzheimer's
6. Unintended Injuries
7. Suicide
8. Diabetes Mellitus
9. Parkinson's Disease
10. Flu and Pneumonia

	Service Area	County	Oregon
Age-adjusted Death Rate, (Average per year 99-01)	833.4	871.8	834.7
Comparative Mortality Figure, (Average per year 99-01)	1.8	1.8	1.0
Years of Life Lost Index, (Average per year 99-01)	1.0	1.1	1.0
Percent of Preventable Hospitalizations (00-02): (COMPdata)	4.78%		4.82%

HEALTH RISK FACTORS (1997, 2000-2001 BRFSS)

	County 97	County 01	Oregon 01
% of Adults who Currently Smoke Cigarettes	21%	20%	21%
% of Adults who Meet Recommended Activity Levels	16%	48%	40%
% of Adults Overweight		38%	37%
% of Adults Obese	15%	24%	20%
% of Adults who Eat 5 Fruits and Vegetables Daily	36%	29%	25%
Had Cholesterol Check Within 5 Yrs (18+ yrs old)	80%	94%	92%
Had Mammogram Within Past 2 Yrs (F 40+ only)	69%	76%	85%
Had PAP Test Within Past 3 Yrs (F 18+ only)	78%	70%	85%

HEALTH CARE RESOURCES

PRACTITIONERS IN SERVICE AREA

Primary Care Practitioners	Licensed
Family Practitioners	9
General Practitioners	0
Obstetricians/Gynecologists	0
General Internists	7
Pediatricians	0
Specialists	
General Surgeons	1
Other Surgeons	0
Other Practitioners	
Certified Nurse Midwives	0
Nurse Practitioners	7
Dentists	7
Physician Assistants	0
Registered Nurses	54
Pharmacists	8
Dental Hygenists	4
Chiropractors	5
Naturopaths	0
Direct Entry Midwife	0
Optometrists	2
Nurse Anesthetists	1
School Guidance Counselors	3
Psychiatrists	1
Psychologists	1
Licensed Social Worker	2
Family Counselor	1
Drug/Alcohol Counselor	4
Total Practitioners	117

SUPPLY AND DEMAND FOR PRIMARY CARE VISITS IN SERVICE AREA

Number of Persons Per Primary Care Provider: 871

Number of Visits Accommodated by:

Primary Care Physicians:	66,850
PA/NP:	17,850
Total:	84,700

Number of Primary Care Visits Needed by 2003 Population: 44,634

HEALTH CARE RESOURCES (continued)

CLINICS IN SERVICE AREA

	Number
Rural Health Clinics (RHC):	2
Federally Qualified Health Clinics (FQHC):	0
School-Based Clinics:	0

HOSPITALS IN SERVICE AREA (2001)

Name:
# of Staffed Beds:
Type:
Trauma Designation:
Other Designation:
% Medicare Discharges:
% Medicaid Discharges:
Net Patient Revenue:
# of Employees :

DESIGNATIONS OF SHORTAGE BY SERVICE AREA

Health Professional Shortage Area (HPSA)

1. Geographic	No
2. Population	Yes
3. Mental Health	Yes
4. Dental	No
Medically Underserved Area (MUA)	Yes
Population (MUP)	No
Office of Rural Health Unmet Need Area	Yes

This report has been prepared by the Oregon Office of Rural Health at Oregon Health and Science University.

Printed on 6/7/2004

Additional information, maps, and lists are available at:
www.ohsu.edu/oregonruralhealth/what is rural.html

For questions, comments, or sources, please contact Emerson Ong at: onge@ohsu.edu

OREGON OFFICE OF RURAL HEALTH

GEOGRAPHY

County: Klamath

Major Town: Klamath Falls

Zip Codes: 97601, 97603, 97625, 97627, 97634

Major Geographic Features: Mountains: 8,000 feet; Four lakes

Elevation: 4105

TRANSPORTATION

Miles from Klamath Falls to:		TYPE OF ROAD
Nearest Larger Town:	Medford	76 — Primary
County Seat:	Klamath Falls	0 — n/a
Nearest Hospital:	Klamath Falls	0 — n/a

Special Transportation Barriers:

Systems: Amtrak and Greyhound; bus route to Lakeview on Red Ball Stage Lines; Limited to dial-a-ride for seniors and disabled outside of Klamath Falls area

WEATHER

Climate Zone: The Cascades, High Plateau

Average Temperature (Winter): 21

Average Temperature (Summer): 82

DEMOGRAPHY (Claritas)

	Population	% Change
1980	47,841	n/a
1990	46,512	-2.8%
2003	52,888	13.7%
2008	55,171	4.3%

CHANGE FROM 1990 TO 2003

Age	1990 Pop.	2003 Pop.	% Change
0-14	10,086	11,027	9.3%
15-44	20,564	20,713	0.7%
45-64	9,106	13,329	46.4%
65+	6,756	7,819	15.7%
Total	46,512	52,888	13.7%

DEMOGRAPHY (continued)

2003 POPULATION BREAKDOWN BY AGE

Age	Service Area				OREGON			
	Male	Female	Total	Percent	Male	Female	Total	Percent
0-14	5,668	5,359	11,027	20.8%	363,040	348,843	711,883	20.0%
15-20	2,549	2,175	4,724	8.9%	153,386	144,820	298,206	8.4%
21-24	1,456	1,371	2,827	5.3%	101,666	93,896	195,562	5.5%
25-34	3,209	3,109	6,318	11.9%	244,262	228,094	472,356	13.3%
35-44	3,366	3,478	6,844	12.9%	257,420	253,150	510,570	14.4%
45-64	6,626	6,703	13,329	25.2%	446,250	458,783	905,033	25.5%
65-74	1,806	2,037	3,843	7.3%	103,199	118,661	221,860	6.2%
75-84	1,224	1,610	2,834	5.4%	69,188	98,915	168,103	4.7%
85+	404	738	1,142	2.2%	22,871	48,565	71,436	2.0%
Total	26,308	26,580	52,888	100.0%	1,761,282	1,793,727	3,555,009	100.0%

OTHER POPULATION CHARACTERISTICS (2003)

	Service Area	Oregon
Hispanic (all, including other and 2 or more, races)	7.8%	8.6%
Asian/Pacific Islander only (non-Hispanic)	1.0%	3.3%
African-American only (non-Hispanic)	0.6%	1.6%
Native American only (non-Hispanic)	3.3%	1.2%
Other, including 2 or more races (non-Hispanic)	2.8%	2.6%
Average Household Size	2.5	2.5
Median Age	38.8	40.0

SOCIOECONOMICS (2000 Census)

	Service Area	County	Oregon
Percent of Population below Poverty Level ($14,675 per year for family of 3 in 2003)	16.1%	16.8%	11.6%
Percent of Population below 200% of Poverty Level	39.0%	40.5%	29.6%
Single Moms w/Children as Percent of Families:	9.9%	9.1%	9.0%
Percent Renter-Occupied Units	34.1%	32.0%	35.7%
Percent of Population 16-64 with Disability and:	20.8%	21.6%	17.4%
Unable to Work	46.5%	49.5%	42.7%
Percent of Households receiving Public Assistance:	4.8%	12.1%	3.6%
Percent of Population 25 and Over without High School Diploma	16.9%	18.5%	14.9%
Percent Population Over 5 who Speak English Less than "very well"	3.0%	3.4%	5.9%
Median Household Income in 1999	$41,708	$31,537	$37,938

SOCIOECONOMICS (various)

	County	Oregon
Receiving Temporary Assistance for Needy Families (4/03)	0.8%	1.2%
Medicaid Eligibles (5/03)	16.3%	11.8%
Children Eligible for Free/Reduced Lunch (03-04 School Yr)	55.0%	40.6%
Receiving Food Stamps (4/03)	15.8%	11.7%
Government Employees as % of Total Employment (4/03)	26.2%	17.8%
Without Health Insurance (2002)	15.4%	14.0%

County Per Capita Income, 2002	$23,002
Rank Among All Oregon Counties	24 of 36
County Median Family Income, 2004	$46,300
Rank Among All Oregon Counties	24 of 36

AVERAGE ANNUAL UNEMPLOYMENT RATES

	County	Oregon	U.S.
1990	9.1 %	5.5 %	5.6 %
2000	8.1 %	4.9 %	4 %
2003	10.2 %	8.2 %	6 %

VITAL STATISTICS (Health Division)

Maternity Characteristics		1998-2002 (Average per year--rates are per 1000 births)						
		TOTAL	Race					Ethnicity
			White	Black	NatAm	Asian	Other	Hispanic
SERVICE AREA	Total Average Births	686	637	7	32	9	1	83
	Low Birth Weight Rate	56.0	53.4	114.3	81.3	44.4	0.0	45.6
	Inadequate Prenatal Care Rate	48.1	43.3	28.6	143.8	66.7		88.7
	Infant Mortality Rate	7.9	7.2	0.0	25.0	0.0	0	7.2
	Teen Birth Rate	158.6	158	229	200	44		201
OREGON	Total Average Births	45,343	41268	948	755	2225	21	7350
	Low Birth Weight Rate	55.6	53.8	102.5	67.6	61.3		55.4
	Inadequate Prenatal Care Rate	53.1	51.4	63.9	113.4	54.8		91.2
	Infant Mortality Rate	5.6	5.5	11.8	8.7	2.5		6.0
	Teen Birth Rate	112	111	189	202	30		162

VITAL STATISTICS (Health Division--continued)

MORTALITY FIGURES (rates are per 100,000 persons)

CAUSE-SPECIFIC DEATH RATES (Average per year 99-02):

	Service Area	OR
Heart Disease:	237.3	201.7
Cancer:	231.6	198.4
Cerebrovascular Disease	81.3	74.7
Chronic Lower Respiratory Disease	89.3	49.5
Unintended Injuries:	44.0	35.1
Alzheimer's:	33.6	27.7
Diabetes:	35.9	26.5
Flu and Pneumonia:	25.1	18.0
Suicide:	23.2	14.4
Alcohol Induced:	18.4	11.0

TOP 10 CAUSES OF DEATH IN COUNTY (2002):

1. Cancer
2. Heart Disease
3. Chronic Lower Respiratory Disease
4. Cerebrovascular Disease
5. Unintended Injuries
6. Diabetes Mellitus
7. Alzheimer's Disease
8. Hypertension
9. Influenza and Pneumonia
10. Alcohol Induced

	Service Area	County	Oregon
Age-adjusted Death Rate, (Average per year 99-01)	952.5	960.6	834.7
Comparative Mortality Figure, (Average per year 99-01)	1.2	1.2	1.0
Years of Life Lost Index, (Average per year 99-01)	1.2	1.2	1.0
Percent of Preventable Hospitalizations (00-02): (COMPdata)	5.49%		4.82%

HEALTH RISK FACTORS (1997, 2000-2001 BRFSS)

	County 97	County 01	Oregon 01
% of Adults who Currently Smoke Cigarettes	23%	20%	21%
% of Adults who Meet Recommended Activity Levels	20%	44%	40%
% of Adults Overweight		35%	37%
% of Adults Obese	18%	28%	20%
% of Adults who Eat 5 Fruits and Vegetables Daily	18%	17%	25%
Had Cholesterol Check Within 5 Yrs (18+ yrs old)	82%	92%	92%
Had Mammogram Within Past 2 Yrs (F 40+ only)	62%	86%	85%
Had PAP Test Within Past 3 Yrs (F 18+ only)	75%	77%	85%

HEALTH CARE RESOURCES

PRACTITIONERS IN SERVICE AREA

Primary Care Practitioners	Licensed
Family Practitioners	40
General Practitioners	0
Obstetricians/Gynecologists	6
General Internists	11
Pediatricians	5
Specialists	
General Surgeons	6
Other Surgeons	5
Other Practitioners	
Certified Nurse Midwives	2
Nurse Practitioners	20
Dentists	28
Physician Assistants	7
Registered Nurses	356
Pharmacists	39
Dental Hygenists	31
Chiropractors	13
Naturopaths	0
Direct Entry Midwife	0
Optometrists	8
Nurse Anesthetists	1
School Guidance Counselors	18
Psychiatrists	3
Psychologists	5
Licensed Social Worker	11
Family Counselor	12
Drug/Alcohol Counselor	30
Total Practitioners	657

SUPPLY AND DEMAND FOR PRIMARY CARE VISITS IN SERVICE AREA

Number of Persons Per Primary Care Provider: 853

Number of Visits Accommodated by:

Primary Care Physicians:	276,750
PA/NP:	68,850
Total:	345,600

Number of Primary Care Visits Needed by 2003 Population: 139,351

HEALTH CARE RESOURCES (continued)

CLINICS IN SERVICE AREA

	Number
Rural Health Clinics (RHC):	
Federally Qualified Health Clinics (FQHC):	1
School-Based Clinics:	0

HOSPITALS IN SERVICE AREA (2001)

Name:	Merle West Medical Center
# of Staffed Beds:	131
Type:	
Trauma Designation:	
Other Designation:	Rural Referral
% Medicare Discharges:	38.8
% Medicaid Discharges:	23.2
Net Patient Revenue:	$72,176,430
# of Employees :	781

DESIGNATIONS OF SHORTAGE BY SERVICE AREA

Health Professional Shortage Area (HPSA)	
1. Geographic	No
2. Population	Yes
3. Mental Health	Yes
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Medically Underserved Area (MUA)	No
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Sources for ORH Service Area Profiles

