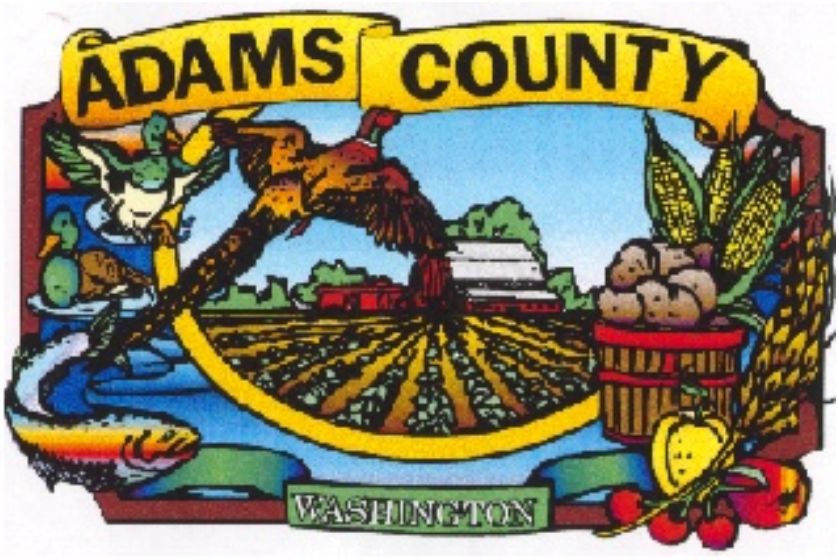

Adams County Health Alliance

Community Health Needs Assessment

Executive Summary

For

Adams County

2014

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DEFINITION OF TERMS/ACRONMYMS

ABCD: Access to Babies and Children's Dentistry
ACA: Affordable Care Act
ACHA: Adams County Health Coalition
ACHD: Adams County Health Department
ACIHCS: Adams County Integrated Health Care Services
Activity: An action that supports and works towards achieving the SMART objectives.
Activity Plan: Once a CHIP is created, activity plans form the work that partnering agencies will create in alignment in working towards community health improvement.
AHEC: Area Health Education Center
Body Mass Index (BMI): A number calculated from a person's weight and height. BMI is a fairly reliable indicator of body fatness for most people. One formula is weight (lb) x 703 divided by height (in) times itself = BMI.
BOH: Board of Health
CASPER: Community Assessment for Public Health Emergency Response
CBHA: Columbia Basin Health Association
CDC: Centers for Disease Control
CHA: Community Health Assessment
CHIP: Community Health Improvement Plan, community wide plan to improve population health status
CHNA: Community Health Needs Assessment, a systematic examination of the health status within a given population, through data and community perception, which helps to identify key problems and assets in a community.
CHNA.org: Website for county data. http://www.communitycommons.org/chna/
CHOS: Community Health Opinion Survey
Community Health Status Assessment: Through data, identifies health status, population demographics and socioeconomics.
Community Themes and Strengths Assessment: Identifies community perceptions and opinions about health needs.
Determinants of Health: Social, genetic, environmental, socioeconomic and other factors that contribute to health status.
DOH: Department of Health, (Washington state)
EARH: East Adams Rural Hospital (changed to East Adams Rural Healthcare during the CHNA process)
Forces of Change Assessment: Identifies current community factors (political, economic, social, etc.) that could detract from or enhance the ability to enact change.
FQHC: Federally Qualified Health Center
Goals: Under each strategic issue, a general target to work towards.
Health: A state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity (WHO).
HFM: Hometown Family Medical Clinic
Inspire: Washington Migrant Health Center located in Othello
IRS: Internal Revenue Service
LHJ: Local Health Jurisdiction

Local Public Health System Assessment: Identifies local capacity of what agencies support any or all of the 10 essential health services of public health through provision of preventative health services in the community.
LRSD: Lind Ritzville School District
MAPP: Mobilizing for Action through Planning and Partnerships, a health assessment model created by the National Association of City and County Health Officials (NACCHO)
MCH: Maternal Child Health
MOU: Memorandum of Understanding
NACCHO: National Association of City and County Health Officials.
Obesity: Percent of adults age 18 or older who have a body mass index (BMI) of 30k/m2 or more.
OCH: Othello Community Hospital
OHCC: Othello Healthy Communities Coalition
OSD: Othello School District
PAID: People Against Illegal Drugs
Patient Protection and Affordable Care Act: Signed into law imposing new requirements that charitable hospitals must meet to continue to qualify for exemption under Section 501 (c) (3) of the Internal Revenue Code. Included were requirements that charitable hospitals conduct a Community Health Needs Assessment (CHNA) every three years and adopt an implementation strategy to meet the identified needs.
Prenatal Care: Rate of women receiving prenatal care in the first trimester (birth risk factor percent) (DOH)
RMC: Ritzville Medical Clinic
SMART Objectives: Specific Measurable Achievable Realistic Time bound. Measurable components will be created under each goal that is specific, measurable, achievable, realistic and time bound. These will be included in the CHIP.
SMS: Special Mobility Service; transportation agency to assist Medicaid covered clients to access medical/dental care
SRHD: Spokane Regional Health District
Strategic Issues: Overarching health related concepts identified into areas to focus on to improve a community's health.
SWOT: Strengths Weaknesses Opportunities Threats

TISSAM: Take it Seriously: Sex, Abstinence and Media

WSD: Washtucna School District

THE BEGINNING AND THE PURPOSE

In March, 2010, the comprehensive health care overhaul, known as the Patient Protection and Affordable Care Act, was signed into law creating new requirements that charitable hospitals must satisfy in order to continue to qualify for exemption under Section 501 (c) (3) of the Internal Revenue Code. Included were requirements that charitable hospitals conduct a Community Health Needs Assessment (CHNA) every three years and adopt an implementation strategy to meet the identified needs. Through data analysis and the community's perception of health needs, a CHNA is done. A CHNA is a systematic examination of the health status within a given population to help identify key problems and assets in a community. This report highlights the findings of the 2013-14 Adams County's CHNA. This includes review of health status, community themes and strengths, forces of change and the local public health system. It serves as a call to action for prevention and care-focused health partners in the community to prioritize and address our identified needs.

COMMUNITY OVERVIEW AND DEMOGRAPHICS

Adams County includes 5 incorporated communities, Othello, Ritzville, Lind, Washtucna and Hatton. Each of the cities has their own local government. The county is governed by a 3 member board of elected county commissioners. These commissioners also act as the Board of Health for the local health department. Ritzville is the county seat and Othello is the largest population area. Adams County is primarily agriculture and agriculture related business. Dry land farming is in the east end of the county, irrigation and row crops are in the "panhandle" area of the county. In addition to farming, there are a few large processing plants located in the Othello area that employ a considerable number of Othello residents and also employ neighboring out-of-county residents. Adams County is located in the east central area of the state bordered by Lincoln, Grant, Franklin and Whitman Counties. The Ritzville area is midway between Spokane and Moses Lake. Othello is located between Moses Lake and the Tri-Cities area. Residents from Adams County communities usually access health care not available in Adams County in the larger neighboring cities. The population of Adams County was 18,765 (2010 Census). Current population estimate is 19,067 for 2013. Population increased from the 2000 to 2010 census by 14% with growth in the "panhandle" area of the Adams County. The Hispanic population accounts for 59% of the population of Adams County (chna.org) this is also more concentrated in the panhandle. Adams County is considered a small rural county.

HISTORY OF COMMUNITY COLLABORATION AND ASSESSMENT

The first community health assessment of Adams County population was conducted in 1996. It was done as local health jurisdictions in Washington State began the effort to assess their population's health. The 1996 assessment was completed using data review, key informant interviews and community forums. It was done with the assistance of the Area health Education Center (AHEC) in

Spokane. Adams County LHJ staff conducted the interviews and forums with AHEC writing the final report.

A comparison summary of results is listed in Appendix 2. (For a full report, please contact Adams County Health Department).

Although the process of assessment is recommended to occur every 3 years, lack of funding has delayed the process in Adams County until now.

In June of 2013, members from the local clinics, hospitals and public health gathered to begin the current process of community health needs assessment utilizing Mobilizing for Action through Planning and Partnerships (MAPP). The process began as a result of Adams County Health Department's need to do a community health assessment (CHA) as part of their strategic planning efforts and the hospitals desire to conduct a CHNA. Throughout this report we will call our process the CHNA. This process was led and facilitated by the local public health department. An alliance was formed between the two area hospitals; Othello Community Hospital (OCH) and East Adams Rural Hospital (EARH), the large Federally Qualified Health Care (FQHC) center, Columbia Basin Health Association (CBHA) and Adams County Integrated Health Care Services(ACIHCS) /Adams County Health Department (ACHD). These entities adopted the title ***Adams County Health Alliance*** (ACHA) and signed the Memorandum of Understanding (MOU) in the fall of 2013.

Adams County has a long history of successful collaboration between the hospitals, clinics, emergency management and the LHJ on other issues. We have collaborated to address communicable disease concerns, client home visiting, healthy communities, immunization at community flu clinics, health fairs, school flu clinics, emergency preparedness drills, homeless assessment and other issues as they come up.

This assessment was conducted somewhat differently than the 1996 assessment. First, LHJ staff and partners reviewed available data to gain information and understanding of our community's health concerns. Next, community health partners were surveyed using survey monkey with specific health questions adapted from the Benton-Franklin health assessment.

Next, a community opinion survey tool was selected to gain information from our community members. Several different tools were reviewed and Alliance members decided to conduct the community opinion survey (CHOS) utilizing CASPER (Community Assessment of Public Health Emergency Response) methodology to elicit broader community opinions. We modeled our community health opinion survey after the successful Wake County, North Carolina survey done in 2013 and we used CASPER because it is a valid sampling tool and requires less number of completed surveys than other validated methods. It also would give us a broader community perspective than was obtained in 1996.

Summary of Current Processes and Methods

In July of 2013, the partners of Adams County, which included hospitals, FQHC and LHJ, agreed to conduct a joint community health needs assessment to satisfy IRS requirements for certain hospitals and to fulfill the Department of Health (DOH) public health standards requirements and strategic plan goals for ACHD. The assessment will also benefit the health department at such time as National Public Health accreditation standards are required. As mentioned in the previous section, the project began in July with data review and presentations by partners and planning for a community health opinion survey. Meetings were held regularly to plan and review. The assessment coordinator and nursing director for Adams County Health Department assumed project leadership. An MOU was signed between alliance partners. A timeline was drawn up and approved by partners.

MAPP Process

ACHA used the MAPP model developed by the National Association of County and City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC). ACHD and the ACHA collaborated on this assessment process that met the requirements for a CHNA for Internal Revenue Service's (IRS) and ACHD public health standards, but more importantly will lay a solid foundation for the development of a Community Health Improvement Plan (CHIP). The concept of health through the MAPP model is that health is not simply a matter of medical treatment or the absence of disease, but must be viewed from a community perspective. The vision for implementing MAPP is:

"Communities achieving improved health and quality of life by mobilizing partnerships and taking strategic action".

The MAPP CHNA process requires broad participation from the community, six phases and four formal assessments briefly described on the following pages.

Obtaining Community Input

Throughout the assessment process members of ACHA provided input based on needed tasks and their personal expertise. The ACHA reviewed previous assessments, current health statistics, and many other data sources relevant to understanding the population of Adams County. The ACHA worked together to complete a Community Health Opinion Survey (CHOS) utilizing CASPER with Adams County Health Department leading this effort. The CASPER is a random systematic sampling method utilized by the CDC for rapid assessment for public health emergency response. It can be tailored for use in non emergent assessment as was used by ACHA. This is a valid sampling method and requires collection of 80% (or 168 completed surveys) of 210 randomly selected households from survey clusters. All census tracts in Adams County were randomly assessed and selected by the CDC CASPER team. CASPER survey planning began in December, 2013 and continued through April, 2014 with extensive review of the planned survey tool. This included agreement by partners on the questions asked and submission of some additional questions related to environmental health concerns. Assistance from the CDC CASPER team was provided during this time to help the lead team understand the sampling, process and methodology to collect the most survey's possible. The CDC determined the sample from census tract information.

