2019 Community Health Needs Assessment Executive Summary

Kadlec Regional Medical Center
Richland, Washington

Understanding and Responding to Community Needs, Together

Improving the health of our communities is fundamental and a commitment rooted deeply in our heritage and purpose. Our mission calls us to be steadfast in serving all with a special focus on our most poor and vulnerable neighbors. This core belief drives the programs we build, investments we make, and strategies we implement.

Knowing where to focus our resources starts with our Community Health Needs Assessment (CHNA), an opportunity in which we engage the community every three years to help us identify and prioritize the most pressing needs, assets and opportunities. In the Washington/ Montana region, Kadlec Regional Medical Center is a member of a collaboration with the Benton-Franklin Health District (BFHD) and the Benton-Franklin Community Health Alliance (BFCHA). The collaborative also includes representatives from Trios Health, Lourdes Health, and Prosser Memorial Health. The 2019 Community Health Needs Assessment was approved by the Kadlec Governance Committee on November 26, 2019 and made publicly available on December 19, 2019.

Our Starting Point: Gathering Community Health Data and Community Input

Through a mixed-methods approach using quantitative and qualitative data, the CHNA process used several sources of information to identify community needs. Benton and Franklin Counties, located in south-central Washington, have a total population of approximately 290,000 people with 77% White, 22.5% Hispanic, 3% Asian, 2.5% Multi-Race, 1.5% Black, and 0.5% American Indian/Alaska Native. Approximately 41,000 people living in the bi-county region are foreign born, regardless of citizenship status, and 30% of households report English is not the primary language spoken in the home. Information collected includes public health status indicators related to obesity, physical health, suicide and mental health, sexual and reproductive health, violence and community safety, substance abuse, homelessness and poverty, access to health care and aging issues. Community input was gathered May through July of 2019. Listening sessions were held with people who have chronic conditions, are from diverse communities, have low-incomes, and/or are medically underserved. Stakeholder interviews and surveys were conducted with people who serve these populations.

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Some key findings:

- Suicide rate in Benton and Franklin Counties is higher (20.11/100,000) than the Washington State rate (17.1/100,000).
- Provider to population ratios, particularly in Franklin County (4100:1), are worse than Washington State (1220:1) ratios.
- Hospitalizations for falls for adults 65+ in Benton and Franklin Counties (2,239/100,000) is higher than Washington State (1,823/100,000) and the death rate from Alzheimer's disease in Benton and Franklin Counties (70.72/100,00) is substantially higher than the Washington State (45.41/100,00) rate.
- Families living at or below the federal poverty level in Benton County (16%) and Franklin County (19%) are higher than the Washington State (13%) rate.
- Dominant themes shared by community members in listening sessions included the need for affordable and accessible comprehensive health care including mental health services; shelters and services for those experiencing homelessness; safe, affordable housing for individuals with low incomes; and increased community safety.
- Stakeholders identified the following high priority, unmet health-related needs: behavioral health challenges which include mental health and substance use disorder; homelessness and lack of safe, affordable housing; and access to behavioral health care with particular concern about not having a detox center or inpatient treatment center.

For more information on the CHNA methods and process, see the full CHNA document on page 7, available on: https://www.kadlec.org/community/community-health-needs-assessment

Identifying Significant Health-Related Needs, Together

Through a collaborative planning process engaging community members and partners, as well as listening session and stakeholder interview participants, the following significant health-related needs were identified:

- Behavioral health challenges
- Access and cost of all health care
- Social determinants of health

The steering committee identified the aging population and youth as disproportionately affected by the top three significant health-related needs. Specific challenges identified for the aging population include the need for specialists, such as neurologists and geriatric providers, the need for more support for older adults living alone in their homes, and the need for more affordable housing for older adults.

For a rank order list and description of significant health needs see page 19, and for resources available to address those needs, see page 21 of the collaborative CHNA Report.

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2019 Collaborative CHNA Significant Health-Related Needs

#1: Behavioral health challenges which include mental health, suicide, and substance use disorders. Groups identified as being especially affected are people experiencing homelessness, youth, older adults, veterans, and those who identify as LGBTQ.

#2: Access and cost of all health care includes access to behavioral health care and medical health care. While insurance enrollment rates have increased due to systemic changes at the federal level, the cost of health care remains a financial burden for many in our community.

#3: Social determinants of health are conditions in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. Significant health-related areas identified include poverty, housing and homelessness, and food insecurity.

While obesity was not identified as a priority in the 2019 CHNA, obesity rates for children, teens, and adults in Benton and Franklin Counties continue to increase and remain higher than the state. According to the CDC, "Childhood obesity is a serious problem in the United States putting children and adolescents at risk for poor health. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer that are some of the leading causes of preventable, premature death." Kadlec is committed to the long-term goal of reducing obesity, and it will continue to be addressed in the 2020 Kadlec Community Health Improvement Plan.

While care was taken to select and gather data that would tell the story of the hospital's service area, it is important to recognize the limitations and gaps in information that naturally occur. The Community Health Improvement Plan development committee will consider the significant health-related needs identified through this community health needs assessment and develop strategies to address needs considering resources, community capacity and core competencies.

Measuring our Success: Results from our 2016 CHNA and 2017-2019 CHIP

This report also evaluates the results from our most recent CHNA and CHIP. Kadlec Regional Medical Center responded by making investments of staff time, cash donations, and grant funding to internal and external programs that were most likely to have an impact on these needs. This summary includes just a few highlights of our efforts across Benton and Franklin Counties. In addition, we invited written comments on the 2016 CHNA and 2017-2019 CHIP reports, made widely available to the public. No written comments were received on the 2016 CHNA and 2017-2019 CHIP. Below is a summary of our outcomes for each priority:

Priority Need	Program or Service Name	Results/Outcomes 2017-2019
Improve access to health care/ health equity	Increase the number of primary care providers serving our community.	1. Five primary care providers added in the fall of 2019.

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	Program or Service Name	Results/Outcomes 2017-2019
	Improve after-hours access to primary care.	1. Educated community on proper utilization of Emergency Department, Urgent Care, and Express Care.
	Continue to develop and mature relationships with and assist outlying rural hospitals.	1. Expanded telemedicine program to meet rural community needs. For example: i. TeleDiabetes Management for Gestational Diabetic 2. TeleMaternal Fetal Medicine
	Workforce development	1. Expanded Family Medicine Residency Program, including rotation at Grace Clinic to provide comprehensive primary care to the uninsured in our community. i. The Elson S. Floyd College of Medicine's inaugural class of medical students was welcomed in August 2017. Kadlec provides clinical sites for Washington State University undergraduate students working on their Bachelor of Science in nursing degree and for their nurse practitioners.
Reduce obesity/promote healthy weight	Expand and engage Community in Health programs.	1. Kadlec Academy a. This four-week after school program was held at 38 schools and programs and four family events reaching approximately 2,500 students. 2. Healthy Ages Mall Walkers Program 2. An average of 60 walkers meet at the Columbia Center Mall each week day to get in their steps as well as benefit from the social connections.
Mental health	Implement TelePsych model.	1. TelePsych program started in July of 2017, serving in-patients and the emergency department.
	Enhance behavioral health services in Kadlec Clinic sites.	1. In 2018, behavioral health services moved to a centralized model and opened a behavioral health clinic with two nurse practitioners. 2. Integrated behavioral health by embedding social workers in primary care clinics.

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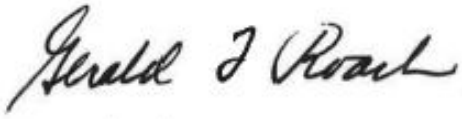
2019 CHNA GOVERNANCE APPROVAL

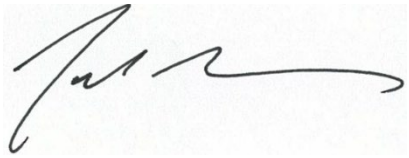
December 19, 2019

Reza Kaleel
Chief Executive
Kadlec Regional Medical Center



December 19, 2019

Jerry Roach
Chair
Kadlec Regional Medical Center



December 19, 2019

Joel Gilbertson

Senior Vice President

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Request a copy without charge, provide comments or view electronic copies of current and previous community health needs assessments: https://www.kadlec.org/community/community-health-needs-assessment

BENTON & FRANKLIN COUNTIES

COMMUNITY HEALTH NEEDS ASSESSMENT

2019

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CHNA STEERING COMMITTEE:

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PUBLIC HEALTH
Prevent • Promote • Protect
BENTON-FRANKLIN HEALTH DISTRICT

Prosser Memorial Health

Benton-Franklin Community HEALTH ALLIANCE

KADLEC

Trios® Health
A UW Medicine Community Health Partner™

LOURDES HEALTH

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Photo Credit: James Coleman

EXECUTIVE SUMMARY

PURPOSE:

The Community Health Needs Assessment (CHNA) helps determine which critical health needs the community will focus on addressing over the next 3-5 years. It is a systematic and shared process for identifying and analyzing community needs and assets throughout Benton and Franklin counties, from Prosser to Connell, from Hover to Hanford. The 2019 CHNA is the result of dozens of stakeholder interviews and focus groups, hours upon hours of research, and multiple community and partner surveys. Not to mention the magic of two large-group exercises to identify and agree on three priority health needs.

Just as our community is more than the sum total of residents and visitors, the health of our community is more than just the health of the individuals who live, work and play in Benton and Franklin Counties. The health status of our residents is important, but equally important is the strength of families and the communities where they live.

Over the past several years, there have been some significant changes in the way our community views itself and its challenges and needs. Those changes are reflected in this document. In 2012, for example, the two strategic priorities were promoting healthy weight/reducing obesity and improving access to health care services. The 2016 CHNA added improving the mental/behavioral health system to the priority needs for our two-county area. The Community Health Improvement Plan (CHIP) was updated in 2017 and highlights on the progress to address these issues are detailed on pages 5-6 of this document.

METHODS:

The framework for the 2019 CHNA is based on a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) reflecting the model used in the prior CHNAs and also provided by Providence St. Joseph Health (PSJH). The CHNA Steering Committee began meeting in March, made up of representatives of the Benton-Franklin Health District (BFHD), Kadlec Regional Medical Center (Kadlec), Trios Health (Trios), Lourdes Health (Lourdes), Prosser Memorial Health (PMH), and the Benton-Franklin Community Health Alliance (BFCHA). PSJH Community Health Investment staff provided invaluable technical assistance including a Spanish-speaking facilitator and qualitative data analysis.

As a result, the 2019 CHNA reflects the health of the community in different ways. The numbers (quantitative data) often tell only part of the story. We were able to flesh out our understanding of the numbers with a formal analysis of the quality of the data by reviewing body language, tone, and frequency of key words/concepts in our interviews and listening sessions. This gives us a much fuller understanding of the needs of our bi-county community.

RESULTS:

Over fifty representatives including public health, hospital and health systems, behavioral health, community service organizations, first responders, business and education gathered for facilitated compression planning session to review and reflect on the data, identify important issues and come to agreement on the critical priorities for change. The three priorities are behavioral health challenges, access and cost of all healthcare and social determinants of health. Social determinants of health are the conditions in the communities where people live, learn work and play. Including them as a priority reflects the growing recognition that factors such as housing, transportation, poverty and even discrimination play an important role in overall health and well-being.

Behavioral Health Challenges

Access and Cost of All Health Care

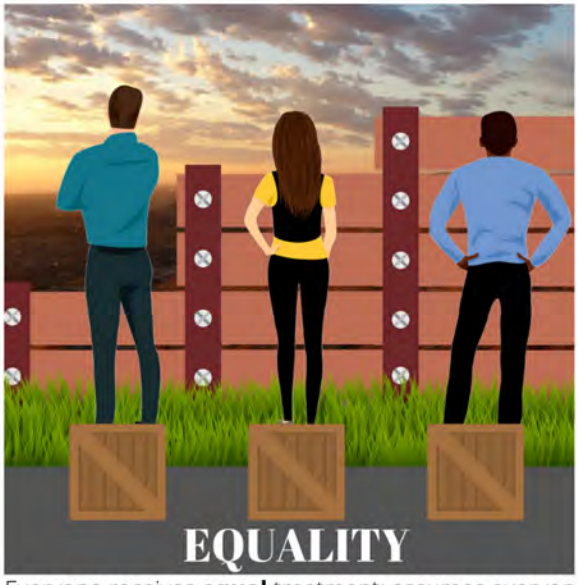
Social Determinants of Health

HEALTH EQUITY

Health Equity works to optimize conditions so that everyone in the community has the opportunity to attain their highest level of health and achieve positive health outcomes. Health outcomes are influenced by a multitude of factors other than genetics and biology, including behavioral, environmental, and social factors. These external factors, known as **Social Determinants of Health** (SDOH) include housing, education, income, healthcare, public safety, and food access. Race, culture, and gender identity are forces in determining how these social determinants are distributed.

Certain population groups are disproportionately impacted by these factors and are, therefore, at a higher risk of various negative health outcomes and adverse health disparities. **Health Disparities** are differences in health status between groups of people related to factors such as race, gender, income, or geographic region. It is important to recognize that differences in health status related to race, culture, and gender identity may, in fact, reflect systematic inequities in how social determinants like housing, food access, and education are distributed.

The CHNA steering committee made intentional efforts to utilize disparities data during the CHNA process. The steering committee worked to ensure there were a variety of stakeholder interviews and listening sessions for various demographic groups either highlighted in the *2018 Disparities Report* published by BFHD or recognized as historically marginalized groups. Some of these priority populations included the elderly, people of color, people who identify as LGBTQ+, people with low-incomes, people experiencing homelessness, and people living with disabilities. This also led to a greater effort to increase the number of Spanish-speaking sessions offered which resulted in three separate Spanish-speaking listening sessions with a Spanish-speaking facilitator and notetakers present.



Everyone receives **equal** treatment; assumes everyone benefits from the same supports.

Everyone receives **equitable** treatment is when everyone gets the supports they need.

When the systemic **barriers are removed**, everyone can see without supports.

Photo Credit: J.D.S/Shutterstock

OUR COMMUNITY

Benton and Franklin Counties, located in south-central Washington, have a total population of approximately 290,000 people. Each of the three main municipalities that make up the Tri-Cities are located within one of these two counties; Kennewick and Richland within Benton County and Pasco within Franklin County. There are numerous other smaller cities located within this jurisdiction including Prosser, Connell, Eltopia, Benton City, West Richland, Finley, Mesa, Basin City, and Kahlotus.

The population estimates for the cities and towns within Benton and Franklin Counties in 2019:

- Benton City: 3,520
- Connell: 5,500
- Kahlotus: 165
- Kennewick: 83,670
- Mesa: 495
- Pasco: 75,290
- Prosser: 6,145
- Richland: 56,850
- West Richland: 15,340

Given these numbers, the estimated population of residents living in unincorporated areas in either county (ex: Finley, Eltopia, Basin City) is 43,000 people.

While the population remains predominantly white, there is a substantial Hispanic/Latinx population that has more than doubled over the past two decades.

Race	Benton County	Franklin County
White	70%	39%
Hispanic (as a race)	22.5%	55.5%
Black	1.5%	1.5%
American Indian/Alaskan Native	.5%	.5%
Asian	3%	2%
Multi-race	2.5%	1.5%

Approximately 41,000 people living in the bi-county region are foreign born, regardless of citizenship status, and 30% of households report English is not the primary language spoken in the home.

The age distribution for Benton and Franklin Counties is approximately:

- 0-17 years: 28%
- 18-34 years: 22%
- 35-64 years: 37%
- 65+ years: 13%

Sources:
Washington State Office of Financial Management
Benton-Franklin Trends
Community Health Assessment Tool (CHAT)

Counties

Primary service area

Secondary service area

The map below illustrates the approximate hospital service area of the four local healthcare systems in the region: Kadlec Regional Medical Center (Kadlec), Trios Health (Trios), Lourdes Health (Lourdes), and Prosser Memorial Health (PMH).

The bi-county region is also considered to be a health care provider shortage area for primary care providers, mental health providers, and dental providers, meaning there are not enough providers for the population size, geographic location, or facility type. Franklin County is also considered to be a medically underserved area which the federal government classifies as an area that has too few primary care providers, high infant mortality, high poverty, or a high elderly population. These definitions and more information can be found on the website for the Health Resources & Services Administration (HRSA).