Geography		*Geography and Weather*
1	Current	Oregon Economic and Community Development Department, Community Profiles
Geography		*Distances*
2	Current	Mapblast
Geography		*Transportation*
3	Current	Tripcheck, Public Transportation
Demography		*Population, Ethnicity, Race, Household Size, and Median Age*
4	2003	Purchased annually from Claritas [by ZIP]
Socioeconomics		*2000 Census*
5	2000	2000 Census Summary File 3 (SF3). Purchased from Claritas. [by ZIP]
Socioeconomics		*County Per Capita Income*
6	2002	Bureau of Economic Analysis, Annual State Personal Income
Socioeconomics		*County Median Family Income*
7	2004	U.S. Department of Housing and Urban Development, Income Limits
Socioeconomics		*Annual Unemployment Rates*
8	2003	Oregon Employment Department, Annual Average Unemployment Rates [by county]
Socioeconomics		*TANF, Food Stamp Eligibles*
9	4/2003	Oregon Department of Human Services, Public Assistance Branch and Service Delivery Area Data, Oregon Public Assistance Programs, Historical Program Information by Branch and County
Socioeconomics		*Reduced/Free Lunch Eligibles*
10	03-04 School Yr	Oregon Department of Education, Statistics and Reports, School Finance Data and Analysis, Reports, Students [by school]
Socioeconomics		*Medicaid Eligibles*
11	5/2003	Oregon Department of Human Services, Oregon Health Plan, OHP Eligibles…Medicaid Eligibles and Expenditures by County
Socioeconomics		*Government Employees*
12	4/2003	Oregon Employment Department, Current Employment by Industry [by county]
Socioeconomics		*Uninsurance*
13	2002	2002 Oregon Population Survey [by region]

Vital Statistics		*Maternity Characteristics by Race*	
14	98-02	Purchased annually from Oregon Department of Human Services, Oregon Public Health Services, Center for Health Statistics (and Vital Records) [by ZIP]	
Vital Statistics		*Cause-Specific Death Rates*	
15	99-02	Purchased annually from Oregon Department of Human Services, Oregon Public Health Services, Center for Health Statistics (and Vital Records). Denominator is current Claritas population. Not age-adjusted. [by ZIP]	
Vital Statistics		*Top 10 Causes of Death in County*	
16	2002	Oregon Department of Human Services, Health Services, Office of Disease Prevention and Epidemiology, Center for Health Statistics. Oregon Vital Statistics County Data 2002, Table 6-32	
Vital Statistics		*Death Rate, Mortality Figure, Years of Life Lost*	
17	99-01	Oregon Department of Human Services; Oregon Public Health Services; Center for Health Statistics (and Vital Records); Deaths by Age, County, and Zipcode (3-Year Aggregate). Denominator is current Claritas population.	
Vital Statistics		*Preventable Hospitalizations*	
18	2000-2002	CompData patient origin system [by hospital and ZIP]	
Health Risk Factors		*Health Risk Factors*	
19	2000-2001	Oregon Department of Human Services; Keeping Oregonians Healthy: Preventing Chronic Diseases by Reducing Tobacco Use, Improving Diet, and Promoting Physical Activity and Preventive Screenings. June 2003 [by county]	
Health Care Resources		*Primary Care Practitioners, Specialists, PAs, and Psychiatrists*	
20	5/2004	Purchased annually from Board of Medical Examiners for the State of Oregon [by ZIP]	
Health Care Resources		*Certified Nurse Midwives, NPs, RNs, and Nurse Anesthetists*	
21	5/2004	Purchased annually from Oregon State Board of Nursing [by ZIP]	
Health Care Resources		*Dentists and Dental Hygenists*	
22	2003	Purchased from Oregon Board of Dentistry [by ZIP]	
Health Care Resources		*Pharmacists*	
23	2003	Purchased from State Board of Pharmacy [by ZIP]	
Health Care Resources		*Chiropractors*	
24	2001	Purchased from State Board of Chiropractic Examiners [by ZIP]	

Health Care Resources		*Naturopaths*	
25	2003	Purchased from Board of Naturopathic Examiners [by ZIP]	
Health Care Resources		*Direct Entry Midwife*	
26	2003	Oregon Board of Direct Entry Midwifery [by ZIP]	
Health Care Resources		*Optometrists*	
27	2003	Oregon Board of Optometry [by ZIP]	
Health Care Resources		*School Guidance Counselors*	
28	2003-2004	Oregon Department of Education [by ZIP]	
Health Care Resources		*Psychologists*	
29	2001	Purchased from State Board of Psychologist Examiners [by ZIP]	
Health Care Resources		*Licensed Clinical Social Worker*	
30	2001	State Board of Clinical Social Workers [by ZIP]	
Health Care Resources		*Professional Counselor/Marriage & Family Therapist*	
31	2003	Oregon Board of Licensed Professional Counselors and Therapists [by ZIP]	
Health Care Resources		*Drug/Alcohol Counselor*	
32	2001	Addiction Counselor Certification Board of Oregon [by ZIP]	
Health Care Resources		*Number of Visits Accommodated by PCP*	
33	2001	Wassenarr, PhD, John D; Thran, Sara L.; ed. (2003) "Table 14: Office Visits per Week, 2001" Physician Socioeconomic Statistics, 2003 Edition. American Medical Association, 49.	
Health Care Resources		*Number of Visits Accomodated by PA/NP*	
34		The average of the the figures derived by CMS (Centers for Medicare and Medicaid Services [formerly HCFA])--Form HCFA-222-92, "Visits and Overhead Cost for RHC/FQHC," Worksheet B--and a study done by the Idaho Rural Health Education Center--Pryzbilla, J. (1996). A Step-by-Step Training Guide to Primary Care Provider Recruitment and Retention, 22-23.	
Health Care Resources		*Primary Care Visits Needed*	

35	2001	Cherry DK, Burt CW, Woodwell DA. National Ambulatory Medical Care Survey: 2001 Summary, Advance Data No. 337, Nation Center for Health Statistics. Aug 11, 2003, Table 3 Number, percent distribution, and annual rate of office visits with corresponding standard errors, by patient's age, sex, and race: United States, 2001
Health Care Resources		*Clinics*
36	Current	Periodic email updates from Nancy Abrams, Primary Care Program Planner at Department of Human Services
Health Care Resources		*Hospitals*
37	2001-2002	American Hospital Directory and Oregon Association of Hospitals and Health Systems
Designations of Shortage		*HPSA*
38	Current	U.S. Dept. of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Health Professional Shortage Areas Database Query
Designations of Shortage		*MUA/P*
39	Current	U.S. Dept. of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, Medically Underserved Areas/Populations Database
Designations of Shortage		*ORH Unmet Need*
40	2002	Oregon Office of Rural Health Unmet Need Designation

2003-2004 Areas of Unmet Medical Need in Rural Oregon

I. Background

In 1989 and again in 1991, the Oregon Legislature passed laws[1] requiring the Office of Rural Health to develop and utilize criteria of medical underservice in several applications:

- The Office of Rural Health is charged with determining eligible "medically underserved" practice sites for rural state loan repayment recipients.

- The Office has responsibility for granting exceptions to the state's rural hospital classification system as it applies to medical staff eligibility for the state's personal income tax credit program. In order for larger rural hospitals' medical staffs to receive this benefit, the Office must determine that the area is "medically underserved."

- Medically underserved criteria are applied to distribution of state funds for rural economic development grants (ORS 442.503) and Area Health Education Centers (ORS 352.095).

- SB 607, passed in 1991, requires the Office to devise a risk assessment formula for rural hospitals that includes a factor reflecting medical underservice.

In response to these requirements, The Office of Rural Health developed a single evolved set of criteria that can be employed in each of the required applications while helping our constituents evaluate their overall health delivery systems and more clearly understand their status and potential for assistance.

[1] Senate Bills 438 (1989) and SB 607 (1991)

II. Selecting a Level of Analysis

In most other states, county boundaries are relatively small, so county-level data is widely used to disseminate information. However, because of the large sizes and wide variations in geography and population centers of many of Oregon's 36 counties, sub-county units were determined to more accurately represent community use of primary medical care services. Postal ZIP code boundaries, which follow logical transportation and market patterns, are used as the building blocks of our sub-county areas. A large amount of demographic, socioeconomic and health status information is currently available at the ZIP code level, including hospital utilization and market share data. The Office of Rural Health grouped these ZIP codes into 130 Oregon "Primary Care Service Areas" using the following criteria:

1. Health resources are generally located within 30 to 40 minutes travel time.

2. Defined areas are not smaller than a single ZIP code and ZIP codes used are geographically contiguous.

3. Defined areas contain a population of generally 800 to 1,000 or more people.

4. Areas constitute a "rational" medical trade or market area considering topography, social and political boundaries, and travel patterns. Additional considerations for service areas are boundaries that:

   a. Are congruent with any existing special taxing districts (e.g., health or hospital districts); and

   b. Include a population which has a local perception that it constitutes a "community of need" for primary health care services, or demonstrates demographic, socioeconomic or ethnic homogeneity. The population should be large enough (800 to 1,000) to be financially capable of supporting at least a single midlevel medical provider.

Using the Office of Rural Health definition of "rural"—"a geographic area 10 or more miles from the centroid of a population center of 30,000 or more"—104 **rural** primary care service areas were delineated. These service area profiles were assembled and hundreds of their demographic, socioeconomic, and healthcare variables were computed in the Primary Care Service Area database. These variables are used in updating the 2003-2004 edition of "Assessing Health Care Needs in Rural Oregon."

III. Methodology

The Office of Rural Health selected five different variables to represent crucial aspects of access to health services in rural areas:

1. Percentage of Primary Care Needs Met
2. Ambulatory Care Sensitive Conditions (ACSC) Ratio
3. Travel Time to Nearest Hospital
4. Comparative Mortality Ratio
5. Low Birth Weight Rate

Data specific to each service area are derived from the Oregon Center for Health Statistics, the Board of Medical Examiners, the Board of Nursing, Claritas, COMPdata, and Mapblast.com. Each variable is converted from a raw score, (e.g., percentage, rate or number) to a uniform score of 0 (worst) to 20 (best), using a method that measures incremental deviations from the mean (set at 10).

Deviations from mean to lowest score = (Mean – Lowest Score)/10
Deviations from mean to highest score = (Highest Score – Mean)/10

Each variable (V) is equally weighted in calculating each service area's total Medical Underservice Score, as follows:

$V_1 + V_2 + V_3 + V_4 + V_5$ = Medical Underservice Score

The best possible Medical Underservice Score is 100. The highest and lowest total scores are discarded and the mean is calculated. Service areas with totals below the mean Medical Underservice Score are the most medically underserved. An explanation each of the variables follows:

V_1 = PERCENTAGE OF PRIMARY CARE NEEDS MET:

This variable attempts to determine practitioner availability with an estimate of the visits a primary care practitioner is able to provide vs. practitioner visits needed by the service area population. Only *primary care* physicians, nurse practitioners and physician assistants are included in this equation as a measure of access to basic health care.

For doctors, visit capacity, meaning the estimated number of office visits a practitioner typically has each year, is taken from the latest issue of the annual Physician Socioeconomic Statistics[2], based on surveys of nonfederal patient care physicians. For NP/PAs, visit capacity is the average of the the figures derived by CMS (Centers for Medicare and Medicaid Services [formerly HCFA])[3] and a study done by the Idaho Rural Health Education Center[4].

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[2] Wassenarr, PhD, John D; Thran, Sara L.; ed. (2003) "Table 14: Office Visits per Week, 2001" *Physician Socioeconomic Statistics, 2003 Edition*. American Medical Association, 49.

[3] Form HCFA-222-92. "Visits and Overhead Cost for RHC/FQHC," Worksheet B

SPECIALTY	VISIT CAPACITY
GP/FP	4900
PEDS	4320
OB/GYN	3900
INT	3250
NP/PA	2550

Primary care visits needed by the population is a measure calculated using annually adjusted rates from the National Center for Health Statistics[5] according to each gender and age breakdown:

Total # of Primary Care Visits Needed = 0.8 x
(([Female Population 0-14] x 2.3) +
([Female Population 15-24] x 2.3) +
([Female Population 25-44] x 3.1) +
([Female Population 45-64] x 4.1) +
([Female Population 65-74] x 6.1) +
([Female Population 75+] x 6.4) +
([Male Population 0-14] x 2.4) +
([Male Population 15-24] x 1.2) +
([Male Population 25-44] x 1.6) +
([Male Population 45-64] x 3.0) +
([Male Population 65-74] x 5.4) +
([Male Population 75+] x 6.7))

Visit capacity for each specialty is multiplied by the number of practitioners in the service area, then these 5 numbers are summed to derive the total visit capacity. Total visit capacity is then divided by the total number of primary care visits needed. The final variable is a percentage of need being met, using the following formula:

$$V_1 = \frac{p_1(4900) + p_2(4320) + p_3(3900) + p_4(3250) + p_5(2550)}{\text{Total \# of primary care visits needed}}$$

[4] Pryzbilla, J. (1996). *A Step-by-Step Training Guide to Primary Care Provider Recruitment and Retention*, 22-23

[5] Cherry DK, Woodwell DA. (2002) National Ambulatory Medical Care Survey: 2000 summary. *Advance data from Vital and Health Statistics*; no. 328, 12.