The Adams County CASPER was conducted April 14, 15 and 16, 2014, by surveyors representing, CBHA, Spokane Regional Health District, EARH, OCH and Adams County Integrated Health Care Services (ACIHCS) which included staff from: ACHD, Mental Health, Chemical Dependency,

Developmental Disabilities and Housing for the Homeless, and Volunteers. 20 teams of 2 person interviewers were dispatched on 4-14. The majority of surveys were collected the first day (108). Less teams were dispatched on day 2 to collect additional surveys (66) and 2 staff returned to pick up 2 surveys on day 3, returning at the request of the family member being surveyed. A total of 176 surveys were collected out of a possible 196, for a 90% response rate, considered a success by CDC standards. Although the cluster sample size is designated as 210 surveys for a CASPER, the CDC was unable to get a random cluster sample that was greater than 196 for Adams County.
For a more detailed review, the AAR from the CASPER and CASPER report is available on request.

Phase One, organize for success and partnership development

Phase one began in 2013 with a signed MOU between Othello Community Hospital, East Adams Community Hospital, Columbia Basin Health Association and Integrated Health Care Services to cement assessment expectations. The MOU clarified the assessment process and partner expectations.
KEY Partners included: EARH, OCH, Mental Health, Chemical Dependency, CBHA, Emergency Management and ACHD. Meetings were facilitated by Callie Moore and Karen Palmer, ACHD. A full list of participants is included at the end of this report.

Phase Two, developing a vision statement

A vision statement was decided on after review of numerous pertinent vision statements, discussion of what was important to our coalition and our communities and what was our long term vision for Adams County. We also reviewed and selected values and goals.

ACHA Vision:

- ***To become the healthiest county in the State***

ACHA Values:

- ***Communication – We value open and meaningful dialogue with the community, media, and other resources***
- ***Accountability – We value clear responsibility and action***
- ***Evidence – We value the adopting of best practices and proven innovations***
- ***Partnership – We value collaboration with businesses, health services, and the community in maintaining the health of Adams County***

ACHA Goals:

- ***Affordable and accessible quality healthcare for all***
- ***Elimination of disparities***
- ***Educated and empowered families and youth***
- ***Community awareness of economic well-being and health***
- ***Continual improvement and measurement of needs of all individuals in Adams County***

Phase Three, four assessments

Assessment One – Themes and Strengths- Community Survey

The community health opinion survey was adapted from a survey completed in 2013 by Wake County North Carolina. A web search was done by lead staff at ACHD to review surveys completed by communities using CASPER to do their community health opinion survey (CHOS). The Wake County survey was chosen as a model based on the completeness of survey questions and their relationship to questions our ACHA wanted to ask our county residents. Wake County is a community of nearly a million residents and they utilized the CASPER to administer their CHOS with success. Their report indicated this survey gave them some of the best information they had ever received from a CHOS. The survey was comprehensive including 56 questions. Our coalition spent several meetings reviewing the survey and adding and eliminating questions until it was more specific to Adams County. It was then translated into Spanish to be consistent with the English version. Spanish speaking staff participated on all teams in the Othello area. In an attempt to eliminate different interpretations of questions, a group of Spanish speaking staff members of ACIHCS reviewed the survey and agreed upon the translation prior to conducting the survey. The survey provided insight to issues of importance to the community. It was administered over 2 days and one short day with 176 surveys collected. This met CASPER guidelines for successful random sampling. The CASPER toolkit can be accessed at: http://www.cdc.gov/nceh/hsb/disaster/casper.htm

The summary report of the questionnaire used by Adams County is included as Appendix 4.

In addition to collecting community opinion data a survey monkey was administered to health partners including clinics, hospitals, schools, law, long term care, child care, emergency management and emergency response partners. 100 surveys were sent to these partners to collect information.

27 responses were received to three questions:

- On a scale of 1-4, how healthy do you think your community is?
- What barriers do you think prevent Adams County from being a healthy community?
- How would you define a healthy community?

Provider survey results are in Appendix 3.

The two graphs below give a summary of responses from the two surveys administered:

Summary of Partner Survey responses below:

Community Health Assessment for Partners – Survey Monkey (27)	**Answers:**
How healthy do you think your community is?	"Fair health" had a 77.8% response (21)
What barriers do you think prevent Adams county from being a healthy community?	Top 3 barriers: Financial (19) 73%, education (18) 69% and transportation availability (12) 46%

How would you define a healthy community? (22 answers 5 skips)	Answers fall in 4 topical areas: (some answers addressed more than one issue) Number of times this was listed: Safety -5 Availability of services and transportation -7 Economically strong – 5 Healthy/active/reduce obesity - 13

This will be incorporated with the community survey as the ACHA determines next steps in developing a Community Health Improvement Plan (CHIP).

CASPER CHOS responses to 3 questions: *Percentages based on multiple responses*

	Adams County Survey Results: (176)	%	English Speaking Only: (67)	%	Spanish Speaking Only: (54)	%
Which top 3 issues affect the quality of life in Adams County						
Low income/poverty	72	15%	32	18%	18	13%
Drug/Alcohol abuse	67	14%	22	12%	21	15%
Unemployment/employment opportunities	56	12%	56	31%	18	13%
Which top 3 issues need the most improvement						
Positive teen activities	73	15%	34	20%	16	13%
More affordable/ better housing	50	10%	12	7%	9	7%
Higher paying employment	42	9%	14	8%	12	10%
Availability of employment	29	6%	14	8%	4	3%
Child care options	19	4%	19	11%	11	9%
Which top 3 health behaviors do people in your community need more information about						
Child care/ parenting	46	9%	18	10%	15	10%
Exercise/fitness	36	7%	6	3%	15	10%
Managing weight	29	6%	7	3%	14	10%
Eating well/nutrition	26	5%	10	6%	26	18%
Substance Abuse/ Prevention	43	9%	21	12%	7	5%
Caring for family with disabilities	19	4%	12	7%	2	1%
Elder Care	31	6%	11	6%	8	6%

After completion of the two surveys, coalition members reviewed responses in detail to facilitate understanding of responses and common themes.
Complete survey results are available upon request.

Assessment Two – Community Health Status – Data Collection and Analysis

ACHA utilized several data sources for review:

- Public Health Indicator data
- Community Health Needs Assessment data from the chna.org website
- Behavior Risk Factor School Survey data
- Strengthening public health infrastructure
- Healthy youth survey (2010)
- Maternal Child Health data tables: National Performance measures
- Health Ranking data
- Oral health: Smile Survey 2010 (ABCD data)
- Community Needs Assessment for Connell, Mattawa and Othello by Eastern Washington University (CBHA report 12-2012)

Several meetings were devoted to review of the data sources. Common themes of concern were:

- Obesity
- Teen pregnancy
- Diabetes
- Access to care; lack of insurance and poverty

Issue:	**Adams County: 2011 data**	**Washington: 2011 data**	**Healthy People 2020 targets:**
Obesity	37%	28%	30.5% Reduce by 10%
Diabetes	15%	8%	Reduce by 10%
Teen Pregnancy	97/100,000	30/100,000	36.2/1000 Reduce by 10%
Access to Primary Care (primary care physician rate/100,000)	63.07/100,000	90.53/100,000	83.9% Increase by 10%
Lack of insurance (% uninsured total population)	23.66%	13.51%	100% insurance coverage
Poverty (income per capita)	$16,538	$30,661	No target set. This measure is being tracked

Data sources and results are listed in Appendix 5.

Assessment Three – Local Public Health System

The Local Public Health System Assessment was completed in 2012 as part of the strategic planning process utilizing SWOT (Strengths, Weaknesses, Opportunities and Threats). The following information was listed as part of the SWOT done by LHJ staff.

Strengths	**Weaknesses**	**Opportunities**	**Threats**
Immunizations	Funding	Education	Funding
Environmental Health services	Restrictions on funding	Participation on coalitions	Communicating public health messaging
Bi-lingual staff	Communication	Media	Loss of services

Staff Experience	Marketing/media	Public health emergency leadership	

The Local Public Health System Assessment identification of agencies and health services within the community that provide any of the ten essential services of public health to the community is below. The activities and agencies addressing these services are listed in the following table, and can generally be broken into three categories; assessment, policy development and assurance.

Local Public Health System Assessment	**Description**	**Agencies/Organizations**
ASSESSMENT		
Monitor Health to identify and solve community health problems	Accurate, periodic assessment of the community's health status, including: identification of health risks, attention to vital statistics and disparities, identifications of assets and resources	ACIHCS ACHD CBHA Ritzville Medical Clinic Hometown Family Medicine OCH EARH Lind-Ritzville School District Othello School District Washtucna School District
Diagnose and investigate health problems and hazards in the community	-Timely identification and investigation of health threats -Response plans to address major health threats	CBHA ACHD Emergency management EARH OCH Law Enforcement Fire Districts
POLICY DEVELOPMENT		
Inform, educate and empower people about health issues	Initiatives using health education and communication sciences to: build knowledge and shape attitudes, inform decision-making choice, develop skills and behaviors for healthy living.	ACIHCS CBHA HFM RMC EARH OCH LRSD OSD WSD Law Enforcement Fire Districts Emergency Management OHCC PAID TiSAM
Mobilize community partnerships	Constituency development	OHCC

to identify and solve health problems	and identification of system partners and stakeholders	ACHA ACIHCS PAID CBHA EARH OCH Emergency Management
Develop policies and plans that support individual and community health efforts	Policy development is implemented and adapted to protect health and guide public health practice	ACHD CBHA EARH OCH Emergency Management
ASSURANCE		
Enforce laws and regulations that protect health and ensure safety	-Review, evaluate, revise and educate about legal authority, laws and regulations -Advocate and support regulations needed to protect and promote health	ACHD Law Enforcement Fire Districts
Link people to needed personal health services and assure the provision of health care when otherwise unavailable	-Identify populations with barriers to care -Provide entry into a coordinated system of care -Ongoing care management -Culturally appropriate and targeted health information for at risk population groups -Transportation and other enabling services	ACHD CBHA RMC HFM OCH EARH LRSD OSD WSD SMS Ministerial Associations INSPIRE
Assure a competent public and personal healthcare workforce	-Assessment of the public health and personal workforce -Quality improvement and life-long learning, leadership development, cultural competence	ACIHCS EARH OCH CBHA HFM RMC

Evaluate effectiveness, accessibility, and quality of personal and population-based health services	-Evaluation questions: Are we doing this right? Are we doing the right things? -Evaluation must be ongoing and should examine: personal health services, population based services, the public health system	ACIHCS ACHD CBHA HFM RMC EARH OCH LRSD OSD WSD ACHA INSPIRE Emergency Management
Research for new insights and innovative solutions to health problems	-Linkages between public health practice and academic/research settings -Epidemiological studies, health policy analyses and health systems research	ACHD CBHA HFM RMC EARH OCH DOH CDC SRHD U of W

Assessment Four – Forces of Change

The Forces of Change assessment looked at trends, events and factors that affect the health of the community, focusing on those that could be threats or opportunities for change. Political, economic, social, technological and legal forces were identified at the local, state and national levels that would impede or assist in addressing the strategic issues

Criteria to consider in determining strategic issues include economics, legality, and acceptability. These are often directly impacted by the Forces of Change acting within the community. For example, there has been increased focus on obesity in local, state and national media. In Adams County, there has also been increased focus on obesity as the county ranks as one of the highest in the state for obesity in the public health indicator data. The Othello Healthy Community Coalition has been working on strategies to address the obesity concern for several years. It is important to take advantage of this increased awareness in the community as an opportunity for change.

Another event that influences this process is the Affordable Care Act. Changes in health care delivery and policy are certain and it is important for the strategic issues to adhere to any legal requirements as well as to work to ensure that new policies address the gaps identified by the strategic issues.

It is also important to recognize the conservative nature of our community; thus, the selection of strategic issues focuses on less controversial issues in order to increase buy in by local government and the community as a whole.

