2019 Community Health Status Assessment

Creating a State of Health

Grady County
Health Department

TABLE OF CONTENTS

1. INTRODUCTION
   - 1.1. Mobilizing for Action through Planning and Partnerships (MAPP)
   - 1.2. The MAPP Process
   - 1.3. Community Health Needs Assessment (CHNA)
2. GRADY COUNTY
   - 2.1. Demographics
   - 2.2. Oklahoma State of the State's Health Report: Grady County Snapshot
3. COMMUNITY HEALTH NEEDS ASSESSMENT
   - 3.1. Sub Committee
   - 3.2. Development
   - 3.3. Questions
   - 3.4. Timeline
4. DATA COLLECTION
   - 4.1. Methods
   - 4.2. Community Partners
   - 4.3. Locations
5. RESULTS
6. CONCLUSION
   - 6.1. Data Analysis
   - 6.2. Data Correlations
   - 6.3. Synopsis
7. NEXT STEPS

1. INTRODUTION

1.1. Mobilizing for Action through Planning and Partnerships (MAPP)

The definition of health encompasses a broad range of conditions, not simply health in terms of healthcare.

Improving health is deliberate to ensure the conditions for a dynamic state of complete physical, mental, spiritual, and social well-being.

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning process for improving public health. This framework helps communities prioritize public health issues, identify resources for addressing them, and take action to improve conditions that support healthy living. MAPP is generally led by the local Health Department and is completed with the input and participation of many organizations and individuals who work, learn, live, and play in the community.

1.2. The MAPP Process

The MAPP Process consists of six phases. In Phase One, community members and agencies form a partnership and learn about the MAPP Process. During Phase Two, those who work, learn, live, and play in the community create a common understanding of what it would like to achieve. During Phase Three, qualitative and quantitative data are gathered to provide a comprehensive picture of health in the community through four assessments. In Phase Four, the data are analyzed to uncover the underlying themes that need to be addressed in order for a community to achieve its vision. In Phase Five, the community identifies goals it wants to achieve and strategies it wants to implement related to strategic issues. During Phase Six, the community implements and evaluates action plans to meet goals, address strategic issues, and achieve the community's vision.

1.3. Community Health Needs Assessment (CHNA)

This report has been prepared to communicate the results of the 2019 Community Health Needs Assessment (CHNA). Provisions of the Patient Protection and Affordable Care Act require each non-profit hospital facility in the United States to conduct a CHNA and adopt an implementation strategy to meet identified community health needs. In conducting the CHNA, non-profit hospitals are required to take into account input from persons who represent the broad interests

of the community served, including those with special knowledge of or expertise in public health. The CHNA approach is strategic with eights steps. These steps include creation of a sub-committee, creation of a list of indicators, collection of data for community selected indicators, organization and analyzation of data, compilation and dissemination of results, creation of a system to monitor indicators over time, creation of a list of challenges and opportunities, and finally sharing the results with the community.

History of MAPP

MAPP was developed to respond to the need to improve public health practice. In 1988, the Institute of Medicine (IOM) published the report *The Future of the Public's Health in the 21st Century,* which asserted that the public health system was in disarray. The report was the impetus for creating several types of assessments, standards, and improvement processes. In 1991, NACCHO, with support from the CDC, developed the Assessment Protocol for Excellence in Public Health (APEX PH) to help local health departments assess community health status and establish the leadership role of the health department in the community. APEX PH was continuously updated and revised through the 1990s. In 1997, the IOM published another report titled *Improving Health in the Community: A Role for Performance Monitoring*, which emphasized the importance of active community involvement in public health performance monitoring and detailed what a community health improvement plan should contain. During this time, public health practitioners were also requesting a process that was driven and owned by the community. In response, APEX PH evolved into MAPP. NACCHO, with support from the CDC, developed MAPP with substantive input from the field and careful attention to research and literature. MAPP was developed to provide structured guidance that would result in an effective strategic planning process that would be relevant to public health agencies and the communities they serve.

2. GRADY COUNTY

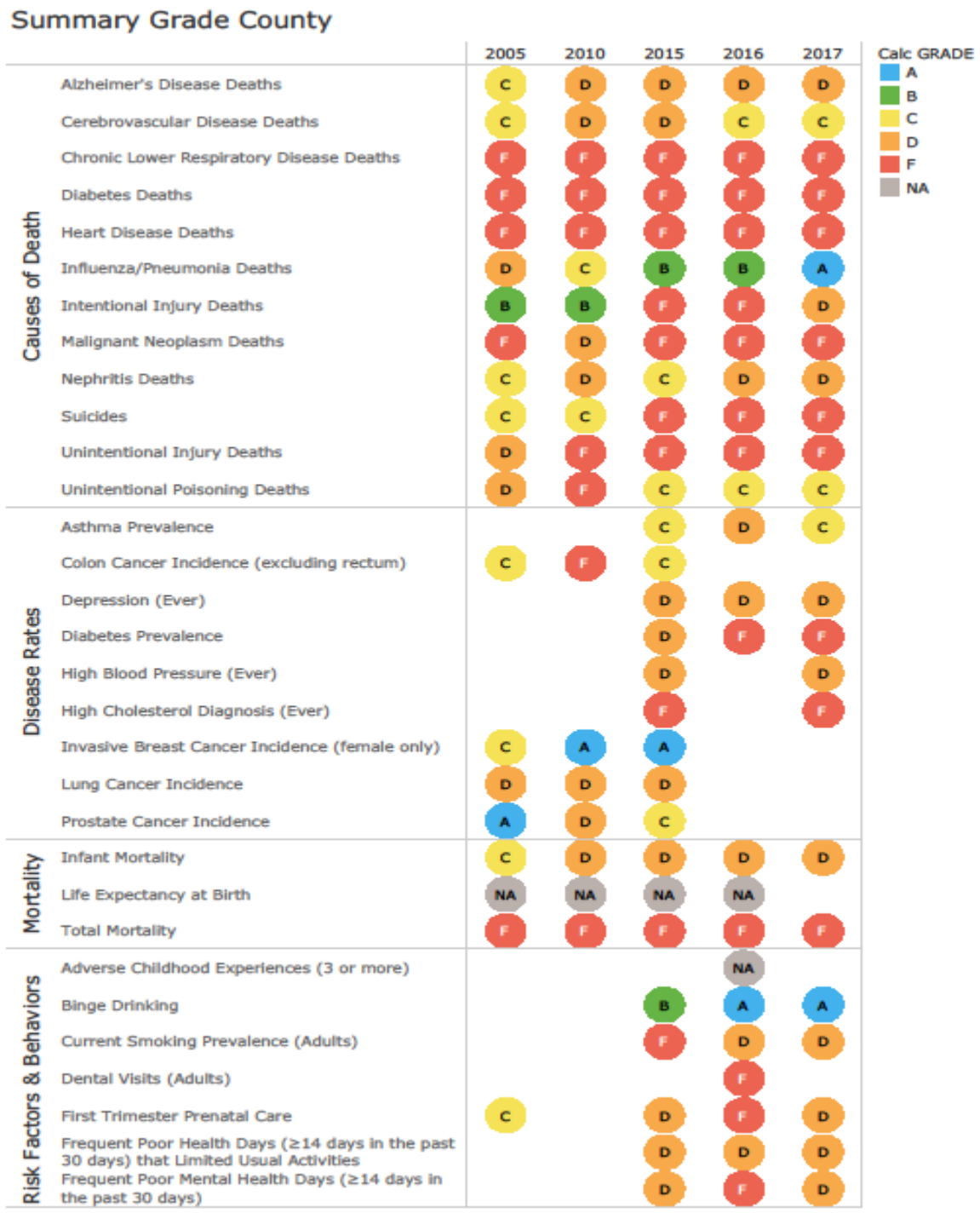
2.1. Demographics

Subject	Number	Percent
SEX AND AGE		
Total population	52,431	100.0
Under 5 years	3,565	6.8
5 to 9 years	3,645	7.0
10 to 14 years	3,761	7.2
15 to 19 years	3,648	7.0
20 to 24 years	3,085	5.9
25 to 29 years	3,248	6.2
30 to 34 years	3,153	6.0
35 to 39 years	3,283	6.3
40 to 44 years	3,330	6.4
45 to 49 years	4,027	7.7
50 to 54 years	4,023	7.7
55 to 59 years	3,479	6.6
60 to 64 years	3,022	5.8
65 to 69 years	2,476	4.7
70 to 74 years	1,797	3.4
75 to 79 years	1,257	2.4
80 to 84 years	864	1.6
85 years and over	768	1.5
Median age (years)	38.3	(X)
Male population	26,000	49.6
Female population	26,431	50.4
RACE		
Total population	52,431	100.0
One Race	50,127	95.6
White	44,994	85.8
Black or African American	1,268	2.4
American Indian and Alaska Native	2,841	5.4
Asian	196	0.4
Native Hawaiian and Other Pacific Islander	36	0.1
Some Other Race	792	1.5
Two or More Races	2,304	4.4
White; American Indian and Alaska Native [3]	1,611	3.1
White; Asian [3]	89	0.2
White; Black or African American [3]	214	0.4
White; Some Other Race [3]	151	0.3

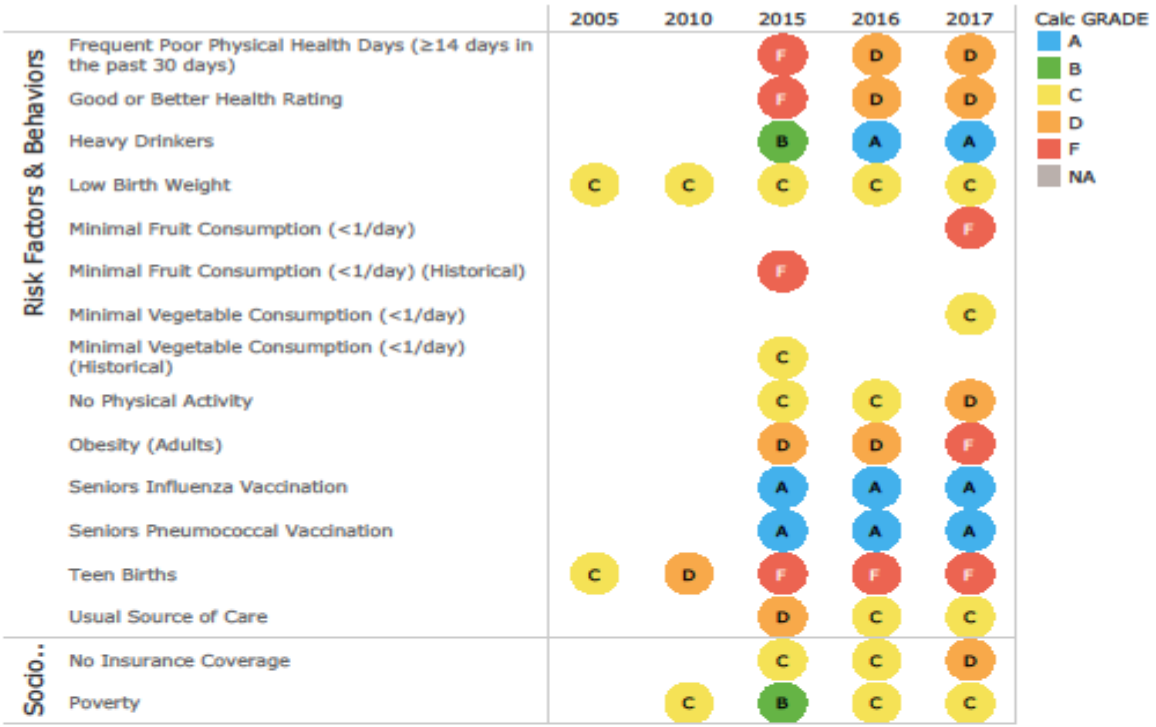
Subject	Number	Percent
HISPANIC OR LATINO		
Total population	52,431	100.0
Hispanic or Latino (of any race)	2,405	4.6
Not Hispanic or Latino	50,026	95.4
HISPANIC OR LATINO AND RACE		
Total population	52,431	100.0
Hispanic or Latino	2,405	4.6
Not Hispanic or Latino	50,026	95.4
RELATIONSHIP		
Total population	52,431	100.0
In households	51,349	97.9
In group quarters	1,082	2.1
HOUSEHOLDS BY TYPE		
Total households	19,892	100.0
Family households (families) [7]	14,535	73.1
Nonfamily households [7]	5,357	26.9
Households with individuals under 18 years	7,031	35.3
Households with individuals 65 years and over	5,099	25.6
Average household size	2.58	(X)
Average family size [7]	3.02	(X)
HOUSING OCCUPANCY		
Total housing units	22,219	100.0
Occupied housing units	19,892	89.5
Vacant housing units	2,327	10.5
HOUSING TENURE		
Occupied housing units	19,892	100.0

*Information obtained from U.S. Census Bureau American FactFinder on 10/01/2019 based on 2010 Demographic Profile Data. (https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF)

2.2. Oklahoma State of the State's Health Report: Grady County Snapshot



Summary Grade County



3. COMMUNITY HEALTH NEEDS ASSESSMENT

3.1. Subcommittee

The subcommittee organization began in the summer of 2018. The Cleveland County Health Department and Norman Regional Health System, including representatives from the Tobacco Settlement Endowment Trust's (TSET) Health Living Program, developed the Community Health Needs Assessment. Representative selection was based on data accessibility, data analyzation abilities, abilities to create a system for managing data, and their interest in the data.