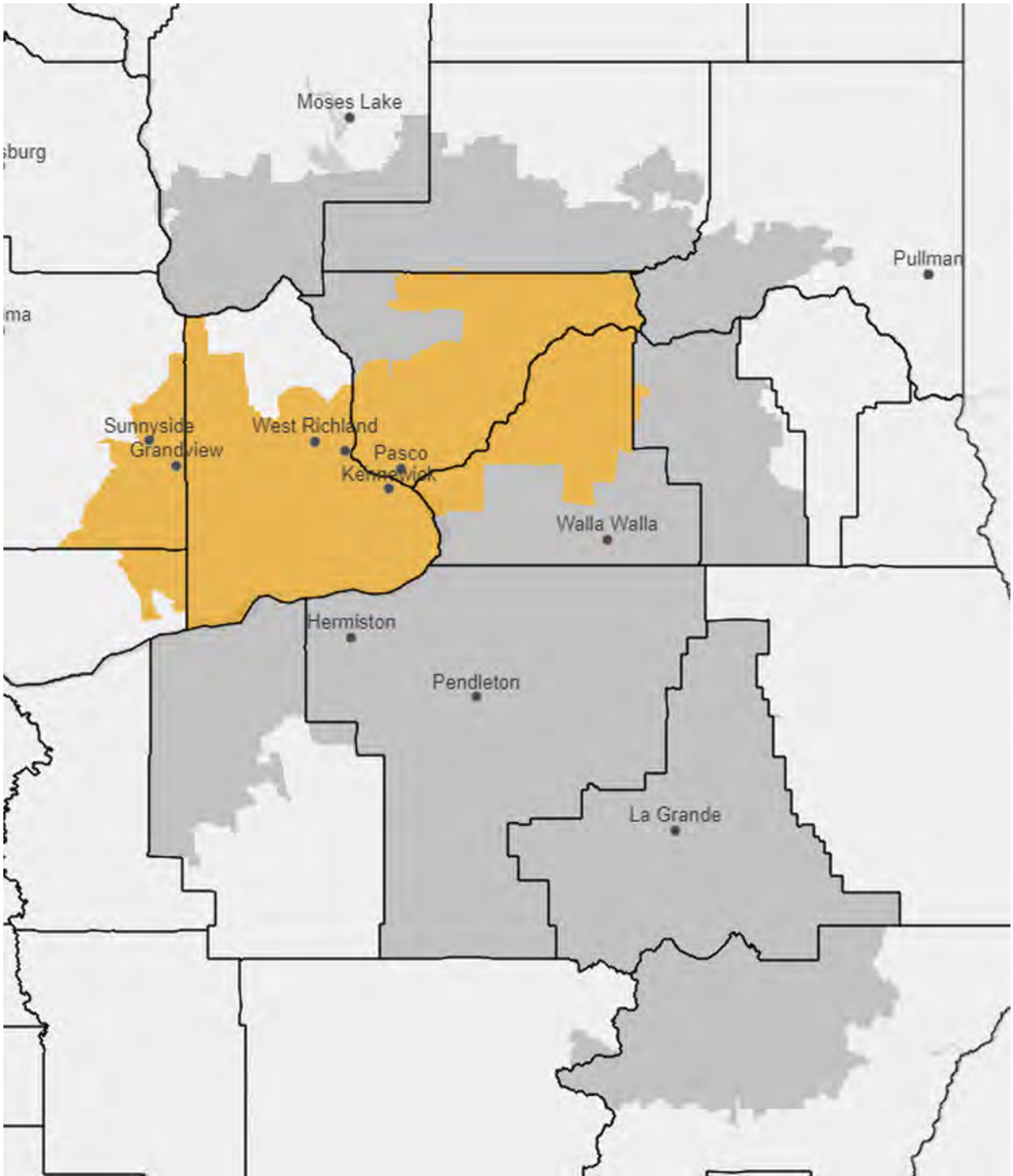


Photo Credit: Mary Lynn Merriman

2017 CHIP ACCOMPLISHMENTS

The updated 2016 CHNA resulted in three priority issues to be addressed by the 2017 Community Health Improvement Plan (CHIP). These priorities were:

- Improve access to health care
- Reduce obesity and diabetes rates
- Improve the mental/behavioral health system

Each priority issue was assigned related goals, along with SMART objectives (Specific, Measurable, Achievable, Realistic, and Time-Bound) to support those goals.

Improve Access to Health Care

The priority issue related to access to health care was broken up into three goals:

- Resources will be identified to reduce barriers and costs of health care
- The community will experience coordinated health care
- The health care delivery system will have the capacity to meet the needs of the community.

To achieve these goals, community partners surveyed the population over the course of two years to fully understand the local barriers to health care, increased the number of Community Health Workers (CHW), expanded enrollment of uninsured citizens onto health care coverage through the Washington Health Benefit Exchange, increased the number of partners distributing community education and engagement materials (rack cards, booklets, etc.), and increased dentist interactions with providers and the community through the annual Eastern Washington Medical-Dental Summit.

The goal of improved access also ties heavily into health equity. To address this, Kadlec has expanded its Family Medicine Residency Program that includes rotations with a local clinic that provides primary care for the uninsured. Prosser Memorial Health (PMH) made similar efforts to increase outreach to under-served populations in need of primary health care with their Community Paramedic Program that resulted in over 600 free home visits to community members in 2018 alone.

Reduce Obesity

The priority issue of reducing obesity and diabetes rates was also divided into three goals:

- Community members will be more physically active
- Adults will make more nutritious food choices
- Promote breastfeeding and improve child nutrition

To achieve these goals, the Benton-Franklin Health District (BFHD) has been working in partnership with local schools to implement Safe Routes to Schools programs and support local cities with enacting Complete Streets policies for new commercial and residential development. Both of these programs are nationally recognized ways to improve access and encourage more physical activity. The Health District has also led the community in breastfeeding best practices through partnerships with local hospitals aimed at eventually applying for the Breastfeeding Friendly Washington status and by operating a peer counseling program through WIC that has received state recognition and awards for excellence.

PMH has supported local farmer's market events to promote healthy eating and hosted free events promoting breastfeeding that provided in-person provider support for breastfeeding patients. Kadlec has partnered with more than 30 area schools to offer a free program that teaches health and wellness information to school-age children.

Improve the Mental/Behavioral Health System

The priority issue of improving the mental/behavioral health system was assigned three goals:

- Create more awareness about whole person health, including behavioral/mental health
- Work to eliminate gaps in the system
- Improve integration and coordination of services

BFHD has partnered with Kadlec and other community partners to host community events such as a lockbox giveaway for storage of handguns. BFHD and Kadlec have also been active in offering various community trainings related to behavioral health including Signs of Suicide, Youth Mental Health First Aid, and Adult Mental Health First Aid. Local partners and businesses have worked hard to stand up the first syringe exchange program in the bi-county region and expand treatment services for those with substance use disorders. Lourdes began working with local law enforcement in Richland, Kennewick, and Pasco to establish mobile outreach teams. This program pairs mental health professionals and counselors with local law enforcement officers in order to respond immediately to any calls with a mental health component. This innovative approach is another example of health equity work in action; a program specifically aimed at serving populations who are often outside the traditional health care system, or those who struggle with access to care.

BFHD also hosted a summit in 2018 that brought together community partners to do compression planning around the topic of youth suicide. Priority issues were identified and potential solutions were outlined in the community work plan.

Photo Credit: Tri-City Herald

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METHODOLOGY

The steering committee consisted of representatives from all the local health care systems (Kadlec Regional Medical Center, Trios Health, Lourdes Health, and Prosser Memorial Health), the Benton-Franklin Community Health Alliance (BFCHA), and the Benton-Franklin Health District (BFHD). The steering committee was formed in March 2019 and began meeting weekly shortly thereafter. From the members on the steering committee, only one person, the Health Officer from BFHD, had been involved in the previous CHNA process from 2013 and the update in 2016. The group decided to use a modified version of the Mobilizing for Action through Planning and Partnerships (MAPP) guidance model promoted by the National Association of County and City Health Officials (NACCHO).

Local Health Status Indicators

Health related data points were identified using the list from the stakeholder survey, the previous 2013 and 2016 CHNA data books, and based on priority issues highlighted by community members and stakeholders. These data points make up the **Local Health Status Indicators**. The Performance Management team from BFHD then compiled the list of desired data points and determined which ones could be supported by a reliable source. Sources used during this process included the Healthy Youth Survey (HYS), Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), Office of the Superintendent of Public Instruction (OSPI), Department of Education, American Community Survey (ACS), and partner-collected data from the local healthcare systems and community organizations. Using all of these sources, the BFHD epidemiologist compiled the most current data on 120 individual data points into a 2019 Data Workbook to bring back to the steering committee for consideration.

Community Input

Qualitative data, or data in the form of words instead of numbers, provides additional context and depth to the CHNA that may not be fully captured by quantitative data. Qualitative data was gathered in an attempt to gain insightful and equitable **Community Input**. This took a significant amount of time and effort in the form of listening sessions with members of priority populations and stakeholder interviews and surveys with those who serve these populations. Based on feedback from the Public Health Officer who participated in the CHNA process in 2016, the steering committee identified community input and involvement as an area of opportunity for improvement. The group wanted to be more intentional about incorporating health equity into this engagement process. One way in which this was accomplished was by utilizing existing tools, like the *2018 Health Disparities Report* published by BFHD. This report helped to inform the ultimate decisions on which priority population groups would be a primary focus for the listening sessions, specifically highlighting the Hispanic/Latinx and the LGBTQ+ communities. Another way the group sought to be more inclusive was to offer multiple listening sessions in Spanish, the other predominant language in Benton and Franklin Counties besides English. A facilitator provided by PSJH was able to conduct three of the 10 listening sessions completely in Spanish with Spanish-speaking notetakers present at all of them. Finally, the steering committee worked diligently to ensure a wide variety of sectors and populations were represented in the 16 stakeholder interviews including representation from the following population and sector categories: behavioral health, homelessness, healthcare, senior population, Hispanic/Latinx population, domestic and sexual violence, first responders, substance abuse, Pre-K-12th grade education, post-secondary education, LGTBQ+ population, refugee population, and persons living with a disability population. The sessions were typically recorded with participant permission, and one or two notetakers were present to capture response information. Data from all of the stakeholder interviews and listening sessions was sent to a qualitative data analyst provided by PSJH for review and analysis.

In an effort to include input from as many community partners as possible, the steering committee opted to disseminate the stakeholder survey from the stakeholder interview packets. An electronic copy was created to distribute through email distribution lists from BFHD, the hospital partners, and BFCHA. Paper surveys were also distributed to 20 coalitions, boards, or community partner agencies. Over 200 survey responses were received and analyzed as part of the **Community Input** data section.

Photo Credit: Prosser Memorial Health

LOCAL HEALTH STATUS INDICATORS

Since the Steering Committee chose to utilize the survey provided in the stakeholder interview packet, the Performance Management Department at BFHD identified 120 individual indicators that fit within one of the 26 categories outlined in the survey. From there, the Steering Committee compared those 120 indicators with the state numbers and kept only the data points for which the local numbers were performing worse than Washington state as a whole. Members then compared this list of remaining data points to the overarching qualitative data themes from the community input and included a handful of indicators where local performance was better than the state's overall, but still a concern to this community. This resulted in approximately 70 indicators that fit within nine overarching topic areas. The following tables list these indicators, followed by a (B), (F), or (B&F) to indicate if the data point is specific to Benton, Franklin, or both Benton and Franklin Counties.

Obesity

Indicator	Local Rate	WA State Rate
Breastfeeding at birth as noted on birth certificate	89% (B&F)	94%
Exclusive breastfeeding while in hospital	Kadlec: 42-51% Trios: 38-46%	51-53%
Breastfeeding 6 month duration among WIC clients	45% (B&F)	51% (2017)
Children (1-5) in the top 15% BMI enrolled in WIC	27% (B&F)	25%
Teens in the top 15% BMI	16% (B&F)	14%
Adults 18+ who have a BMI of 30 kg/m2	33% (B&F)	28%

Physical Health

Indicator	Local Rate	WA State Rate
Adults reporting excellent or very good health status	49% (B&F)	53%
Adults who have been told they have asthma by a doctor	14% (F)	13%
Adults who have had a stroke	3%	3%
Hospitalization rate due to chronic obstructive pulmonary disease and bronchiectasis	154.16/100,000 (B&F)	87.44/100,000
Adults who have been told by a doctor they have diabetes	10% (B&F)	9%
Rate of unintentional injury hospitalizations	470.71/100,000 (B&F)	435.16/100,000

Suicide and Mental Health

Indicator	Local Rate	WA State Rate
Suicide rate - overall	20.11/100,000 (B&F)	17.1/100,000
Youth suicide rate (10-17)	5.54/100,000 (B)	4.69/100,000
Young adult suicide rate (18-24)	17.7/100,000 (B)	16.43/100,000
Suicide rate (65+)	23.3/100,000 (B&F)	19.58/100,000
Youth suicide ideation	23%* (B)	23%
Youth suicide planning	19% (B)	18%
Hospitalization from self-harm	6.39/100,000 (B&F)	10.09/100,000
Youth depression	40%* (B&F)	40%
Adults reporting 14 poor mental health days a month	15% (B&F)	12%

*** Indicates that other grade levels had larger differences from the state level data**

Sexual and Reproductive Health

Indicator	Local Rate	WA State Rate
Youth who did not use a condom last time they had sex	48% (B&F)	47%
Youth who did not use any form of contraception last time they had sex	26% (B&F)	22%
Teen birth rate	11.6/1,000 (B&F)	7.2/1,000
Rate of reported cases of gonorrhea	142.81/100,000 (F)	137.09/100,000
Rate of reported cases of syphilis	13.02/100,000 (B&F)	16.97/100,000
Rate of reported cases of chlamydia	3,623/100,000 (B&F)	2,950/100,000
Percent of reported chlamydia cases that were treated	91% (B&F)	96%
HIV test done in the past 5 years	18% (B&F)	22%

Violence and Community Safety

Indicator	Local Rate	WA State Rate
Youth who have been bullied	20%* (B&F)	19%
Youth feel safe at school	78%* (B&F)	79%
Domestic violence - overall	761.65/100,000 (F)	742.71/100,000
Domestic violence - youth	10% (B&F)	11%
Physical abuse by an adult - youth	24% (B&F)	25%
Verbal abuse by an adult - youth	15% (B&F)	15%
Child abuse and neglect rate	39/1,000 (B)	37.8/1,000
Reported sexual assaults – overall	125.4/100,000 (B&F)	91.6/100,000
Sexual assault – youth	18%* (B&F)	19%
Youth witnessed sexual assault	32%* (B&F)	31%
Youth gang involvement	6% (B&F)	6%
Youth arrests	42.3/1,000 (B&F)	8.8/1,000
Youth drug related arrests	6.5/1,000 (B&F)	2/1,000

*** Indicates that other grade levels had larger differences from the state level data**

Substance Abuse

Indicator	Local Rate	WA State Rate
Youth alcohol use	18%* (B&F)	19%
Youth Rx drug abuse	4%* (B&F)	4%
Youth cigarette use	5% (B&F)	2%
Youth E-cigarette use	22% (B)	21%
Youth marijuana use	16%* (B&F)	18%
Opioid overdose hospitalization	19.86/100,000 (B&F)	17.73/100,000
Opioid overdose deaths	8.6/100,000 (B&F)	9.25/100,000
Opioid Prescribing rates	89.9/100 (B)	(57.2/100)

*** Indicates that other grade levels had larger differences from the state level data**

Homelessness and Poverty

Indicator	Local Rate	WA State Rate
Population experiencing food insecurity	9% (B&F)	12%
Youth living outside parent's home	11%* (B&F)	11%
Elderly living in poverty	9% (F)	8%
People living at or below the federal poverty level	13% (B) & 16% (F)	12%
Families living at or below the federal poverty level	16% (B) & 19% (F)	13%
Population living in a food desert	9% (B&F)	10%

*** Indicates that other grade levels had more significant differences from the state level data**

Access to Health Care

Indicator	Local Rate	WA State Rate
Adults with health insurance	83% (B&F)	87%
Adults with a personal doctor	72% (B&F)	74%
Adults who have visited a dentist in the past 1-2 years	77% (B&F)	80%
Primary Care Provider (PCP) to population ratio	F: 4100:1 | B: 1470:1	WA: 1220:1
PCP (non-physician) to population ratio	F: 2047:1 | B: 1071:1	WA: 1171:1
Mental Health Provider to population ratio	F: 780:1 | B: 470:1	WA: 310:1
Access to nearby medical facilities	NA	NA

Aging Issues

Indicator	Local Rate	WA State Rate
Hospitalizations for falls – Adults 65+	2,239.35/100,000 (B&F)	1,823.09/100,000
Death rate from Alzheimer's disease	70.72/100,000 (B&F)	45.41/100,000

COMMUNITY INPUT

The CHNA steering committee recognizes the value in having community members and community stakeholders participate in the CHNA process and share their perspectives. As the people who live and work in the counties, they have firsthand knowledge of the needs and strengths of their community. To gather these perspectives, the steering committee conducted listening sessions with community members and surveyed or interviewed community stakeholders.