(Note: p_1 = # of FP/GPs ; p_2= # of pediatricians; p_3 = # of OB/GYNs; p_4 = # of internists; and p_5 = # of NP/PAs .)

A V_1 score of 0 means that there are no primary care providers in the service area.

V_2 = AMBULATORY CARE SENSITIVE CONDITIONS (ACSC) RATIO:

Ambulatory care sensitive conditions (also known as preventable hospitalizations) are a set of inpatient diagnoses that would likely have been preventable or unnecessary had they been treated with timely and effective ambulatory care. These include many common conditions such as asthma, diabetes, hypertension, and pneumonia. Many studies have shown that high rates of admissions for these conditions can be indicative of serious access or primary care performance problems[6]. Other studies have also shown that areas with high numbers of elderly and low-income residents, minorities, and the uninsured tend to have higher rates of preventable hospitalizations[7].

For this calculation, we utilized the widely-used list of (ICD-9-CM) ACSC diagnoses pioneered by John Billings[8]. Three years' worth (2000-2002) of Oregon inpatient admissions by ZIP Code were retrieved from COMPdata.

$$\text{ACSC Rate} = \frac{\text{2000-2002 ACSC Admissions}}{\text{2000-2002 Total Admissions}}$$

$$V_2 = \frac{\text{ACSC Rate for Service Area}}{\text{ACSC Rate for State}}$$

An ACSC ratio less than "1.00" indicates that the area has a lower preventable hospitalization rate than the state as a whole; a value equal to "1.00" equals the state's rate; and a value greater than "1.00" indicates above average hospitalization for preventable diseases.

V_3 = TRAVEL TIME TO NEAREST HOSPITAL:

This third variable is used to account for a service area's remoteness or proximity from a comprehensive source of hospital care. A service area may appear to be underserved because of a low primary care capacity percentage, when, in fact, it is near a larger city or town that is able to meet some of its needs.

Accordingly, mileage is calculated from the largest town/city in each of the 104 rural service areas to the nearest town/city with a hospital, unless the city already has a hospital, in

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[6]Bindman, Andrew B.; Grumbach, Kevin; et. al. Preventable Hospitalizations and Access to Health Care. *The Journal of the American Medical Association* (274) July 26, 1995: 305-311

[7]Billings, John; Zeitel, Lisa; et. al. Impact of Socioeconomic Status on Hospital Use In New York City. *Health Affairs* (Spring 1993): 162-173

[8]Billings, John; Anderson, Geoffrey M.; Newman, Laurie S. Recent Findings On Preventable Hospitalizations. *Health Affairs* (Fall 1996): 239-249

which case the driving time is defaulted to 10 minutes. Driving time and distance are calculated annually by using the online directions at www.mapblast.com.

V_4 = COMPARATIVE MORTALITY RATIO:

This variable compares the service area's crude death rate (not adjusted for age or other factors) to the death rate for the entire state. This non-age-adjusted rate is a valuable measure because it reflects a number of unique qualities that may affect rural areas, e.g., a higher proportion of elderly, a greater number of laborers in dangerous occupations, lack of emergency medical transport systems, and disadvantaged ethnic populations. Three years' worth of mortality data are used (1999-2001), and then averaged for one year in order to control for aberrations that may occur annually with small numbers in some service areas.

$$\text{Crude Death Rate} = \frac{\text{Resident Deaths}}{\text{Population}} \times 1000$$

$$V_4 = \frac{\text{Crude Death Rate for Service Area}}{\text{Crude Death Rate for State}}$$

A comparative mortality ratio less than "1.00" indicates that the area has a lower death rate than the state as a whole; a value equal to "1.00" equals the state's death rate; and a value greater than "1.00" indicates above average mortality.

V_5= LOW BIRTH WEIGHT RATE:

In calculating the final variable, several different options were considered to reflect access to care for the most vulnerable populations. While infant mortality is the most typical choice in this category, problems arise when using this measure in a rural context because in many very small communities, infant mortality is a very rare event. Because this index relies on relativity for its validity, a more common event, low birth weight (< 2500 grams or 5.5 pounds), was chosen instead, and data averaged from the last five years (1997-2001) to account for small populations in certain areas.

Infant mortality is commonly used to target a failure in the health care system. Similarly, rates of low birth weight babies are highest for mothers who receive inadequate prenatal care.[9] Low birth weight values can also be used to predict future demands on the health care (and social) systems of a community. Low birth weight infants:

- account for nearly half of all infant deaths in the first year of life and 70% of all deaths in the first four weeks of life.
- are significantly more likely to suffer from long term handicapping conditions such as mental retardation, cerebral palsy, visual and hearing defects and lung disease.

[9]Curry, Mary Ann and Kellerhouse, Kristine. *Oregon's Babies: How Healthy Are They?* The Oregon Healthy Mothers, Healthy Babies Coalition, April 1991.

- are more likely to have some form of learning disability.[9]

V_5 (Five-Year Average Low Birth Weight Rate) = (([1st Year Total Low Birth Weight Amount]/[1st Year Total Births])+([2nd Year Total Low Birth Weight Amount]/[2nd Year Total Births])+([3rd Year Total Low Birth Weight Amount]/[3rd Year Total Births])+([4th Year Total Low Birth Weight Amount]/[4th Year Total Births])+([5th Year Total Low Birth Weight Amount]/[5th Year Total Births])/5)*1000

IV. Findings and Conclusions

Oregon's rural service areas display a range of scores from 29 to 80, with a mean (average) of 53.1. A score of 53 or less is considered to have unmet health care needs.

Using this method, 54 of the 104 rural service areas have unmet healthcare needs. Halfway, Condon, Elgin, Shady Cove, East Klamath, Mill City/Gates, and Nehalem all scored below 40. In contrast, the highest ranked service area, Ashland, scored an 80 out of 100. The Unmet Need areas are scattered throughout the state, but it is worth noting that three of the largest service area groupings—the southern coast, the Mid-Columbia region, and the southeast—are also concentrated in areas where health districts exist. In these areas, local citizens recognized that their health care needs were underserved and have voted to tax themselves in order to financially support a hospital, clinic or ambulance service. In a few cases, however, such as in Bandon, Florence, Lakeview, or Burns, the location of a hospital alone does not keep the area from having unmet healthcare needs. These places still suffer from high preventable hospitalizations, high mortality rates, and/or above average low birth weight rates.

Although many of these regions have also been designated by the federal government as either medically underserved (MUA/MUPs) or Health Professions Shortage Areas (HPSAs), the intent of this exercise is not to replace or challenge the federal designations, but rather to complement them using more complex measures that are uniquely sensitive to Oregon's rural health environment.

The Office of Rural Health, state agencies, legislators, and other advocates of rural healthcare will find this instrument a useful means to evaluate health care services in rural Oregon. Its greatest strengths lie in its sensitivity to small variations among rural service areas, and the ability to be updated annually, as new data become available. Further, the Primary Care Service Area database is linked to an in-house GIS system, which provides mapping capability for all of the various results, from the statewide to ZIP code levels. This makes it easier for the reader to visually comprehend and compare this complex data, furthering the cause of rural health in Oregon.

V. Notes

1. Physician/physician assistant licensure data: Oregon Board of Medical Examiners, May 2003
2. Nurse practitioner licensure data: Oregon Board of Nursing, May 2003

3. Death data: Oregon Center for Health Statistics, 1999-2001
4. Low birthweight data: Oregon Center for Health Statistics, 1997-2001
5. 2002 population estimates: Claritas
6. ACSC Hospitalizations: COMPdata
7. Distance data: Mapblast.com

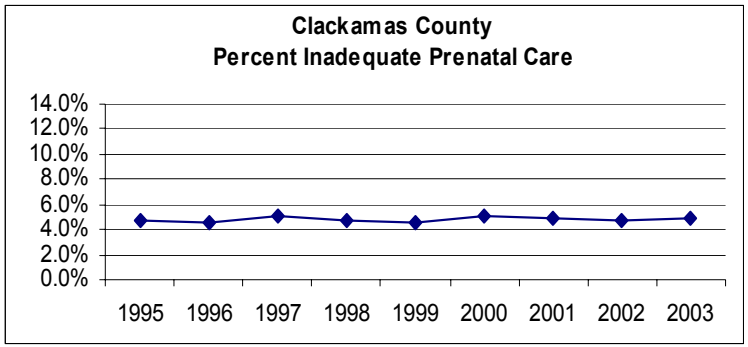
Additional information, maps, and rankings of all the service areas are available at: www.ohsu.edu/oregonruralhealth/what%20is%20rural.html

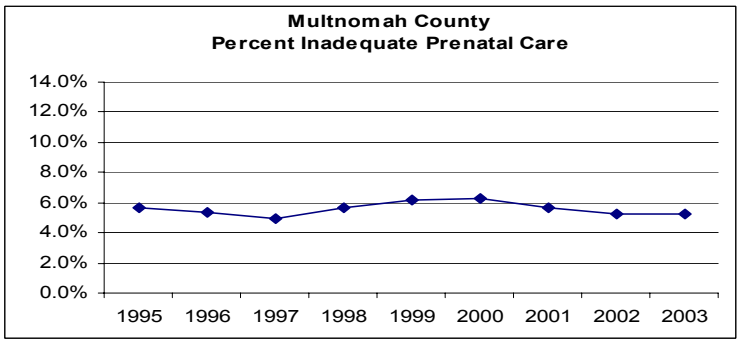
For questions, contact Emerson Ong at the Oregon Office of Rural Health, Oregon Health and Science University, (503) 494-5226 or email onge@ohsu.edu.

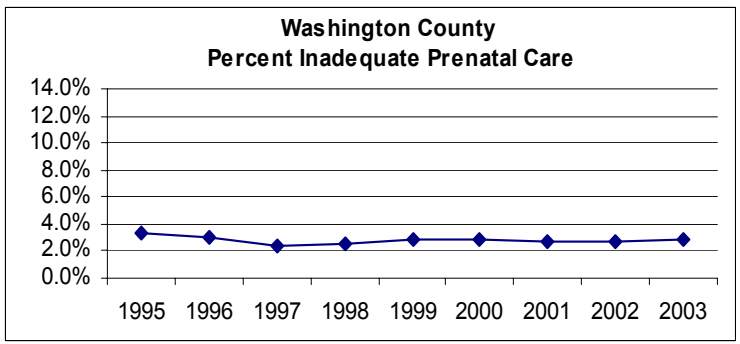
Selected Access-Related Outcomes Measures

- Inadequate Prenatal Care
- Selected Ambulatory Care Sensitive Conditions

Portland Metropolitan Region: Inadequate Prenatal Care, 1995-2003





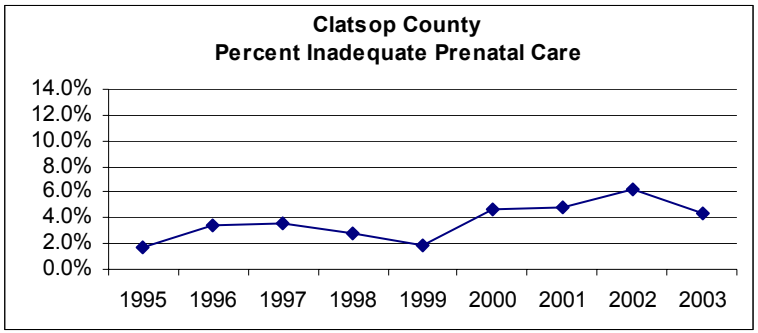


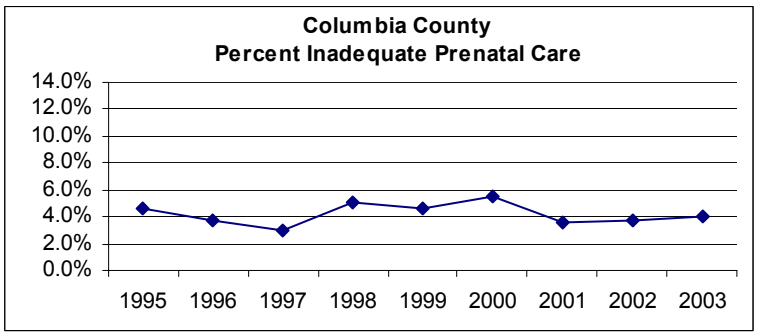
Inadequate prenatal care:

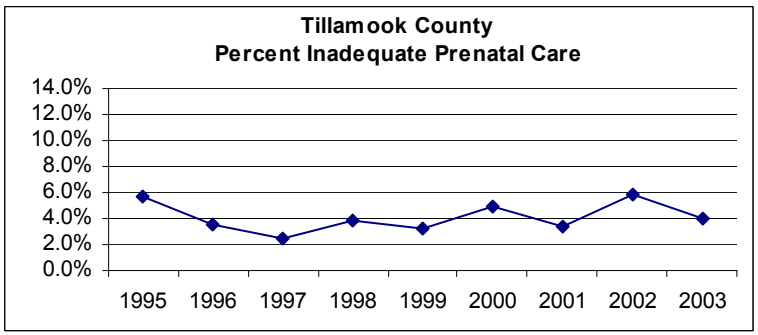
Less than 5 prenatal visits or prenatal care that began in the third trimester.

Source: Oregon Department of Human Services, Center for Health Statistics.