FORCES OF CHANGE ASSESSMENT

Category	Force	Threat	Opportunity
Political	-Affordable Care Act -BOH priorities and policies	-Lack of understanding of ACA -Health Care Provider resistance -Limited/lack of funding	-Healthcare expansion of Medicaid to more citizens -Insurance coverage improvements covering preventive care and preexisting conditions -"Triple Aim" (better health, better care, lower costs) drives a better healthcare model
Economic	-Economy -Current health care system unsustainable -Public Health System dismantled	-Increasing poverty -Decreasing funding -Delay in seeking medical care due to lack of resources -Change -Loss of funding/program cutbacks	-Opportunity to introduce new programs -Willingness to collaborate and pool limited resources -Willingness to change -Restructure public health model
Social	-Age and ethnicity - Differences between cities -Conservative population -Mental health stigma	-Disparities -Language barriers -Different agendas -Lack of openness to deal with sensitive issues -Discrimination -Fear of seeking treatment	-Influence health of younger population before disease/illness arise -Create culturally sensitive messages -Grant opportunities require more collaborative partnerships -Educate community to remove stigma/false information

Technological	-Internet -Telemedicine -Social Media	-Older population not as comfortable with new technologies -Larger volume of misinformation -Investment of current technology a barrier to migrating to newer technologies -Reimbursement for new technology is not available (ie teletherapy)	-Social media allows small groups to have big impact -Small ideas can grow "go viral" -Telemedicine getting more mainstream
Legal	HIPPA/Patient confidentiality	-Barrier to collaboration between agencies when not able to share information	-Care Coordination between agencies

Phase Four, prioritization of the community health needs

The strategic issues were identified through a process called compression planning. This process was begun at a planning meeting, continued by lead staff and circulated to members via email for decisions on strategic issues. Given the information from all four assessments, the coalition found consensus around three strategic issues: **Obesity, Positive Teen Activities and Substance Abuse.**

These issues were identified as having the greatest feasibility based on the available resources, the potential for change, alignments with the community vision and overlapping on all four assessments. Our planning activities will include analysis to identify factors that may cause health issues. Some factors may be linked such as lack of positive teen activities and substance abuse and strategies to address one of these issues may address both. As the ACHA develops specific objectives, this will be kept in mind.

Goals for Strategic Issues:

How to promote healthy weight and reduce obesity?
Goal #1: Community members will make healthier food choices
Goal #2: Community members will be more physically active
Goal #3: Mothers will breastfeed their infants

How to provide positive teen activities?
Goal # 1: Teens will have opportunities for positive activities
Goal # 2: Identify ongoing positive teen activities
Goal # 3: Strengthen and promote ongoing positive teen activities

How to reduce substance abuse? Goal #1: Identify resources available in the community for substance abuse prevention Goal #2: Identify gaps within existing systems for substance abuse prevention Goal #3: Strengthen and promote existing programs or identify opportunities for new programs

From the three strategic issues, broad goals were identified and will be linked to evidence based prevention models that can be used by health care agencies and organizations across the county to improve population health. A current list of activities available to address the selected issues will be compiled so that we can draw on what is already in place. With funding limitations our goal will be to enhance and get information out about those activities we are all already doing that address our strategic issues and through collective impact we will strategize to maximize our energy to choose one or two additional activities to address the strategic issues.

Next Steps:

Phase Five, Goals and Strategies

A Community Health Improvement Plan (CHIP) and an action plan will be created to support and evaluate activities pertaining to the identified strategic issues and goals. A CHIP will be created through the ACHA with technical assistance from ACHD.

The action plan will be created in alignment with evidence based/informed methods and tailored by agencies to support and move towards achieving better population health throughout Adams County. Although multiple agencies may choose to include additional health issues, the goal is that all partnering health agencies will be working towards similar priorities as identified through this process.

Phase Six, Action Cycle

The Action Cycle links three activities – planning, implementation, and evaluation. Each of these activities builds upon the others in a continuous and interactive manner. While the Action Cycle is the final phase of MAPP, it is by no means the end of the process. During this phase, the efforts of the previous phases begin to produce results, as the local public health system develops and implements an action plan for addressing priority goals and objectives. This is one of the most challenging phases, as it may be difficult to sustain the process and continue implementation over time (NACCHO, MAPP).

Plan

- Organize for action by convening the necessary participants, establishing an oversight committee which will be ACHA for implementation activities, and preparing for implementation.
- Develop realistic and measurable objectives related to each strategic goal and establish accountability by identifying responsible parties.
- Develop action plans aimed at achieving the outcome objectives and addressing the selected strategies.

Implement

- Review action plans looking for opportunities to coordinate and combine resources for maximum efficiency and effectiveness (collective impact).
- Implement and monitor the progress of action plans.

Evaluate

- Prepare for evaluation by engaging stakeholders and describing the activities to be evaluated.
- Focus the evaluation design by selecting evaluation questions, the process for answering these questions, the methodology and plan for carrying out the evaluation, and a strategy for reporting results.
- Gather credible evidence that answers the evaluation questions. Justify the conclusions.
- Ensure that the results of the evaluation are used and shared with others. Celebrate the successes of the process.

Throughout the assessment process, organizers have assessed and asked "who and what is missing". Feedback was received during the process and has been incorporated as much as possible. Results will be used to improve the next assessment process. Ideas and suggestions for the next CHNA are welcome. Please share your thoughts at ACHD website: http://www.co.adams.wa.us/departments/temp_helth.asp

To achieve our vision of "the healthiest county in the state" is a call to action for better collaboration and communication. It will require implementing evidence based programs that target at risk populations. It will require engaging our citizens to be active participants in their own health. Finally it will be necessary to measure performance to make sure we are making progress toward better population health.

RESOURCES:

Demographics and Population Information:

Community Health Needs Assessment (CHNA) toolkit: The CHNA toolkit is a free web-based platform designed to assist hospitals (with particular attention to critical access and other smaller facilities), non-profit organizations, state and local health departments, financial institutions, and other organizations seeking to better understand the needs and assets of their communities, and to collaborate to make measurable improvements in community health and well-being. http://www.communitycommons.org/chna/

Health Data:

Public Health Indicator Data: http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/PublicHealthSystemResourcesandServices/PublicHealthImprovementPartnership/LocalPublicHealthIndicators

BRFSS Data: http://www.cdc.gov/brfss/

Strengthening Public Health Infrastructure: http://www.acponline.org/newsroom/strengthen_public_health_infrastructure.htm

Healthy Youth Survey (2010): http://www.doh.wa.gov/DataandStatisticalReports/DataSystems/HealthyYouthSurvey

MCH data tables: National Performance Measures. https://mchdata.hrsa.gov/DGISReports/PerfMeasure/default.aspx

Health Ranking Data: http://www.countyhealthrankings.org/

MAPP Model: http://www.naccho.org/topics/infrastructure/mapp/

Ten Essential Services of Public Health: http://www.cdc.gov/nphpsp/essentialServices.html

WHO definition of Health: http://who.int/about/definition/en/print.html

KEY PARTNERS

Othello Community Hospital – Connie Agenbroad
East Adams Rural Healthcare – Brenda Herr, Gary Bostrom, Dina McBride
Columbia Basin Health Association – Dulcye Field
Emergency Management – Jay Weise
Adams County Integrated Health Care Services – Vicki Guse, Administrator
Includes:
Gloria Ochoa, Chemical Dependency
Patrice Dial, Mental Health/Housing for the Homeless
Brent Stenson, Environmental Health/Data Review
Stacy Cutter, Environmental Health/Data Compilation/Review
Karen Palmer, Personal Health/Data Compilation/Assessment Coordinator
Callie Moore, Personal Health/CHNA Lead

We would like to thank the 27 key partners responding to the Survey Monkey.

We would like to thank the 176 CHOS survey respondents for their time and contribution to the success of this CHNA.

We would like to thank Benton Franklin Health District whose needs assessment and process served as a guide for us.

APPENDICES:

Appendix 1 - Adams County Population Estimate

Appendix 2 - Comparison of 1996 and 2014 issues

Appendix 3 - Survey Monkey, provider survey results

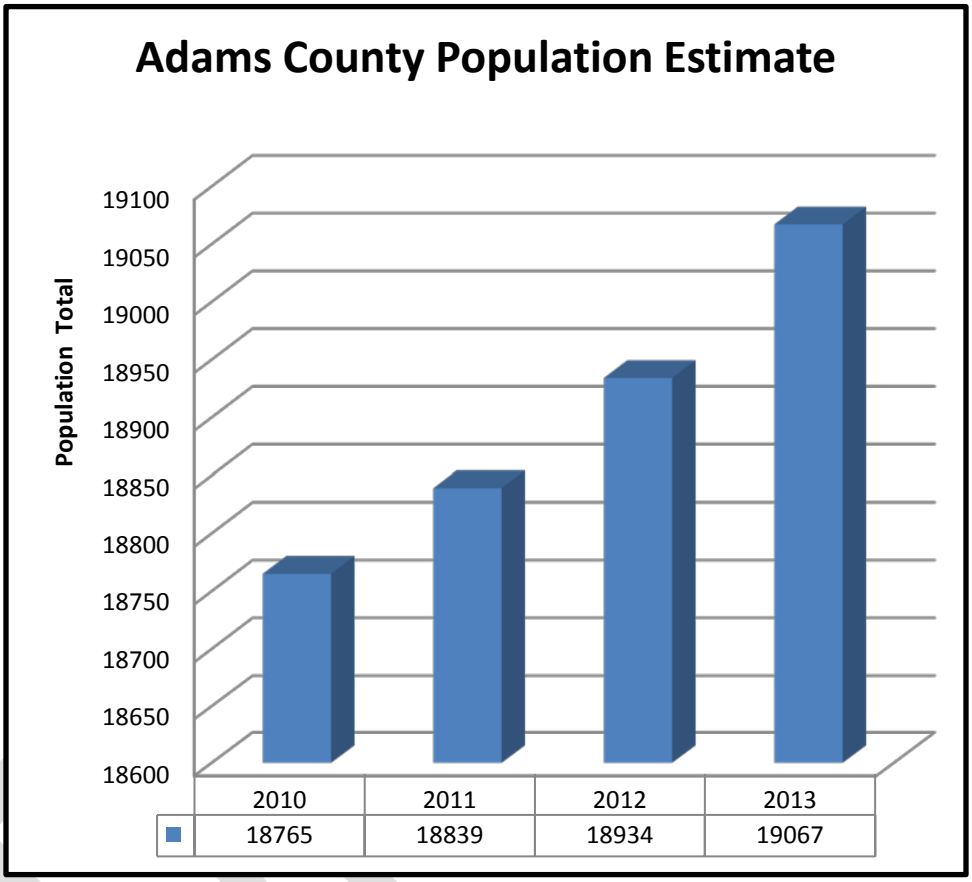
Appendix 4 - Adams County Community Health Opinion Survey

Appendix 5 - Adams County Data (chna.org)

Appendix 1

SOURCE: American Fact Finder annual estimates of the resident population

(April 1, 2010 to July 1, 2013)



Appendix 2

Comparison of issues between 1996 community assessment and 2014 community assessment

Compare and contrast Table for 1996 and 2014

1996 issues of concern	2014 issues of concern	Comments
14th of 39 counties for per capita income	Low income/poverty	There continues to be concern about income, poverty, employment opportunities.
Higher than state rate of poverty	Unemployment/employment opportunities	
Lower than state rate of graduation	More affordable/ better housing	
	Higher paying employment	
	Availability of employment	
Heart disease the leading cause of death over 65	Managing weight	Although heart disease was the concern in 1996, diabetes and obesity are current concerns. Issues of concern in 2014 also relate to heart disease improvement.
	Exercise/fitness	
	Eating well/nutrition	
Unintentional injury the leading cause of death among 1-24 year olds		This issue was not listed as a concern in 2014.
Higher than state rate of teen pregnancy		Although not listed directly in the top categories for strategic planning, this continues to be a concern in 2014
Nitrate contamination in drinking water		No mention of this in 2014
High Chlamydia rate		Still a concern but not addressed in strategic plan.
Mumps outbreak		Not a concern in 2014
	Child care options	This was not mentioned as a concern in 1996
	Child care/ parenting	This was not mentioned as a concern in 1996
Low smoking rate among pregnant women		Not listed as a concern this is a positive and the smoking rate continues to be low and a positive in our county
	Drug/Alcohol abuse	This was not listed in 1996
	Positive teen activities	This was not listed in 1996