3.2. Development

The subcommittee met at the Norman Regional Hospital in Norman to discuss question selection, question phrasing, and collection methods. Resources including Healthy People 2020, 2015 Cleveland County Health Survey, St. Catherine of Siena Medical Center Community Health Needs Assessment, and St. Francis Hospital Community Health Needs Assessment Survey were utilized in question selection.

3.3. Questions

The subcommittee reviewed and selected a list of indicators based on the twelve categories of data suggested in the Mobilizing for Action through Planning a Partnerships (MAPP): User's Handbook. Listed below is the breakdown of each question's alignment with the categories of data.

Category of Data	2019 Community Health Needs Assessment Survey Questions
Social Determinants of Health Inequity	Q1. In general, how would you rate your overall health?
Social and Mental Health	Q2. In general, how would you rate your overall mental or emotional health?
Social and Mental Health	Q3. How many days in the past month were you not able to work due to poor physical health?
Social and Mental Health	Q4. How many days in the past month have you experienced anxiety, depression or any emotional problems that affected your ability to perform daily activities?
Social and Mental Health	Q5. In the past 12 months, have you sought treatment at any of the following for anxiety, depression or any emotional problems? Check all that apply.
Health Resource Availability	Q6. In the last 12 months, how many times did you visit your healthcare provider?
Health Resource Availability	Q7. What types of health screenings and/or services are needed to keep you and your family healthy? Check all that apply.

Social Determinants of Health Inequity	Q8. Have you been told you have any of the following health conditions? Check all that apply.
Behavioral Risk Factors	Q9. If you have been diagnosed with a chronic illness, are you taking medication and/or making lifestyle changes?
Behavioral Risk Factors	Q10. Please check all the health behaviors that apply to you.
Social Determinants of Health Inequity	Q11. How do you prefer to receive health information? Check all that apply.
Social Determinants of Health Inequity	Q12. In your opinion, what are the major health concerns in your community? Check all that apply.
Health Resource Availability	Q13. In the past 12 months, did any of the following keep you or your family from receiving needed medical care? Check all that apply.
Quality of Life	Q14. What is needed to improve the health of your family and neighbors? Check all that apply
Health Resource Availability	Q15. Where would you go for emergency medical services if you were able to take yourself?
Health Resource Availability	Q16. Which of the following preventive procedures have you had in the past 12 months? Check all that apply.
Health Resource Availability	Q17. How likely are you to seek care using a Virtual Care provider on your smart phone or computer for yourself or child?
Health Resource Availability	Q18. Do you have health insurance?
Social Determinants of Health Inequity	Q19. Have you had regular access to food in the past year?
Social Determinants of Health Inequity	Q20. What food services has your household participated in during the past year? Check all that apply.
Demographic Characteristics	Q21. What is the zip code of your current residence?
Demographic Characteristics	Q22. What is your current housing situation?
Demographic Characteristics	Q23. Do you feel safe in your neighborhood?
Demographic Characteristics	Q24. How many days the past 30 days have you used public transportation?
Demographic Characteristics	Q25. What is your age?
Demographic Characteristics	Q26. What racial or ethnic group do you identify with?
Demographic Characteristics	Q27. What gender do you identify with?
Social Determinants of Health Inequity	Q28. Please indicate your highest level of education.
Social Determinants of Health Inequity	Q29. Are you a Veteran?
Social Determinants of Health Inequity	Q30. How many people live in your household?
Social Determinants of Health Inequity	Q31. What is your average annual household income?
Social Determinants of Health Inequity	Q32. What is your current employment status?

3.4. Timeline

The initial timeline included finalization of question selection by December 2018, distribution of surveys to the public beginning in April 2019, and collection completion by July 2019. Due to available sample size based on the number of respondents, the extension of the completion date to August 31, 2019 occurred.

4. DATA COLLECTION

4.1. Methods

The 2019 Community Health Needs Assessment Survey was distributed to the public in electronic and paper formats. English and Spanish version were available. The Office of Minority Services at the Oklahoma State Department of Health provided Spanish translation services. The subcommittee utilized Survey Monkey to provide the electronic format platform.

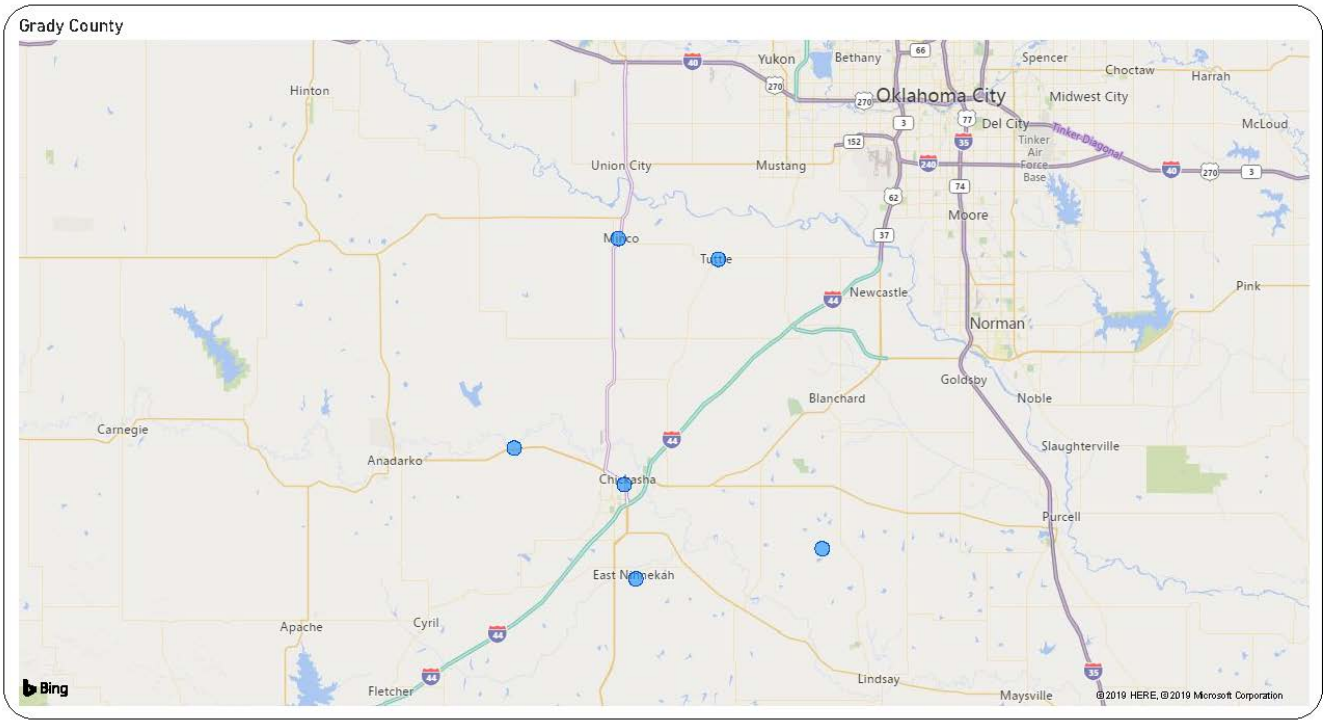
4.2. Community Partners

Local community partners included the Chickasha Area YMCA, Chickasha Public Library and the Tuttle Library.