Listening Sessions

Ten listening sessions were completed with a total of 96 community members. Participants shared their vision for a healthy community, the health-related needs of their community, and the assets that currently help their community be healthy. Following are the dominant themes from the sessions:

- **Community members' vision for a healthy community**
  - People are outside playing, walking, and being active
  - The community is diverse and inclusive, where all people can live well
  - Community members feel safe and kids can play freely
  - People spend time together and take part in social events
  - Local health care services are accessible and affordable
  - People take care of one another, especially those who most need support
- **Health-related needs of the community**
  - Affordable medical care, dental care, and prescriptions, specifically low-cost or free
  - Timely, convenient, and local medical care
  - Resources for people who need help and increase knowledge of local resources
  - Affordable mental health services that are responsive to people's unique needs
  - Shelters and services for individuals experiencing homelessness
  - Safe, affordable, clean housing, especially for individuals with low-incomes
  - Increased community safety
- **Community strengths and assets**
  - Community resource fairs and financial assistance programs
  - Multiple local hospitals and access to free medical services
  - Educational opportunities for adults and children
  - Access to healthy and fresh food
  - Community openness to diversity and people's unique needs
  - Close proximity to natural resources and activities
  - Opportunities for people to exercise outdoors and be physically fit
  - Good transportation services

Community Stakeholder Surveys

The CHNA steering committee wanted to include as many opportunities for input from stakeholders as possible. They surveyed 256 stakeholders to provide additional insight into the prioritization of health-related needs. Stakeholders were asked to identify their top five health-related needs in the community. Stakeholders prioritized one health-related need substantially above the others: behavioral health challenges, including both mental health and substance use disorder. After this need, two more needs were given high priority and tied for importance: access to behavioral health services and homelessness and housing instability. These top three health-related needs mirror those of the stakeholders who completed interviews. The top three health-related needs are summarized as follows:

- Behavioral health challenges
- Access to behavioral health
- Homelessness and housing insecurity

Community Stakeholder Interviews

The steering committee completed 16 community stakeholder interviews, including 40 stakeholders, or people who are invested in the well-being of the community and have firsthand knowledge of community needs and strengths. Stakeholders were asked to rank the unmet health-related needs of their communities. For those identified needs, stakeholders shared which populations are most affected by the needs, gaps in community services to address the need, and barriers to services for community members. The top three unmet health-related needs identified by stakeholders were classified as high priority. The next three unmet-health related needs were classified as medium priority. Stakeholders were also asked to identify community assets that help make the community healthier and opportunities they see for community organizations to better work together.

High Priority Unmet Health-Related Needs

- Behavioral health challenges (includes both mental health and substance use disorder): Stakeholders were concerned about the high amount of substance abuse in the community and lack of treatment options. Additionally, they were concerned about youth mental health and rising youth suicide. They identified people experiencing homelessness, young people, older adults, veterans, and individuals who identify as LGBTQ+ as more affected by behavioral health challenges. Stakeholders named stigma and a lack of funding for treatment as barriers to addressing this issue. They saw mental health services in schools and integration of behavioral health screenings in primary care as gaps in services.

- Homelessness/lack of safe, affordable housing: Stakeholders identified housing as foundational to addressing all other health-related needs. They spoke to needing more shelters, affordable housing, transitional housing, and resources to support people experiencing homelessness. They specifically identified young parents, transgender people, women, people with substance abuse disorder, people leaving domestic violence, young people, and families with low-incomes as particularly affected.

- Access to behavioral health care: Stakeholders were particularly concerned about not having a detox center or an inpatient treatment center in Benton and Franklin Counties. Additionally, they shared that a lack of mental health providers and lack of affordable mental health care contributes to the behavioral health challenges.

Medium Priority Unmet Health-Related Needs

- Access to medical care: Stakeholders shared that the complexity of the healthcare system is a barrier to people getting the medical care they need. They stated there are currently not enough providers in the area, particularly specialists, contributing to long wait times for appointments. Specifically, there are gaps in medical care for veterans, people identifying as LGBTQ+, and people who are undocumented.

- Domestic violence, child abuse/neglect: Stakeholders were concerned about the long-term impact child abuse has on children's healthy development, as well as the interaction between domestic violence and other issues such as substance abuse and homelessness. Teen girls, individuals identifying as LGBTQ+ and/or people with disabilities were identified as groups disproportionately affected by violence. Stakeholders saw safe places for children currently in danger and community spaces for survivors of domestic violence to support one another as gaps in community services.

- Aging problems (such as memory, hearing, and vision loss): Stakeholders felt their community is aging and the current support services are not sufficient to meet the growing need. To better meet this need, stakeholders stated Benton and Franklin Counties need a memory care unit, more geriatric providers, and more caregiver support groups. Additionally, stakeholders shared there needs to be more education around healthy aging, dementia, and Alzheimer's for the general community and providers.

Photo Credit: Megan Fullmer and Kadlec

"We got a lot of organizations in town that, while they're doing great things, they think they're the only kids on the block or are the only ones that can do it or they're doing it the most perfect way and it ends up siloing everybody involved, whether it's community members or other organizations."
– Community Stakeholder

Photo Credit: Canva

Stakeholders were asked, "What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve?" Participants named a variety of organizations, programs, and local services they see as a community strength (See Appendices for a full list). The most shared themes were as follows:

Opportunities for Community Organizations to Work Together

- More collaboration and less competition: Stakeholders shared they need more opportunities to collaborate with one another. They see the current coalitions as a strength and think there need to be more opportunities to learn from one another and collaborate on solutions.

- Communication and relationship building: Stakeholders named numerous community organizations and programs that are currently working to meet health-related needs, but there is little communication between them. They would like to see more relationship building among organizations and sharing of up-to-date information and resources.

Community Strengths and Assets

- Collaboration between organizations and coalitions to address needs: Opportunities for organizations to work together and leverage their unique strengths were highlighted as a community asset.

- Innovative approaches to addressing behavioral health challenges: Programs such as the Trueblood Program and the Mental Health Court are working to provide support to individuals whose mental health impacts their criminal behavior.

- Providing services in schools: 3 Rivers Wraparound with Intensive Services (WISe) and Communities in Schools are providing supports and access to services to students in schools, addressing behavioral health challenges and other needs.

"We also have a couple of really great community organizations that are doing a lot of that coordination and laying over like Communities in Schools. That's been a tremendous boon to all of our school districts that have access there. And every school in the district wants a site coordinator because it allows education folks to do education and then all of those systemic barriers that our families in poverty are often facing, there is somebody that can help coordinate those community services for them. " – Community stakeholder

Data Blending

Community members and stakeholders identified many of the same health-related needs as priorities. The specifics of the need may have varied slightly. An overview of the health-related needs of both community members and stakeholders blended together is as follows (in no particular order):

Behavioral Health Care (access to and challenges)
Both groups identified the importance of having affordable mental health services available, particularly for youth and people identifying as LGBTQ+. Both groups identified stigma as a barrier to addressing behavioral health challenges and noted a need for more mental health providers. Stakeholders emphasized a need for substance use disorder treatment and a detox center.

Homelessness/Safe, Affordable Housing
Both groups shared a need for more shelters, more low-income housing for families, more affordable housing for older adults, and more resources (such as showers and laundry facilities) for people experiencing homelessness. Community members emphasized wanting good quality, clean homes. Stakeholders identified a need for more transitional housing and wet shelters.

Access to Medical Care
Both groups identified a need for more specialists and primary care providers to increase access to appointments. Both groups identified a need for more accepting medical services for LGBTQ+ individuals and more affordable services for people who are undocumented. Stakeholders emphasized the need for patient advocates to help navigate the complexity of the health care system, while community members emphasized the need for more affordable care, including dental care.

Community Safety and Child Well-Being
Both groups were concerned with the well-being of children and their safety, as well as the importance of schools in meeting children's social-emotional needs. Community members were most concerned with gang violence in their community, while stakeholders emphasized a concern for domestic violence.

Aging Problems
Both groups acknowledged a need for more specialists and services for older adults, especially those living alone in their homes. Stakeholders were especially concerned about access to services for people with varying forms of dementia, such as Alzheimer's disease, and saw a need to better educate community members on local resources related to aging issues.

Photo Credit: Canva

PRIORITIZATION PROCESS & CRITERIA

The steering committee chose to evaluate the **Local Health Status Indicators** by comparing them to Washington State rates. Data points that were worse than the state numbers for Benton, Franklin, or Benton and Franklin combined were identified first. The data points were then narrowed down further by the steering committee by considering other factors like change over time, comparison to target numbers outlined by *Healthy People 2020*, and the severity of the difference between the local and state numbers. These data points were then grouped into like categories of overarching topics and the steering committee added additional data points related to each topic and based on the priority issues highlighted through **Community Input**, regardless of local numbers vs state numbers, to present a more complete picture. This resulted in a list of approximately 70 data points categorized into nine topic areas: obesity, physical health, mental health and suicide, substance abuse, homelessness and poverty, aging issues, community violence and safety, access to health care, and sexual and reproductive health.

Community Compression Planning

The steering committee then scheduled a community partner compression planning session to which they invited agencies and partners from their respective distribution lists and specifically invited partners who participated in listening sessions and stakeholder interviews. The compression planning session was held in July 2019 at the location of the normally occurring BFCHA meetings with a professional facilitator. Over 50 representatives from community partners and agencies attended the compression planning session and participated in prioritization activities. Participants included representation from health care networks, local clinics, public health, first responders, behavioral health, long term care facilities, local chambers of commerce, student nursing programs, and other service-oriented community-based organizations. Participants reviewed the 70 data points in a small group discussion format. Participants were also provided visual aids that indicated whether a data point was worse than the state number, identified by community members and partners as an issue, or selected previously as a health priority in the prior CHNAs from 2013 and 2016. Each group shared the data points that were significant to their group and lumped like data points together based on overarching themes, resulting in seven priority health issue topics: obesity, youth sexual and reproductive health, violence and community safety, social determinants of health, behavioral health challenges, access and cost of all health care, and aging and long term care issues. Participants then proceeded to select their top three priorities. This resulted in three issues rising to the top as clear priorities, three falling to the bottom, and one mid-range priority. Participants selected the top three priority issue topics:

- Behavioral Health Challenges
- Access and Cost of All Health Care
- Social Determinants of Health

Photo Credit: Benton-Franklin Health District

Disparities Data

One thing that was clear from the majority of stakeholder interviews, community listening sessions, data review, and compression planning discussions was that not all population groups are affected by these health issues equally. Some population groups, specifically the elderly, youth, and LGBTQ+, experience additional barriers, challenges, or negative health outcomes related to the top three health needs.

Some of these challenges were brought to light in qualitative data from the listening sessions or stakeholder interviews. For example, access to healthcare is an issue for many residents regardless of demographic group, as evident by the provider to population ratios in the area. If someone requires more specialized care, like members of the LGBTQ+ community, living in an area that is already experiencing a healthcare provider shortage makes finding someone who is qualified and able to provide services to them even more difficult.

Other challenges and outcomes were quite apparent in the quantitative data from the local health status indicators. For example, young adults and, even more so, the elderly population, show alarming rates of suicide deaths when compared to other age groups.

These kind of clear disparities in health outcomes and challenges should not be ignored and need to be addressed with targeted interventions. The steering committee, therefore, intends to incorporate these population groups into the upcoming Community Health Improvement Plan, with focused objectives and activities aimed at better addressing the needs of these specific demographic groups.

Public Discussion

The steering committee also wanted to include the general public in the CHNA process and health priorities discussion. They chose to host a Facebook Live event with Dr. Amy Person, a member of the steering committee, to review the three priority health issues and answer questions from community members. Leading up to the event, the steering committee shared advertisements on their social media platforms and sent out invitations to community partners. A summary of the top three health priorities was published on the BFHD website for the community to view before the event and a link was provided for the public to submit questions ahead of time.

The Facebook Live event was held in August 2019 and was viewed and shared from the Benton-Franklin Health District's Facebook page. It also included an incentive for community members to share the video, resulting in 25 shares and over 850 views from just BFHD's Facebook page. Dr. Person answered several submitted questions from the public and walked the audience through the selection process and results with help from visual aids and a Kadlec staff member conducting the interview.

Photo Credit: Shutterstock

"I would just be repetitive in saying that addiction is a real disease and yet we don't treat people who are addicted like we treat other sick people. We treat them like outcasts and throwaways and bad people."
– Community Stakeholder

Photo Credit: Kadlec Regional Medical Center

FINDINGS: 2019 PRIORITY HEALTH NEEDS

The priority health needs identified through the 2019 CHNA process are as follows:

- Behavioral Health Challenges
- Access and Cost of all Health Care
- Social Determinants of Health

Behavioral Health Challenges

The compression planning group identified this topic as one of the most important unmet health-related needs in the community. Local health status indicators support this as a community issue, as well community input from the Stakeholder Interviews and Listening Sessions. The compression planning participants grouped mental health, suicide, and substance use disorder under this topic.

Stakeholders agreed that mental health needs are so important because they affect almost every population. Groups named as being especially affected by mental health challenges were the following:

- People experiencing homelessness (adults and youth)
- Young people (ranging from elementary school through high school)
- Older adults
- Veterans
- Individuals who identify as LGBTQ+

Participants highlighted the complexity of this issue, stating that these groups often overlap with one another. For example, a person may be experiencing homelessness and also be a veteran or LGBTQ+. Youth were specifically mentioned by multiple stakeholders as a group that has unmet mental health challenges due to exposure to violence and content related to suicide online. Adverse Childhood Experiences (ACEs), such as abuse and neglect, were also cited as strong contributors to mental health issues and substance use disorder later in life. Many stakeholders also mentioned the lack of treatment options and detox facilities, as well as the continuing stigma towards people who use drugs, as a gap in the community that has perpetuated the issue of substance use disorder.

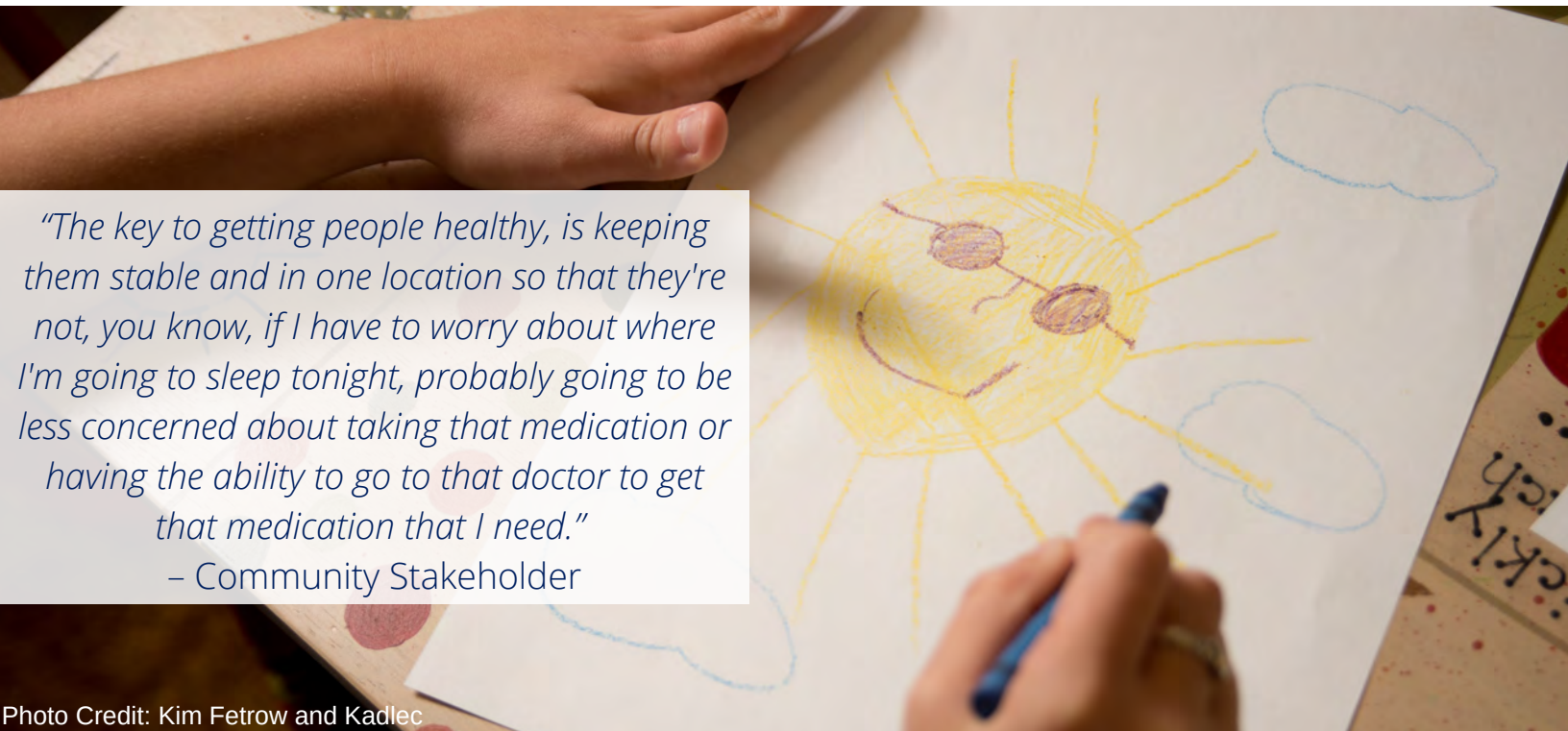
Access and Cost of all Health Care

The compression planning group identified this topic as a priority issue from the previous CHNA that needed to be continued and expanded in this iteration. In the 2013 CHNA, insurance enrollment was a focus under the access priority, but after systematic changes at the federal level that resulted in higher insured rates, the focus for the 2019 CHNA has been shifted. The compression planning participants chose to combine the issues of behavioral health care access and access to medical care, since both components are experiencing similar issues. Another area of focus related to access that was highlighted both through community input and the compression planning session was the cost of health care, even with insurance, and how it can be too much of a financial burden for struggling residents. Finally, another significant area of concern for those at the compression planning meeting was the provider to population ratios for the bi-county region. This concern was echoed in the listening sessions with community members expressing frustration and concern about the wait times to see a provider or access to a provider who also has specialization in the unique needs of specific population groups like LGBTQ+ or adults living with disabilities.