Appendix 3

COMMUNITY HEALTH NEEDS ASSESSMENT FOR ADAMS COUNTY – SURVEY MONEY RESULTS

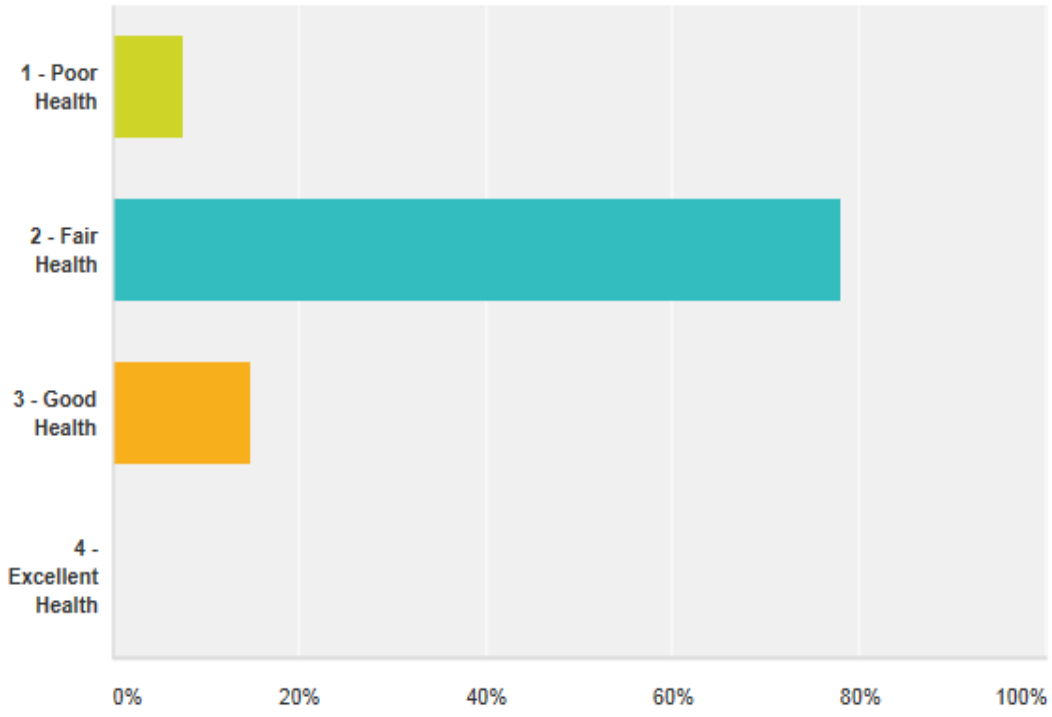
Provider Survey Results

Provider Survey conducted

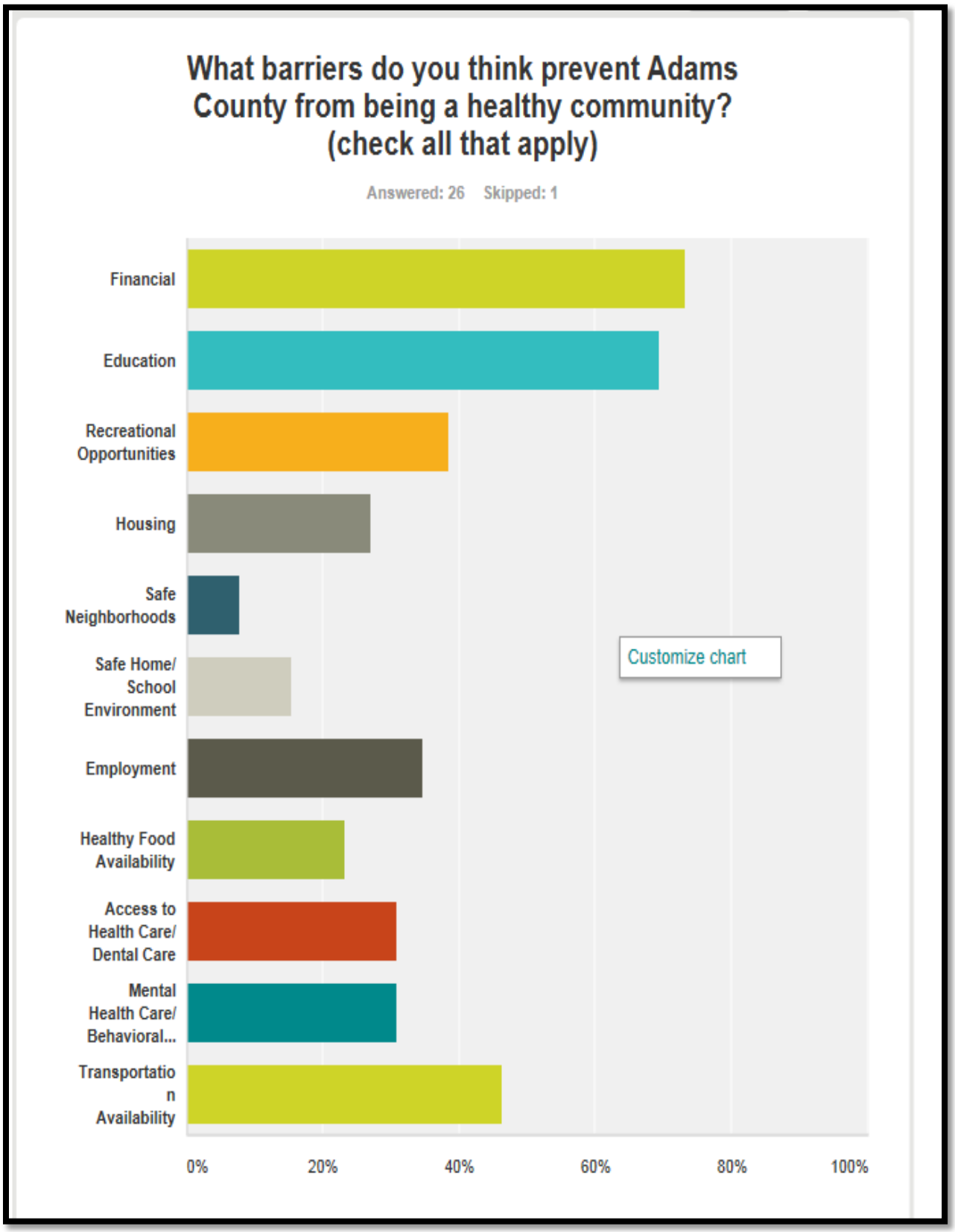
December, 2013

On a scale of 1-4, how healthy do you think your community is?

Answered: 27 Skipped: 0



Answer Choices	Responses	
1 - Poor Health	7.41%	2
2 - Fair Health	77.78%	21
3 - Good Health	14.81%	4
4 - Excellent Health	0%	0
Total		27


What barriers do you think prevent Adams County from being a healthy community? (check all that apply)
Answered: 26 Skipped: 1
Financial
Education
Recreational Opportunities
Housing
Safe Neighborhoods
Safe Home/ School Environment
Employment
Healthy Food Availability
Access to Health Care/ Dental Care
Mental Health Care/ Behavioral...
Transportation Availability
Customize chart
0%
20%
40%
60%
80%
100%

Answer Choices	Responses	
Financial	73.08%	19
Education	69.23%	18
Recreational Opportunities	38.46%	10
Housing	26.92%	7
Safe Neighborhoods	7.69%	2
Safe Home/ School Environment	15.38%	4
Employment	34.62%	9
Healthy Food Availability	23.08%	6
Access to Health Care/ Dental Care	30.77%	8
Mental Health Care/ Behavioral Health	30.77%	8
Transportation Availability	46.15%	12
Total Respondents: 26		

Comments (2)

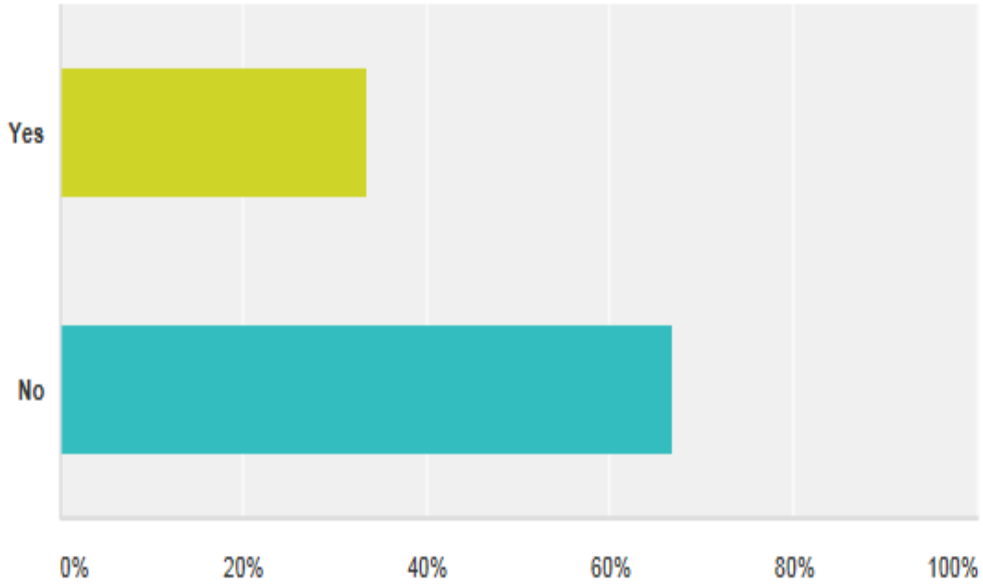
How would you define a healthy community?

Answered: 22 Skipped: 5

1. Availability of services and safety within the community
2. Activities/information seminars to help prevent DM or obesity. If here, Othello, would give more opportunities to participate year round with physical activities or swimming year round that for me would be considered a healthy community
3. More recreational activities healthier food selections
4. Strong, healthy good economically
5. People making healthy choices for themselves and their children less drug abuse, no gang influence, strong police presence, more activities for children
6. Good outreach programs and affordable care
7. The community is staying actively involved
8. Healthy is good physical health, safe and rich in employment opportunities
9. More community programs to promote physical fitness for all ages. Restaurants with healthier food choices. Public transportation for people to get to appointments and such. More hiking and walking tails. Clean parks and communities. Too many people think someone else will pick up after them.
10. Lower obesity rates, more visible people out walking around town and using the public parks, etc.
11. Thriving financially and no barriers between community members
12. No obese
13. Active engaged in healthy past times
14. Prevalence of Chronic & Acute diseases Access to health care and use of it interest in healthy living.
15. HealthCare available to all at an affordable cost. Access to specialist care without the hassle. Better patient training to prevent spread of infectious disease (MRSA, CRE, C. Diff, etc.)
16. One who supports the community? Shops, medical treatment, fuel, dining and supports the schools and our future generations of children.
17. A physically active community that has a wide variety of opportunities for year-round fitness for all ages. A community that practices health eating practices. The community would also include a fair amount of educated and involved citizens willing to read about and be informed of current sources of information about health areas such as nutrition, depression, mental health, active lifestyles, preventative health care practices and mental/cognitive deployment issues.
18. Community resources available to everyone in need of them not just the people who qualify for health/food benefits based upon income or lack of. The hard working middle class still struggles for medical care, etc., but are expected to pay for it when we really struggle to afford it.
19. One that is free from drugs, gangs and poverty.
20. A healthy community is where all members of the community health needs are met.
21. Active, safe, neighborhoods where people feel free to do activities outside.
22. Active, educational, accessible to alternate things.

Would you be willing to participate in the Community Health Need Assessment process?

Answered: 27 Skipped: 0



Answer Choices	Responses	
Yes	33.33%	9
No	66.67%	18
Total		27

Appendix 4

ADAMS COUNTY COMMUNITY HEALTH OPINION SURVEY –April, 2014

Talking with people about their opinions on healthcare
and other health-related issues in Adams County.