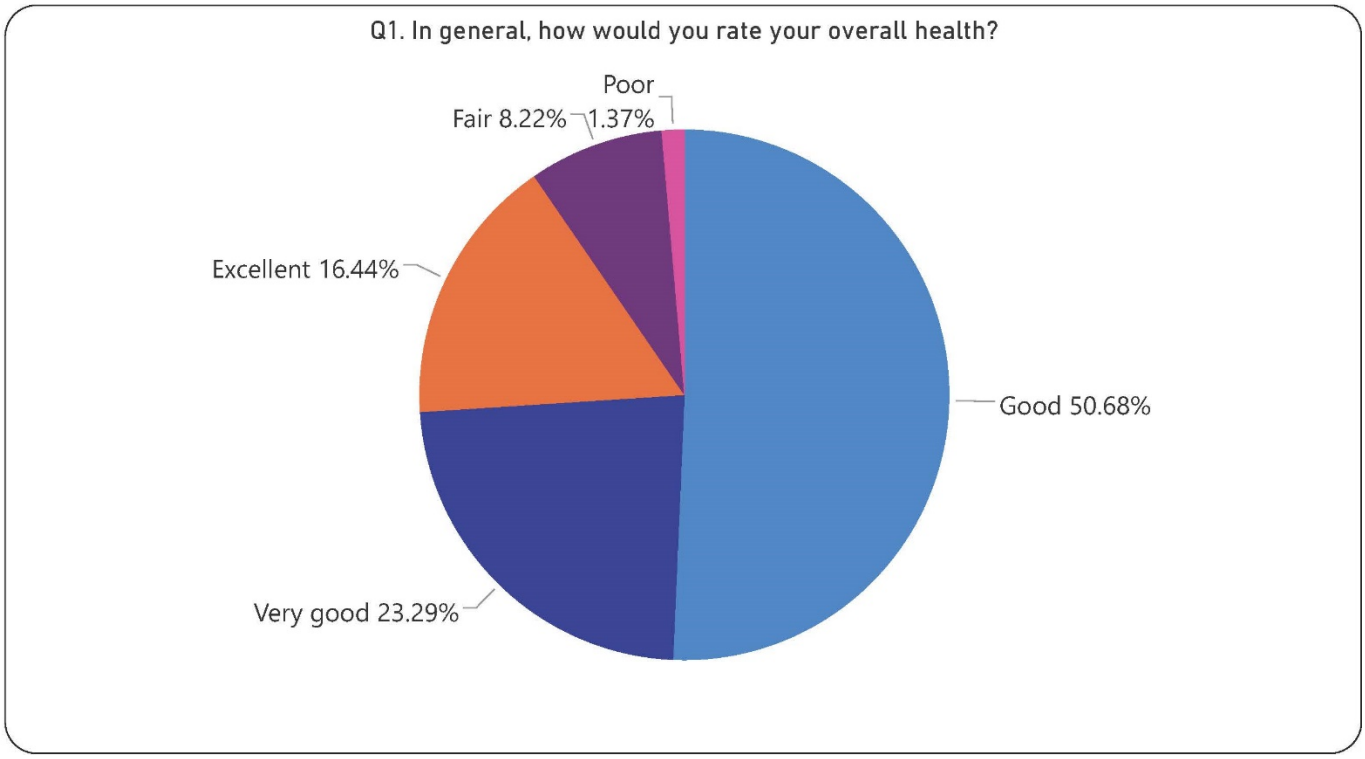
4.3. Locations

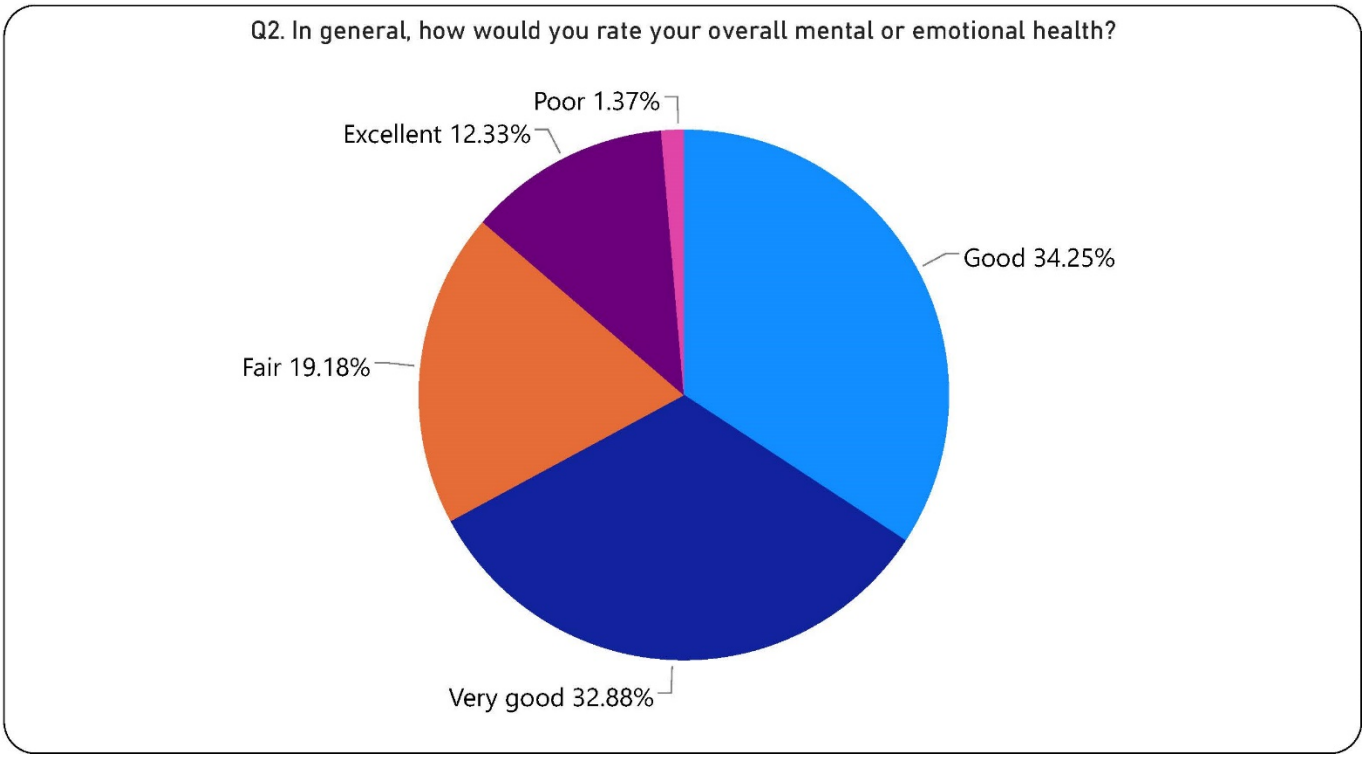
Paper surveys and collection boxes were available to the public at the Chickasha Area YMCA and the Chickasha Public Library from July 15, 2019 until September 4, 2019. They were also available at the Tuttle Library from August 1, 2019 to September 5, 2019.

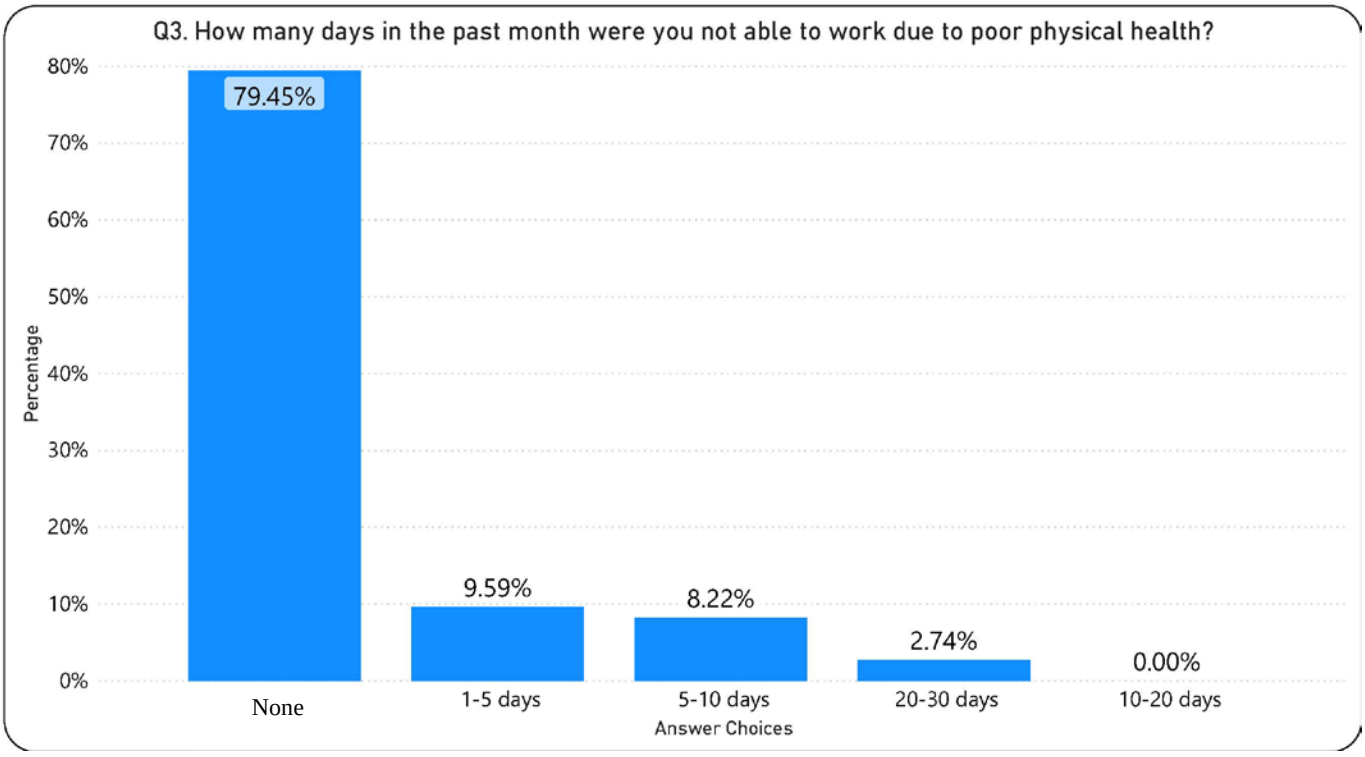
The zip codes represented in survey responses: 73002, 73018, 73059, 73067, 73082, 73089, and 73092.