North Coast Region: Inadequate Prenatal Care, 1995-2003





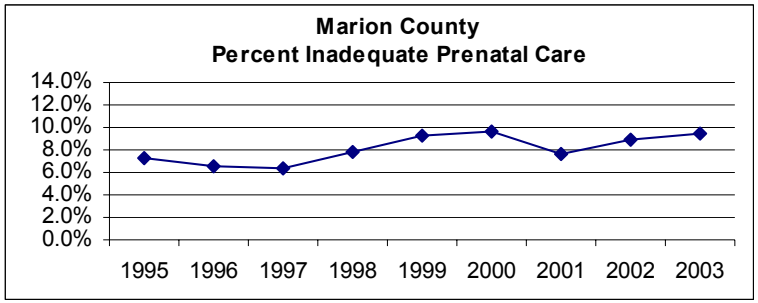


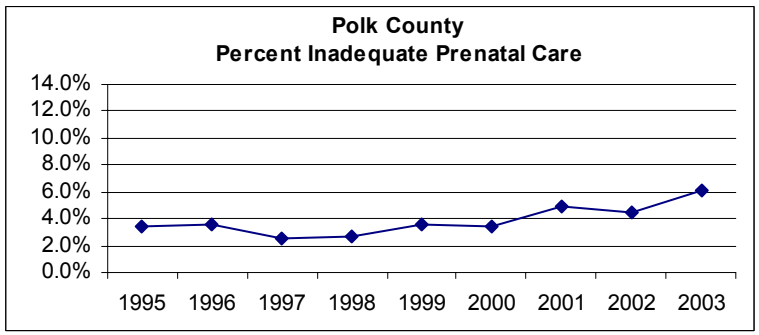
Inadequate prenatal care:

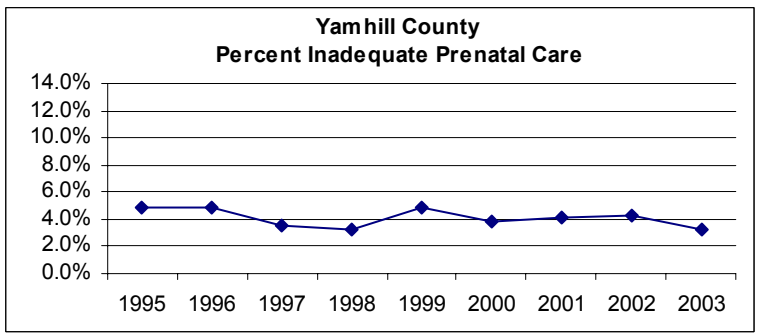
Less than 5 prenatal visits or prenatal care that began in the third trimester.

Source: Oregon Department of Human Services, Center for Health Statistics.

Mid-Willamette Valley Region: Inadequate Prenatal Care, 1995-2003





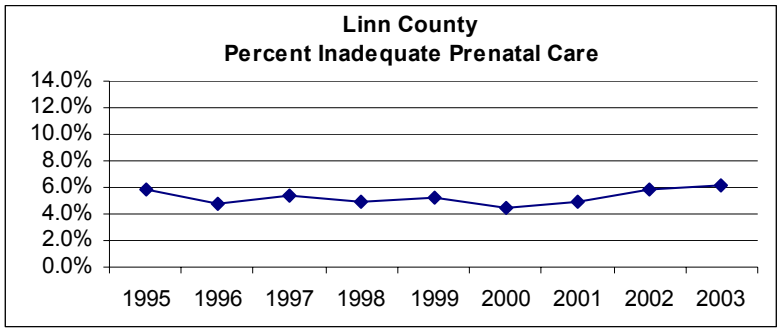


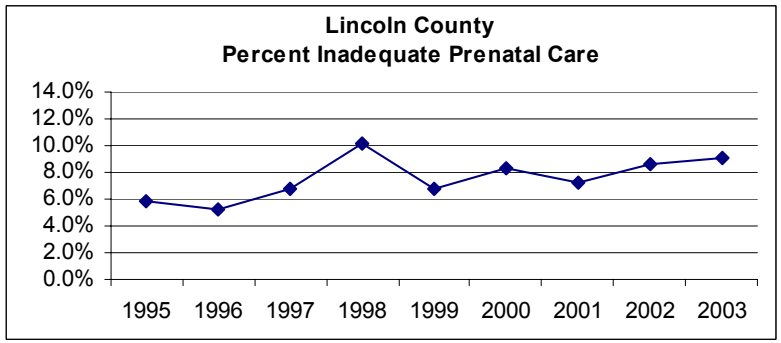
Inadequate prenatal care:

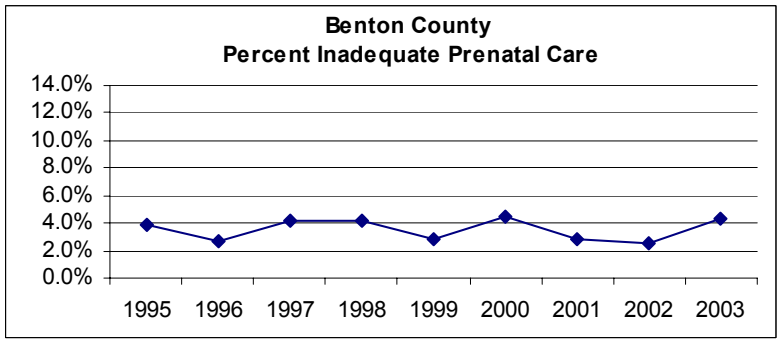
Less than 5 prenatal visits or prenatal care that began in the third trimester.

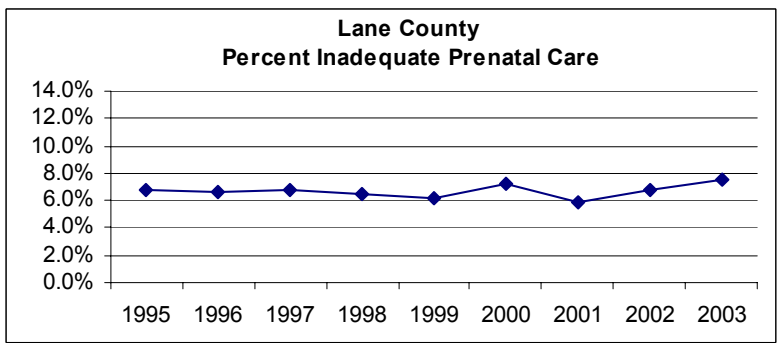
Source: Oregon Department of Human Services, Center for Health Statistics.

South Willamette Valley Region: Inadequate Prenatal Care, 1995-2003







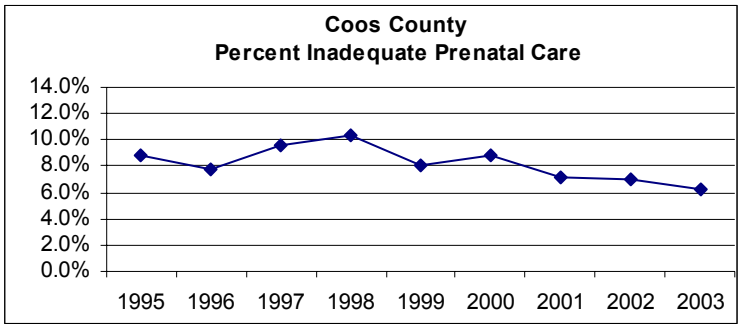


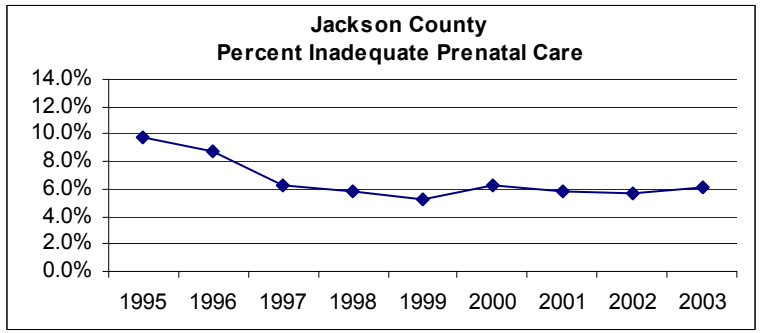
Inadequate prenatal care:

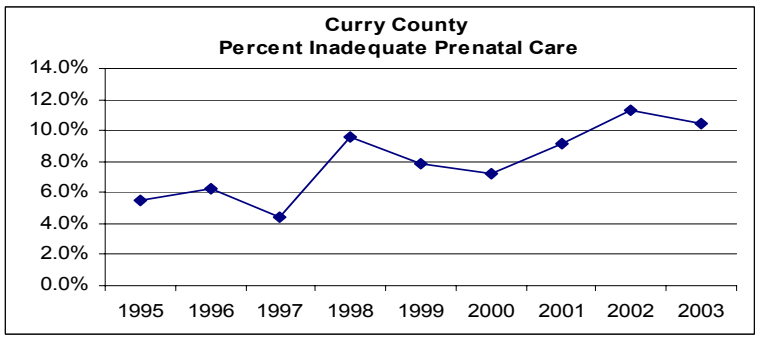
Less than 5 prenatal visits or prenatal care that began in the third trimester.

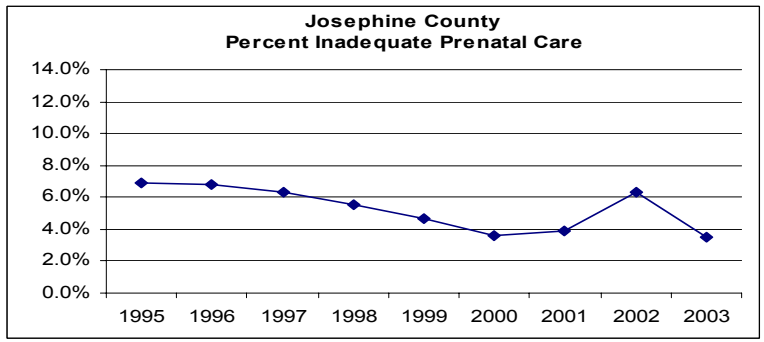
Source: Oregon Department of Human Services, Center for Health Statistics.

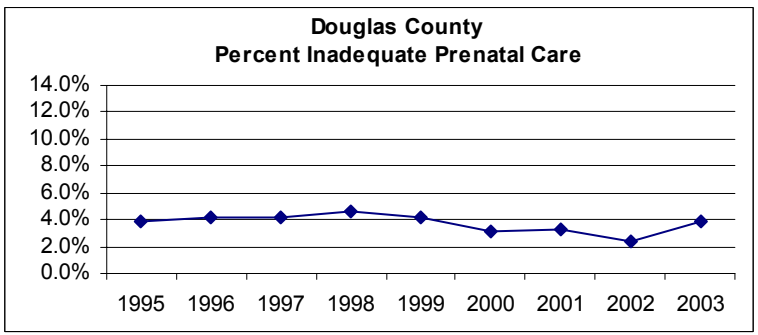
Southwestern Region: Inadequate Prenatal Care, 1995-2003









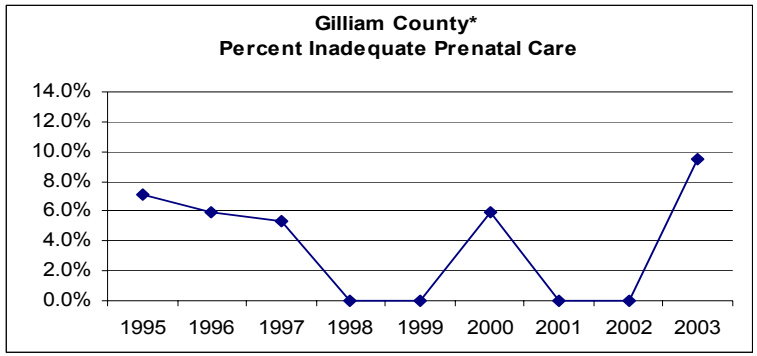


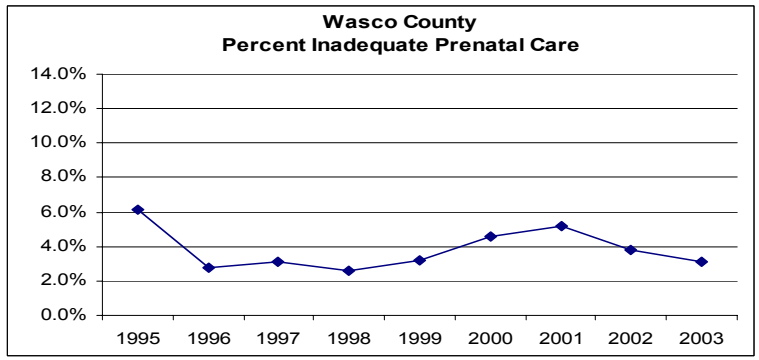
Inadequate prenatal care:

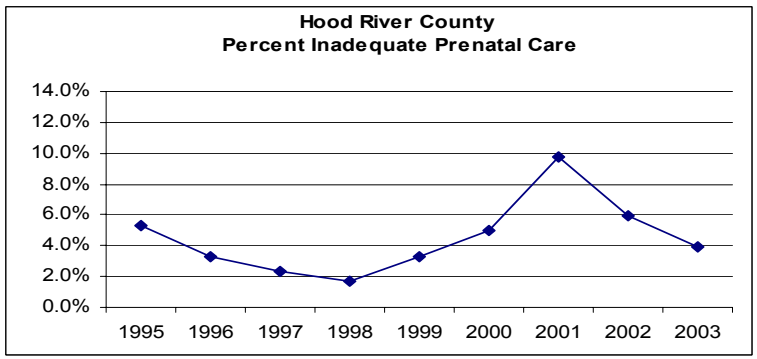
Less than 5 prenatal visits or prenatal care that began in the third trimester.