PART 1: COMMUNITY

Table 1: Community Issues

	Frequency (n=479)	% of Responses
Which top three issues affect the *quality* of life in Adams County? (Multiple answers were given)		
1. Low income/poverty	72	15%
2. Drug/alcohol abuse	67	14%
3. Unemployment/ Employment opportunities	56	12%

	Frequency (n=489)	% of Responses
Which top three issues /services *need the most improvement* in your neighborhood or community? (Multiple answers were given)		
1. Positive teen activities	73	15%
2. More affordable/ better housing	50	10%
3. Higher paying employment	42	9%

	Frequency (n=499)	% of Responses
Which top three health behaviors do people in your own community need more information about? (Multiple answers were given)		
1. Child care/parenting	46	9%
2. Exercising/fitness	36	7%
3. Managing weight	29	6%

PART 2: HEALTH

Table: 2 Your health – How people in Adams County rated their health

	Frequency (n=176)	% of Responses
Excellent	33	19%
Good	74	42%
Fair	44	25%
Poor	15	8%
Don't know/not sure	10	6%

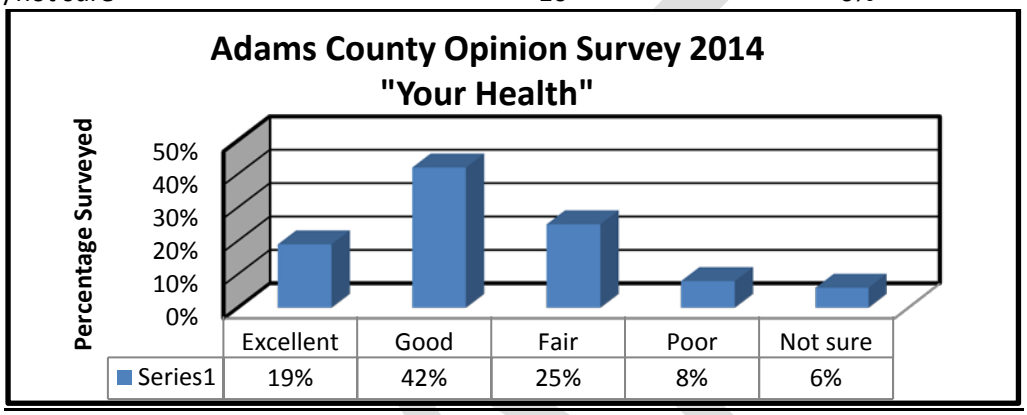


Table 3: Past 12 month was there any time you did not have health insurance:

	Frequency (n=176)	% of Responses
Yes	64	36%
No	112	64%

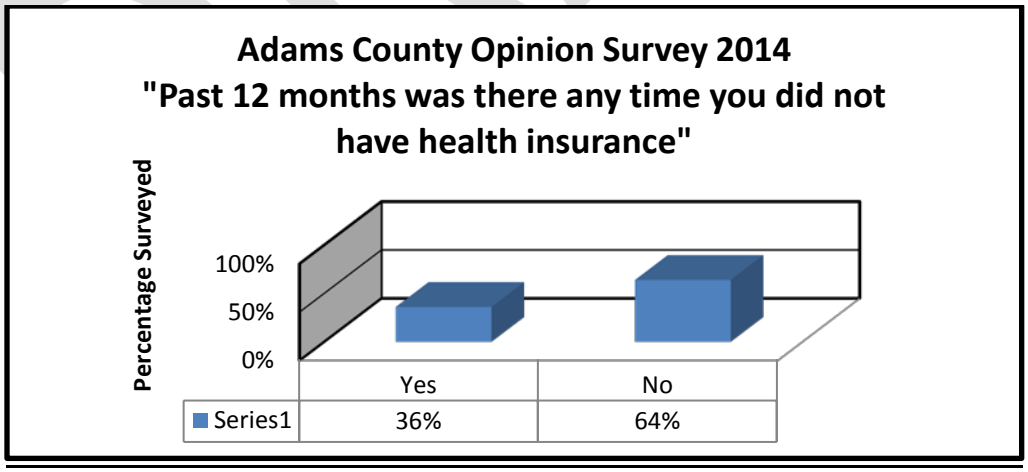


Table 4: What is your health insurance plan?

	Frequency (n=191)	% of Responses
(Multiple answers were given)		
Private/Employment	38	20%
Private/Purchased	24	13%
Medicare	43	23%
Medicaid (Provider One)	32	16%
No Health Plan	28	15%
Don't know/not sure	6	3%
Other	20	10%

(This includes: Secondary retirement, Aflac, Tri-Care for Life, AARP, Medicare Supp., and VA)

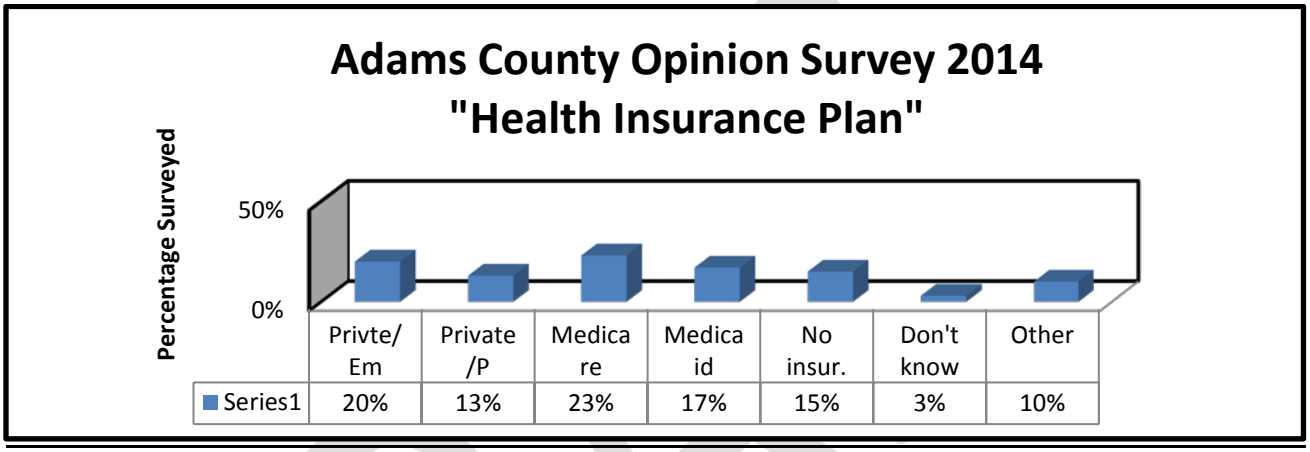


Table 5: Where do you go when you are sick?

	Frequency (n=179)	% of Responses
Doctor's Office	116	65%
Free/low cost clinic	46	26%
School Nurse	0	
Health Dept.	1	
Family/Friend	2	1%
Hospital	2	1%
Emergency Room	2	1%
Pharmacy	0	
Workplace	0	
Urgent Care	2	1%
Therapist/Counselor	0	
Other:	8	5%

(Other includes: 1-VA, 6-do not go to the doctor, 1- treats self)

Table 6: Where do you get medical advice?

	Frequency (n=176)	% of Responses
Othello	134	76%
Moses Lake	11	6%
Pasco	1	

Yakima	2	
Ritzville	12	7%
Lind	3	
Tri Cities	1	
Connell	4	
Spokane	4	
Did not answer/missed	8	

(5% of those surveyed seek medical care from Spokane, Yakima, Connell, or Tri-Cities. 7% did not seek medical care or did not answer the question)

Table 7: How long since you visited a doctor for a routine checkup: (does not include being sick, pregnant or chronic)

	Frequency (n=176)	% of Responses
Within the past year	99	56%
1-2 years	40	24%
3-5 years ago	13	7%
More than 5 years	13	7%
Never had a check-up	0	
Don't know/not sure	11	6%

Table 8: Have you had problems getting health care, filling a prescription, getting Mental Health care,disability or dental care?

	Frequency (n=176)	% of Responses
Yes	25	14%
No	148	86%
Not answered	3	

Table 9: If problems occurred, which problems did you have?

	Frequency (n= 68)	% of Responses
(Multiple answers were given)		
Didn't have insurance	14	21%
Didn't have transportation	6	8%
Didn't have separate dental insurance	9	13%
Didn't have child care	3	4%
Insurance didn't cover what I needed	9	13%
Didn't know where to go for care	2	3%
Could not afford out-of-pocket cost (deductible)	8	13%
Can afford it/did not want to pay that much	2	3%
I could not get an appt.	3	4%
I had problems with Medicare D	2	3%
Interpreter who speaks my language not available	2	3%
Insurance not accepted by my health care provider	2	3%
Other: No comments	6	9%

Table 10: How long since you visited a dentist for a routine check-up?

	Frequency (n=109)	% of Responses
Within the year	45	41%
1-2 years	25	23%
3-5 years	19	17%
More than 5 years	12	12%
Never been to a dentist for a check-up	8	7%

(This question was skipped 67 times)

Table 11: Have you used alternative medicine in the past 12 months?

	Frequency (n=176)	% of Responses
Yes	55	31%
No	121	69%

Table 12: How often do you have someone help you read/understand health related materials?

	Frequency (n=176)	% of Responses
Always	24	14%
Frequently	20	11%
Occasionally	33	19%
Never	99	56%

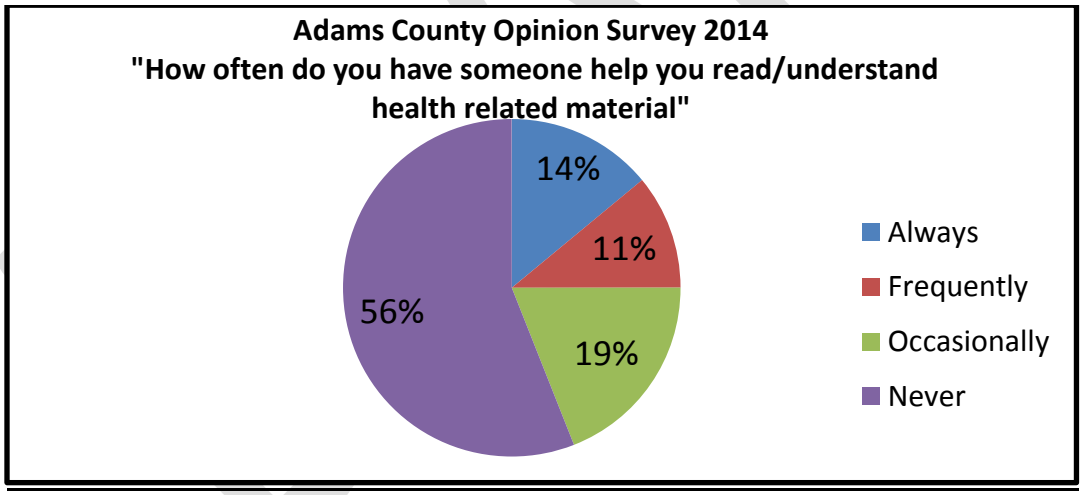


Table 13: Do you have problems learning about your medical condition because of difficulty understanding written information?

	Frequency (n=175)	% of Responses
Always	21	12%
Frequently	8	5%
Occasionally	18	10%
Never	128	73%

(This question was not answered 1 time)

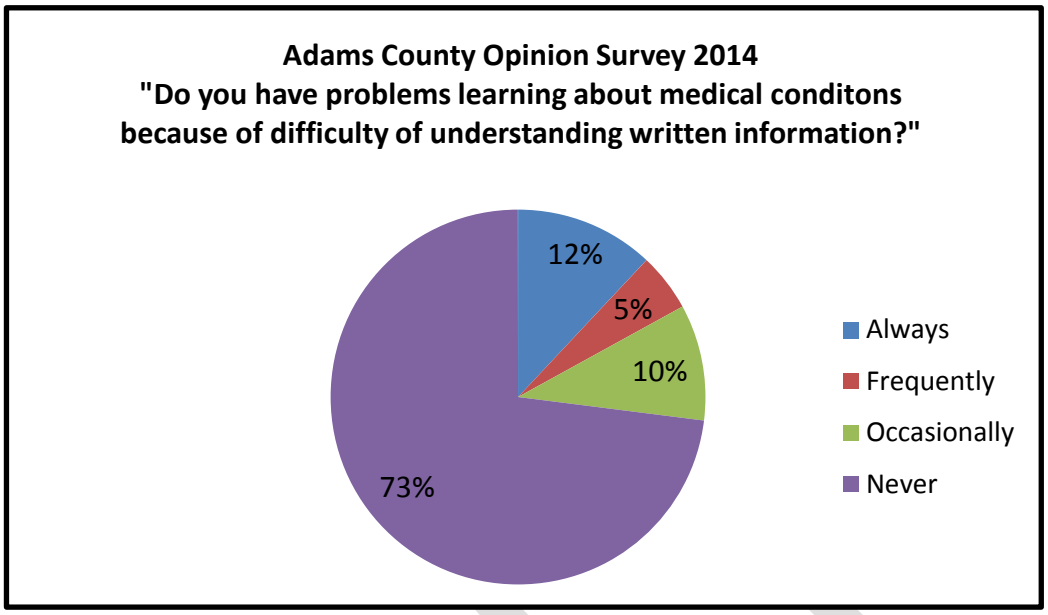


Table 14: If a friend or family member needed counseling for a mental health or a drug/alcohol abuse problem, who is the first person you would tell them to call or talk to?