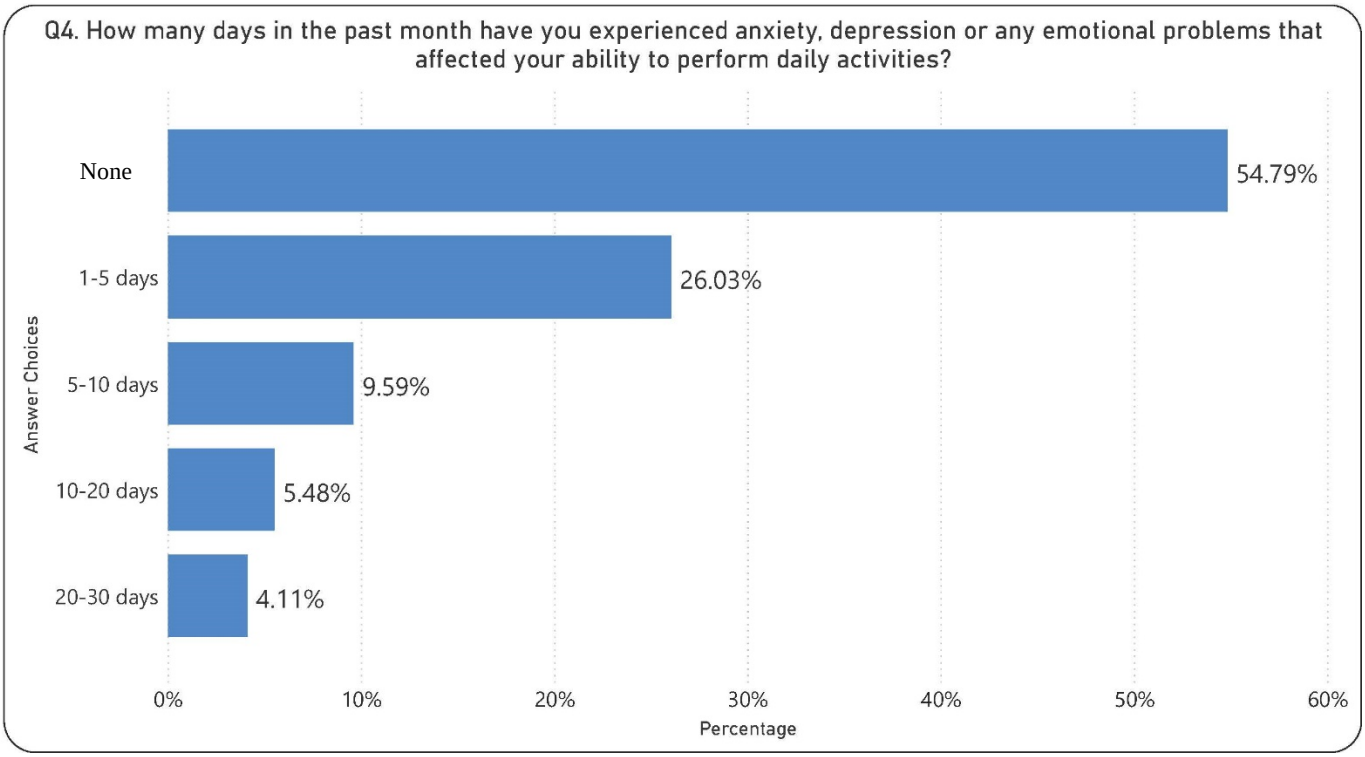


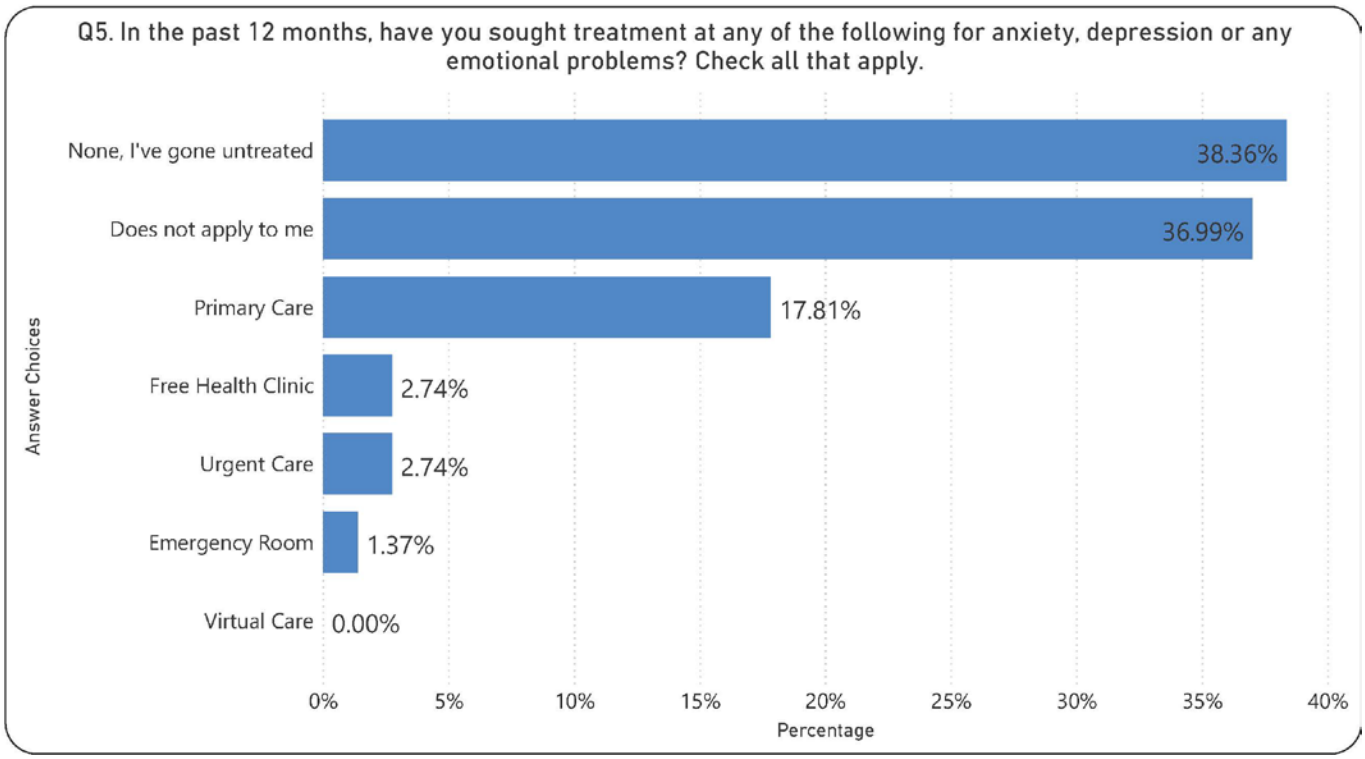
4. RESULTS

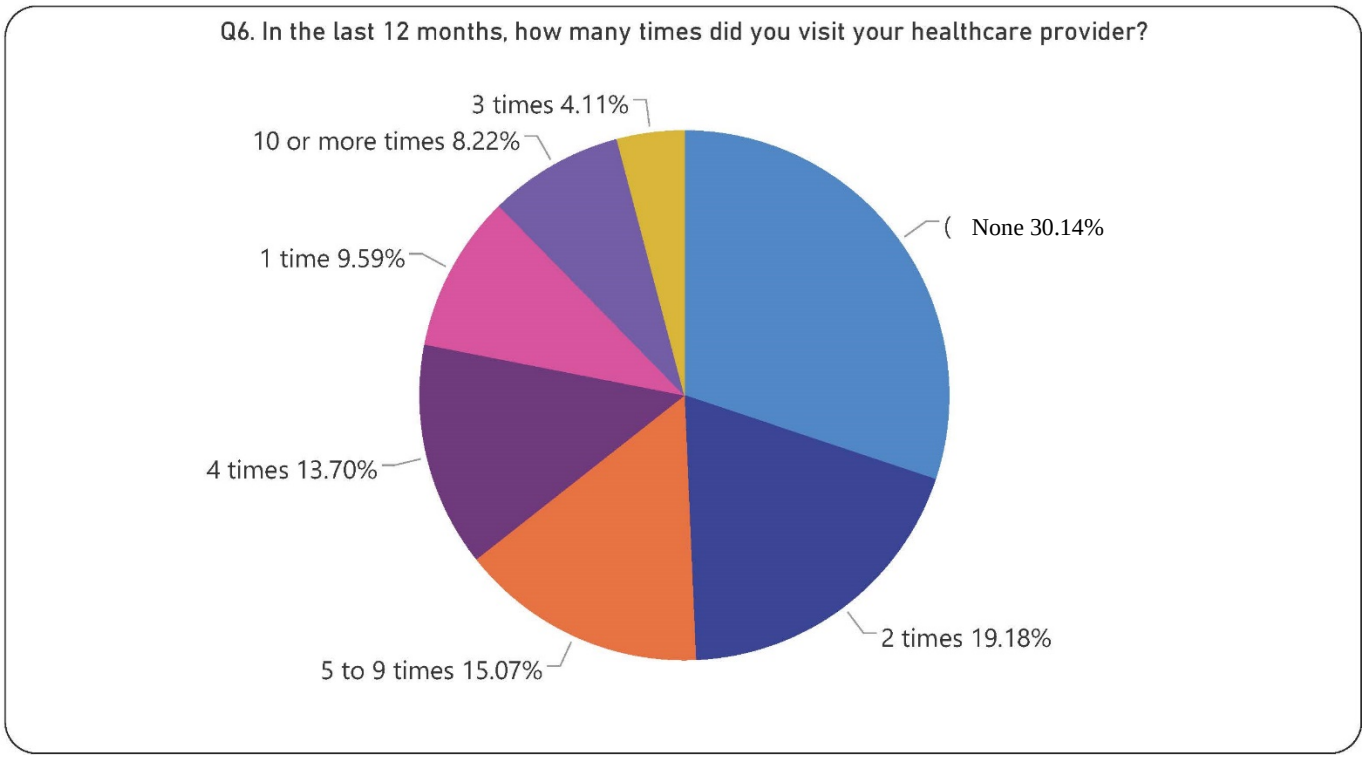








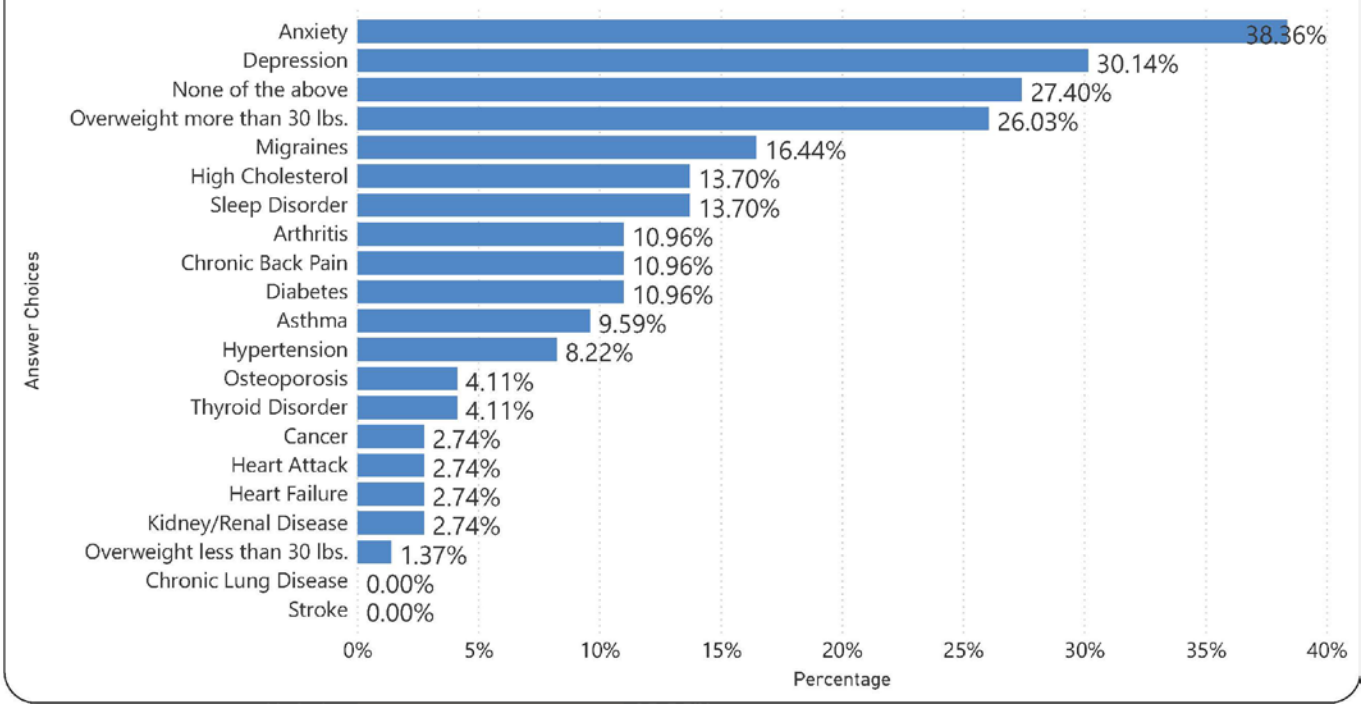




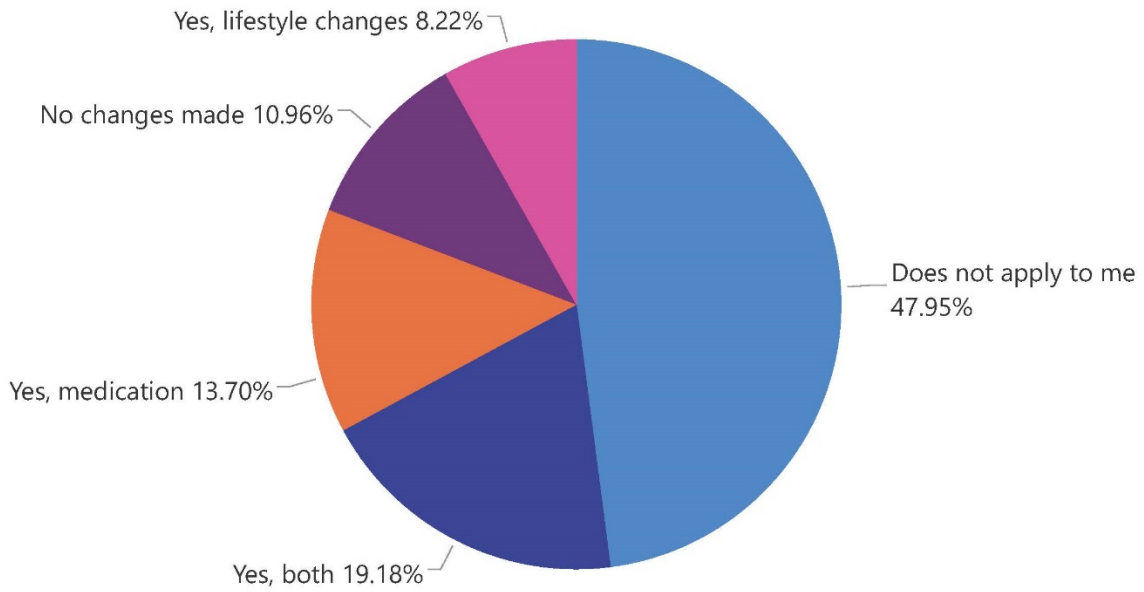
Q7. What types of health screenings and/or services are needed to keep you and your family healthy? Check all that apply.

Answer Choices	Percentage
Routine well checkups	47.95%
Blood pressure	43.84%
Dental Screenings	43.84%
Exercise/physical activity	30.14%
Vaccination/immunizations	30.14%
Mental Health/depression	27.40%
Cholesterol	23.29%
Diabetes	20.55%
Nutrition	19.18%
Weight loss help	19.18%
Cancer	17.81%
Heart disease	15.07%
Emergency preparedness	9.59%
Prenatal care	8.22%
Infection outbreak prevention	6.85%
Memory loss	6.85%
Quitting smoking	6.85%
Eating disorders	5.48%
HIV/AIDs & STDs	4.11%
Falls prevention for the elderly/disabled	2.74%
Suicide prevention	2.74%
Drug and alcohol abuse	1.37%

Q8. Have you been told you have any of the following health conditions? Check all that apply.