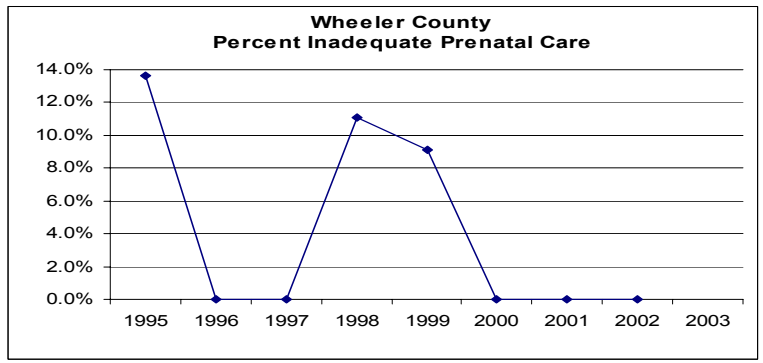
Source: Oregon Department of Human Services, Center for Health Statistics.

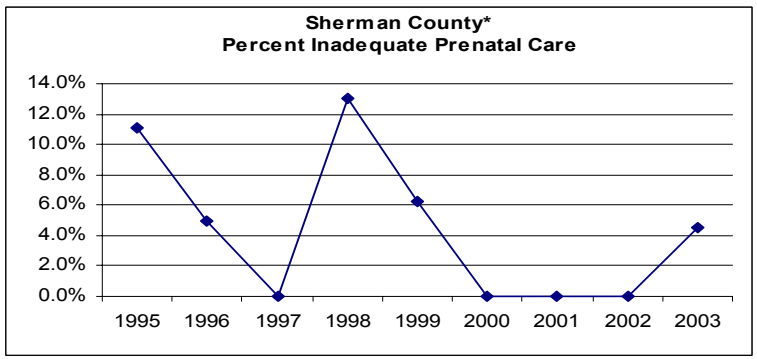
Columbia Gorge Central Region: Inadequate Prenatal Care, 1995-2003











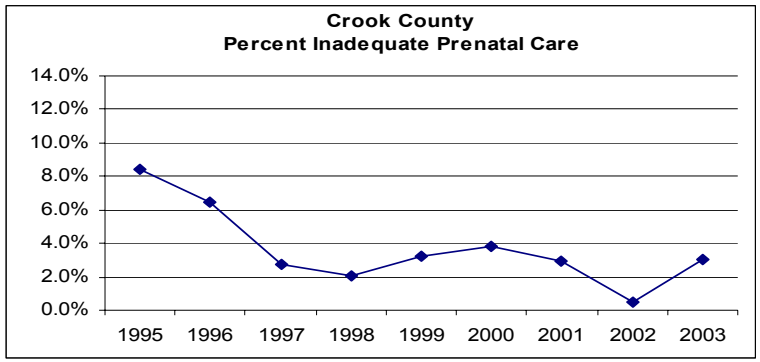
Inadequate prenatal care:

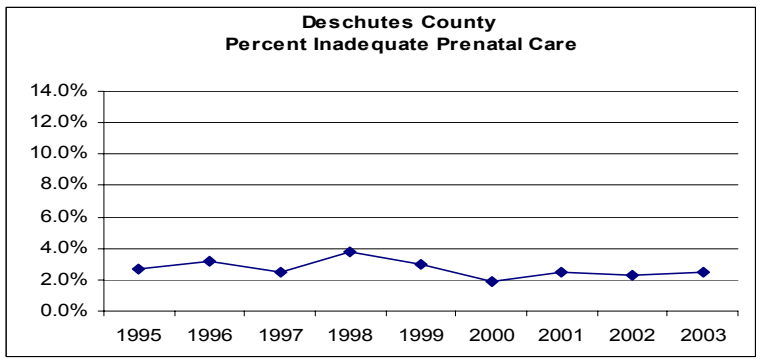
Less than 5 prenatal visits or prenatal care that began in the third trimester.

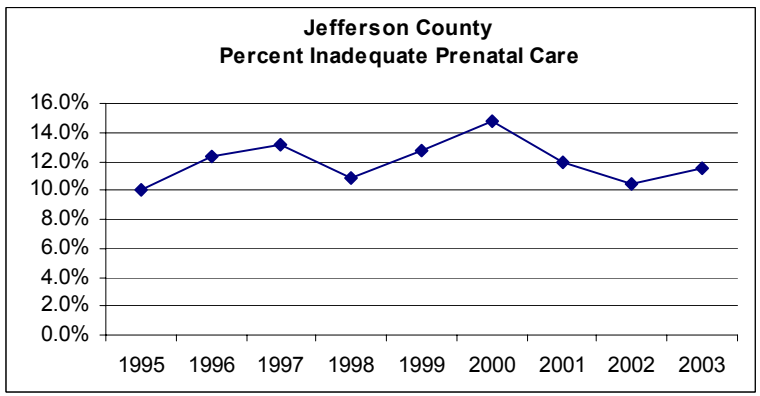
Source: Oregon Department of Human Services, Center for Health Statistics.

*Less than 30 annual births in Gilliam, Sherman, and Wheeler counties.

Central Region: Inadequate Prenatal Care, 1995-2003





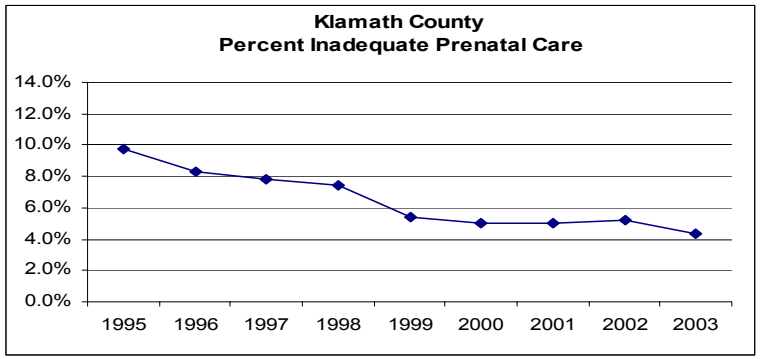


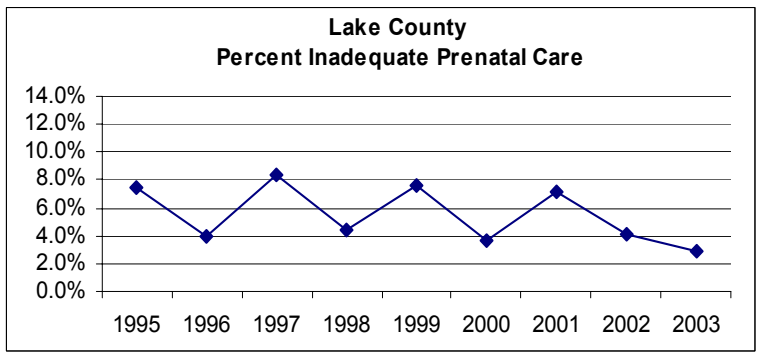
Inadequate prenatal care:

Less than 5 prenatal visits or prenatal care that began in the third trimester.

Source: Oregon Department of Human Services, Center for Health Statistics.

South Central Region: Inadequate Prenatal Care, 1995-2003



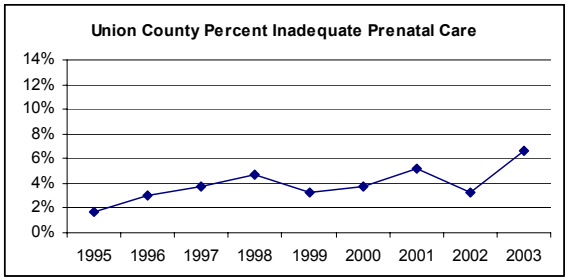


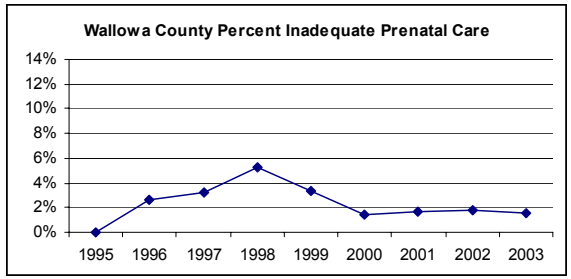
Inadequate prenatal care:

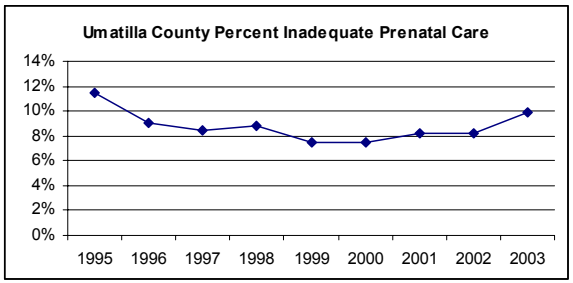
Less than 5 prenatal visits or prenatal care that began in the third trimester.

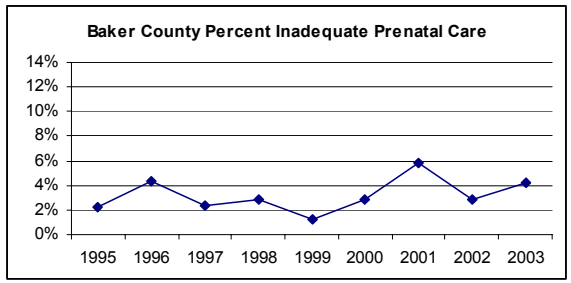
Source: Oregon Department of Human Services, Center for Health Statistics.

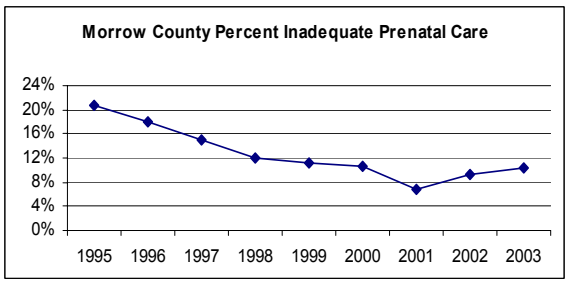
Eastern Region: Inadequate Prenatal Care, 1995-2003

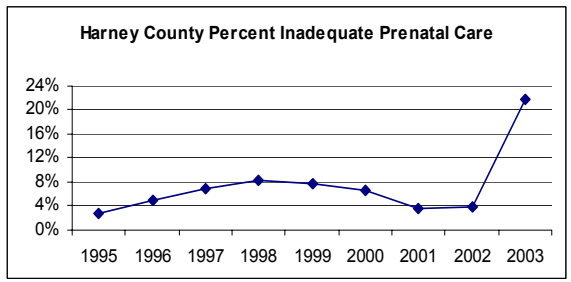


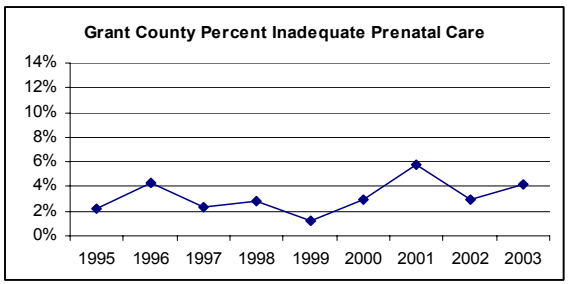


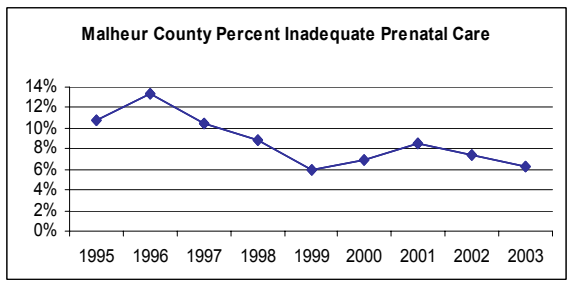












Inadequate prenatal care:

Less than 5 prenatal visits or prenatal care that began in the third trimester.

Source: Oregon Department of Human Services, Center for Health Statistics.