	Benton County	Franklin County	Washington State
Primary Care Provider to population ratio:	1470:1	4100:0	1220:1
Non-Physician Care Provider to population ratio:	1071:1	2047:1	1171:1
Mental Health Provider to population ratio:	470:1	780:1	310:1

Social Determinants of Health

Social Determinants of Health (SDOH) was identified as the third priority issue by the compression planning group. SDOH are external factors that affect one's health besides biology and genetics. Examples of SDOH include housing, education, income, healthcare, public safety, and food access. The compression planning group referenced Maslow's Hierarchy of human needs which asserts that physiological and safety needs like a home, food, water, and employment are the most basic, fundamental needs a person requires to survive. Similarly, as the group discussed, these needs are necessary to ensure a person can achieve their greatest level of health and a lack of resources related to these needs affects a person's ability to meet the other health needs addressed in the CHNA. Stakeholders held these same sentiments, arguing that a person who has no home or no food is not going to be able to effectively focus on addressing their mental health challenges or treating their chronic disease. Understanding how these factors are so interconnected to all other health priorities and how broad of a scope SDOH truly is, the compression planning group chose to focus on poverty, housing and homelessness, and food insecurity.



"The key to getting people healthy, is keeping them stable and in one location so that they're not, you know, if I have to worry about where I'm going to sleep tonight, probably going to be less concerned about taking that medication or having the ability to go to that doctor to get that medication that I need."
– Community Stakeholder

Photo Credit: Kim Fetrow and Kadlec

Photo Credit: Kim Fetrow and Kadlec

COMMUNITY ASSETS & RESOURCES

The listening sessions and stakeholder interviews also gave the steering committee the chance to identify community assets and resources that currently help address these health priorities.

Participants in the listening sessions identified the following aspects of their community as a strength or asset:

- Community resource fairs and financial assistance programs
- Multiple local hospitals and access to free medical services
- Educational opportunities for adults and children
- Access to healthy and fresh food
- Community openness to diversity and people's unique needs
- Close proximity to natural resources and activities
- Opportunities for people to exercise outdoors and be physically fit
- Good transportation services

Participants in the stakeholder interviews identified the following aspects of their community as a strength or asset:

- Collaboration between organizations and coalitions to address needs: Opportunities for organizations to work together and leverage their unique strengths were highlighted as a community asset.
- Innovative approaches to addressing behavioral health challenges: Programs such as the Trueblood Program and the Mental Health Court are working to provide support to individuals whose mental health impacts their criminal behavior.
- Providing services in schools: 3 Rivers Wraparound with Intensive Services (WISe) and Communities in Schools are providing supports and access to services to students in schools, addressing behavioral health challenges and other needs.

Community partnerships are essential in implementing a collective action approach for any community wide level efforts. This CHNA was only possible thanks to the dedication from numerous sectors, agencies, and partners spanning both counties. This list identifies the partner organizations who assisted in the CHNA process through stakeholder interviews, listening sessions, data sharing, compression planning, or completion of the stakeholder survey:

- Adverse Childhood Experiences (ACEs) Collaborative
- Aging and Long Term Care
- Alzheimer's Association
- Amistad Elementary
- A New Start in Life (ANSIL)
- Behavioral Health Committee
- Ben Franklin Transit
- Benton Franklin Community Health Alliance
- Benton Franklin Early Learning Alliance (BFELA)
- Benton-Franklin Health District
- Benton Franklin Recovery Coalition
- Benton Franklin Youth Suicide Prevention Coalition
- Boys and Girls Club of Benton and Franklin Counties
- Chaplaincy Healthcare
- Columbia Basin College (CBC)
- Columbia Basin Veteran's Center
- Community in Schools Benton-Franklin
- Domestic Violence Services of Benton and Franklin Counties (DVS)
- Educational Service District 123 (ESD123)
- Emergency Medical Services (EMS)
- Grace Clinic
- Human Services Coalition
- Kadlec Regional Medical Center
- Law Enforcement/Police Chiefs
- Lourdes Health
- Lower Valley Kiwanis
- My Friend's Place; Safe Harbor
- Parents and Families of Lesbians and Gays (PFLAG)
- People for People; 2-1-1
- Planned Parenthood of Greater Washington and North Idaho (PPGWNI)
- Prosser Memorial Health
- Prosser School District
- Prosser Thrive Coalition
- Senior Life Resources; Meals on Wheels
- Support, Resource, and Advocacy Center (SARC)
- Tierra Vida
- Tri-Cities Cancer Center
- Tri-Cities Community Health (TCCH)
- Tri-Cities Food Bank
- Tri-Cities Residential Services (TCRS)
- Tri-City Regional Chamber of Commerce
- Trios Health
- Lourdes Mobile Outreach Team
- Tri-City Union Gospel Mission
- United Way of Benton and Franklin Counties
- Vintage at Richland
- Washington State University Tri-Cities (WSUTC)
- World Relief
- You Medical

Thank you to all the dedicated members of these agencies and coalitions for their assistance on this project.

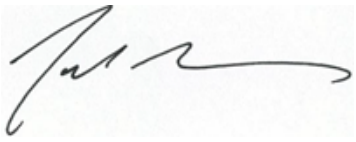
Photo Credit: Prosser Memorial Health

GOVERNING APPROVAL

Kadlec Regional Medical Center

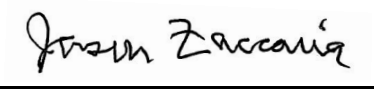
Reza Kaleel, Chief Executive

Jerry Roach, Community Board Chair

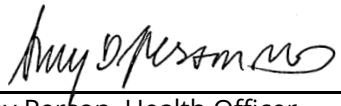


Joel Gilberston, Senior Vice President
Community Partnerships, Providence St. Joseph Health

Benton-Franklin Health District

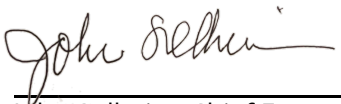


Jason Zaccaria, District Administrator



Dr. Amy Person, Health Officer

Trios Health



John Solheim, Chief Executive Officer

Lourdes Health

Rob Monical, Chief Executive Officer

Prosser Memorial Health

Craig J. Marks, Chief Executive Officer

Benton Franklin Community Health Alliance

Kirk Williamson, Program Manager

APPENDICES

Appendix 1: Key Community Stakeholder Interview Guide

Appendix 2: Community Health Survey

Appendix 3: Health Status Indicators Workbook

Appendix 4: Qualitative Data: Listening Sessions and Stakeholder Interviews

Appendix 1: Key Community Stakeholder Interview Guide

Key Community Stakeholder Interview Guide

Key Community Stakeholder	Hospital Representatives
Date and Time of Interview Location	(Please list all attendees)
Key Community Stakeholder Names/Titles (please list all attendees)	
Organization Name	
Address	
Phone(s)/Email	

Interview Questions	
Purpose	**Question**
To understand the role of the stakeholder's organization and community served	1. How would you describe your organization's role within the community?
	2. How would you describe the community your organization serves? Please include the geographic area.
To identify and prioritize unmet health related needs in the community, including the social determinants of health	3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.

	4. **Can you prioritize these issues? What are your top concerns*?*** ***[Note to interviewer: encourage ranking of at least top three health needs in order of priority]***
	5. **Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]**
To identify populations disproportionately affected by the unmet health-related needs	6. **Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs?**
To identify gaps in services that contribute to unmet health-related needs	7. **Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health-related needs you identified earlier. We have a particular concern for those that are low income, vulnerable or are experiencing health inequities.**
To identify barriers that contribute to unmet health-related needs	8. **Please identify and discuss specific barriers for the persons you serve that contribute to the unmet health-related needs you identified earlier.**
To identify community assets that can be leveraged, such as initiatives that are already addressing these health-related needs	9. **What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health related needs you identified earlier? Can you rank them in terms of effectiveness?**

To identify opportunities for collaboration between organizations	**10. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?**
Anything else	**11. What other things do you think we should hear about?**
Other comments:	

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).

	Aging problems (e.g. memory loss/hearing/vision loss)		Access to oral health providers
	Air quality, e.g. pollution, smoke		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/recreation
	Gang activity/violence		Behavioral health challenges (includes both mental health and substance use disorder)
	HIV/AIDS		Poor schools
	Homelessness/lack of safe, affordable housing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to medical care		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Access to behavioral health care		Other:

To be completed by interviewer after interview is complete
1. Was the interview recorded? YES / NO *[please circle]* a. If yes, how long is the recording: _____ minutes, ____ seconds b. Title of the recording:
2. Were there any questions the stakeholder did not seem to understand or struggled to answer?
3. Are there any questions you would recommend editing or removing?
Other comments:

Appendix 2: Community Health Survey

Date	Meeting
Name/Title	
Organization	
Address	
Phone(s)/Email	

Using the table below, please identify the five most important "issues" that need to be addressed to make Benton and Franklin Counties healthy (1 being most important).

	Aging problems (e.g. memory loss/hearing/vision loss)		Access to oral health providers
	Air quality, e.g. pollution, smoke		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/recreation
	Gang activity/violence		Behavioral health challenges (includes both mental health and substance use disorder)
	HIV/AIDS		Poor schools
	Homelessness/lack of safe, affordable housing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to medical care		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Access to behavioral health care		Other:

Appendix 3: Health Status Indicators Workbook

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Total population	CHAT	2017	193,500	90,330	283,830	7,310,300
Age 0-17 (Children and Youth)	CHAT	2017	50,237	29,875	80,112	1,649,570
Age 18+ (Adults)	CHAT	2017	143,263	60,455	203,718	5,660,730
Males	CHAT	2017	97,121	46,536	143,656	3,647,557
Females	CHAT	2017	96,379	43,794	140,174	3,662,743
Percent of adults reporting their general health status as excellent or very good.	BRFSS	2015-17	50.53%	46.98%	49.11%	52.7%
The number of years a newborn can expect to live if the current age-specific death rates remain constant. For life expectancy calculations of older age groups, the result is the number of years of additional life a person in that age group can expect to live, if the current death rates for that age group remain constant.	CHAT	2017	79.87	81.29	80.3	80.25
Years of healthy life expected at age 20 Additional years a 20 year-old is expected to live in good, very good, or excellent health (age 18-19)	Washington State DOH Local Public Health Indicators 2011	2014			50	50
Years of potential life lost (YPLL) before age 65 per 100,000 population	CHAT	2017	3,887.75	2,711.36	3,496.25	3,504.15
Leading causes of death	CHAT	2017	Heart, Cancer, Alzheimer's, Lower Respiratory, Accidents	Heart, Cancer, Alzheimer's, Accidents, Lower Respiratory	Heart, Cancer, Alzheimer's, Accidents, Lower Respiratory	Heart, Cancer, Alzheimer's, Accidents, Lower Respiratory
Rate of births that die before first birthday per 1000	CHAT	2016	4.71	4.89	4.78	4.31
Percent of women who report receiving a mammogram within the past 2 or 3 years.	BRFSS	2016	80.70%	81.40%	80.89%	82.6%
Percent of adults who report they have had a blood stool test in the past year, sigmoidoscopy in the past 5 years, or colonoscopy in the past 10 years	BRFSS	2016	73.89%	57.99%	70.53%	69.9%
Pertussis rate by county-cases per 100,000	CHAT	2018	2.58	3.32	2.82	10.15
Percent of adults (18+) who received a flu immunization in the last 12 months	BRFSS	2017	43.50%	35.60%	41.80%	43%
Percent of adults age 18 or older who report binge drinking (5 drinks for men; 4 drinks for women) on at least 1 occasion in last 30 days	BRFSS	2017	14.9%	7.40%	13.00%	16.4%
Percent of youth (6th, 8th, 10th, 12th) who report alcohol consumption in the past 30 days	HYS	2018	6th: 2.5% 8th: 10.6% 10th: 17.1% 12th: 25.9%		6th: 2.7% 8th: 11.7% 10th: 18.0% 12th: 25.8%	6th: 2.4% 8th: 8.4% 10th: 18.5% 12th: 27.9%

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Percent of mothers who have ever breastfed their babies as noted on the birth record	Birth Certificates	2018	89.64%	88.83%	89.34%	94.11%
Percent of adults age 18 or older who have body mass index of 30 kg/m2 or more (Percent of adults with a BMI=30+)/percent of adults that are overweight	BRFSS	2017	30.6%	40.00%	32.80%	27.8%
6th grade: Percent of youth who have ever used illicit drugs (yes) 8th-12th grade: any use in past 30 days	HYS	2018	6th: 1.6% 8th: 9.9% 10th: 17.3% 12th: 24.4%		6th: 1.9% 8th: 10.8% 10th: 17.5% 12th: 25.1%	6th: 1.6% 8th: 8.7% 10th: 20.1% 12th: 27.3%
Percent of Rx medication overdose (rate per 100,000)	CHAT	2017	60.16	51.5		62.01
Percent of women giving birth who smoked at any time during pregnancy.	CHAT	2017	8.52%	3.06%	6.44%	8.12%
Percent of youth physically active 60 min/day for the past 7 days	HYS	2018 (7 days)	6th: 29.0% 8th: 33.1% 10th: 26.7% 12th: 19.8%		6th: 27.3% 8th: 31.5% 10th: 25.2% 12th: 20.0%	6th: 26.9% 8th: 28.3% 10th: 21.6% 12th: 21.4%
Percent of adults age 18 or older who report they now smoke cigarettes every day.	BRFSS	2017	14.30%	11.40%	13.00%	13.1%
Percent of youth surveyed who did not use a condom last time they had sexual intercourse (% of all youth, including those who reported no sexual activity, ONLY asked 8th, 10th, and 12th graders)	HYS	2018	8th: 5.1% 10th: 11.7% 12th: 20.8%		8th: 6.1% 10th: 12.4% 12th: 22.8%	8th: 4.3% 10th: 13.8% 12th: 23.0%
The total number of births per 1000 population	CHAT	2017	13.25	17.42	14.58	11.97
Prevalence of fertility in BF Counties	CHAT	2017	71.95	85.69	76.63	61.53
Pregnancy and Abortion: The number of induced abortion per 100 pregnancies (excluding fetal loss)	CHAT	2017	12.79%	10.11%	11.79%	16.32%
Rate of women receiving prenatal care in the first trimester	CHAT	2017	83.54%	81.40%	82.72%	81.09%
Birth risk factor percent of women receiving late or no prenatal care (prenatal care initiated during thrid trimester or not at all)	CHAT	2017	4.38%	4.01%	4.23%	5.59%
Percent of births with a birth weight <2500g	CHAT	2017	7.14%	5.28%	6.43%	6.61%
Percent of births with an estimated gestation age <37 weeks	CHAT	2017	9.80%	9.64%	9.74%	9.47%
Adults who report they have ever been told by a doctor, nurse, or other health professional that they had asthma.	BRFSS	2017	16.00%	13.75%	15.37%	15.13%