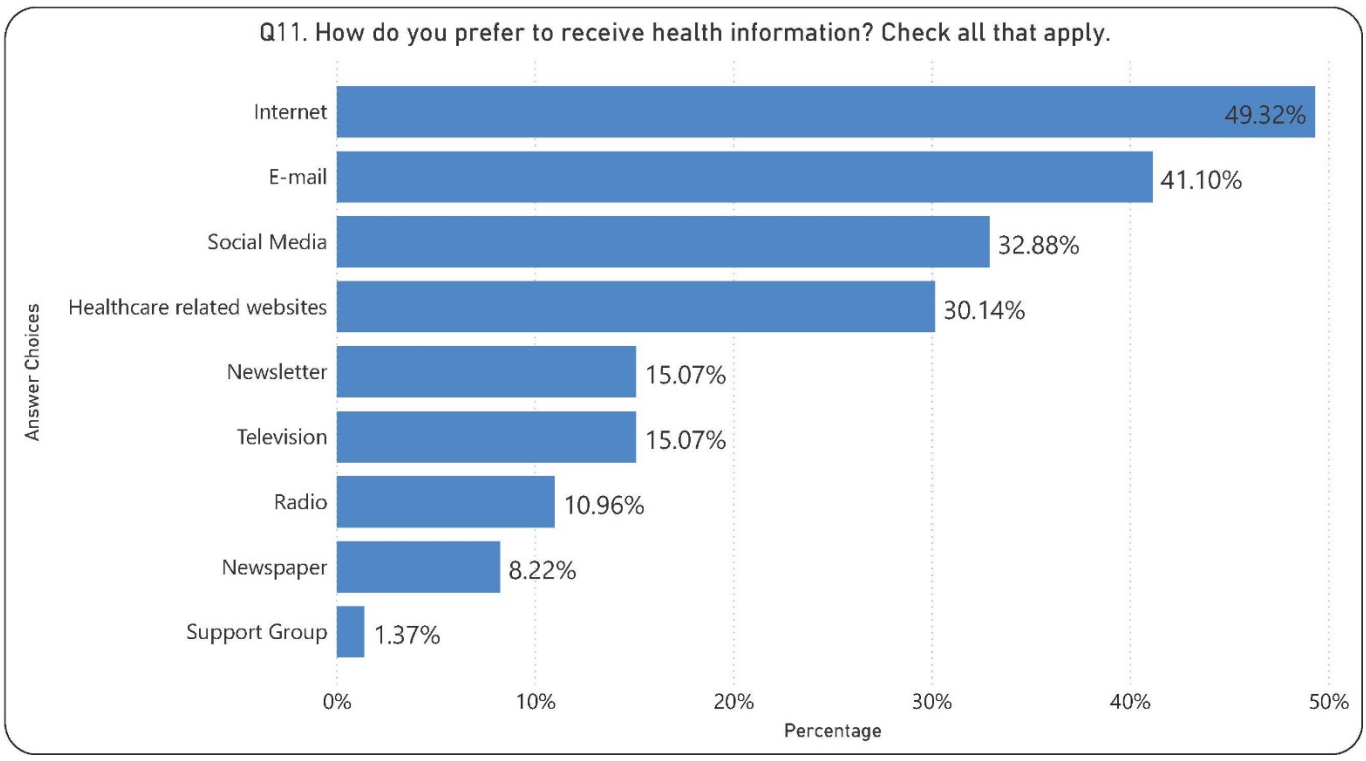


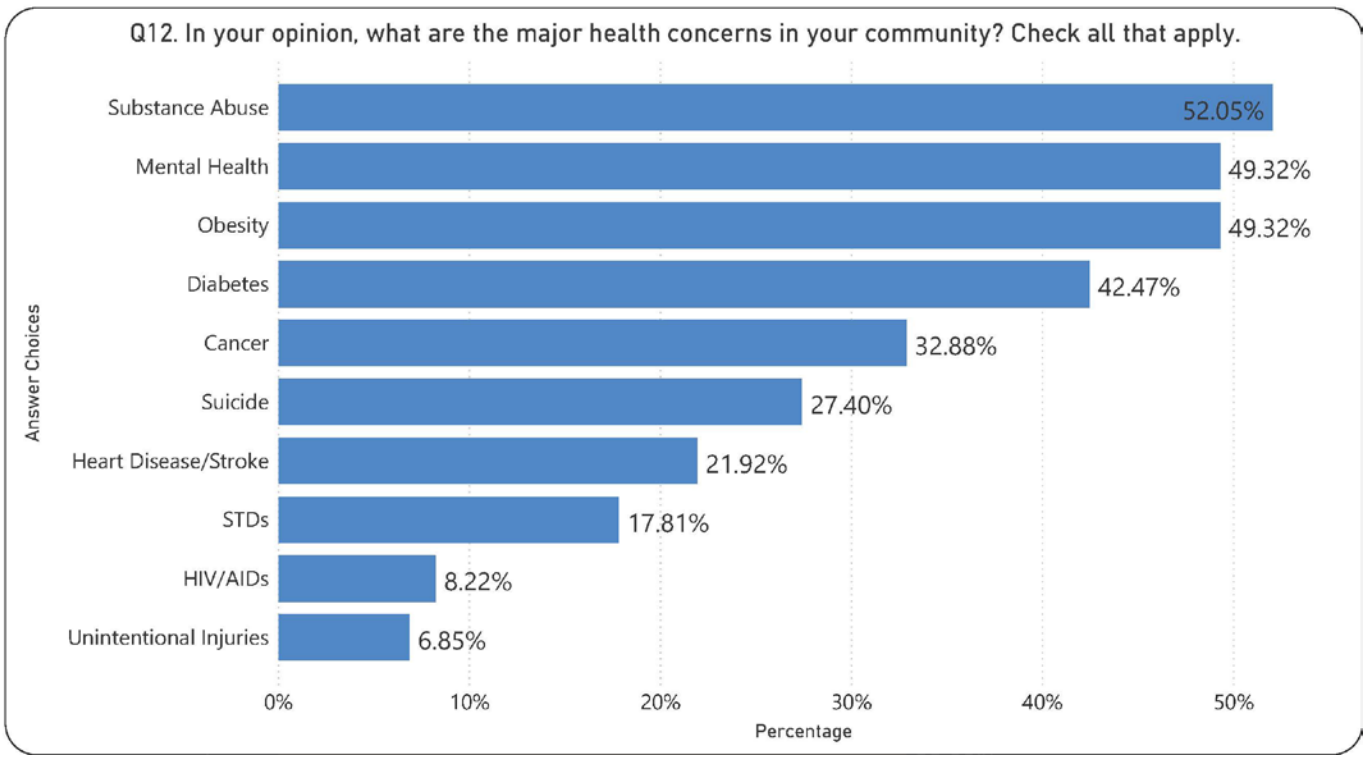
Q9. If you have been diagnosed with a chronic illness, are you taking medication and/or making lifestyle changes?



Q10. Please check all the health behaviors that apply to you.

Answer Choices	Percentage
I eat fast food at least once a week	54.79%
I use sunscreen or protective clothing for planned time in sun	43.84%
I receive a flu shot each year	42.47%
I exercise at least three times per week	39.73%
I use tobacco or tobacco products	24.66%
I eat at least 5 servings of fruits or vegetables daily	23.29%
I have access to a wellness program through my employer	20.55%
None of the above apply to me	10.96%
I use cannabis or marijuana products to relax or to ease pain	8.22%
I use cannabis or marijuana on a recreational basis	5.48%
I have more than four drinks (if female) of alcohol or five drinks (if male) per day	1.37%
I have used opioids that have not been prescribed to me	0.00%



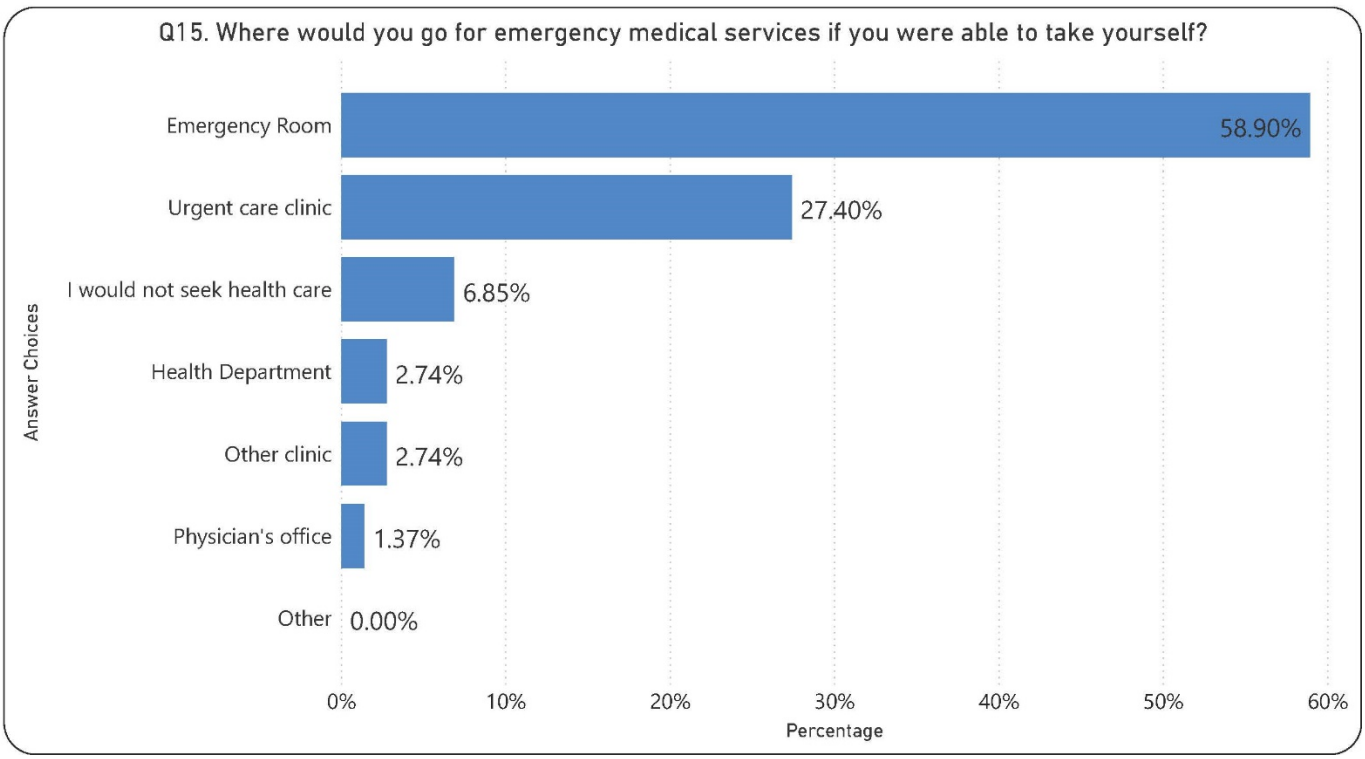


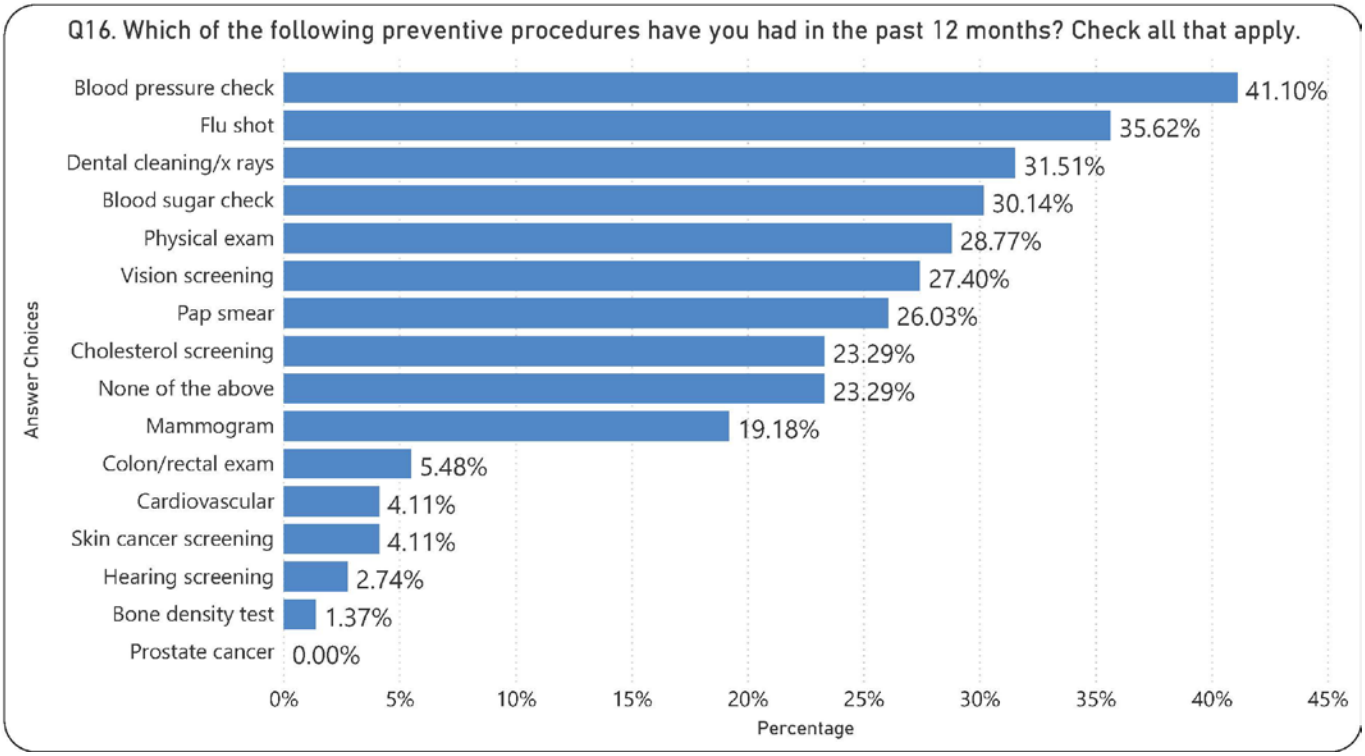
Q13. In the past 12 months, did any of the following keep you or your family from receiving needed medical care? Check all that apply.