Ambulatory Care Sensitive Conditions

Agency for Healthcare Research and Quality (AHRQ)
Prevention Quality Indicators

AHRQ Prevention Quality Indicators

- Bacterial pneumonia
- Adult asthma
- Diabetes long-term complication
- Urinary tract infection
- Dehydration
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)

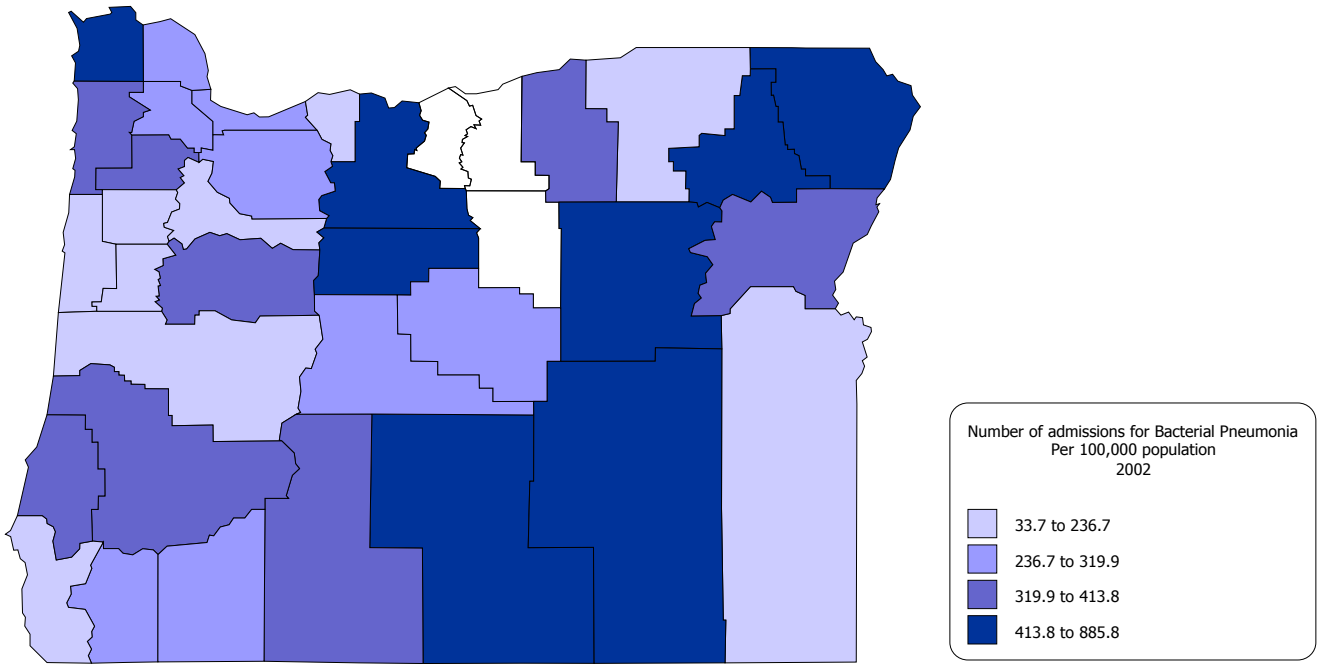
The following indicators are not included as there were too few counties with adequate numbers (>20) to be included in the analysis:

  - Diabetes short-term complications
  - Angina without procedure
  - Perforated appendix
  - Hypertension
  - Pediatric asthma
  - Uncontrolled diabetes
  - Pediatric gastroenteritis
  - Lower-extremity amputation among patients with diabetes

AHRQ Prevention Quality Indicators

- Set of measures that can be used with hospital inpatient discharge data to identify "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.
- 2002 Oregon hospital discharge data.
- Analysis conducted by patient’s county of residence rather than hospital location.
- AHRQ recommends benchmarking against statewide or regional rates.

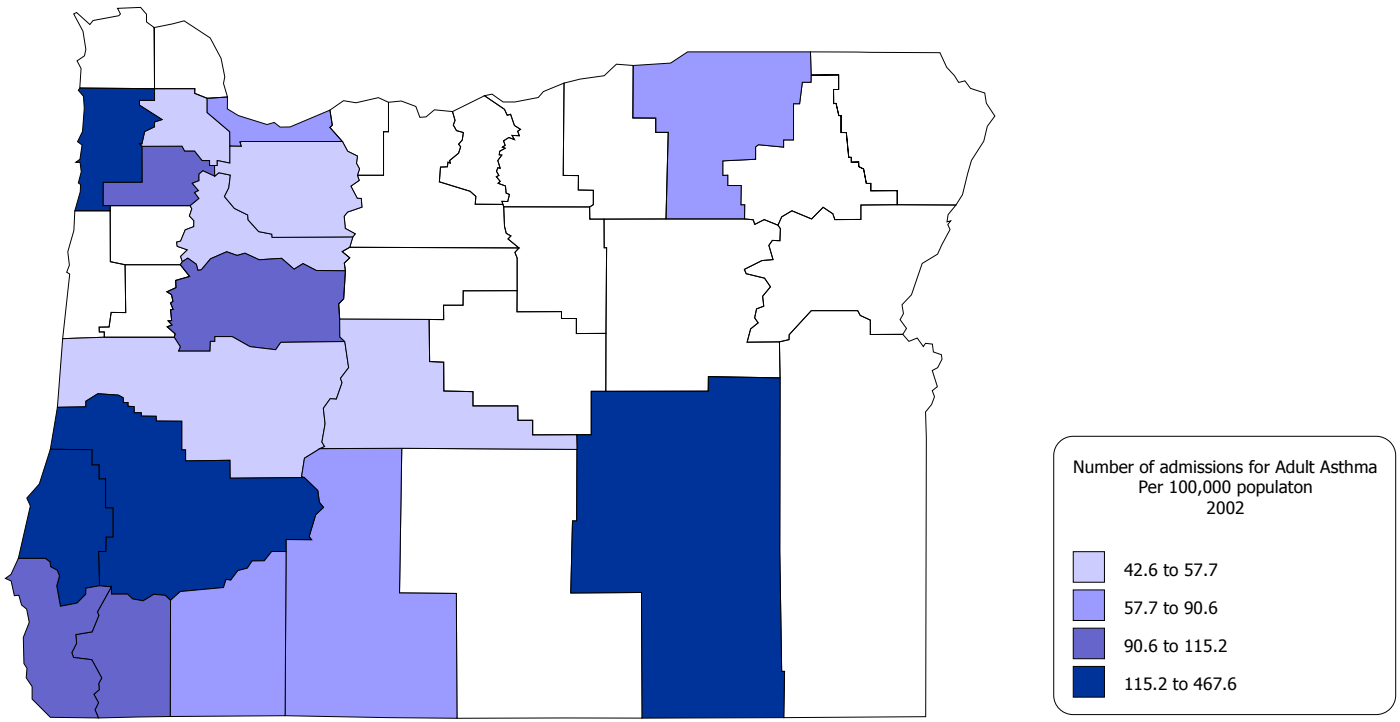
Admissions for Bacterial Pneumonia



- Counties with no shading indicate data suppressed; less than 20 cases.
- Rational for inclusion in AHRQ indicator set: Bacterial pneumonia is a relatively common acute condition, treatable for the most part with antibiotics.*
- Risk adjusted for age and sex.
- State population rate = 262.0 admissions per 100,000 population.

*AHRQ, Guide to Prevention Indicators, AHRQ Pub. No. 02-R0203, Oct. 2001, Revision 3 (January 9, 2004).

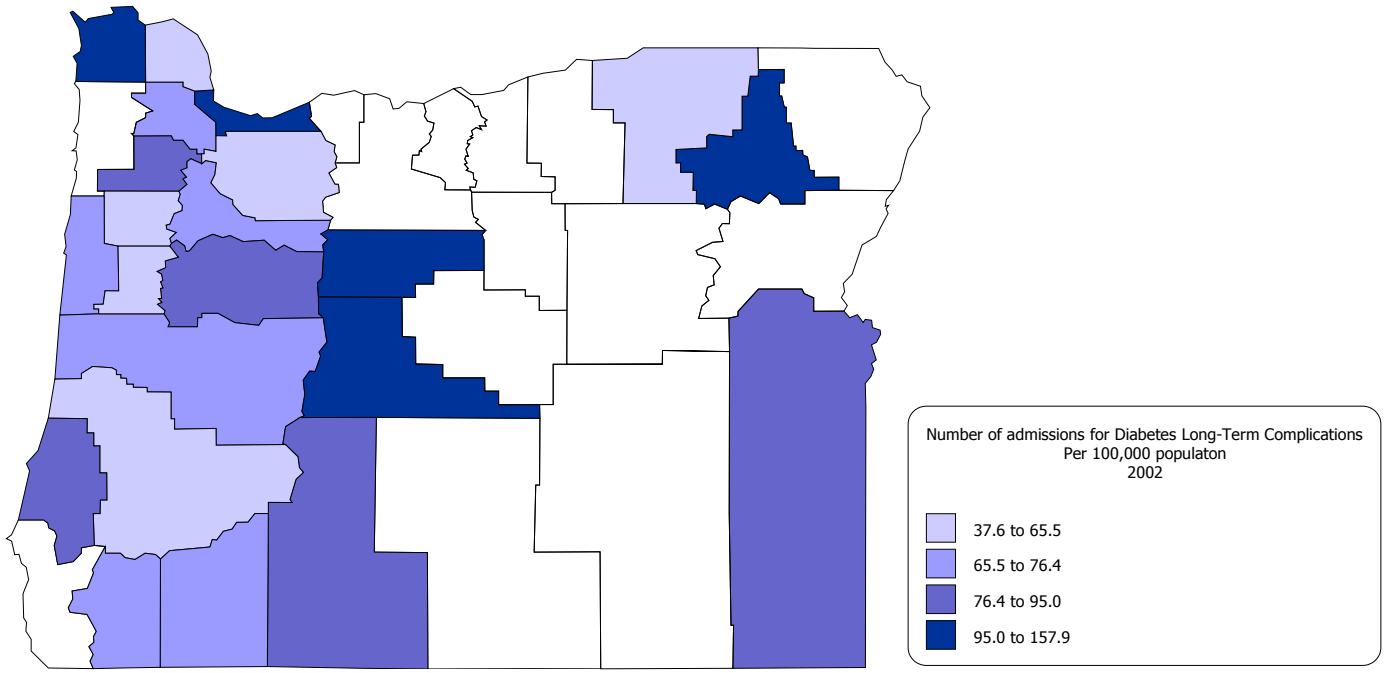
Admissions for Adult Asthma



- Counties with no shading indicate data suppressed; less than 20 cases.
- Rational for inclusion in AHRQ indicator set: Asthma is one of the most common reasons for hospital admission and emergency room care. Most cases of asthma can be managed with proper ongoing therapy on an outpatient basis.*
- Risk adjusted for age and sex.
- State population rate = 69.1 admissions per 100,000 population.

*AHRQ, Guide to Prevention Indicators, AHRQ Pub. No. 02-R0203, Oct. 2001, Revision 3 (January 9, 2004).

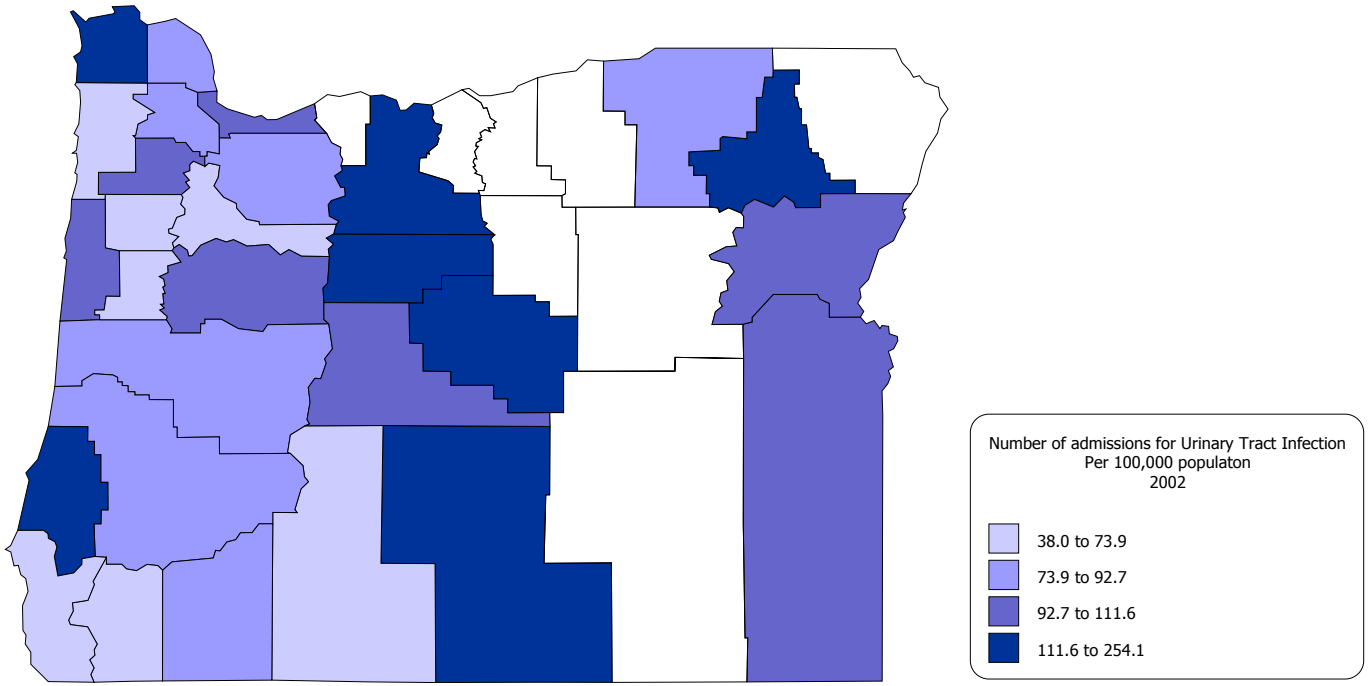
Admissions for Diabetes Long-Term Complications



- Counties with no shading indicate data suppressed; less than 20 cases.
- Rational for inclusion in AHRQ indicator set: Proper outpatient treatment and adherence to care may reduce the incidence of diabetic long-term complications.*
- Risk adjusted for age and sex.
- State population rate = 72.3 admissions per 100,000 population.