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Percent of youth who have been told by a doctor or medical provider that they have asthma	HYS	2018	6th: 12.4% 8th: 17.1% 10rh: 20.3% 12th: 21.4%		6th: 12.2% 8th: 16.3% 10th: 18.5% 12th: 20.1%	6th: 12.6% 8th: 18.3% 10th: 21.3% 12th: 21.2%
Age adjusted rate of all cancer incidence in per 100,000	CHAT	2012-2016	452.53	388.71	436.17	503.29
Percent of adults that ever had a stroke (Cerebrovascular disease)	BRFSS	2013-2017	2.95%	2.21%	2.74%	2.67%
Rate of of adults age 18 or older who have ever been told by a doctor that they have diabetes, Did not include gestational or pre-diabetic	BRFSS	2017	9.38%	10.23%	9.62%	9.08%
Rate of reported cases of all non-latent syphilis	CHAT	2013-2017	5.09	5.26	5.14	6.59
Percent of reported Chlamydia infections that received treatment in women ages 15-24	CHAT	2017	90.72%	91.37%	91.00%	96.42%
Rate of cases of Pertussis	BFHD, Hospital Data	2017	3.02	1.78	2.61	10.30
Percent of adults ages 18-64 who report having health insurance	BRFSS	2012-2017	85.19%	77.84%	83.13%	87.35%
Percent of children ages 0-17 who have health insurance	ACS	2017	95.87%	96.11%	95.96%	96%
Percent of adults age 18 or older who report having a personal doctor or healthcare provider	BRFSS	2011-2017	73.97%	66.65%	71.92%	73.97%
Percent of adults age 18 or older who report visiting a dentist, dental hygienist or dental clinic within the past year (12 months) or two (24 months).	BRFSS	2016	79.60%	69.84%	77.10%	79.69%
Prevalence of measured youth who report being bullied in the past 30 days	HYS	2018	6th: 29.9% 8th: 26.6% 10th: 27.2% 12th: 16.6%		6th: 30.1% 8th: 25.9% 10th: 20.0% 12th: 15.4%	6th: 31.2% 8th: 27.4% 10th: 19.3% 12th: 16.9%
Percent of adults age 18 or older who report 14 or more days of poor mental health in the past month	BRFSS	2015-16	16.46%	12.31%	15.35%	12.20%
Rate of deaths due to accidental drowning per 100,000	CHAT	2016-17	0.26	0	0.18	0.38
Rate of hospitalizations for falls for people under age 65 (rate per 100,000)	CHAT	2017	115.3	77.52	102.78	126.59
Rate of hospitalization for unintentional injury per 100,000 children ages 0 to 17	CHAT	2016-17	49.27	61.22	53.71	62.74

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Overall motor vehicle related deaths or hospitalizations (includes collisions involving motor vehicles, bicycles, pedestrians)	CHAT	2017	33.8	37.37	34.95	50.81
Prevalence of violent crime	WASPC	2017				328.21
Prevalence of property crime	WASPC	2017	4111.11	3219.31	3827.29	4611.68
Prevalence of youth brininging a weapon to school in the past 30 days	HYS	2018	6th: 1.1% 8th: 3.6% 10th: 4.8% 12th: 5.7%		6th: 1.6% 8th: 4.4% 10th: 5.0% 12th: 5.6%	6th: 8th: 10th: 12th:
Percent of people living at or below the U.S. federal poverty level	U.S. Census	2017	13.40%	15.90%		12.20%
Percent of families with children under 18 living below poverty level	U.S. Census	2017	15.50%	19.10%		12.80%
Percent of children under 18 living in poverty	U.S. Census		19.80%	24%		15.80%
Percent of youth (0-17) who had to skip or cut the size of a meal in the last year	HYS	2018	8th: 11.3% 10th: 13.2% 12th: 15.5%			8th: 9.6% 10th: 12.4% 12th: 15.5%
Percent of days meeting the Washington State Department of Ecology 24-hour average healthy air goal of <=20ug/m3 for particulate matter 25 microns in diameter or less (PM2.5)	DOH	2018	95.63%	96.40%	96.01%	94.35%
Median Cost of Childcare for a toddler at childcare centers	http://www.childcarenet.org/about-us/data/2018-county-data-reports	2017	$823	$758	$791	$936
Percent of low income population living more than 1/2 mile from a supermarket for urban areas and 20 miles for rural areas	USDA food desert atlas	2015	5.52%	17.35%	9.17%	9.90%
4-Year cohort high school drop out rate	OSPI	2016-17	10.35%	12.13%	10.92%	11.48%
Percent of youth in the top 15% Body Mass Index by reported height and weight, based on CDC growth charts (obesity).	DOH LPHI, CDC growth charts, 2018 HYS, Pediatricians and WIC	2018	8th: 13.48% 10th: 14.38% 12th: 16.56%	8th: 13.45% 10th: 18.47% 12th: 22.18%	8th: 13.47% 10th: 15.60% 12th: 18.36%	8th: 11.9% 10th: 13.7% 12th: 16.9%
Percent of youth who used a pain killer to get high, like Vicodin, Oxycontin (oxy, OC) or percent in the last 30 days)	HYS	2018	6th: 8th: 2.3% 10th: 3.3% 12th: 4.2%		6th: 8th: 2.7% 10th: 3.6% 12th: 4.6%	6th: 8th: 2.4% 10th: 3.6% 12th: 3.8%

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Percent of youth who smoked cigarettes in the past 30 days	HYS	2018	6th: 1.0% 8th: 2.8% 10th: 4.9% 12th: 7.4%		6th: 1.1% 8th: 2.9% 10th: 4.8% 12th: 7.3%	6th: 1.0% 8th: 1.4% 10th: 2.3% 12th: 3.6%
Percent of youth who used electronic cigarettes in the past 30 days	HYS	2018	6th: 3.4% 8th: 11.4% 10th: 21.6% 12th: 24.7%		6th: 3.5% 8th: 12.0% 10th: 20.4% 12th: 23.0%	6th: 3.0% 8th: 10.4% 10th: 21.2% 12th: 30.0%
Percent of youth surveyed who had sex but did not use a condom last time they had sexual intercourse (ONLY asked 8th, 10th, and 12th graders)	HYS	2018	8th: 45.7% 10th: 49.6% 12th: 49.6%		8th: 60.6% 10th: 48.3% 12th: 49.1%	8th: 56.0% 10th: 47.2% 12th: Low count
Age Specific Birth Rate: The number of births to women aged 10-19 per 1000 women age 10-19.	CHAT	2017	10	14.37	11.6	7.2
Last HIV test (HIVST5) In past 5 years	BRFSS	2011-17	0.1324	0.1235	0.1298	0.1626
Age Adjusted rate of Hospitalizations due to chronic obstructive pulmonary disease and bronchiectasis	CHAT	2017	172.09	97.38	154.16	87.44
Rate of reported cases of gonorrhea	CHAT	2017	111.63	142.81	121.55	137.09
Age adjusted rate of reported cases of all syphilis	CHAT	2013-2017	13.62	11.90	13.02	16.97
Rate of reported Chlamydia infections per 100,000 women ages 15 to 24	CHAT	2017	3479.52	3896.21	3623.58	2950.17
Percent of youth who felt so sad or hopeless almost every day for 2 weeks or more in a row, that they stopped doing some of their usual activities	HYS	2018	8th: 34.0% 10th: 40.4% 12th: 43.1%		8th: 35.5% 10th: 39.9% 12th: 42.8%	8th: 32.2% 10th: 40.0% 12th: 40.7%
Age adjusted Rate of deaths from intentional self-harm/suicide per 100,000	CHAT	2017	22.92	13.47	20.11	17.1
Percent of youth who feel safe at school	HYS	2018	6th: 85.6% 8th: 80.8% 10th: 79.1% 12th: 81.8%		6th: 84.9% 8th: 79.5% 10th: 77.5% 12th: 79.4%	6th: 85.3% 8th: 79.8% 10th: 79.0% 12th: 80.5%
Rate of domestic violence offenses reported to law enforcement per 100,000	DOJ, DV Comm. (2011), Community crime map	2017	538.5	761.65	609.52	742.71
Percent of youth who report that they have ever been physically abused by an adult	HYS	2018	8th: 20.3% 10th: 25.5% 12th: 25.2%		8th: 20.8% 10th: 24.3% 12th: 23.9%	8th: 20.4% 10th: 25.2% 12th: 26.5%
Rate of hospitalizations for falls for adults ages 65 or older (rate per 100,000)	CHAT	2017	2371.08	1781.86	2239.35	1823.09

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Rate of unintentional injury hospitalizations	CHAT	2017	482.35	424.32	470.71	435.16
OSPI homeless student population	OSPI	2017-2018	564 homesless students	548 homeless students	1,112 Homeless students (2017-2018 school year); 51% Male, 49% Female; 64% Hispanic/Latino (30% wa State); 28% White; 30% Limited Emglish; 17% Special Education.	
Point in time Count	Department of Commerce	2015-2019			2019: 152; 2018: 163; 2017: 223; 2016: 277; 2015: 272	
Annual shelter count	My Friend's Place (MFP); Domestic Violence Services (DVS); A New Start in Life (ANSIL); Union Gospel Mission (UGM)	2018			MFP: 300+ Drop Ins; 88 drop ins needed overnight beds = 316 drop in nights; 44 long term residents; 100% occupancy rate all year; 19 of 44 involved with gangs; #1 drop in services for food, shelter, rest, and safe haven. 53% Female 45% male 18% LBGTQ 42% Caucasian 33% Hispanic 18% African American	
211 housing data	211 call data	2018			1,227 housing related calls (10,380 total issues)	
Rate of youth (10-17) deaths from intentional self-harm/suicide per 100,000	CHAT	2008-17	5.54	2.6	4.52	4.69
Rate of elder (65+) deaths from intentional self-harm/suicide per 100,000	CHAT	2008-17	24.34	19.61	23.3	19.58

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Rate of young adult (18-24) deaths from intentional self-harm/suicide per 100,000	CHAT	2008-17	17.7	13.16	16.16	16.43
Age adjusted non-fatal hospitalizations from intentional self-harm/suicide per 100,000	CHAT	2016-17	6.99	2.95	6.39	10.09
percent of students who seriously contemplated suicide in past 12 months	HYS	2018	8th: 19.4% 10th: 23.4% 12th: 23.2%		8th: 19.7% 10th: 22.3% 12th: 21.3%	8th: 20.1% 10th: 23% 12th: 22.1%
Percent of students who made a plan to attempt suicide in past 12 months.	HYS	2018	8th: 16.8% 10th: 19.1% 12th: 18.2%		8th: 10th: 12th:	8th: 15.9% 10th: 17.9% 12th: 18%
Rate of opioid overdose hospitalizations per 100,000	CHAT	2017	20.66	17.85	19.86	17.73
Rate of opioid deaths per 100,000	CHAT	2017	9.22	7.56	8.60	9.25
Percent of students who used marijuana in the past 30 days	HYS	2018	6th: 1.1% 8th: 9.5% 10th: 15.3% 12th: 22.2%		6th: 1.3% 8th: 10.3% 10th: 16.0% 12th: 22.6%	6th: 1.3% 8th: 7.2% 10th: 17.9% 12th: 26.2%
Rate of opioid perscriptions per 100 residents	https://www.cdc.gov/drugoverdose/maps/rxcounty2017.html	2017	89.8	52.9		57.2
Percent of elderly living in poverty	ACS		7.6%	9.4%		7.9%
Total youth arrests per 1,000 youth aged 10-17	https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state	2017			42.3	8.8
Total youth arrests for drug crimes per 1,000 youth	https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state	2017			6.5	2.0
Percent of youth who report that they are sworn at, humiliated or insulted by an adult in their home often or very often	HYS	2018	8th: 12.8% 10th: 14.9% 12th: 14.7%		8th: 12.9% 10th: 14.5% 12th: 14.5%	8th: 12.2% 10th: 14.5% 12th: 14.4%
Percent of youth who have ever been forced into a sexual situation.	HYS	2018	Overall: 8th: 11.6% 10th: 18.8% 12th: 25.4%		Overall: 17.76% 8th: 13.3% 10th: 18.2% 12th: 23.9%	8th: 12.3% 10th: 18.9% 12th: 25.2%

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Percent of youth who have ever seen someone else forced into a sexual situation.	HYS	2018	Overall: 8th: 24% 10th: 33.1% 12th: 36.7%		Overall: 30.34% 8th: 27.9% 10th: 31.6% 12th: 31.9%	8th: 24.9% 10th: 31.1% 12th: 31.4%
Rate of death from Alzheimer's disease	CHAT	2017	70.57	71.12	70.72	45.41
Provider to population ratio (PCP)	County Health Rankings - American Medical Association	2016	1470:1	4100:1		1220:1
Provider to population ratio (PCP other than physician)	CMS - National Provider Identification	2018	1071:1	2047:1		1171:1
Provider to population ratio - Mental Health Providers	CMS - National Provider Identification	2018	470:1	780:1		310:1
Percent of mothers who exclusively breastfed babies while in hospital, according to local hospital data	hospital data?	2017-2018			38-47%; Kadlec: 42-51%; Trios: 38-45%	NATIONAL: 50-53%
Breastfeeding 6 month duration for WIC data for entire Benton and Franklin Counties	WIC State	2018			44.65%	51% (2017)
Percent of youth age 1-5 and enrolled in WIC in the top 15% Body Mass Index by reported height and weight, based on CDC growth charts (obesity).	WIC State	2017-2018	26%	27%	26.5%	25%
Reported Sexual Assault	https://www.waspc.org/crime-statistics-reports	2017			125.4 per 100000 residents (2017)	91.6 per 100000 residents (2017)
Percent of youth who dated within the past 12 months and report that they were physically hurt by a partner	HYS	2018	Overall: 8th: 7.4% 10th: 9.2% 12th: 8.2%		Overall: 9.6% 8th: 8.8% 10th: 9.7% 12th: 9.4%	Overall: 8th: 9.5% 10th: 10.7% 12th: 11.6%
percentage of youth who live somewhere other than parent's home	HYS	2018	Overall: 8th: 10.3% 10th: 10.9% 12th: 11.9%		Overall: 8th: 11.2% 10th: 10.9% 12th: 12.5%	Overall: 8th: 9.6% 10th: 10.8% 12th: 12.6%
Percentage of youth who reported they were involved with a gang	HYS	2018	Overall: 8th: 6.2% 10th: 5.4% 12th: 4.8%		Overall: 6% 8th: 6.7% 10th: 5.8% 12th: 5.1%	Overall: 8th: 6.6% 10th: 6.2% 12th: 6%

Description	Sources	Data Year	Benton	Franklin	Benton & Franklin	Washington
Percentage of youth involved in a physical fight	HYS	2018	Overall: 8th: 25.7% 10th: 19% 12th: 13%		Overall: 26.9% 8th: 35.4% 10th: 29.8% 12th: 17.4%	Overall: 8th: 26.1% 10th: 18.8% 12th: 15.7%
211 food data	211 call data	2018			844 food related calls (10,380 total issues)	
Share of the population with food insecurity	https://www.feedingamerica.org/research/map-the-meal-gap/by-county?referrer=http%3A//map.feedingamerica.org/county/2013/overall	2013-2017			9.48% (2013-2017)	12% (2012 - 2016)
Child abuse and neglect rate	https://www.dshs.wa.gov/ffa/research-and-data-analysis/county-and-state	2017	39 per 1000	28.3 per 1,000	35 per 1000 youth (2017) - increase from 28 per 1000 in 2016	37.8 per 1000 youth (2017)
Students who had sex but did not use any method of contraception.	HYS	2018	8th: 31.4% 10th: 26.9% 12th: 15.0%		8th: 23.2% 10th: 25.8% 12th: 19.9%	8th: 23.7% 10th: 22.0% 12th: 15.3%

Appendix 4: Qualitative Data: Listening Sessions and Stakeholder Interviews

Qualitative Data: Listening Sessions and Stakeholder Interviews

Prepared for Kadlec Regional Medical Center and Partners

Community Health Needs Assessment 2019

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Last Updated: July 24, 2019

Contents

Executive Summary

The Community Health Needs Assessment (CHNA) Steering Committee for Benton and Franklin Counties, consisting of representatives from Benton Franklin Community Health Alliance, Benton-Franklin Health District, Kadlec Regional Medical Center, Trios Health, Lourdes Health, and Prosser Memorial Health, recognize the value in having community members and community stakeholders participate in the CHNA process and share their perspectives. As the people who live and work in the counties, they have first-hand knowledge of the needs and strengths of their community. To gather these perspectives, the Steering Committee conducted listening sessions with community members and interviews with community stakeholders. Qualitative data, or data in the form of words instead of numbers, provides additional context and depth to the CHNA that may not be fully captured by quantitative data alone.