Answer Choices	Percentage
None apply	52.05%
Do not have vision insurance	27.40%
Do not have dental insurance	24.66%
Do not have health insurance	23.29%
Could not afford the co-pay	21.92%
Could not afford to fill the prescription	17.81%
Could not afford glasses or hearing aids	12.33%
Do not have a primary care provider	6.85%
Office hours were not convenient	6.85%
Provider did not accept my insurance	6.85%
Fearful of what might be found on an exam	4.11%
Transportation	4.11%
Provider did not accept my child's insurance	2.74%
Could not get an appointment	1.37%
Language barrier	1.37%

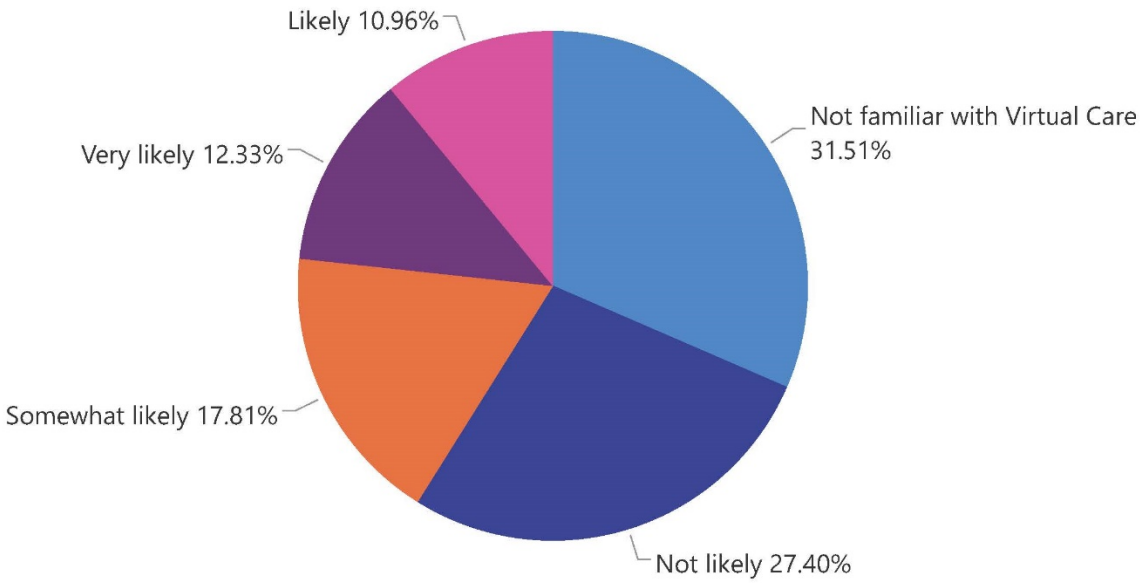
Q14. What is needed to improve the health of your family and neighbors? Check all that apply

Answer Choices	Percentage
Free or affordable health screenings	54.79%
Healthier Food	45.21%
Mental health services	39.73%
Recreation facilities	28.77%
Job Opportunities	27.40%
Wellness services	27.40%
Safe places to walk/play	26.03%
Substance abuse rehabilitation	15.07%
Transportation	15.07%
I don't know	12.33%
Specialty physicians	12.33%
Other	5.48%



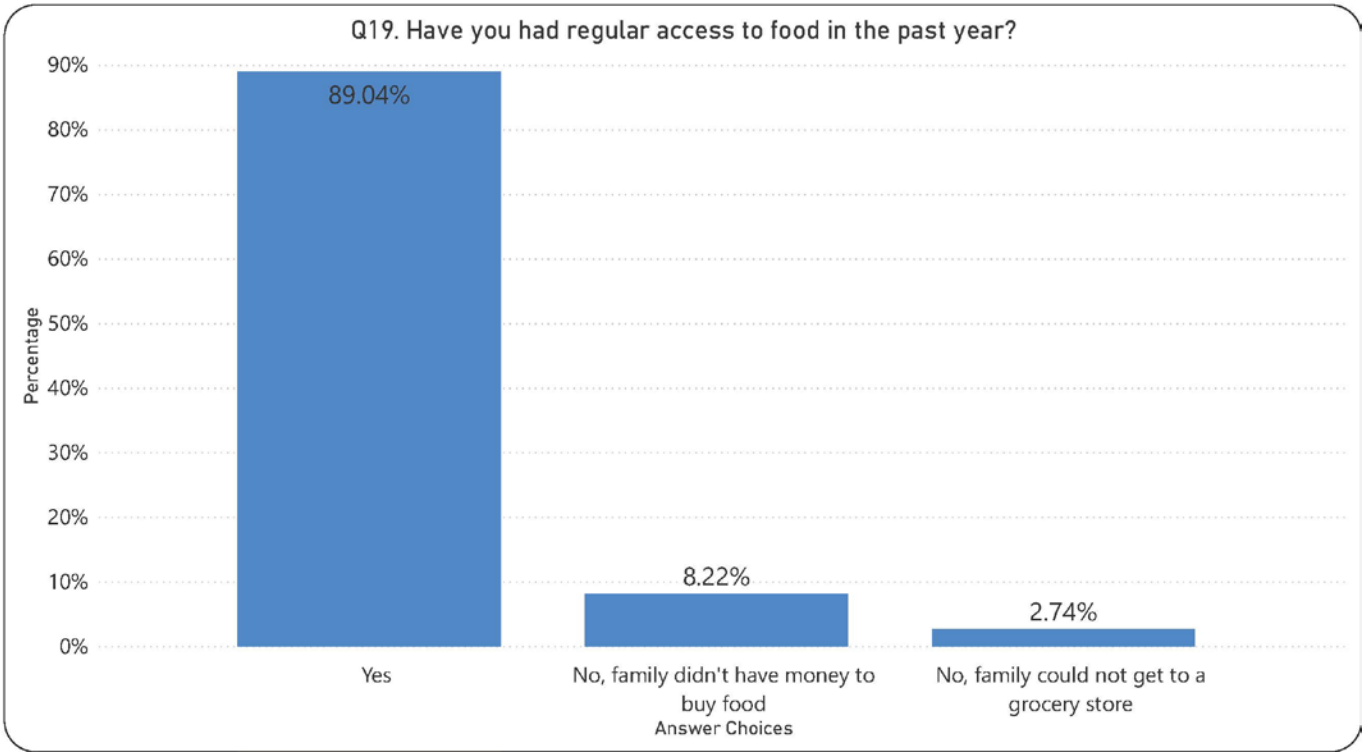


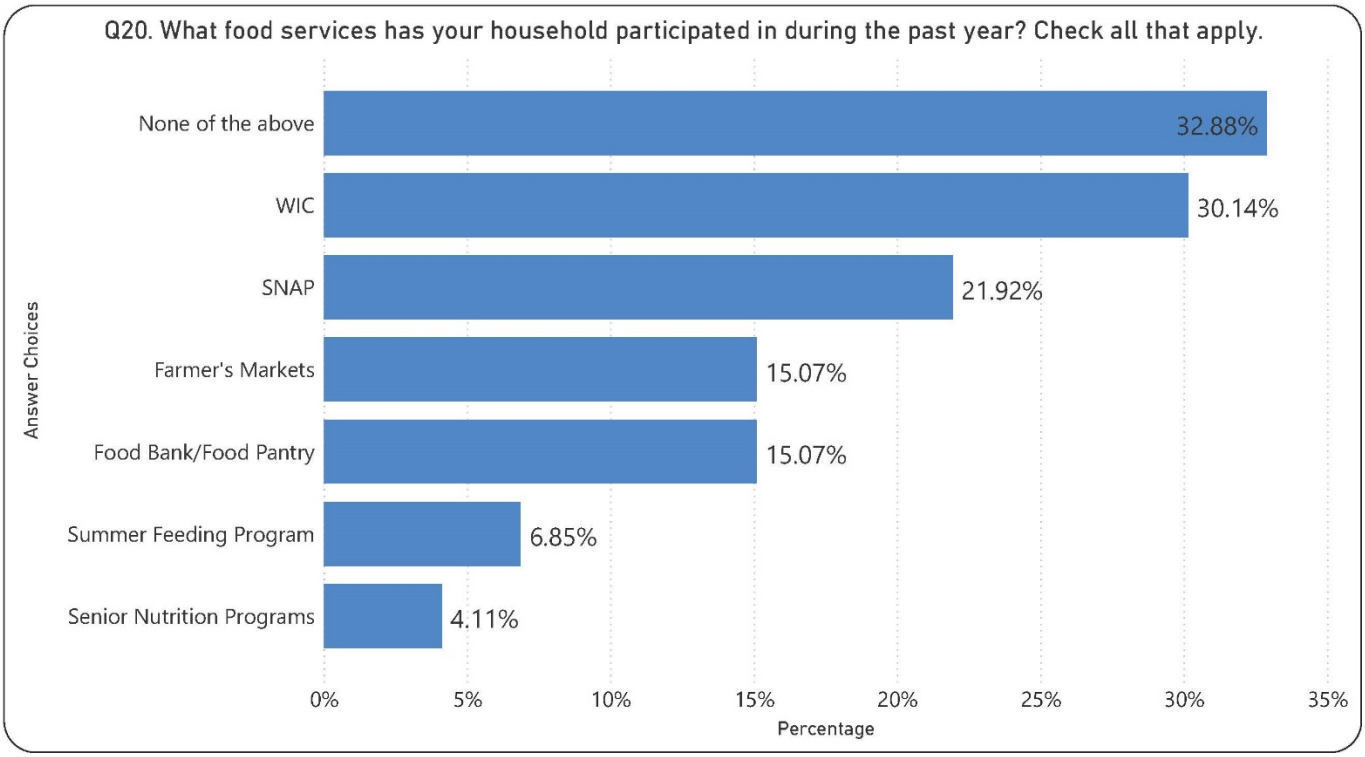
Q17. How likely are you to seek care using a Virtual Care provider on your smart phone or computer for yourself or child?