*AHRQ, Guide to Prevention Indicators, AHRQ Pub. No. 02-R0203, Oct. 2001, Revision 3 (January 9, 2004).

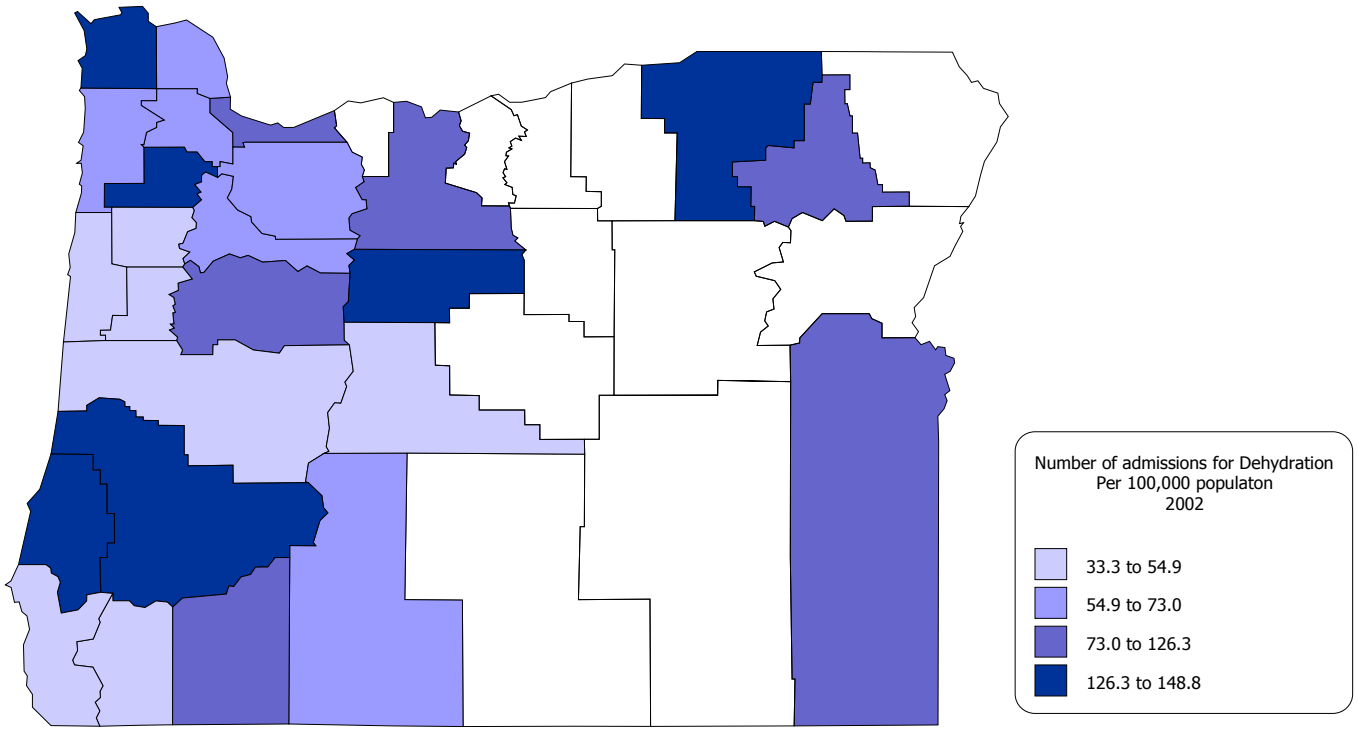
Admissions for Urinary Tract Infections



- Counties with no shading indicate data suppressed; less than 20 cases.
- Rational for inclusion in AHRQ indicator set: Urinary tract infection is a common acute condition that can usually be treated with antibiotics in an outpatient setting.*
- Risk adjusted for age and sex.
- State population rate = 89.1 admissions per 100,000 population.

*AHRQ, Guide to Prevention Indicators, AHRQ Pub. No. 02-R0203, Oct. 2001, Revision 3 (January 9, 2004).

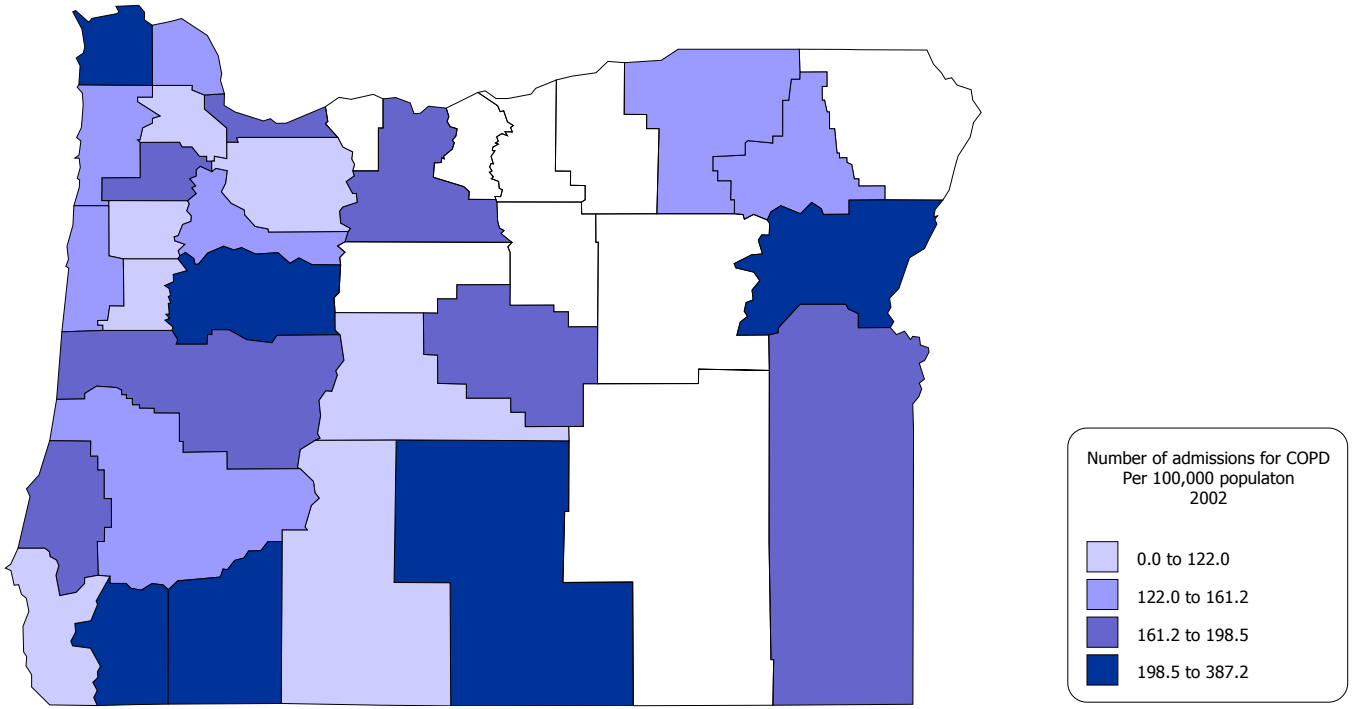
Admissions for Dehydration



- Counties with no shading indicate data suppressed; less than 20 cases.
- Rational for inclusion in AHRQ indicator set: Dehydration is a serious acute condition that occurs in frail patients and patients with other underlying illnesses following insufficient attention and support for fluid intake.*
- Riskadjusted for age and sex.
- State population rate = 70.8 admissions per 100,000 population.

*AHRQ, Guide to Prevention Indicators, AHRQ Pub. No. 02-R0203, Oct. 2001, Revision 3 (January 9, 2004).

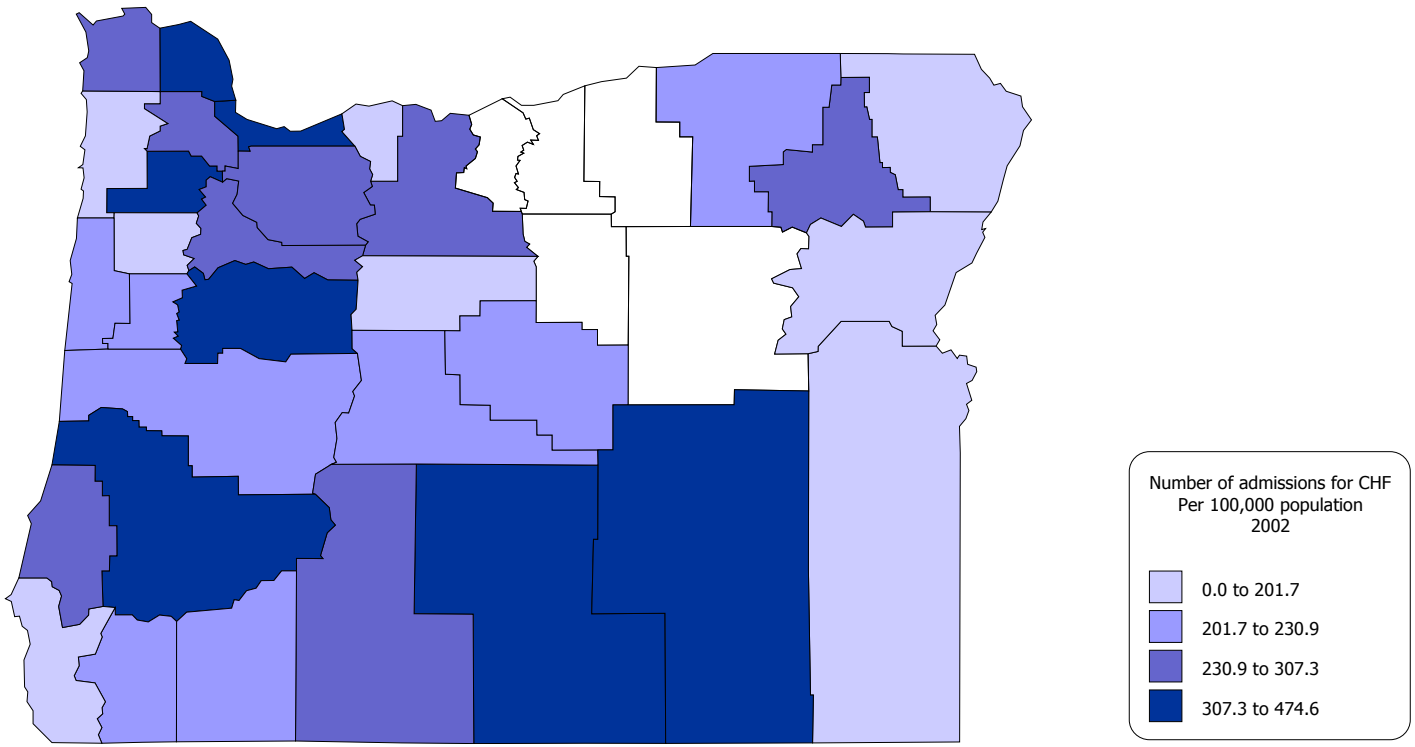
Admissions for Chronic Obstructive Pulmonary Disease (COPD)



- Counties with no shading indicate data suppressed; less than 20 cases.
- Rational for inclusion in AHRQ indicator set: proper outpatient treatment may reduce admissions for COPD.*
- Risk adjusted for age and sex.
- State population rate = 145.2 admissions per 100,000 population.

*AHRQ, Guide to Prevention Indicators, AHRQ Pub. No. 02-R0203, Oct. 2001, Revision 3 (January 9, 2004).

Admissions for Congestive Heart Failure



- Counties with no shading indicate data suppressed; less than 20 cases.
- Rational for inclusion in AHRQ indicator set: Congestive heart failure (CHF) can be controlled in an outpatient setting for the most part; however, the disease is a chronic progressive disorder for which some hospitalizations are appropriate.*
- Risk adjusted for age and sex.
- State population rate = 263.6 admissions per 100,000 population.

*AHRQ, Guide to Prevention Indicators, AHRQ Pub. No. 02-R0203, Oct. 2001, Revision 3 (January 9, 2004).