	Frequency (n=176)	% of Responses
Doctor	43	24%
Family member	16	9%
Support group (AA, Al-Anon)	19	11%
Private counselor/therapist	9	5%
Minister/religious official/church	18	10%
Adams County Community Counseling	28	16%
Crisis line	13	7%
Other	10	7%
Don't know/not sure	20	11%

Table 15: Where do you engage in exercise or physical activities?

	Frequency (n=194)	% of Responses
(Multiple answers were given)		
I don't exercise	28	14%
Public rec.center, parks or trails	24	12%
Home	77	40%
Neighborhood	27	13%
Private gym/pool	8	4%
Work	16	8%
Church or faith setting	3	2%
Malls	0	
School setting	2	1%
Senior Citizen Center	3	3%
Other (not specified)	6	3%

Table 16: For those that answered "I don't exercise", are there reasons why you don't exercise:

	Frequency (n=33)	% of Responses
I don't' like to exercise	6	18%
I would need child care	1	3%
It costs too much to exercise (equipment- gym)	2	6%
I'm physically unable	1	3%
I'm too tired to exercise	3	9%
There is no safe place to exercise	0	
I don't have enough time to exercise	7	21%
I don't need to exercise	3	9%
I don't have access to a facility that has the things I need; (pool, track, etc)	4	12%
Other (not specified)	6	18%

(This question was not answered 143 times)

Table 17: Has a doctor, nurse or health professional EVER told you that you had the following?

	Frequency (n=176)	% of (YES) Responses*

	YES	NO	NOT SURE	
Cancer	12	163	1	7%
Asthma	13	163	1	7%
Heart Disease	16	160		9%
Congestive Heart Failure (CHF)	6	170		3%
Chronic Obstructive Pulmonary Disease (COPD)	4	172		2%
Depression	43	131	2	24%
High Blood Pressure	57	119		32%
High Cholesterol	44	129	3	25%
Overweight/Obese	57	119		32%
Osteoporosis	13	163		
Chronic Pain	23	153		
Diabetes (not during pregnancy)	25	151		

**These were individually asked questions and the percentages were based on the total number of "yes" responses for that particular question.*

Table 18: After which of these activities do you *routinely* wash your hands?

	Frequency (n=176)	% of responses
Before you prepare cook or eat food	162	92%
After you use the restroom,help a child use the restroomor change a diaper	167	95%
After you touch an animal or clean up animal waste	139	79%
Before playing withchildren	94	53%
After you cough, sneeze or blow your nose	122	69%
Before and after you care for a wound	138	78%
After being outdoors	122	69%
After you touchgarbage	135	77%
Before or after you touch another person/shake hands	72	41%
After you handle itemscontaminated by the floor or sewage	138	78%
Before or after caring for someone who is sick	135	77%
After handling uncooked foods, raw meat, poultry or fish	149	85%

Table 19: What symptoms would prevent you from going to work?

		Frequency (n=176)	% of (Yes) Responses*
	Yes	**No**	
Fever	99	77	56%
Diarrhea	123	53	70%
Vomiting	129	47	73%
Flu	116	60	66%
Stomach Cramps	65	111	37%
Headache	50	126	28%
Migraine	84	92	48%
Nausea	65	111	37%
Head Cold (runny nosecough, etc)	73	103	41%
Allergy Symptoms	51	125	29%
Mildly Injured Extremity (hand, foot, etc)	75	101	43%

**These were individually asked questions and the percentages were based on the total number of "yes" responses for that particular question.*

AGE/GENDER SPECIFIC HEALTH QUESTIONS:

Table 20:	Frequency (n=176)	% of Responses
Gender:		
Male	56	32%
Female	119	68%
Refused	1	

Age:		
65+	43	24%
55-64	34	19%
45-54	20	11%
35-44	38	22%
25-34	24	14%
18-24	17	10%
18-64	133	76%

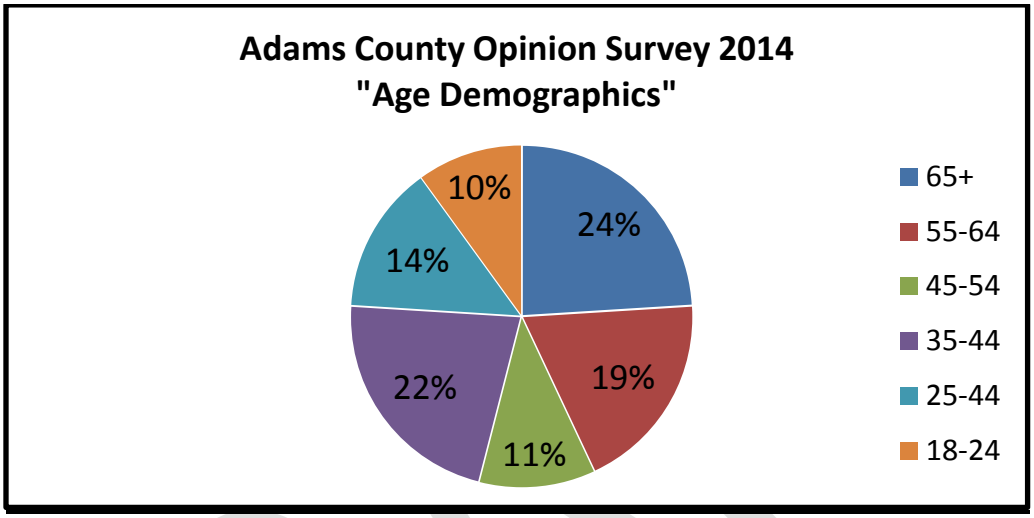


Table 21: Have you ever had a colonoscopy?(Only for people over 50)

	Frequency (n=83)	% of Responses
Yes	54	65%
No	29	35%

(This question was not answered 93 times)

Table 22: Do you have an annual prostate exam? (Only males over 40)

	Frequency (n=46)	% of Responses
Yes	22	48%
No	24	52%

(This question was not answered 130 times)

Table 23: Do you have a mammogram at least every other year? (Only females over 40)

	Frequency (n=71)	% of Responses
Yes	48	67%
No	23	33%

(This question was not answered 105 times)

Table 24: Do you have pap smear at least every other year? (Only females over 21)

	Frequency (n=108)	% of Responses
Yes	67	62%
No	41	28%

(This question was not answered 68 times)

Table 25: In the past 12 months did you provide any long-term or disability care? If yes, what was the relationship to that person?

	Frequency (n=165)	% of Responses
Elderly or disabled parent/grandparent	24	15%
Disabled child	3	2%
Grandchild	2	1%
Foster child/ren	0	
Disabled spouse/partner	5	3%
Friend/chronic disease	6	4%
None	111	67%
Other	14	8%

(This question was not answered 11 times)

Table 26: In the last 12 months did you have a difficult time finding additional care or supportwithin Adams County for the person or people indicated above?

	Frequency (n=176)	% of Responses
Yes	15	9%
No	161	91%

Table 27: If yes, what was the main reason you, the caregiver, had a problem?

	Frequency (n=18)	% of Responses
(Multiple answers were given)		
Access to service	8	44%
Didn't know where servicesare available	7	40%
Work responsibilities	0	
Couldn't find a suitable long-term care facility	1	5%
Transportation	0	
Caregiver illness	0	
Can't pay for services	2	11%

(This question was not answered 158 times)

Table 28: Do you have any children age 18 or under?

	Frequency (n=176)	% of Responses
Yes	76	43%
No	100	57%

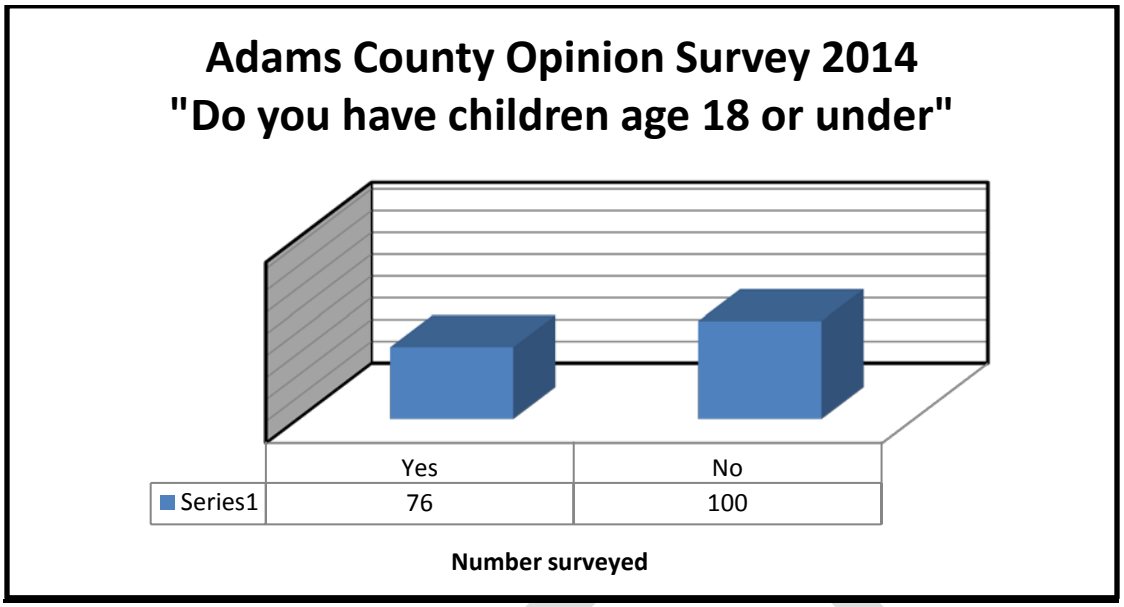


Table 29: What are the ages of your children:

	Frequency (n=130)	% of Responses
0-4	38	29%
5-9	36	28%
10-14	33	25%
15-18	23	18%

Table 30: During the past 12 months was there any time your child/ren did not have insurance or coverage?

	Frequency (n=176)	% of Responses
Yes	9	
No	167	95%

Table 31: Do you talk to your children about any of the following topics? ("Yes" answers)

	Frequency (n=566)	% of Responses
(Multiple answers were given)		
Alcohol use	51	9%
Tobacco use	43	8%
Drug use/includingprescription	47	8%
Guns	46	8%
Sexual Activity	38	7%
Reckless driving &Speeding	34	6%
Truancy	37	7%
Gangs	36	6%
Criminal Activity	39	7%
Exposure to negative/ risky Internet content	46	8%
Eating disorders	3	
Bullying	40	7%

Texting while driving	35	6%
Self-Harm (cutting, burning, mutilation)	27	5%
Thoughts of suicide	26	5%
Other	10	2%
I don't think my child is engaging in any risky behavior	8	2%

Table 32: Do you think any of your children or your children's friends are engaging in any of the following risky behaviors?

	Frequency (n=144)	% of Responses
(Multiple answers were given)		
Alcohol use	9	6%
Tobacco use	8	5%
Drug use including prescription	10	7%
Guns	3	2%
Sexual Activity	6	4%
Reckless driving &speeding	6	4%
Truancy	7	5%
Gangs	5	3%
Criminal activity	4	3%
Exposure to negative/risk yinternet content	7	5%
Eating disorders	3	2%
Bullying	7	5%
Texting while driving	7	5%
Ingesting or inhaling harmful substances	2	1%
Self-Harm (cutting, burning, mutilation)	2	1%
Other	11	8%
I don't think my child is engaging in anyrisky behavior	47	33%

Part 3: EMERGENCY PREPAREDNESS

Table 33: Is anyone in your household trained in CPR?

	Frequency (n=176)	% of Responses
Yes	82	47%
No	94	53%

Table 34: In a disaster, what source would you first turn to for information?

	Frequency (n=190)	% of Responses
(Multiple answers were given)		
Television	47	25%
Radio	22	12%
Internet	15	7%
Smart phone	22	12%
Print Media	3	3%
Neighbors or word ofmouth	12	6%

211	1	
911	40	21%
Other	16	8%
Don't know/not sure	12	6%

Table 35: Does anyone in your household have a disability or medical problem that would make it more difficult to deal with an emergency like a hurricane, power outage, etc?