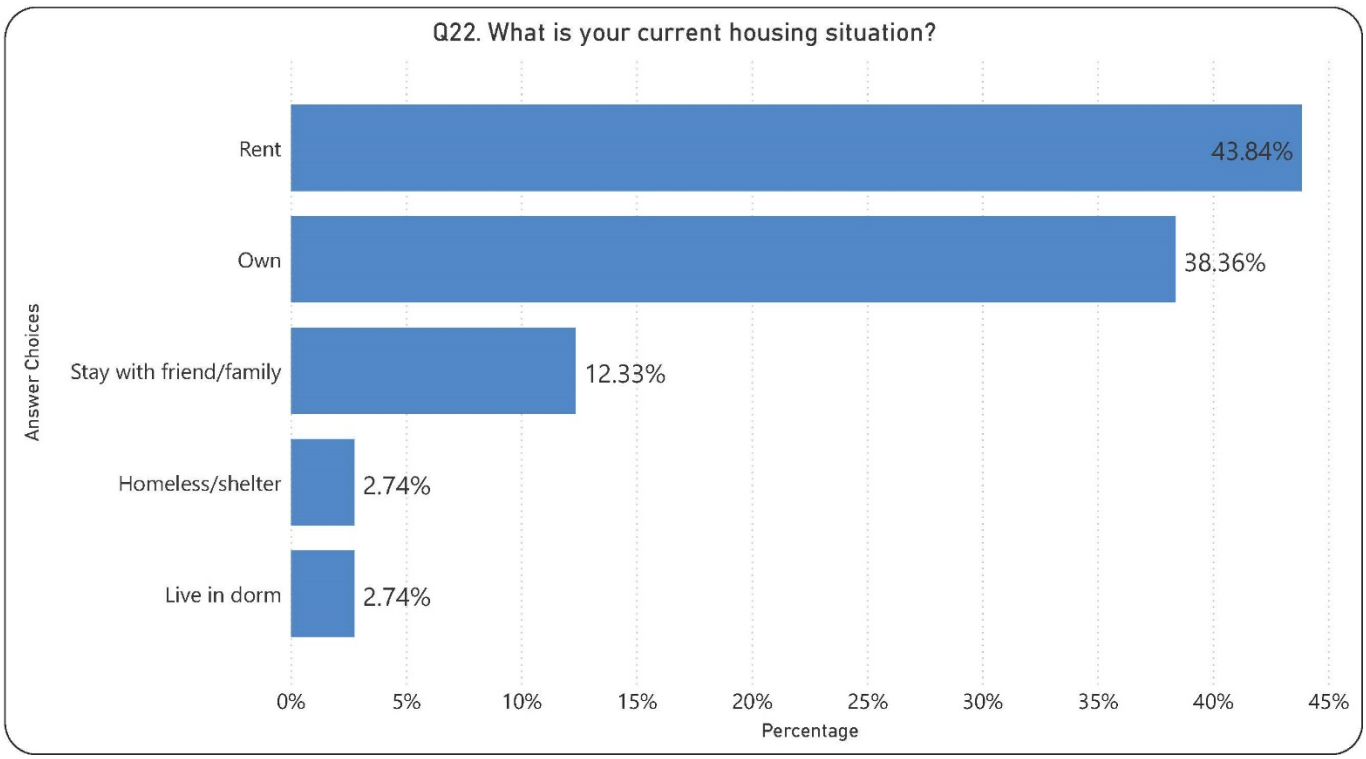


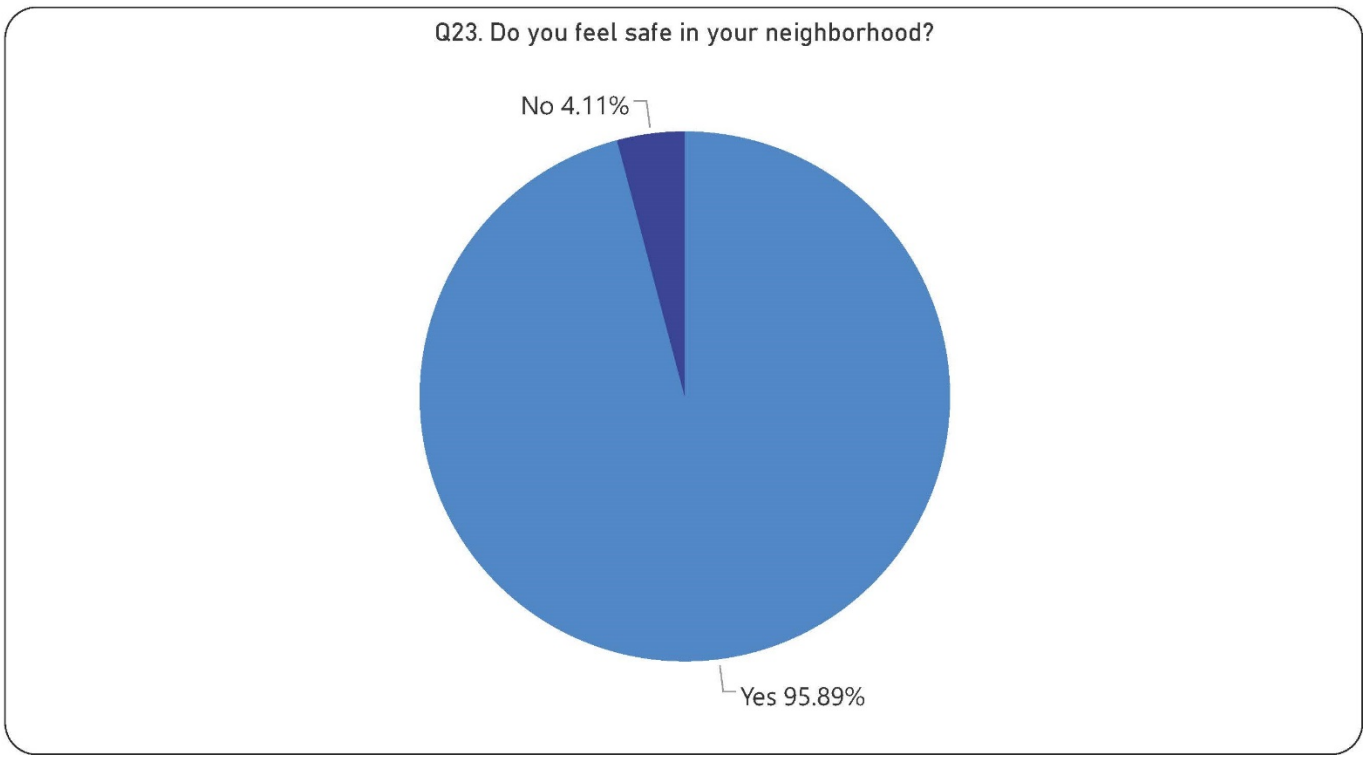
Q18. Do you have health insurance?

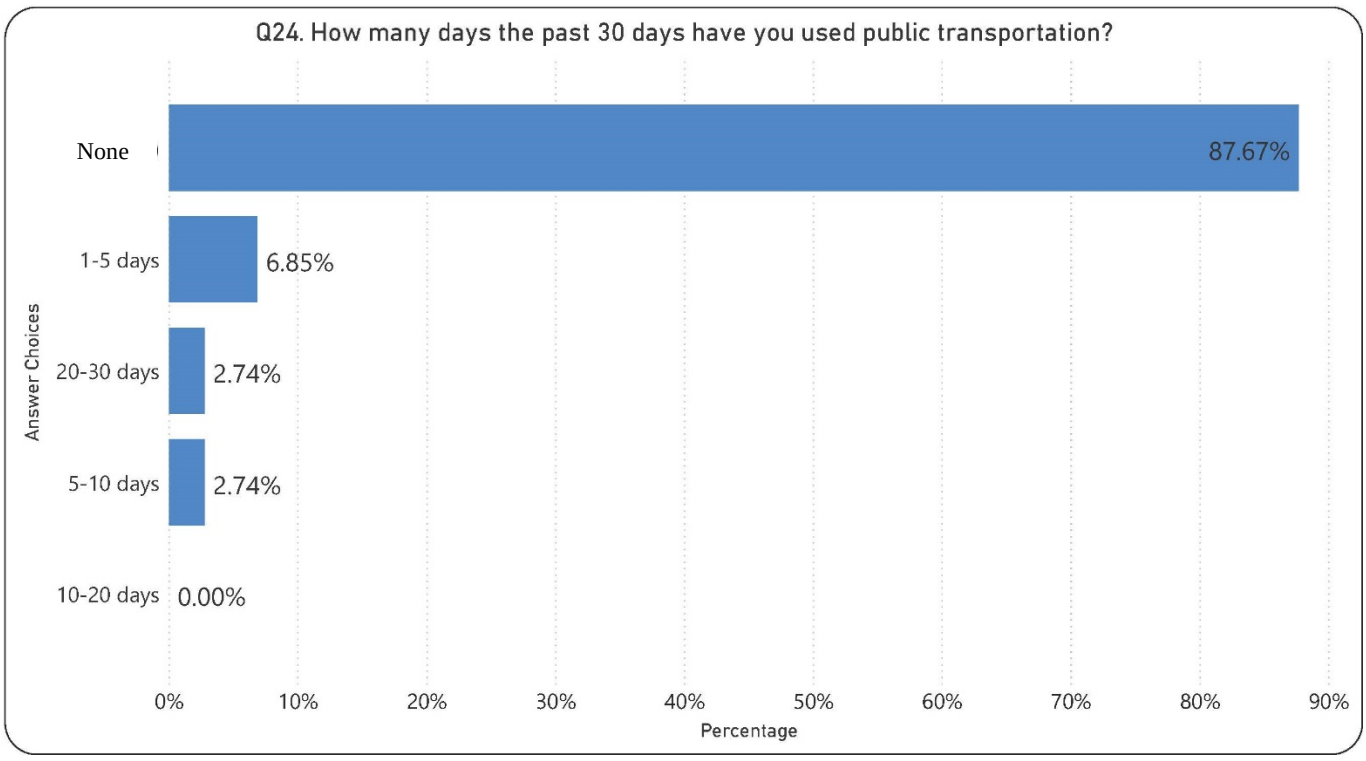
Answer Choices	Percentage
Yes, Employer Based Program	39.73%
No	20.55%
Yes, Medicaid	17.81%
Yes, Commercial/Individual Policy	9.59%
Yes, Medicare	9.59%
Yes, Health Insurance Market Plan/Federal Exchange Policy	1.37%
Yes, Indian Health	1.37%
Yes, VA	0.00%