Safety Net Sites in Oregon - 2004

Baker

Site Type	Name
Hospital	St. Elizabeth Health Services
LHD	Baker County Health Department-Mountain Valley
LHD	Baker County Health Department
Other	Pine Eagle Clinic
Rural Health	Baker Clinic
SBHC	Baker High Student Health Center

Benton

Site Type	Name
Hospital	Good Samaritan Regional Medical Center
LHD	Benton County Health Department
Rural Health	Alsea Rural Health Care, Inc.
SBHC	Monroe Middle School
SBHC	Lincoln Elementary School

Clackamas

Site Type	Name
FQHC	Clackamas County Public Health Division Oregon City
FQHC	Clackamas County Public Health Division Molalla Clinic
FQHC	Clackamas County Public Health Division Sandy Health
Hospital	Willamette Falls Hospital
Hospital	Kaiser Sunnyside Medical Center
Hospital	Legacy Meridian Park Hospital
Hospital	Providence Milwaukie Hospital
LHD	Clackamas County Mental Health
LHD	Clackamas County Public Health Division
SBHC	Oregon City High School

Clatsop

Site Type	Name
FQHC	Coastal Family Health Center
FQHC	Clatsop Behavioral Health Clinic
Hospital	Columbia Memorial Hospital
Hospital	Providence Seaside Hospital
LHD	Clatsop County Health & Human Services
LHD	Clatsop County Health & Human Services
Rural Health	Providence North Coast Clinic
VA	PVAMC Warrenton Camp Rilea Clinic

Columbia

Site Type	Name
LHD	Columbia County Public Health Services
Rural Health	Clatskanie Clinic
Rural Health	Providence Family Medicine Vernonia
SBHC	Sacagawea Health Center

Coos

Site Type	Name
Hospital	Bay Area Hospital
Hospital	Coquille Valley Hospital
Hospital	Southern Coos Hospital
Indian/Tribal	Coquille Community Health Center-Coquille Tribe
Indian/Tribal	Coos, Lower Umpqua & Siuslaw Confederated Tribes
LHD	Coos County Public Health
Other	Waterfall Clinic
Rural Health	Powers Clinic
VA	Bandon Community Based Outpatient Clinic

Crook

Site Type	Name
FQHC	Ochoco Community Clinic
Hospital	Pioneer Memorial Hospital
LHD	Crook County Health Department

Curry

Site Type	Name
Hospital	Curry General Hospital
LHD	Curry County Health Department
LHD	Curry County Health Department
LHD	Curry County Mental Health Program
LHD	Curry County Health Department
Rural Health	Curry Family Medical
Rural Health	Oak Street Health Clinic
Rural Health	The Brookings Clinic
VA	Brookings Community Based Outpatient Clinic

Deschutes

Site Type	Name
Hospital	St. Charles Medical Center - Redmond
Hospital	St. Charles Medical Center - Bend
LHD	Becky Johnson Community Center
LHD	Deschutes County Human Services
Rural Health	La Pine Community Clinic
VA	PVAMC Bend Clinic

Douglas

Site Type	Name
FQHC	Umpqua Community Health Clinic
FQHC	Umpqua Community Health Clinic
Hospital	Mercy Medical Center
Hospital	Lower Umpqua Hospital
Indian/Tribal	Cow Creek Health & Wellness Center-Cow Creek Band
LHD	West Douglas County Office
LHD	North Douglas County Office
LHD	Douglas County Health & Social Services
LHD	South Douglas County Office
Rural Health	Mercy Health Clinic
SBHC	Roseburg High School

Gilliam

Site Type	Name
Rural Health	Arlington Medical Center
Rural Health	Gilliam County Medical Center

Grant

Site Type	Name
Hospital	Blue Mountain Hospital
LHD	Grant Mental Health Clinic & Drug Out patient txt
LHD	Grant County Health Office

Harney

Site Type	Name
Hospital	Harney District Hospital
Indian/Tribal	Wadatika Health Center- Burns Paiute Tribe
LHD	Harney Behavioral Health
LHD	Harney County Health Department

Hood River

Site Type	Name
FQHC	La Clinica del Carino
Hospital	Providence Hood River Memorial Hospital
LHD	Hood River County Health Department

Jackson

Site Type	Name
FQHC	La Clinica del Valle
FQHC-LA	Community Health Center
Hospital	Providence Medford Medical Center
Hospital	Ashland Community Hospital
Hospital	Rogue Valley Medical Center
LHD	Jackson County Health & Human Services
Rural Health	Shady Cove Clinic
Rural Health	Rogue River Health Clinic
SBHC	Scenic Middle School
SBHC	Phoenix High School
SBHC	Kids Health Connection Jackson Elementary School
SBHC	Kids Health Connection Washington Elementary School
SBHC	Crossroads Alternative High School
SBHC	Ashland High School
SBHC	Jewett Elementary School
SBHC	Kids Health Connection Oak Grove Elementary School
SBHC	Crater High School
VA	VA Southern Oregon Rehabilitation Center & Clinics

Jefferson

Site Type	Name
Hospital	Mountain View Hospital
Indian/Tribal	Warm Springs Health & Wellness Center-Confederated
LHD	Best Care Treatment Services/Jefferson County
LHD	Jefferson County Health Department

Josephine

Site Type	Name
FQHC	Siskiyou Community Health Center
Hospital	Three Rivers Community Hospital
LHD	Josephine County Public Health Department
Rural Health	Siskiyou Pediatric Clinic, LLP
SBHC	Lorna Byrne Middle School

Klamath

Site Type	Name
FQHC	Klamath Health Partnerships
FQHC	Sprague Valley Medical Center
Hospital	Merle West Medical Center
Indian/Tribal	Klamath Tribal Dental Clinic-Klamath Tribes
Indian/Tribal	Klamath Tribal Health & Family Services-Klamath Tribes
Indian/Tribal	Klamath Tribal Medical Clinic
LHD	Klamath County Department of Public Health
LHD	Klamath Mental Health Center
Other	Bonanza Clinic
VA	Klamath Falls Community Based Outpatient Clinic

Lake

Site Type	Name
Hospital	Lake District Hospital
LHD	North Lake County Health Department
LHD	Lutheran Community Services NW/Lake County
Rural Health	North Lake Clinic

Lane

Site Type	Name
FQHC	Lane County Human Services-Metro
FQHC	Lane County Human Services-New Roads for Youth
FQHC	White Bird Clinic
Hospital	Peace Harbor Hospital
Hospital	McKenzie-Willamette Hospital

Hospital	Cottage Grove Community Hospital
Hospital	Sacred Heart Medical Center
LHD	Lane County Health & Human Services
LHD	Lane County Health & Human Services Mental Health
Rural Health	John Herscher D.O.
Rural Health	Peace Health - CGSLMG
Rural Health	McKenzie River Clinic
Rural Health	Health Associates of Peace Harbor Hospital
Rural Health	The Lakeside Clinic
SBHC	North Eugene High School
SBHC	South Eugene High School
SBHC	Springfield High School
SBHC	Churchill High School
SBHC	Sheldon High School
VA	Eugene Community Based Outpatient Clinic

Lincoln

Site Type	Name
Hospital	Samaritan North Lincoln Hospital
Hospital	Samaritan Pacific Communities Hospital
Indian/Tribal	Siletz Community Health Clinic-Confederated Tribes of
Indian/Tribal	Siletz Community Clinic
LHD	Lincoln City Mental Health
LHD	Lincoln County Mental Health Program
LHD	Lincoln County Human Services Department
Rural Health	Samaritan Coastal Clinic
Rural Health	Samaritan Physicians Clinic
Rural Health	Yachats Community Clinic
Rural Health	Coastal Health Practitioners
Rural Health	Lincoln City Medical Center
SBHC	Waldport SBHC
SBHC	Toledo High School
SBHC	Taft High School
SBHC	Newport High School

Linn

Site Type	Name
Hospital	Samaritan Lebanon Community Hospital
Hospital	Samaritan Albany General Hospital
LHD	Linn County Department of Health Services

LHD	Linn County Department of Health Services
LHD	Linn County Department of Health Services

Malheur

Site Type	Name
FQHC	Valley Family Health Care-Ontario Clinic
FQHC	Valley Family Health Care
FQHC	Valley Family Health Care-Nyssa Health Care
Hospital	Holy Rosary Medical Center
LHD	Malheur County Health Department
LHD	Lifeways Behavioral Health-Malheur County
Rural Health	Malheur River Clinic
Rural Health	Malheur Memorial Health Center
Rural Health	Jordan Valley Health Clinic, Inc.

Marion

Site Type	Name
FQHC	West Salem Clinic
FQHC	Yakima Valley Farmworkers Clinc-Silverton Pediatric
FQHC	Lancaster Women's Clinic
FQHC	Yakima Valley Farmworkers Clinic-Salud Medical Center
Hospital	Silverton Hospital
Hospital	Salem Hospital
Hospital	Santiam Memorial Hospital
Indian/Tribal	Chemawa Health Center
LHD	Marion County Health Department
LHD	Marion County Children's Mental Health
LHD	Marion County Health Department
Other	Willamette Family Medical Clinic
VA	PVAMC Salem Clinic

Morrow

Site Type	Name
Hospital	Pioneer Memorial Hospital
LHD	Morrow County Health Department
Rural Health	Irrigon Medical Clinic
Rural Health	Pioneer Memorial Clinic

Multnomah

Site Type	Name
FQHC	Southeast Health Center
FQHC	Taft Hotel
FQHC	Yakima Valley Farmworkers Clinic
FQHC	Native American Rehabilitation Association
FQHC	Gateway Children's Center
FQHC	DCD-Donald Long
FQHC	Metro Child Care Resource & Referral MH
FQHC	Clara Vista Family Resource Center MH
FQHC	Saint Francis Dining Hall
FQHC	Russell Street Dental Clinic
FQHC	Multnomah County Mental Health & Addiction Services
FQHC	Central Parole & Probation MH
FQHC	CARES NW Mental Health
FQHC	Portland Alternative Health Center
FQHC	Rockwood Neighborhood Health Access Center
FQHC	North Portland Health Center
FQHC	La Clinica de Buena Salud
FQHC	Parkrose Neighborhood Health Access Center
FQHC	Mid-County Health Center
FQHC	North Portland Clinic Health Services
FQHC	Hooper Detox
FQHC	New Avenues for Youth
FQHC	Westside Health Center
FQHC	Northeast Health Center
FQHC	Multnomah County Primary Care
FQHC	Old Town Clinic
FQHC	Outside In
FQHC	East County Health Center
Hospital	Shriners Hospital for Children
Hospital	Portland Veteran Affairs Medical Center
Hospital	Oregon Health & Science University
Hospital	Legacy Good Samaritan Hospital
Hospital	Legacy Emanuel Hospital & Health Center
Hospital	Legacy Mount Hood Medical Center
Hospital	Adventist Medical Center
Hospital	Providence Portland Medical Center

LHD	Multnomah County Health Department STD/TB/HIV
Other	North Portland Nurse Practitioner Community Health
Other	PACS Family Health Center
Other	West Burnside Chiropractic Clinic
Other	The Wallace Medical Concern
SBHC	Marshall High School
SBHC	Cleveland High School
SBHC	Lincoln Park Elementary School
SBHC	Parkrose High School
SBHC	Lane Middle School
SBHC	Portsmouth Middle School
SBHC	Jefferson High School
SBHC	Roosevelt High School
SBHC	George Middle School
SBHC	Madison High School
SBHC	Grant High School
SBHC	Binnsmead Middle School
SBHC	Whitaker (Lakeside)

Polk

Site Type	Name
FQHC	Total Health Community Clinic
Hospital	West Valley Community Hospital
Indian/Tribal	Grand Ronde Health & Wellness Center-Confederated
LHD	Polk County Health Department

Sherman

Site Type	Name
Rural Health	Morro Medical Center

Tillamook

Site Type	Name
FQHC	Tillamook County Health Department
FQHC	Tillamook County Health Department
FQHC	Tillamook County Dental Clinic
FQHC	Tillamook County Health Department
Hospital	Tillamook County General Hospital
LHD	Tillamook Family Counseling-Tillamook County Mental
Rural Health	Bayshore Family Medicine
Rural Health	The Rinehart Clinic
Rural Health	Tillamook Medical Associates, PC

Umatilla

Site Type	Name
FQHC	Yakima Valley Farmworkers Clinic-Hermiston
Hospital	Good Shepherd Medical Center
Hospital	St. Anthony Hospital
Indian/Tribal	Yellow Hawk Clinic-Confederated Tribes of Umatilla
LHD	Umatilla County Public Health Division
LHD	Umatilla County Public Health Division
LHD	Umatilla County Mental Health Program
LHD	Umatilla County Public Health Division
Rural Health	Good Shepherd Medical Group
SBHC	Pendleton High School
SBHC	Sunridge Middle School

Union

Site Type	Name
Hospital	Grande Ronde Hospital
Rural Health	Elgin Family Health Center
Rural Health	Union Family Health Center
SBHC	La Grande High School

Wallowa

Site Type	Name
Hospital	Wallowa Memorial Hospital
LHD	Wallowa County Health Department
LHD	Wallowa County Mental Health Clinic

Wasco-Sherman

Site Type	Name
FQHC	La Clinica del Carino in The Dalles
Hospital	Mid-Columbia Medical Center
LHD	Wasco Sherman Public Health Department
LHD	Gilliam, Hood River, Wasco, Sherman Mental Health
LHD	Wasco Sherman Mid Columbia Center for Living
Other	Greater Oregon Behavioral Health

Washington

Site Type	Name
FQHC	Virginia Garcia Memorial Healthy Start OB Clinic
FQHC	Virginia Garcia Memorial Health Center
FQHC	Virginia Garcia Memorial Health Center
FQHC	Virginia Garcia Memorial Health Center

Hospital	Providence St. Vincent Medical Center
Hospital	Willamette Valley Medical Center
Hospital	Tuality Community Hospital
LHD	Washington County Department of Health & Human
LHD	Washington County Department of Health & Human
LHD	Washington County Department of Health & Human
LHD	Washington County Health & Human Services Mental
SBHC	Merlo Station High School

Wheeler

Site Type	Name
Rural Health	Asher Clinic

Yamhill

Site Type	Name
FQHC	Virginia Garcia Memorial Health Center
Hospital	Providence Newberg Hospital
LHD	Yamhill County Public Health
LHD	Yamhill County Mental Health Programs
SBHC	Willamina High School