Listening Sessions

Ten listening sessions were completed with a total of 96 community members. Participants shared their vision for a health community, the health-related needs of their community, and the assets that currently help their community be healthy. Following are the dominant themes from the sessions:

Community members' vision for a healthy community

- People are outside playing, walking, and being active
- The community is diverse and inclusive, where all people can live well
- Community members feel safe and kids can play freely
- People spend time together and take part in social events
- Local health care services are accessible and affordable
- People take care of one another, especially those who most need support

Health-related needs of the community

- Affordable medical care, dental care, and prescriptions, specifically low-cost or free
- Timely, convenient, and local medical care
- Resources for people who need help and more knowledge of local resources
- Affordable mental health services that are responsive to people's unique needs
- Shelters and services for individuals experiencing homelessness
- Safe, affordable, clean housing, especially for individuals with low-incomes
- Increased community safety

Community strengths and assets (See Table 2 for a complete list)

- Community resource fairs and financial assistance programs
- Multiple local hospitals and access to free medical services
- Educational opportunities for adults and children
- Access to healthy and fresh food
- Community openness to diversity and people's unique needs
- Close proximity to natural resources and activities
- Opportunities for people to exercise outdoors and be physically fit
- Good transportation services

Community Stakeholder Interviews

The Steering Committee completed 16 community stakeholder interviews, including 40 stakeholders, or people who are invested in the wellbeing of the community and have first-hand knowledge of community needs and strengths. Stakeholders were asked to rank the unmet health-related needs of their communities. For those identified needs, stakeholders shared which populations are most affected by the needs, gaps in community services to address the need, and barriers to services for community members. The top three unmet health-related needs identified by stakeholders were classified as high priority. The following three unmet-health related needs (four through six) were classified as medium priority. Stakeholders were also asked to identify community assets that help make the community healthier and opportunities they see for community organizations to better work together.

High Priority Unmet Health-Related Needs

- Behavioral health challenges (includes both mental health and substance use disorder): Stakeholders were concerned about the high amount of substance abuse in the community and lack of treatment options. Additionally, they were concerned about youth mental health and rising youth suicide. They identified people experiencing homelessness, young people, older adults, veterans, and individuals who identify as LGBTQ+ as more affected by behavioral health challenges. Stakeholders named stigma and a lack of funding for treatment as barriers to addressing this issue. They saw mental health services in schools and integration of behavioral health screenings in primary care as gaps in services.

- Homelessness/ lack of safe, affordable housing: Stakeholders identified housing as foundational to addressing all other health-related needs. They spoke to needing more shelters, affordable housing, transitional housing, and resources to support people experiencing homelessness. They specifically identified young parents, transgender people, women, people with substance abuse disorder, people leaving domestic violence, young people, and families with low-incomes as particularly affected.

- Access to behavioral health care: Stakeholders were particularly concerned about not having a detox center or an inpatient treatment center in Benton and Franklin Counties. Additionally, they shared that a lack of mental health providers and lack of affordable mental health care contributes to the behavioral health challenges.

Medium Priority Unmet Health-Related Needs

- Access to medical care: Stakeholders shared that the complexity of the healthcare system is a barrier to people getting the medical care they need. They stated there are currently not enough providers in the area, particularly specialists, contributing to long wait times for appointments. Specifically, there are gaps in medical care for veterans, people identifying as LGBTQ+, and people who are undocumented.

- Domestic violence, child abuse/ neglect: Stakeholders were concerned about the long-term impact child abuse has on children's healthy development, as well as the interaction between domestic violence and other issues such as substance abuse and homelessness. Teen girls, individuals identifying as LGBTQ+ and/or with disabilities were identified as groups disproportionately affected by violence. Stakeholders saw safe places for children currently in

danger and community spaces for survivors of domestic violence to support one another as gaps in community services.

- Aging problems (such as memory, hearing, and vision loss): Stakeholders shared their community is aging and the current support services are not sufficient to meet the growing need. To better meet this need, stakeholders shared Benton and Franklin Counties need a memory care unit, more geriatric providers, and more caregiver support groups. Additionally, stakeholders shared there needs to be more education around healthy aging, dementia, and Alzheimer's for the general community and providers.

Community strengths and assets (See Table 4 for a complete list)

- Collaboration between organizations and coalitions to address needs: Opportunities for organizations to work together and leverage their unique strengths were highlighted as a community asset.

- Innovative approaches to addressing behavioral health challenges: Programs such as the True blood Program and the Mental Health Court are working to provide support to individuals whose mental health impacts their criminal behavior.

- Providing services in schools: 3 Rivers Wraparound with Intensive Services (WISe) and Communities in Schools are providing supports and access to services to students in schools, addressing behavioral health challenges and other needs.

Opportunities for community organizations to work together

- More collaboration and less competition: Stakeholders shared they need more opportunities to collaborate with one another. They see the current coalitions as a strength and think there need to be more opportunities to learn from one another and collaborate on solutions.

- Communication and relationship building: Stakeholders named numerous community organizations and programs that are currently working to meet health-related needs, but there is little communication between them. They would like to see more relationship building among organizations and sharing of up-to-date information and resources.

Community Stakeholder Surveys

The CHNA Steering Committee wanted to include as many opportunities for input from stakeholders as possible. They surveyed 256 stakeholders to provide additional insight into the prioritization of health-related needs. Stakeholders were asked to identify their top five health-related needs in the community. Stakeholders prioritized one health-related need substantially above the others: behavioral health challenges, including both mental health and substance use disorder. After this need, two more needs were given high priority and tied for importance: access to behavioral health services and homelessness and housing instability. These top three health-related needs mirror those of the stakeholders who completed interviews. The top three health-related needs are summarized as follows:

1. Behavioral health challenges (includes both mental health and substance use disorder)

2. Access to behavioral health
2. Homelessness and housing insecurity (tied with access to behavioral health)

The subsequent three health related needs were also given high priority over the other needs (in order of ranking):

3. Obesity
4. Access to medical care
5. Domestic violence

Access to medical care and domestic violence were also prioritized by the stakeholders who completed interviews. Obesity was not previously identified.

Data Blending

Community members and stakeholders identified many of the same health-related needs as priorities. The specifics of the need may have varied slightly. An overview of the health-related needs of both community members and stakeholders blended together is as follows (in no particular order):

Behavioral health care (access to and challenges)

Both groups identified the importance of having affordable mental health services available, particularly for youth and people identifying as LGBTQ+. Both groups identified stigma as a barrier to addressing behavioral health challenges and noted a need for more mental health providers. Stakeholders emphasized a need for substance use disorder treatment and a detox center.

Homelessness/ safe, affordable housing

Both groups shared a need for more shelters, more low-income housing for families, more affordable housing for older adults, and more resources (such as showers and laundry facilities) for people experiencing homelessness. Community members emphasized wanting good quality, clean homes. Stakeholders identified a need for more transitional housing and wet shelters.

Access to medical care

Both groups identified a need for more specialists and primary care providers to increase access to appointments. Both groups identified a need for more accepting medical services for LGBTQ+ individuals and more affordable services for people who are undocumented. Stakeholders emphasized the need for patient advocates to help navigate the complexity of the health care system, while community members emphasized the need for more affordable care, including dental care.

Community safety and child wellbeing

Both groups were concerned with the wellbeing of children and their safety, as well as the importance of schools in meeting children's social-emotional needs. Community members were most concerned with gang violence in their community, while stakeholders emphasized a concern for domestic violence.

Aging problems

Both groups acknowledged a need for more specialists and services for older adults, especially those living alone in their homes. Stakeholders were especially concerned about services for people with Alzheimer's and dementia and the need to educate the community on aging problems.

Listening Sessions

Introduction

The CHNA Steering Committee conducted listening sessions to learn from community members about what they see as their community's needs and strengths. The goal of the listening sessions was to better understand how community members define a healthy community, what issues they want to see addressed, and what resources they think are working well. In a small group environment, a facilitator guided the conversation by asking a few broad questions.

Methodology

Selection and recruitment

A total of 10 listening sessions, with 96 participants, were conducted in Benton and Franklin Counties with the help of community-based organizations (see Table 1). These organizations invited the people that they serve to join the listening sessions through word of mouth and flyers. Seven listening sessions were conducted in English and three in Spanish. Facilitators were chosen from the Steering Committee and Providence St. Joseph Health. Kadlec is part of the family of mission-driven organizations that make up Providence St. Joseph Health, serving communities across a seven-state footprint. Therefore, members from their system's office provided technical expertise in the collection and analysis of the qualitative data. Each facilitator received guidance on group facilitation.

Table 1: Listening Sessions

Location	**Date and Time**	**Language**	**Number of Participants**
Washington State University Tri-Cities	4/12/19, 1pm	English	6
Union Gospel Mission	5/14/19, 2pm	Spanish	7
Tierra Vida	5/14/19, 6pm	Spanish	10
Meals on Wheels	5/15/19, 10am	English	8
Amistad Elementary	5/15/19, 6pm	Spanish	12
Vintage at Richland	5/16/19, 10am	English	9
Columbia Basin College	5/22/19, 1pm	English	11
Benton-Franklin Health District in partnership with PFLAG	5/23/19, 6pm	English	7
A New Start in Life	5/28/19, 10am	English	21
Benton-Franklin Health District	5/30/19, 2pm	English	5
		Total Participants	**96**

Facilitation Guide

The facilitation guide was developed by Providence St. Joseph Health and included an icebreaker and three questions (see Appendix 1 for complete script in English and Spanish). The session was always started with an icebreaker, designed to help participants think about how they would define their own community. Participants were asked to draw a picture of their community and then describe it to the group. After the icebreaker, participants were asked the following questions:

1. What makes a healthy community? How can you tell when your community is healthy?
2. What's working? What are the resources that currently help your community to be healthy?
3. What's needed? What more could be done to help your community be healthy?

Training

Training for note-taking was conducted prior to each session. Most volunteer note-takers were trained by staff from Providence St. Joseph Health in note-taking skills. Note-takers were asked to record key themes from the session and any quotes that captured an idea particularly well. Note-takers were instructed to capture what the participant said as accurately as possible without adding their own interpretation of the comment. Additionally, they were instructed to note where they were including their own observations of the group or group energy. Two note-takers were present for each listening session and both collected similar information. Providence St. Joseph Health provided a note-taking template for data collection that was used by all note-takers.

Data collection

Three sets of notes were collected during the listening sessions: facilitator notes on a flip chart and two sets of notes from the note-takers. The listening sessions were not recorded due to logistical constraints and to improve the comfort of participants. Note-takers recorded key points from the listening session as well as any notable quotes from participants. Additionally, they included their own observations about body language, group agreement or disagreement, and eagerness to answer questions. If the listening session was conducted in Spanish, note-takers were given the option to take notes in English, Spanish, or a combination of languages depending on their comfort. At the end of each listening session, the note-takers and facilitator spent about 30 minutes debriefing the session dynamics, common themes, and anything that was surprising. The notes from the debriefing session were recorded separately to capture the energy of the session and the dominant themes. The two sets of note-taker notes, flip chart notes from the facilitator, and debrief notes were compiled and used for analysis.

Analysis

Qualitative analysis of listening sessions was conducted by Providence St. Joseph Health using Atlas.ti, a qualitative data analysis software. The data was coded into themes, which is a process of grouping similar ideas across the listening sessions, while preserving the individual voice.

The analyst typed all notes exactly as written. If the notes were in Spanish, the analyst typed the notes in Spanish and then created a second set of translated notes in English. The next step was to merge the four sets of notes (facilitator notes, two sets of notes form the note-takers, and debrief notes) into one set of notes. The facilitator notes were used as the basis for the merged notes, with the note-taker notes and debrief notes used to fill in details and context. The location of the listening session was removed from the file and assigned a number to reduce the potential for coding bias and the files were imported into Atlas.ti.

The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded three domains relating to the topics of the questions, 1) Vision, 2) Needs, and 3) Strengths.

The analyst then went through each of the notes again and coded the information line by line. All information was coded and new codes were created as necessary. All quotations, or pieces of information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were grouped together into the same category. These categories reflect the major themes from the listening sessions and the codes are the supporting information for the themes. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool to look at which codes occurred most often within the three domains. For example, the code "access to care" occurred often within the vision domain and also within the needs domain. Then, using the co-occurrence table, the analyst determined which codes were frequently used together. For example, access to care may be frequently coded with transportation, allowing for better understanding of how transportation affects a person's ability to access the care they need.

The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together. Due to some difference in note-taking, determining exact frequency of themes was challenging. Some note-takers grouped comments by listening session participants, while others placed each comment on a different line, making it difficult to reliably prioritize. Therefore, within the findings section, the themes are presented in order of seeming priority based on the notes and the analyst is confident in the themes shared.

Findings

Ten listening sessions at 10 community organizations were completed with a total of 96 community participants. Participants were asked broad questions about their vision for a healthy community, the health-related needs of their community, and the resources that currently help their community be healthy. The following paragraphs are the most dominant themes expressed throughout the listening sessions.

Vision

Listening session participants were asked, "What makes a healthy community? How can you tell when your community is healthy?" Participants described their vision for a healthy community. The most common themes from the listening sessions were the following:

People are outside playing, walking, and being active

Participants shared that a healthy community should be visibly healthy. This means that people are outside walking, playing sports, exercising, biking, etc. Additionally, people, especially children, eat good, nutritious food.

The community is diverse and inclusive, where all people can live well

Participants described a healthy community as a place where diversity is seen as a strength, and all people are accepted. Particularly important was the idea that people are respected and everyone has the opportunity to thrive and be open about who they are.

Community members feel safe and kids can play freely

Participants viewed safety as a core component to a healthy community. When people feel safe they are more likely to go outside and be active or meet their neighbors. A safe neighborhood is one free of drugs, gangs, crime, and violence. Particularly important to participants was the idea that their children are safe at school and can play freely outside without threat of danger. Included in participants' vision for a safe community is effective law enforcement that acts as a guardian and not as an enemy.

People spend time together and take part in social events

Participants described a healthy community as one where people spend time together. They talked about barbecues, birthday parties, block parties, and other opportunities for people to come together. Additionally, a healthy community has spaces, such as community centers, where events can be held and people can meet.

Local health services are accessible and affordable

In a healthy community, participants envisioned a place where everyone could get the health care services they need. This means there are enough providers in the area, close to where people live, and at low cost. Everyone has health insurance, including coverage for dental and vision care, and everyone can get preventative health care services.

People take care of one another, especially those who most need support

In a healthy community participants described a place where people know one another and act neighborly, for example a place where a neighbor can "borrow sugar." People are smiling, open to meeting one another, and honest with each other. Participants noted volunteerism as a sign of people caring for one another. Specifically, community members knowing when people need help without being "nosy or a nuisance" was shared.

Needs

Participants were asked, "What's needed? What more could be done to help your community be healthy?" Community members shared ways their community could improve to better meet their vision described above. The most shared themes from the listening sessions were the following:

Affordable medical care, dental care, and prescriptions, specifically low-cost or free

Participants frequently noted needing more affordable health care services, such as free or low-cost clinics in Benton and Franklin Counties. Currently, many of low-cost or free medical and dental services are in neighboring towns. Participants said they need more flexible income requirements for financial support for medical services. Specifically, one person said the only way a person qualifies for financial support is if they make "next to nothing." Participants also noted they need affordable prescriptions, especially if they do not have health insurance.

Timely, convenient, and local medical care

Participants shared their community needs more primary care physicians and specialists, specifically providers who stay in the area. They noted they are unable to get in to see a primary care provider in a timely manner because of long wait times. Additionally, they said they need more convenient clinic hours, such as evening availability.

Resources for people who need help and more knowledge of local resources

Participants shared their communities are lacking sufficient resources and support services for specific populations. Community members were especially concerned about individuals who are unable to work due to injury or mental illness, older adults alone in their homes, individuals experiencing homelessness, and families/individuals with incomes just above the income cutoff to qualify for many support services. Participants stated their community needs more resources to help people going through tough times and also more communication around what resources are available.