	Frequency (n=176)	% of Responses
Yes	28	16%
No	148	84%

Table 36: In the event of a large-scale disaster, which of the following statements best represents your belief? Would you say …

	Frequency (n=175)	% of Responses
I can handle the situation without preparation	11	9%
Preparation, planning and emergency supplies will help me	115	64%
Nothing I do will help me handle the situation	4	2%
Don't know/not sure	45	25%
(This question was not answered 1 time)		

Table 37: In the first 72 hours following a disaster, whom would you rely on the most for assistance?

	Frequency (n=194)	% of Responses
(Multiple answers were given)		
Household member	32	17%
People in my neighborhood	24	12%
Fire, police, emergency personal	57	29%
Non-profit organizations, such as American Red Cross or the Salvation Army	11	6%
State and Federal Government agencies (FEMA)	16	8%
Other friends/family	44	23%
My faith community such as acongregation	10	5%

Table 38: If public authorities announced a mandatory evacuation from your community due to a large-scale disaster or emergency, would you evacuate:

	Frequency (n=176)	% of Responses
Yes	157	89%
No	13	8%
Don't know/not sure	6	3%

Table 39: What would be the main reason you might not evacuate if asked to do so?

	Frequency (n=137)	% of Responses
Lack of transportation	16	12%
Lack of trust in publicofficials	3	2%
Concern about personal safety	3	2%
Concern about family safety	32	23%
Concern about leaving pets	5	4%
Concern about traffic jams and inability to get out	3	2%
Concern about leaving property behind	5	4%
Health problems	5	4%
Other	33	24%
Don't know/not sure	32	23%

(This question was not answered 39 times)

PART 4: DEMOGRAPHICS

Table 40: How would identify your race or ethnicity?

	Frequency (n=174)	% of Responses
White/Caucasian	67	38%
Black/African American	1	
Hispanic	100	57%
Asian/Pacific Islander	0	
Native American	0	
Multiracial	4	3%
Other/specify: (other race was not specified)	2	1%

(2 refused to answer the question)

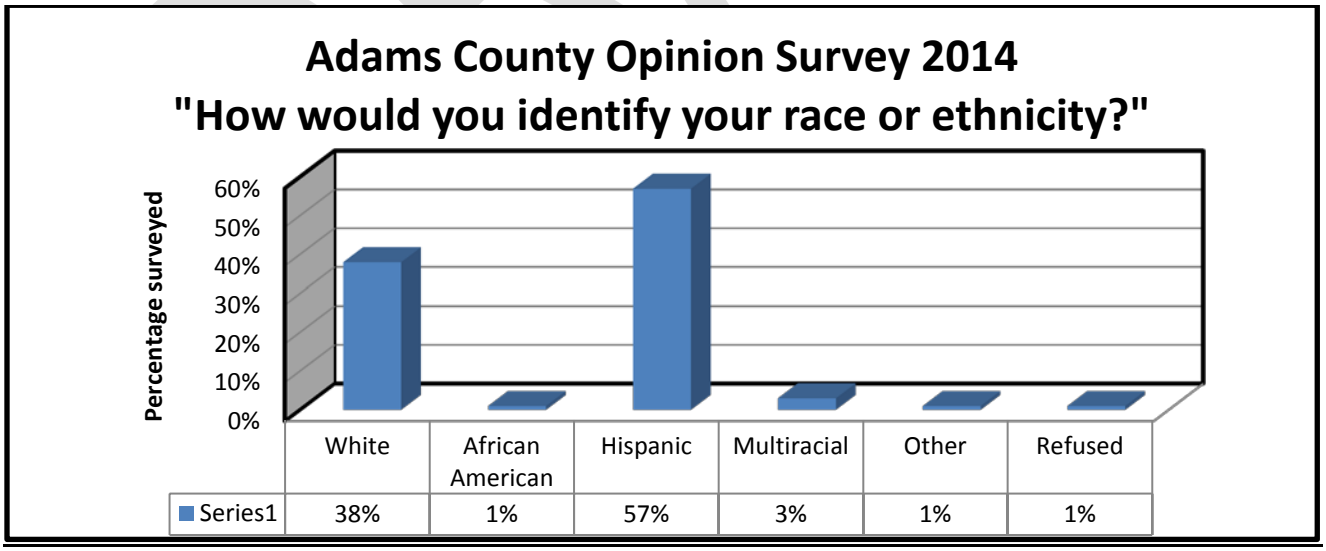


Table 41: What language do you speak at home?

	Frequency (n=206)	% of Responses
(Multiple answers were given)		
English	117	57%
Spanish	82	40%
Mixteco	7	3%

(30 responded as being bilingual)

Table 42: What is your marital status?

	Frequency (n=171)	% of Responses
Married	97	56%
Divorced	18	11%
Widowed	17	10%
Separated	7	4%
Never married	14	8%
A member of an unmarried couple	18	11%

Table 43: What is the highest level of school, college or training that you have completed?

	Frequency (n=176)	% of Responses
Never attended school/or onlyattended kindergarten	8	5%
Grades 1-8(elementary)	41	23%
Grades 9-11 (some high school)	21	12%
Grades 12 or GED (high schoolgraduate)	53	30%
College 1-3 years (some collegeor technical school)	34	19%
College 4 years or more(college graduate)	16	9%
Graduate School or Higher	3	2%

(24% of those surveyed had attended or completed college or a technical school)

Table 44: Including yourself, how many people live in your household?

	Frequency (n=176)	% of Responses
1 per house	29	16%
2 per house	47	26%
3 per house	24	14%
4 per house	26	15%
5 per house	26	15%
6 per house	11	6%
7 per house	8	5%
8 per house	1	1%
9 per house	4	2%

Table 45: Does this number include anyone who had to move in because they did not have a place to live?

	Frequency (n=176)	% of Responses
Yes	18	10%
No	158	90%

Table 46: What is your employment status?

	Frequency (n=173)	% of Responses
Employed full- time	59	34%
Employed part-time	22	13%
Retired	42	24%
Student	1	
Homemaker	21	12%
Unemployed short term(less than 27 weeks)	7	5%
Unemployed long term(27 weeks or more)	9	5%
Disabled	12	7%
More than one job	0	

(This question was not answered 3 times)

Appendix 5 CHNA DATA

Adams County Data from the CHNA.org website by category and measure. Data obtained from a variety of data sources dated 2008-2013

Measure: Demographics

Category	Definition	County rate or %	State rate or %	US rate or %	Significance
Total Population	County pop: Number - 18,289 Land area - 1924.47 sq miles Pop density per sq mi 9.50	NA	NA	NA	*Low density – under 50.1 Rural County* *WA = 100 per sq mi* *US = 88 per sq mile*
Change in Total Pop	2010 census data, change from 2000 to 2010	14%	14.09%	9.71%	*2nd highest category for population change*
Male Population	9343	51.09%	Reversed %	Reversed %	
Female Population	8946	48.91%	Reversed %	Reversed %	*Not significant*
Population under 18	6244	34%	23.5%	24%	*Higher young pop*
Population age 0-4	2008	10.98%	6.51%	6.58%	*Higher % of pop*
Population age 5-17	4236	23.16%	17.08%	17.57%	*Same*
Population age 18-64	10,017	54.7%	64.2%	62.9%	*Unique health needs*
Population age 18-24	1,829	10%	9.7%	9.9%	*same*
Population age 25-34	2,402	13.3%	13.8%	13.2%	*same*
Population age 35-44	2,212	12%	13.7%	13.6%	*same*
Population age 45-54	2,042	11.1%	14.7%	14.5%	*Same*
Population age 55-64	1,532	8.3%	12%	11.5%	*same*

Population age 65+	2,028	11%	12.3%	12.9%	*SAME*
Median age	POP. Median age	29.50	37.10	37	
Linguistically Isolated households	% of pop 5 and older who live in a home /no person >14 speaks only English/or speaks a non English lang. and speak Eng. Very well..	3,370 / 20%	284,451/4.5%	14,321,466/5%	*Higher pop.isolated*
Population with limited English	Pop. 5+/speak lang. other than Eng. @ home/or less than very well.	4,556 /27.9%	491,386/7.9%	24,950,792/8.7%	*Higher isolated pop. 5+ with limited English proficiency*
Population geographic mobility	In-migration by assessing changes in residence w/in 1 year	644/3.6%	449,423/6.8%	18,633,068/6.15%	*A move to a new house w/in county of residence excluded*
Foreign born population	5 of pop. Foreign-born	25.4%	12.8%	12.81%	*% is greater than the national % rate*
Hispanic Population	People who identify as Hispanic,Latino, or Spanish	57.8%	10.9%	16.5%	*% total is greater than the national %*
Urban and Rural Pop	%living in urban/rural	(U)59.8% (R) 40.1%	(U)84.0% (R) 15.9%	(U) 80.8% (R) 19.1%	*Identified using pop density, count and size*

Measure: Social and Economic Factors

Category	Definition	County rate or %	State rate or	US rate or %	Significance
Adequate social or emotional support	% of adults aged 18+ who self-report they receive insufficient social and emotional support all/most of time	24% pop. w/out adequate Social/Emotional support	17.10% pop. w/out adequate Social/Emotional support	20.93% pop. w/out adequate Social/Emotional support	*Associated with poor health. Ensuring access to social/economic provides a foundation for a healthier comm..*
Children eligible for free and reduced lunch	% and # eligible for Free/Reduced Price Lunch	76.31% Eligible Total enrolled 4,424 # eligible 3,376	40% Eligible Total enrolled 1,045,265 # eligible 419,896	48% Eligible Total enrolled 49,692,766 # eligible 24,021,069	Access to vulnerable pop. Which are likely to social support needs. Combines with poverty helps to measure gaps in eligibility/enrollment

Children in Poverty	% of population under age 18 in Poverty with income below 200% FPL	34	17	20	*Poverty creates barriers to access including health services, food and poor health status*
High School Grad rate	On time graduation rate Healthy People 2020 target (82.4)	77	73	75	*Research suggests education is one of the strongest predictors of health*
Income over 75,000 (family)	Families that report income of 75,000 or greater	23%	47%	42%	*Economic and social insecurity often are associated with poor health*
Population in poverty (100%)	Living in household with income below FPL	25%	13%	14%	*Poverty creates barriers to access including health services, food and poor health status*
Population in poverty (200%)	Living in household with income below 200% of the FPL.	56%	29%	33%	*Poverty creates barriers to access including health services, food and poor health status*
Population receiving Medicaid	% of the population enrolled in Medicaid	No data (Map indicated over 27%)	16%	20%	*Assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; providers can use this measure to identify gaps in eligibility/enrollment*
Teen Births	Rate of total births to women under the age of 15-19 per 1,000 female population 15-19	104.20	33	41	*Teen parents have unique social, economic, and health support services/high rate may indicate the prevalence of unsafe sex practices*
Population with AD degree	Population aged 25+ obtained an Associate's level degree or higher	21%	39%	36%	*Educational attainment has been linked to positive health outcomes*

Population receiving SNAP	Average % of population receiving the Supplemental Nutrition Assistance Program *24*%(SNAP)	16%	16%	15%	*Assesses vulnerable populations which are more likely to have multiple health access, health status, and social support needs; providers can use this measure to identify gaps in eligibility/enrollment*
Population with no HS diploma	Persons aged 25+ w/out a high school diploma (or equivalency) or higher	32%	10%	15%	*Educational attainment has been linked to positive health outcomes*
Unemployment rate	Total unemployment number report area of June 2013 age 16 and older	7.50	7	7.69	*Unemployment creates financial instability and barriers to access including insurance coverage ,health services, food, and other that contribute to poor health status*
Uninsured (adults)	% of adults age 18to 64 w/out health insurance coverage	35%	20%	21%	*Lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services*
Uninsured (children)	Reports the % of children under age 18 w/out health insurance	9%	6%	8%	*Lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services*
Uninsured (total)	Reports total civilian non-institutionalized population w/out health insurance coverage	No data	14%	16%	*Lack of insurance is a primary barrier to healthcare access including regular primary care, specialty care, and other health services*