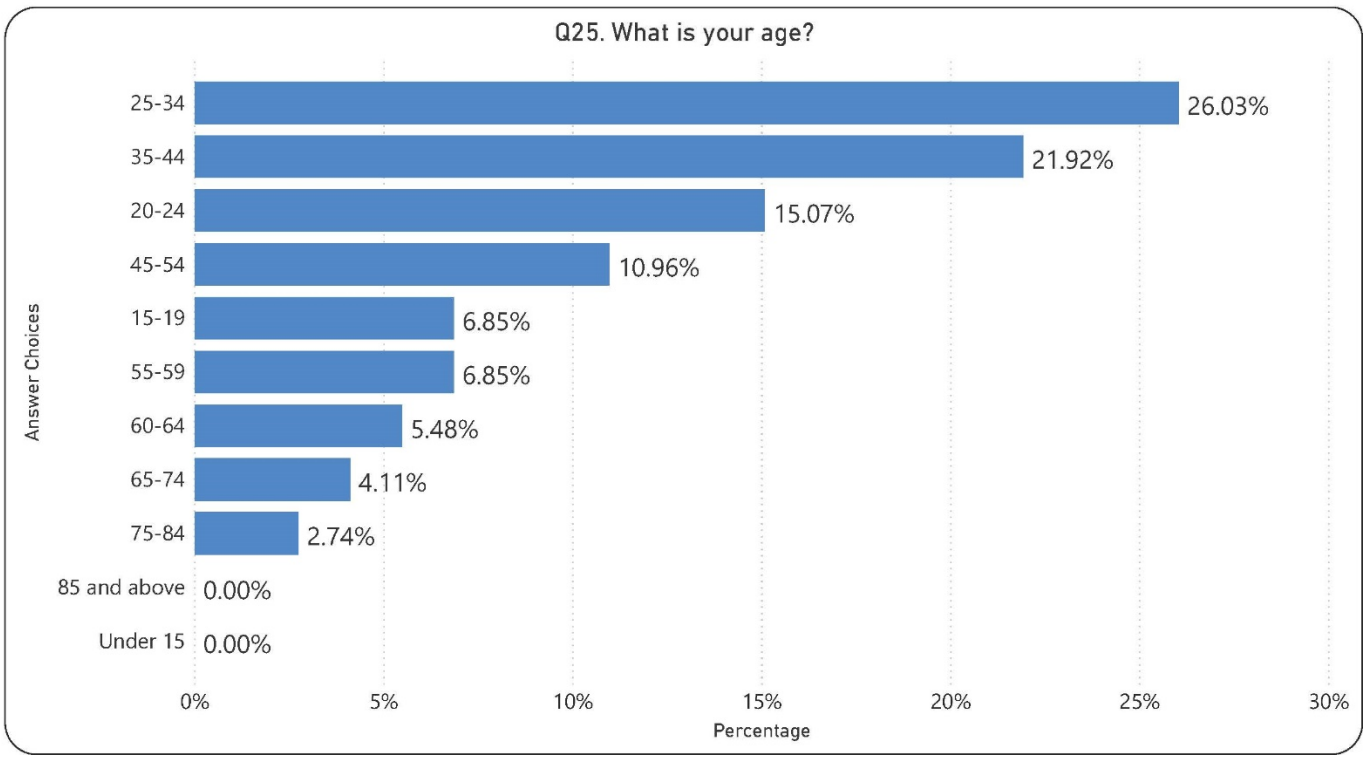








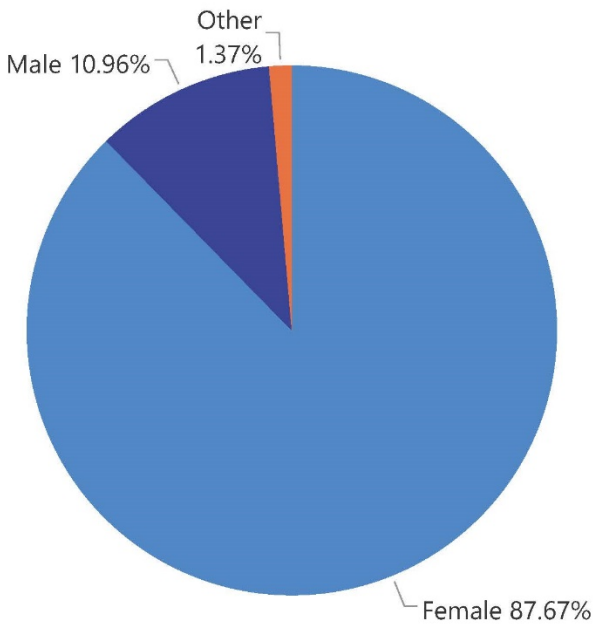


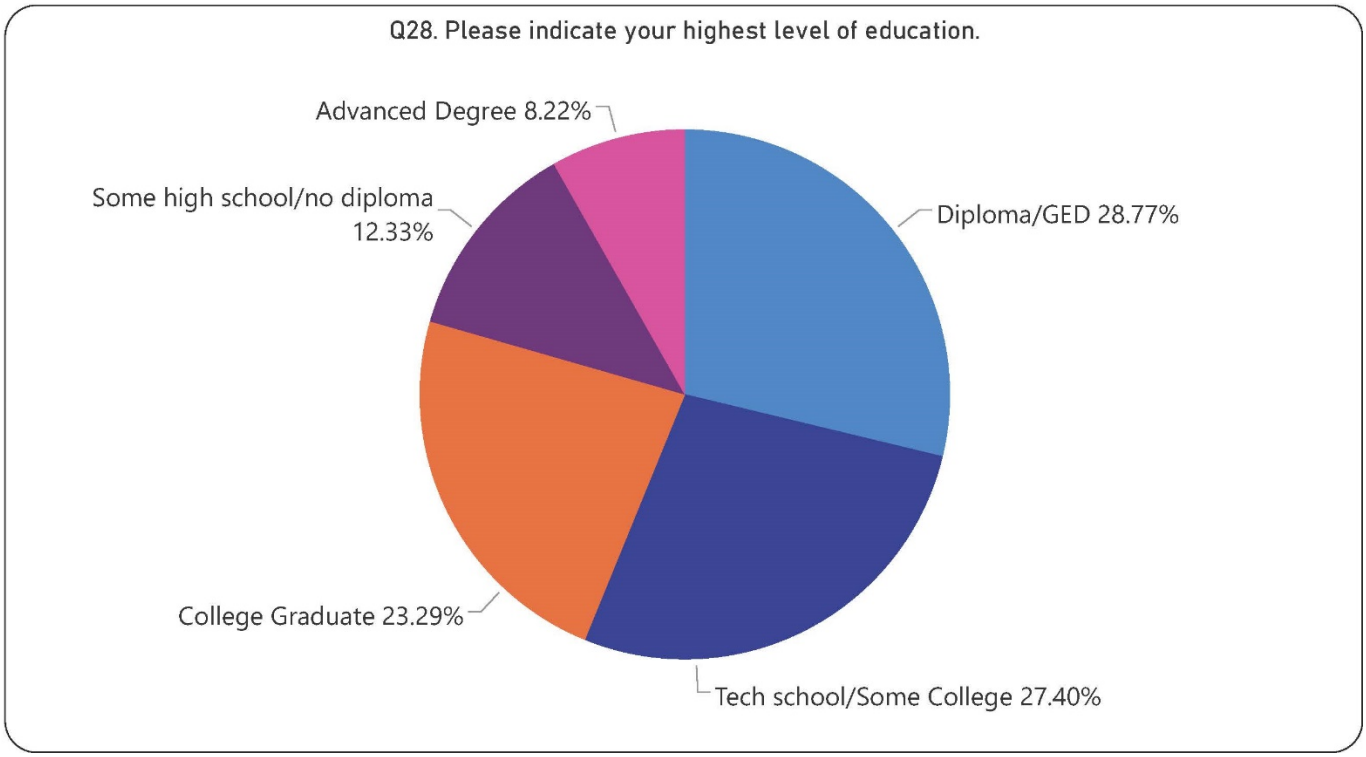


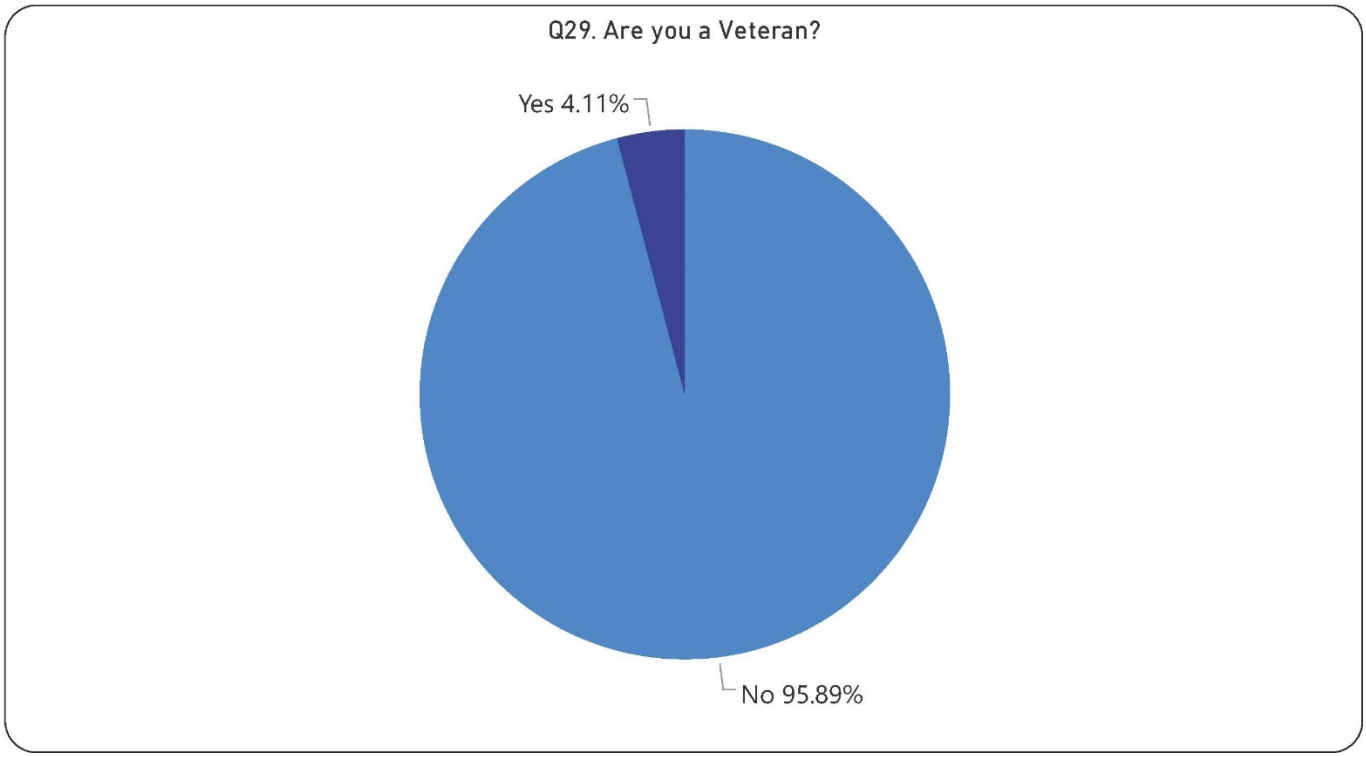
Q26. What racial or ethnic group do you identify with?

Answer Choices	Percentage
White	75.34%
Black or African American	9.59%
American Indian or Alaska Native	6.85%
Hispanic or Latino	6.85%
Other	1.37%
Asian	0.00%
Native Hawaiian or other Pacific Islander	0.00%

Q27. What gender do you identify with?







Q31. What is your average annual household income?

Answer Choices	Percentage
Less than $10,000	24.66%
$25,001 to $40,000	20.55%
$40,001 to $60,000	17.81%
$10,000 to $25,000	15.07%
$60,001 to $80,000	13.70%
$100,001 or more	5.48%
$80,001 to $100,000	2.74%

Q32. What is your current employment status?

Answer Choices	Percentage
Full time	39.73%
Part time	21.92%
Unemployed	20.55%
Retired	6.85%
Student	5.48%
Receiving SSI/SSDI	4.11%
Seasonal	1.37%

5. CONCLUSION

5.1. Data Analysis

Most Notable:

- 21% of respondents report not having health insurance.
- 21% of respondents reported being unemployed, with 40% reporting being employed full time.
- 25% of respondents needed or sought treatment for anxiety, depression, or emotional concerns with 38% reporting they went untreated.
- Free or affordable health screenings, healthier food, and mental health services were selected as the highest needs for improving the health of family members and neighbors.

Needs Attention:

- 26% of respondents experienced anxiety, depression or other emotional problems that affected their ability to perform daily activities for 1-5 days in the last month and 19% reported 5-30 days that were affected.
- Barriers to receiving comprehensive medical care included not having health, dental, and/or vision insurance, and not being able to afford co-pays or pay for prescriptions.
- 11% reported either a lack of transportation or money as barriers to regular food access
    - 30% of respondents utilize Women, Infant, and Children (WIC), 22% utilize Supplemental Nutrition Access Program (SNAP), and 4% report utilizing senior nutrition programs.

By the Numbers:

- The demographics of the respondents were
    - 88% female, 11% male, and 1% reported as other
    - The highest percentage of respondents fell between 25-34 years of age
    - 75% of respondents were white, 10% Black or African American, 7% American Indian or Alaska Native, 7% Hispanic or Latino, and 1% reported as other
    - 44% rent their home, 38% own their home, 12% report staying with friends or family, and 3% reported being homeless
- 51% of those responding rate their overall health as good, with only 40% reporting their overall health as very good to excellent.
- 34% rate their overall mental or emotional health as good, with 45% reporting their overall mental or emotional health as very good to excellent.
- 79% of those surveyed reported zero days in the past month where they were unable to work due to poor health, 10% reported being unable to work due to poor physical health 1-5 days in the past month.
- 33% visited their healthcare provider 1-3 times in the last 12 months, 37% visited their healthcare provider 4-10 times or more in the last 12 months, and 30.14% did not visit their healthcare provider at all.
- Most of those surveyed prefer to receive health information by the internet, email, or social media.
- Substance abuse, mental health, obesity, and diabetes were selected as the top major health concerns in the community.
- Blood pressure checks, flu shots, dental cleanings/x-rays, blood sugar and physical exam screenings were the most highly utilized preventive procedures in the past 12 months.

- Prostate cancer, bone density, hearing, and skin cancer screenings were the least utilized preventive procedures in the past 12 months.
- 23% of respondents said they were likely to very likely to use virtual care, with 27% reporting they are not likely to use virtual care, 32% were not familiar with virtual care.
- 96% of those survey said they feel safe their neighborhood.
- The top four health screening and/or services needed to keep families health are:
    - Routine Well Checkups
    - Blood Pressure Screenings
    - Dental Screenings
    - Exercise and Physical Activity
- The top four reported health conditions experience by respondents are:
    - Anxiety
    - Depression
    - Overweight by more than 30 pounds
    - Migraines
- Respondents reported participating in the following health behaviors the most:
    - Consume fast food at least once a week
    - Using sunscreen or protective clothing for planned time in the sun
    - Receiving an annual flu shot
    - Exercise at least 3 time per week

5.2. Data Correlations

A total of 73 surveys were received from Grady County residents. This sample is approximately .14% of the population based on the 2010 census. Based on demographic information the sample represents the general population for statistical relevance. The majority of respondent reporting is consistent with the State of the State's County Report Card for Grady County in all aspects except mental or emotional identification and support and lack of chronic illnesses.

5.3. Synopsis

More research is indicated for the population of Grady County for mental health indicators, access to fresh fruits and vegetables, and chronic illness occurrence. The residents of Grady County are requesting more recreation facilities, job opportunities, wellness services, safe places to walk and play, substance abuse rehabilitation, and transportation.

6. NEXT STEPS

The data from the 2019 Community Health Needs Assessment Survey will be compiled with data from additional assessments. All of this information will be presented to the community leaders. They will select two to three priority areas of focus for community health improvement for the next three years.

The selected priorities and the associated objectives and strategies will be available to the public through the Grady County Health Improvement Plan.