Affordable mental health services that are responsive to people's unique needs

Participants agreed their community needs more mental health services and needs to make therapy the norm to decrease stigma around mental illness. Participants noted the services need to be more affordable for people. Additionally, participants mentioned needing more counselors for youth and psychological support that meets specific needs of groups. For example, mental health professionals who are experienced and skilled in providing services to individuals who identify as LGBTQ+.

Shelters and services for individuals experiencing homelessness

Participants shared there are only two facilities that offer housing for individuals experiencing homelessness (Union Gospel Mission and Safe Harbor) and there is a community need for more homeless services, including safe places to shower and use the bathroom, mental health services, and shelters.

Safe, affordable, clean housing, especially for individuals with low incomes

Participants described a need for more affordable housing in their communities, in particular low-income housing. They specifically said people need more than a roof over their head, but rather a clean and livable place. Additionally, there is a need for more affordable housing options for older adults with low-incomes.

Increased community safety

Participants had mixed ideas how to make their communities safer, including addressing gang activity, creating Neighborhood Watch groups, increasing police presence in high crime areas, taking a harder stance on bullying in schools, and improving emergency response times.

Assets/Strengths

Participants were asked, "What's working? What are the resources that currently help your community be healthy?" Participants named a variety of organizations, programs, and local services they see as a community strength (see Appendix 1). The most shared themes were as follows:

Community resource fairs and financial assistance programs

Community members shared the greatest strength of their community is the organizations that provide support and resources to people that need help. Local resource fairs and health fairs help people find

support services and are opportunities to share health related information. Organizations that provide financial assistance, donated items, or discounts to individuals with low incomes were also named as important for community wellbeing. These organizations included local churches and schools. Additionally, participants said organizations that help people access services, such as DSHS and the Benton Franklin Community Action Committee are a strength.

Multiple local hospitals and access to free medical services

Listening session participants said having three hospitals in the Tri-Cities improves their access to health care services. Access to free vaccines through various organizations and free health care services at Grace Clinic is also a strength, especially for uninsured individuals. Participants shared the Washington State Health Care Authority improves health insurance access.

Educational opportunities for adults and children

Participants generally had positive comments about the local education system. They shared they see Washington State University and Columbia Basin College as good higher education programs that offer opportunities for their community. Additionally, local reading programs, Kindergarten readiness programs, and scholarships all support education for children, which community members saw as important for the wellbeing of future generations.

Access to healthy and fresh food

Participants shared local food banks, Meals on Wheels, and Second Harvest help make accessing healthy, good quality food easier. Meals on Wheels is especially important for people who are not mobile. Second Harvest ensures children have food in schools and during vacations. Community gardens and farmers' markets also make it easier for people to get fresh produce.

Community openness to diversity and people's unique needs

Community members see the diversity and openness in Benton and Franklin Counties as a strength. In particular, individuals who identify as LGBTQ stated that the acceptance from other LGBTQ identifying individuals is "phenomenal and unbelievable. Everyone feels loved." Additionally, providers who want to learn how to be more responsive and sensitive to patients' specific needs is seen as a strength.

Close proximity to natural resources and activities

Benton and Franklin Counties are closely situated to mountains and hiking trails, which participants saw as important for community wellbeing. Parks, rivers, and outdoor activities were also named as a strength.

Opportunities for people to exercise outdoors and be physically fit

Because of the green space and parks in the Tri-Cities, community members thought people are active and enjoy outdoor activities. Local gyms, the YMCA, and sports leagues also help people be physically fit.

Good transportation services

The public transportation system helps people get around town and is free for students. Dial-A-Ride helps older adults get to appointments.

Community identified assets

The following table lists all of the community organizations, programs, or services that were named by community members during the listening sessions.

Table 2: Community Identified Assets

Health-related need	Community program, organization, or services (number of times mentioned)
Advocacy and Support	Mirror Ministries PFLAG
After School Programs and Activities	Boys and Girls Club YMCA
Aging Services	50+ Club Aging and Long-Term Care Home Health Kadlec Healthy Ages
Community Connection	Kennewick Community Center Richland Community Center
Education/ Literacy	Columbia Basin College (3) Delta High School: STEM-based curriculum Public library (3) READY! for Kindergarten program Kennewick Ronald McDonald: READ Up program Tri-Tech Skills Center Washington State University
Emergency Services	Fire Department/ EMTs (2)
Environmental Conservation	Energy Northwest Generating Station at Pacific Northwest National Friends of Badger Mountain Laboratory
Food Security	Meals on Wheels (2) Second Harvest: Bite 2 Go program and food for seniors, mobile markets (4) Food banks (2)
Health Care Access	Benton-Franklin Health District (2) Grace Clinic (2) Kadlec Healthplex Kadlec Neurological Resource Center Needle exchange Planned Parenthood Greater Washington and Idaho Tri-Cities Cancer Center VA Clinic Washington State Health Care Authority (2)
Homeless Services and Housing	A New Start in Life (2) Habitat for Humanity Rebuilding Columbia Tierra Vida Union Gospel Mission (2)
Low-Cost Shopping	Secondhand Stores: Goodwill

	Walmart
Other	Frequent blood drives (2) Laser Interferometer Gravitational-Wave Observatory Local sports teams The TRAC
Resources and Social Services	Catholic Family Charities Churches: Rental assistance and donations (4) Community Action Committee in Pasco (2) DSHS (2) IMPACT! Compassion Center Sabado Gigante Resource Fair in Kennewick schools Utility Services Assistance Work Source
Service Organizations	Kiwanis (2) Knights of Columbus Rotary
Transportation	Ben Franklin Transit System (3) Dial-A-Ride (2) People for People

Limitations

Community-based organizations recruited the people they serve to participate in listening sessions and those interested and available attended. Therefore, their voices do not represent the entire community and the data are not generalizable beyond the context in which it was gathered. Additionally, while demographics for participants were not gathered, a majority of the sessions were conducted in English and may not have been representative of the demographics of the community. Listening sessions were not conducted in languages other than English and Spanish. Additionally, listening sessions were not conducted outside of the Tri-Cities in rural areas of Benton and Franklin Counties and therefore may not have captured the unique needs of these communities. Listening sessions were coordinated by Steering Committee members, and while they were intentional about recruiting a variety of community members from Benton and Franklin Counties, there may be some selection bias as to who was selected.

Note-takers were recording themes and information by hand in a fast-paced environment. Therefore, they may not have been able to capture all of the information shared in the sessions. To compensate for this, three sets of notes were collected. Additionally, because the note-takers were quickly documenting the themes, their own perspectives and biases may have influenced their interpretation of certain comments. Because of the fast-paced nature of the sessions, very few complete and reliable quotes were collected by the note-takers. Therefore, very few quotes are included in the findings. Additionally, for listening sessions in Spanish, some note-takers chose to translate in real-time, documenting their notes in English, while others took notes in Spanish and then were translated later. Real-time interpretation may be influenced by the note-takers' understanding of a comment or personal bias. Translation after the session may have lacked context.

Multiple facilitators were used for the listening sessions. Therefore, facilitators' emphasis on certain questions, examples given, and feedback (verbal or through body language) may have influenced the conversations. Additionally, the size of the listening sessions ranged from 5 to 21 participants (with an

average of 10). Therefore, some listening sessions may have been dominated by certain voices more than others, meaning that some community members may have had more opportunity to share their thoughts and perspectives.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Stakeholder Interviews

Introduction

The CHNA Steering Committee recognizes the expertise of community leaders who help make Benton and Franklin Counties healthier. The Steering Committee interviewed 40 stakeholders, people who are invested in the wellbeing of the community and have first-hand knowledge of community needs and strengths. The goal of the interviews was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

Methodology

Selection

A total of 16 interviews, including 40 stakeholders, were completed by members of the Steering Committee. Stakeholders were selected by members of CHNA Steering Committee based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. The Steering Committee aimed to engage stakeholders from hospitals, social service agencies, clinics, and government to ensure a wide range of perspectives.

Table 3: Stakeholder Interviews

Organization	**Name**	**Title**	**Sector**
Alzheimer's Association	Joan Acres	Outreach Coordinator	National organization, Alzheimer's and dementia
	Joel Loiacono	Regional Director	
Benton-Franklin Health District	Carla Prock	Senior Manager for Healthy People in Communities Program	Government, public health
	James Dawson	Senior Manager for Surveillance and Investigation Programs	
Benton Franklin Recovery Coalition	Michele Gerber	President	Community based organization, behavioral health
Chaplaincy Health Care	Gary Castillo	Executive Director	Community based organization, behavioral health and palliative care
	Tom Adams	Director of Behavioral Health	
Columbia Basin Veterans Center	Ana Curtis	Case Manager	Community based organization, veterans affairs
	Augustine Perez	Administrative Services	
	Joetta Rupert	Executive Director	

Communities in Schools of Benton-Franklin	Joelyn Nye-Felt	Program Director	State organization, education
	Corina Thomas	Program Manager	Community based organization, domestic violence
Domestic Violence Services	Deborah Culverhouse	Development Director	
	Zac Schileika	Teen and Family Advocate, Domestic Violence Advocate, Prevention Specialist	
Grace Clinic	Avonte Jackson	Clinic Manager	Community based organization, health care
	Connie Rode	Nursing Director	
	Kathy Brault	Medical Director	
	Mark Brault	Volunteer CEO	
Kadlec Community Health Programs	Catherine Manderbach	Healthy Ages Program Manager	Hospital, health care
	Corey Wakeley	Healthy Ages Program Manager	
	Edna Felix	Health Educator, Kadlec Academy	
	Karen Hayes	Manager, Community Health Investment	
	Megan Fullmer	Assistant, Community Health	
Lourdes Health	Bethany Hale	Crisis Supervisor	Hospital, health care
	Cameron Fordmeir	Manager Outpatient Services	
	Deanna Petrilli	Mobile Outreach Professional	
My Friend's Place	Heather Shindehite	Executive Director	Community based organization, homelessness
	Sienna Skeels	Case Manager	
Parents and Friends of Lesbians and Gays (PFLAG)	Carly Coburn	Vice Chair	National organization, LGBTQ+ support and advocacy
	Jeffrey Robinson	Chair	
Planned Parenthood Greater Washington and Idaho	Susan Sisson	Director of Clinical Systems	National organization, health care
	Cristal Alatorre	Health Center Manager	
	Marisol Lister	Community Outreach Manager	
Support, Advocacy and Resources Center	Desiree Reynolds	Director of Human Trafficking	Community based organization, sexual assault and violence
	JoDee Garretson	Executive Director	
	Rosanna Herrera	Director of Client Services	
Tri-Cities Food Bank	Frances-ann Hiemstra	Office Manager	Community based organization, food security
	Howard Rickard	President, Board of Directors	

	VJ Meadows	Executive Director	
Tri-Cities Residential Services	Tammi LaDoux	Executive Director	Community based organization, behavioral health

Facilitation Guide

The facilitation guide was developed by Providence St. Joseph Health and included ten questions. The topics for the interview were the following:

- The role of the organization and community served
- Prioritization of unmet health related needs in the community, including social determinants of health
- Populations disproportionately affected by the unmet health-related needs
- Gaps in services that contribute to unmet health-related needs
- Barriers that contribute to unmet health-related needs
- Community assets that address these health-related needs
- Opportunities for collaboration between organizations

Participants were given a list of health-related needs and asked to identify the five most important issues that need to be addressed to make the community healthy.

Training

Providence St. Joseph Health provided guidance on how to conduct a stakeholder interview, including basic language on framing the purpose of the interview. Each facilitator was provided a list of questions to ask the stakeholder, as well as sample prompting questions.

Data Collection

Facilitators were instructed to record the interview and take basic notes to capture main themes. A facilitator and separate note-taker attended most of the stakeholder interview sessions. The note-taker recorded key points from the interviewer. At the end of the interview, the facilitator sent the audio file and notes to the analyst.

Analysis

Qualitative analysis of stakeholder interviews was conducted by Providence St. Joseph Health using Atlas.ti, a qualitative data analysis software. The data was coded into themes, which is a process used to group similar ideas across the listening sessions, while preserving the individual voice.

A third party transcribed all of the audio files. The analyst listened to all audio files and confirmed an accurate transcription. For the four interviews without corresponding audio files, the analyst typed the notes exactly as written. The stakeholder names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti.

The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) role of organization, 2) population served

by organization, 3) unmet health-related needs, 4) disproportionately affected population, 5) gaps in services, 6) barriers to services, 7) community assets, and 8) opportunities to work together.

The analyst then went through each of the notes again and coded the information line by line. All information was coded and new codes were created as necessary. All quotations, or pieces of information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. These categories reflect the major themes from the listening sessions and the codes are the supporting information for the themes. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "behavioral health challenges" occurred often with the code "stigma." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need, as well as the gaps in services, and the barriers to addressing those needs. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

The analyst used question five from the stakeholder interview guide to prioritize the unmet health-related needs. Each stakeholder ranked their top five health-related issues from the provided list of health-related needs. If the stakeholder ranked a need as the number one priority, that need was given five points. If ranked second, given four points, and so on. In this way, the analyst used a weighted ranking system to prioritize the needs based on the stakeholders' input. If a stakeholder ranked two needs as their first priority, each of those priorities was assigned five points, although their fifth priority (one point) was dropped from the scoring. Therefore, each stakeholder was only allowed to rank five health-related needs.

Findings

Stakeholders were asked to identify their top five health-related needs in the community. Three needs stood out as universally important to stakeholders and were categorized as high priority. Three needs were also frequently prioritized and categorized as medium priority.

High Priority Unmet Health-Related Needs

Across the board, stakeholders were most concerned about the following health-related needs (in order of priority):

1. Behavioral health challenges (includes both mental health and substance use disorder)
2. Homelessness/ lack of safe, affordable housing
3. Access to behavioral health care

Behavioral health challenges (includes both mental health and substance use disorder)

Behavioral health challenges was noted by almost all of the stakeholders. Many of the stakeholders were concerned about substance abuse in the community and the lack of treatment options, which they saw as contributing to the number of people with substance abuse disorders (discussed further under access to behavioral health care). Participants were also concerned about the mental health of young

people and the rise of youth suicide. Participants mentioned Adverse Childhood Experiences (ACEs), such as abuse and neglect, as strong contributors to mental illness.

Stakeholders shared this health need is so important because it affects almost every population. Groups named as being especially affected by mental health challenges were the following:

- People experiencing homelessness (adults and youth)
- Young people (ranging from elementary school through high school)
- Older adults
- Veterans
- Individuals who identify as LGBTQ+

Participants noted the complexity of this issue, stating that these groups often overlap, for example a person may be experiencing homelessness and also be a veteran. Youth in particular were mentioned by multiple stakeholders as a group that has unmet mental health challenges due to exposure to violence and content related to suicide online, as well as a lack of engagement from parents.

> "We live in a society, if you look at our youth these days, suicide is not something to be scared of. Suicide is a rite of passage… And we need to back these teachers up too. We need to stop saying, 'this is your field here, you play on that and here's 5,000 players you have to take care of.'" – Community stakeholder

Stakeholders shared the primary barrier to addressing behavioral health challenges is stigma. Additionally, a lack of funding for substance abuse and mental health treatment were noted as contributing to the unmet behavioral health challenges in the community.

> "So I think stigma for mental health issues. People talk about it like it's everybody else, but that's not true. So really doing what we can to reduce the stigma about having mental health challenges would be really good." – Community stakeholder

Stakeholders saw the following gaps in services to address the problem:

- For youth, sufficient mental health services in the schools and engagement of parents in supporting youth mental health
- Treatment options that acknowledge substance abuse as an illness and provide support to people before they end up in poverty or lose their homes
- Behavioral health screenings in primary care and general integration of behavioral health and primary care, including streamlined communication and collaboration between providers.

> "I would just be repetitive in saying that addiction is a real disease, and yet we don't treat people who are addicted like we treat other sick people. We treat them like outcasts and throwaways and bad people. And sometimes their behavior is offensive and so that drives us away as humans. But we are supposed to look past the symptoms to the actual disease and in the case of addiction, we don't, we just punish people." – Community stakeholders

Homelessness/ lack of safe, affordable housing

Stakeholders saw safe, stable housing as foundational for addressing all other health-related problems and therefore about three out of four stakeholders identified housing as a top priority. Most

stakeholders described gaps in homelessness resources or safe housing for the populations they work with, resulting in many housing-related needs being named.