Measure: Physical Environment

Category	Definition	County rate or %	State rate or %	US rate or %	Significance
Air Quality (Ozone)	% of dys per yr. Ozone(03) levels above Nat. air quality	0%	0%	0.47%	*Poor air qual. Contribute to resp. issues*
Air Quality (particulate matter)	Levels 2.5 levels above Nat. Air Quality	0.51%	3.15%	1.19%	*same*
Fast Food Restaurant access	# of fast food Rest. Per 100,000 pop	11/58.74	4,744/70.5	216,243/70.4	*A measure of healthy food access and env. Influences dietary behaviors*
Grocery Store Access	# of grocery stores/100,000	7/37.38	1,486/22.10	64,366/20.85	*Same*
Liquor Store Access	# of beer,wine,liquor store 100,000 pop	10.68/2	5.59/376	10,32/31,876	*same*
Park access	% of pop. Living ½ mile from a park	6,929/37%	3,317,028/49%	120,503,664/39.5%	*same*
Population w low food access	% of pop. Living n census tracts designated as food desert	48.38% 9,060 (pop.)	23.9% 1,613,215 (pop.)	23.6% 72,905,540 (pop.)	*High pop. And geographies facing food insecurity*
Low Income Pop w low food access	same	26.6%	5.39%	6.27%	
Recreation and Fitness facility access	# per 100,000 pop of rec/fitness facilities	5.34	11.58	9.56	
Reports the # of SNAP-authorized store per 100,000 pop.	# of stores per 100,000	15 (number of stores) 80.08 (rate per 100,000)	4,845 (#of stores) 72.5 (rate per 100,000 stores)	245,113 (# of stores) 78.44 (rater per 100,000)	*Supplemental Nutrition Assistance Program /benefits*
Use of Public Transport	pop. Using pubic trans. As primary means of commute to work (Emp. Age 16+)	30	175,467	6,915,208	

WIC authorized food store access	# of stores /retail est. per 100,000 that accept WIC program	6 (# of stores) 31.53 rate per 100,000	776 (# of stores) 11.30 rate per 100,000	50,042 (# of stores) 15.60 rater per 100,000	

Measure: Clinical Care

Category	Definition	County rate or %	State rate or %	US rate or %	Significance
Access to primary care	PCP rate per 100,000 pop	53.39%	90.2%	84.7%	*A shortage of health prof. contributes to access and health status issues*
Breast Cancer Screening (mammo)	% female Medicare enrollees with Mammogram in past 2 years	58.77%	66.02%	65.37%	Low rate may indicate access to care issues, lack of health knowledge, insufficient provider outreach, social barriers
Cervical Cancer Screening (pap)	% Pop. With Regular Pap Test	77.1%	77.1%	80.42%	Low rate may indicate access to care issues, lack of health knowledge, insufficient provider outreach, social barriers
Colon Cancer Screening (Sig/colon)	% Pop. Ever screened for Colon Cancer	53.3%	61.8%	57.45%	As above
Dental Care Use (adult)	% adults with no dental exam	39.76%	27.66%	30.15%	% of adults 18+ who self report they have not had dental care within the past year
Diabetes Management (Hgb H1c test)	% Medicare Enrollees with Diabetes with annual exam	87.89%	86.45%	83.81%	Indicator of health of DM patient and likelihood of future complications
Facilities Designated HP shortage areas	Total HPSA facility designations (#)	3	243	8340	Shortage of health prof. contributes to access and health status issues
FQHC's	Rate of Federally Qualifies Health	16.02% (3)	1.93% (130)	1.73% (5402(	Promote access to ambulatory care in

	Centers per 100,000 population				areas designated as medically underserved
High BP management	% adults not taking medication	29.2%	28.0%	21.7%	Indicator of poor health, access to care, lack of knowledge, etc
HIV screening	% adults never screened (self-reported, age 18-70)	70.1%	69.7%	60.1%	Early detection and treatment of health problems
Lack of consistent source of primary care	% adults without a regular doctor	34.1%	21.6%	19.3%	Access, to prevent major health issues and ER visits
Pneumonia Vaccine (65+)	% pop. With annual Pneumonia Vac	69.5%	71.1%	66.34%	Decreases the risk of developing future health problems
Pop living in HPSA shortage area	% of designated pop underserved	53.3%	73.89%	61.10%	Access
Preventable Hospital events	Ambulatory Care Sensitive (ACS) condition discharge rate	56.3%	46.4%	66.5%	ACS conditions include pneumonia, dehydration, asthma, DM, or other that could have been prevented with primary care

Measure: Health Behaviors

Category	Definition	County rate or %	State rate or %	US rate or %	Significance
Alcohol consumption	18 older self-report men 2+qd/women1qd	11.8%	15.1%	15.0%	*Determinants of future health(cancer, cirrhosis/mental)*
Alcohol expenditures	% of total household alcohol expense	No data	1.7%f	1.79%	*same*
Fruit/veg. consumption	Age 18+ less than 5serving per day	79%	74%	75%	*Unhealthy eating habits may cause sig. health issues*
Fruit/veg. expenditures	Fruit/veg. purchase	No data	1.58%	1.45%	*same*

Physical Activity (adult)	20+report no leisure time for activity (self)	26.7%	18.7%	23.67%	*same*
Soda Expenditures	%total home exp.	No data	0.4%	0.49%	*same*
Tobacco Expenditures	Tot. exp. For cigs	No data	1.44%	1.59%	*same*
Tobacco use (current smokers)	18+currently smoking	11.2%	16.1%	18.5%	*Less reported smoking in Adams Co.*
Tobacco use (former or current smokers)	18+currently smoking some days or qd	29.5%	42.2%	42.9%	*same*
Tobacco use (quit attempts)	Attempted to quit at least 1 day /year	48.2%	57.6%	58.4%	*same*

Measure: Health Outcomes

Category Definition County rate or % State rate or % US rate or % Significance

Accident Mortality 2006-2010	Reports the rate of death due to unintentional injury (accident) per 100,000 population	7 42.88 per 100,000	2,670 39.69 per 100,000	121,217 39.07 per 100,000	*Relevant –accidents are the leading cause of death in the U.S.*
Asthma prevalence	Percentage of adults aged 18 and older who self-report that they have been told by a health professional that they had asthma	Total adults 1,554 13.19%	761,944 14.99%	31,061,484 13.20%	*Asthma is a prevalent problem in the US that is often exacerbated by poor environmental conditions*
Breast Cancer Incidence	Adjusted incidence rate(100,00 population per year) of females with breast cancer	8,739	196,716	No data	*Cancer is a leading cause of death and it is important to identify cancers separately to better target interventions*
Cancer Mortality	Reports the rate of death due to malignant neoplasm.	24	11,607	566,121	*Cancer is a leading cause of death in the U.S.*
Cervical Cancer Incidence	Reports the age adjusted incidence rate of females with	8,639 (total pop)	196,716	No data	*Cancer is a leading cause of death and it is important to identify separately to*

	cervical cancer				*better target interventions*
Chlamydia Incidence	Reports incidence rate of Chlamydia cases per 100,000 population	82(reported cases) 474.40 (per 100,000 pop.)	21,287 (reported case) 326 (per 100,000 pop.)	1,236,680 (reported) 406.89 (per 100,00 pop.)	*It is a measure of poor health status and indicates the prevalence of unsafe sex practices*
Colon and Rectum Cancer Incidence	Reports age adjusted incidence rate of colon and rectum cancer	No data	No data	141,281	*Cancer is a leading cause of death and it is important to identify cancers separately to better target interventions*
Diabetes Prevalence	Reports the % of adults aged 20 and older who have ever been told by a doctor that they have diabetes	1,141 population 10.40 %	395,186 population 7.75%	20,615,282 population 8.72%	*Diabetes is a prevalent problem in the U.S.; it may indicate an unhealthy lifestyle and puts individuals at risk for further health issues*
Gonorrhea Incidence	Reports incidence rate of Gonorrhea per 100,000 population	2 (cases) 10.70 (per 100,000 pop.)	2,864 (reported case) 42.59 (per 100,000 pop.)	307,929 (reported cases) 99.74 (per 100,000 pop.)	*It is a measure of poor health status and indicates the prevalence of unsafe sex practices*
Heart Disease Mortality	Reports the rate of death due to coronary heart disease	20 (average annual deaths 128.08 (per 100,000)	8,065 (average annual death) 121.14 (per 100,000)	432,552 (average annual death) 134.65 (per 100,000)	*Heart disease is a leading cause of death in the U.S.*
Heart Disease Prevalence	Reports the % of adults aged 18 and older who have been told by a doctor that they have coronary heart disease or angina	528 (total adults) 4.48 % with heart disease	175,893 (total adults) 3.46 % with heart disease	10,183,713 (total adults) 4.33% with heart disease	*Coronary heart disease is a leading cause of death in the U.S. and is also related to high blood pressure ,high cholesterol, and heart attacks*
HIV Prevalence	Reports prevalence rate of HIV per 100.000 population	7 (pop. with HIV)	9,643 (pop. with HIV)	724,515 (pop with HIV)	*HIV is a life-threatening communicable disease that disproportionately affects minority populations and may also indicate the*

					prevalence of unsafe sex practices.
Homicide	Reports the rate of death due to assault (homicide)	No data	203	17,564	*Homicide rate is a measure of poor community safety and is a leading cause of premature death*
Infant Mortality (total births in Adams County 2,863)	Reports the rate of deaths to infants less than one year of age per 1, 00 births.	24 total deaths 8.38 per 1,000 births	3,088 total deaths 5.14 per 1,000 births	393,074 total births 6.71 per 1,000 births	*High rates of infant mortality indicate the existence of broader issues pertaining to access to care and maternal and child health*
Low Birth Wt (<2,500g)	Reports the % of total births that were low birth weight (Under 2500g) Can also highlight the existence of health disparities	169 6.13%	36,477 6.21%	2,359,843 8.10%	*Low birth weight infants are at high risk for health problems*
Lung Cancer Incidence	Reports the age adjusted incidence rate (case per 100,000 pop.) of lung cancer adjusted age groups	No data	No data	208,652	*Cancer is a leading cause of death and it is important to identify cancers separately to better target interventions*
Lung Disease Mortality	Reports the rate of death due to chronic lower respiratory disease per 100,000.	5	2,789	133,806	*Lung disease is a leading cause of death in the U.S.*
MVC death (2006-2010)	Reports the rate of death due to motor vehicle crashes (includes motor vehicle, a non-motorist, a fixed object and a non-fixed object an overturn and any other non-collision	2	627	40,120	*Motor vehicle crash deaths are preventable and they area a cause of premature death.*
Obesity (adult)	Reports the % of adults aged 20 and	3,945 pop.	1,341,720 27.07 with	61,460,308 27.14 with BMI>	*Excess weight is a prevalent problem in*

	older who self-report that they have a BMI greater than 30.0 (obese)	33.2 with BMI> 30.	BMI>30.	30.	*the U.S.; it indicates an unhealthy lifestyle and puts individuals at risk for further health issues*
Overweight (adult)	Reports the % of adults aged 18 and older who self-report having a BMI of 25.0 and 30.0 (overweight)	4,026 37.39	1,826,288 35.03	85,495,735 35.78	*Excess weight is a prevalent problem in the U.S. it indicates an unhealthy lifestyle and puts individuals at risk for further health issues*
Pedestrian Motor Vehicle Death	Reports the rate of pedestrians killed by motor vehicles	Total deaths (2)	Total deaths (183)	Total deaths (12,750)	*Pedestrian-motor vehicle crash deaths are preventable and they are a cause of premature death*
Poor Dental Health	Reports the % of adults age 18 and older who self-report that 6 or more of their permanent teeth have been removed due to tooth decay, gum disease, or infection	1,294 population 10.98 %	611,001 population 12.02%	36,842,620 population 15.65%	*Lack of access to dental care and/or social barriers to utilization of dental services*
Poor General Health	Reports the % of adults age 18 and older who self-report having poor or fair health	2,793 23/70%	680,070 13/60%	36,429,871 15.84%	*This indicator is a measure of general poor health status*
Population w any disability	Reports the % of the total civilian non-institutionalized pop. With a disability	No data	8105,548	36,490,048	*Disabled individuals comprise a vulnerable pop. That requires targeted services and outreach by providers*
Premature death	Report Years of Potential Life Lost	55 total premature deaths	20,436	1,074,667,048	*A measure of premature death can provide a unique and comprehensive look at overall health status*

Prostate Cancer Incidence	Reports the age adjusted incidence rate of males with prostate cancer	No data	No data	215,232	*Cancer is a leading cause of death and it is important to identify cancers separately to better target interventions.*
Stroke Mortality	Reports the rate of death due to stroke	7	2,66	133,107	*Stroke is a leading cause of death in the U.S.*
Suicide	Reports the rate of death due to intentional self-harm (suicide)	No data	888	35,841	*Suicide is an indicator of poor mental health.*