> "The key to getting people healthy, is keeping them stable and in one location so that they're not, you know, if I have to worry about where I'm going to sleep tonight, probably going to be less concerned about taking that medication or having the ability to go to that doctor to get that medication that I need." – Community stakeholders

Participants noted there are only two shelters available in Benton and Franklin Counties: Union Gospel Mission and My Friend's Place (for people under 18 years). Participants do not see the current resources for homelessness as sufficient, due to their limited number of beds and limited populations served. They universally spoke to needing more shelters, more affordable housing, more transitional housing, and more resources to support people experiencing homelessness. Participants identified housing as an issue for a variety of reasons and named several gaps in services for specific populations:

- Shelters in the community, particularly for young parents (under 18 years), trans people, and women
- Wet shelters, those that do not require sobriety for people with substance abuse disorder
- Transitional housing for people leaving domestic violence
- Transitional housing for young people over 18 years (those too old to stay at My Friend's House, but still needing some support transitioning to independent living)
- Affordable single family homes in the Tri-Cities

Additionally, stakeholders identified gaps in support services for people experiencing homelessness:

- Resources and support for people needing safe, affordable housing who have a criminal background or a mental illness
- Safe community spaces for people experiencing homelessness to come together, drink coffee and have a conversation
- Resources for people experiencing homelessness such as a place to shower or do laundry

> "I mean it will always come back to housing… Oftentimes people have to be being evicted before they can receive any assistance and at that point it's often too late for them to remain housed and get caught up. And once they have to be rehoused it's just having an eviction on top of all the other things." – Community stakeholders

Access to behavioral health care

Stakeholders were concerned about a lack of both substance abuse and mental health treatment centers in Benton and Franklin Counties and named a variety of general gaps in services:

- Detox center: This need was mentioned in a third of the interviews. Without a detox center, people cannot get clean and therefore cannot access shelters or safe housing, contributing to homelessness
- Inpatient treatment center: Without an inpatient treatment center people have to be sent to other cities to receive help which is a burden on family members and the individual
- A lack of mental health providers leading to long wait times for mental health services

- Affordable mental health care for all people (those on Medicaid or private insurance, as well as those uninsured)

> "Well, the fact that we are very underserved for services for addicted people. So if a person is sick with addiction, they often have very immediate needs and we don't have a way to meet those. We have to send them somewhere else. That takes time. And often you lose them in the process. They go into withdrawal or they say, 'you know, this isn't going to work. I'm not going to do it.' And so if we had services right here, then we would be able to help people and not lose them in that critical, vulnerable time." – Community stakeholder

Stakeholders also shared gaps in services for the populations they serve:

- Young people, particularly LGBTQ+ youth, need more mental health support in schools. Currently counselors are overburdened by the number of students they are expected to support
- Veterans need more immediate mental health care in the area, in particular, female veterans need access to more female mental health providers
- Individuals identifying as LGBTQ+ need more competent providers who are accepting and supportive
- People with developmental disabilities and a mental illness need more competent providers who are especially skilled in meeting their needs

> "And then just LGBTQ awareness for medical providers and I would say also, support staff in schools. I know that we have a pretty high youth suicide rate I believe. And just some other groups I meet with bring it up as a concern a lot, like there isn't necessarily a whole lot of support for youth and middle schools, high schools, just around LGBTQ issues. I know some of them have even had trouble starting or maintaining their [Gay-Straight Alliance] clubs and such because of push back from administration." – Community stakeholder

Medium Priority Unmet Health-Related Needs

Many stakeholders prioritized health-related needs based on the work they do on a daily basis and the needs they see in the populations they serve, therefore the medium priority needs may be influenced by the stakeholders' sectors of work. Three community health issues were prioritized by stakeholders as medium priority (in order of priority):

6. Access to medical care
7. Domestic violence, child abuse/ neglect
8. Aging problems (such as memory, hearing, and vision loss)

Access to medical care

Stakeholders most often spoke about the complexity of navigating the healthcare system as the biggest barrier for patients in accessing the care they need. Stakeholders identified a patient champion or advocate as a gap in services, stating that many patients are unaware of their health insurance benefits or overwhelmed by the number of steps it takes to get the care they need. A lack of health literacy for many patients contributes to this challenge.

> "People often don't understand the healthcare system. And so I think for a lot of people, they need somebody to be their advocate and to really, you know, push or keep calling for that

> phone call or for that appointment if they really need it or, you know, to have a health navigator who does understand the system. So I think that would be really helpful." – Community stakeholder

In general, stakeholders identified access to medical care as an unmet health-related need for the following reasons:

- A lack of specialists in the Tri-Cities forces many people to travel to other areas for care
- A lack of primary care physicians contributes to the long wait times for an appointment
- Inconvenient hours for available appointments make it difficult for working adults to go to appointments

Several gaps in services for specific populations were noted:

- For veterans, a VA hospital in the Tri-Cities
- For patients identifying as LGBTQ+, competent, respectful, and understanding providers. In particular, services for transgender patients are largely unavailable outside of Planned Parenthood
- For patients who are undocumented, affordable medical care and prescriptions

> "We have four or five different Facebook groups for the Tri-Cities, for LGBTQ+ people and that is probably one of the number one questions I see asked, 'Who is a therapist that you would recommend? Who is a counselor that you would recommend? Are there any gay friendly primary care physicians?'… But [providers] will only take so many patients before they can't take anymore." – Community stakeholder

Barriers to care exist for certain patient populations as well:

- Youth under 18 years need parental consent to access medical care, but youth experiencing homeless often are unable to get this consent

Domestic violence, child abuse/ neglect

Stakeholders, particularly those who work with survivors of domestic violence, identified domestic violence and child abuse/ neglect as a prevalent community issue that intersects with many other issues. Stakeholders shared that survivors of domestic violence often have issues finding housing and may cope with the violence through substance abuse or criminal activity. Domestic violence negatively impacts children, affecting their healthy development and long-term mental health. Therefore, the needs related to domestic violence and child abuse/ neglect overlap with those related to homelessness, behavioral health challenges, and access to behavioral health care.

> "Look at any police station's newsfeed and you're lucky if you don't see a domestic violence incident once a day. People don't talk about it. They don't, it's like the hidden secret that we keep up in the cupboard and only access when, you know, times are really, really tough… And unfortunately due to the complacency that the general community has around that, we only see that with the clients we serve and you don't see a lot of emphasis around stopping domestic violence or the importance of domestic violence generally in our community." – Community stakeholder

Teen girls and individuals identifying as LGBTQ+ and/or with disabilities were identified as groups disproportionately affected by violence. Stakeholders identified the following gaps in the community for addressing domestic violence:

- Places for children who are in current danger
- Neutral environments for people in domestic violence situations to support one another and find empowerment and community

> "There's no environments for [people in domestic violence situations] to sit there and talk about and then rely on each other. Which I mean, if you look at it, if they had that and they could build each other up and be there for each other, then they may not need to rely on all the great services we have in our community at some point in time or it may, and we've seen this happen with our support groups, that speeds up the process. Because when I'm sitting across from you and I find out that you've been through similar stuff that I have, all of a sudden I'm not alone anymore." – Community stakeholder

Aging Problems (such as memory, hearing, and vision loss)

Stakeholders, particularly those who work with aging populations, identified aging problems as an unmet health-related need for a few reasons:

- A general lack of public understanding around dementia and Alzheimer's
- A lack of resources to support family caregivers supporting aging individuals
- A lack of resources to support the increasing number of aging people in the community, especially those needing memory care

> "I don't think people really fully appreciate [the Silver Tsunami] and then all of the care that's needed as people are aging that really does end up increasing re-admittance rates and ED utilization." – Community stakeholder

The current needs to address the aging-related issues of Benton and Franklin Counties are the following:

- A memory care unit
- Better training of healthcare providers to more accurately diagnose Alzheimer's and get patients connected to a specialist
- More neurologists and geriatric providers
- More caregiver support groups
- More education around healthy aging and the available resources

Assets

Participants were asked, "What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the person you serve?" Participants named a variety of organizations, programs, and local services they see as a community strength (See Table 4: Stakeholder Identified Community Assets for a full list). The most shared themes were as follows:

Collaboration between organizations and coalitions addressing needs

Stakeholders shared that any coalition or opportunity for collaboration is an important strength of the community because it leverages the expertise of multiple organizations. One example is the Benton

Franklin Recovery Coalition, which is working to address the behavioral health challenges in the community.

> "And there are a lot of coalitions and a lot of groups as problems come up, as our substance abuse problems come up, there's now a recovery coalition… So you know it's more folks getting together and actually working on an issue and trying to work holistically." – Community stakeholders

Innovative approaches to addressing behavioral health challenges

Stakeholders identified a variety of programs that are addressing behavioral health challenges in the community in innovative ways. One example is the True Blood Program, a collaboration between mental health professionals and law enforcement. Another is the Mental Health Court which takes a strengths-based approach to providing support to individuals whose mental illness impacts their criminal behavior.

> The Mental health court—decriminalizing mental health, identifying underlying issues with criminal behavior and treating them. No longer making jail the Court of Last Resort. – Summary of community stakeholder comments

Providing services in schools

Stakeholders named youth as an especially underserved population for many of the unmet health-related needs in the community. Therefore, they saw reaching youth in schools as an asset. They specifically named 3 Rivers Wraparound with Intensive Services (WISe) as an important program for incorporating mental health services into schools. Additionally, they noted Communities in Schools as important for supporting students' needs and reducing the burden on teachers.

> "We also have a couple of really great community organizations that are doing a lot of that coordination and laying over like Communities in Schools. That's been a tremendous boon to all of our school districts that have access there. And every school in the district wants a site coordinator because it allows education folks to do education and then all of those systemic barriers that our families in poverty are often facing, there is somebody that can help coordinate those community services for them. And that's something we hear back a lot is there are a lot of great services in our community but people don't know about them." – Community stakeholder

Community stakeholder identified assets

The following table lists all of the community organizations, programs, or services that were named by community stakeholders during the interviews.

Table 4: Community Stakeholder Identified Assets

Health-related need	**Community program, organization, or services (number of times mentioned)**
After School Programs and Activities	Girls on the Run YMCA
Aging Services	Adults Day Services Alzheimer's Association (2) Aging and Long Term Care Chaplaincy Health Care

	Kadlec Community Health programs: education and support groups (3) Powerful Tools
Behavioral health care	3 Rivers Wraparound with Intensive Services (WISe) (2) Benton Franklin Recovery Coalition Comprehensive Healthcare Cork's Place Drug Court Jail Diversion Team Mental Health Court (3) Mental Health First Aid Needle exchange Signs of Suicide (SOS) Prevention Program (2) True Blood Program (2) Youth Suicide Prevention Coalition
Education/ Literacy	Benton Franklin Early Learning Alliance Communities in Schools (2) Educational Service District 123
Food Security	Food banks Meals on Wheels (Memory Café) (2) Second Harvest (mobile markets and food pantries) (3)
Health Care Access	Benton Franklin Health District (3) Community Health Alliance Grace Clinic Greater Columbia Accountable Community of Health (3) Lourdes Mobile Outreach Team Planned Parenthood
Homeless Services and Housing	A New Start in Life Housing Resource Center Salvation Army
LGBTQ+ Specific Support Services	Camp 10 Trees LGBTQ+ bars (such as The Out and About) LGBTQ+ reading clubs PFLAG Pride, Diversity Trans Support Group Pride Foundation Spectra Art Gallery TRANScend
Other	Columbia Basin Non-Profit Association Kadlec On Call radio program Leadership Tri-Cities
Resources and Social Services	2-1-1 Churches

Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Stakeholders only had two suggestions:

More collaboration and less competition

Stakeholders spoke to the complexity of many of the health-related needs of their communities, such as homelessness and substance use disorder. Stakeholders overwhelmingly recognized that no one organization can solve these big issues, but rather it will take coalitions, cooperation across sectors, and a willingness to learn from one another. Stakeholders spoke to the fact that there can be competition for funding or for clients, but that does not serve the community well. Instead they would like to see more opportunities to share expertise, collaborate on grants, support one another, and create innovative solutions.

> "We got a lot of organizations in town that, while they're doing great things, they think they're the only kids on the block or are the only ones that can do it or they're doing it the most perfect way and it ends up siloing everybody involved, whether it's community members or other organizations." – Community stakeholder

Communication and relationship building

Stakeholders shared that one of their greatest challenges is not having up-to-date information about community resources. They know that there are a lot of organizations doing great work, but with changes in funding and turnover in the social services sector, often times they are unsure who to refer to or which organizations can provide specific services. Therefore, having an opportunity to meet one another, build relationships, and update their resource lists would help them better serve their clients. Stakeholders shared having a quarterly or annual event to come together and share resources would be helpful.

> "But I think if, if we could have even a monthly meeting or an annual meeting or something... I mean, let's face it, nonprofit, social services, there's a lot of turnover all the time. Maybe even in hospitals, I don't know. But people move on. Nobody stays. And so keeping your contacts updated, keeping relationships, constant communication. You have to keep maintaining relationships and sometimes you don't, we all get so busy we don't have the time." – Community stakeholder

Limitations

Stakeholders were selected by Steering Committee members and while they were intentional about recruiting stakeholders from a variety of types of organizations there may be some selection bias as to who was selected as a stakeholder.

Four of the 16 stakeholder interviews were not recorded. Therefore, these interviews lack details in comparison to those that were recorded. The voices of the stakeholders who were not recorded may not be as dominant in the summary of findings and no direct quotes were recorded.

Multiple facilitators were used for the stakeholder interviews. Therefore, facilitators' emphasis on certain questions, examples given, and feedback (verbal or through body language) may have influenced the conversations.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

Stakeholder Surveys

Introduction

The CHNA Steering Committee wanted to include as many opportunities for input from stakeholders as possible. They surveyed 256 additional stakeholders apart from those included in the interviews. The goal of this survey was to provide additional insight into the prioritization of health-related needs.

Methodology

Selection

A total 256 surveys were completed by community stakeholders. Steering Committee members distributed the surveys at community meetings and sent links to electronic versions. Stakeholders were selected by members of CHNA Steering Committee based on their knowledge of the community and engagement in work that directly serves people who are economically poor and vulnerable. The Steering Committee aimed to engage stakeholders from hospitals, social service agencies, clinics, and government to ensure a wide range of perspectives.

Survey

The survey was developed in partnership by Benton-Franklin Health District and Providence St. Joseph Health. The survey was taken from Question 5 of the stakeholder interview guide and asked the following: "Using the table below, please identify the five most important 'issues' that need to be addressed to make your community healthy (1 being most important)." Participants were given a list of health-related needs to choose from (see Appendix 3).

Data Collection

Steering Committee members distributed the survey on paper at local meetings having to do with community health, safety, and wellbeing. Steering Committee members sent an electronic version of the survey on Survey Monkey to other stakeholders whose voices they wanted to capture. All responses were compiled by Benton-Franklin Health District in an Excel spreadsheet and shared with the analyst.

Analysis

Analysis of the surveys was conducted by Providence St. Joseph Health using Excel. Each stakeholder ranked their top five health-related issues from the provided list of health-related needs. If the stakeholder ranked a need as the number one priority, that need was given five points. If ranked second, given four points, and so on. In this way, the analyst used a weighted ranking system to prioritize the needs based on the stakeholders' input. If a stakeholder failed to rank the health-related needs (used check marks or assigned all needs a 1 ranking), their survey was excluded from the analysis. Stakeholders who completed the prioritization of health-related needs during the stakeholder interview were not included in this analysis. Fifteen surveys were excluded from the 271 collected, meaning 256 surveys were included in the final analysis.

Findings

Stakeholders were asked to identify their top five health-related needs in the community. Stakeholders prioritized one health-related need substantially above the others: behavioral health challenges, including both mental health and substance use disorder. After this need, two more needs were given high priority and tied for importance: access to behavioral health services and homelessness and housing instability. These top three health-related needs mirror those of the stakeholders who completed interviews. The top three health-related needs are summarized as follows:

1. Behavioral health challenges (includes both mental health and substance use disorder)
2. Access to behavioral health
2. Homelessness and housing insecurity (tied with access to behavioral health)

The subsequent three health related needs were also given high priority over the other needs (in order of ranking):

3. Obesity
4. Access to medical care
5. Domestic violence

Access to medical care and domestic violence were also prioritized by the stakeholders who completed interviews. Obesity was not previously identified.

Limitations

Stakeholders were selected by Steering Committee members and while they were intentional about recruiting stakeholders from a variety of types of organizations there may be some selection bias as to who was selected as a stakeholder.

Stakeholders were not able to provide context to their answers, therefore, there may be specific components of the needs that were not captured by the survey. Some stakeholders used an older version of the survey with the same concepts, but slightly different language. This may have affected their understanding of the need.

Summary and Data Blending

The following figure is a high-level summary of the needs prioritized by community members and community stakeholders:

Community Member Prioritized Needs

- Affordable medical care, dental care, and prescriptions
- Timely, convenient, and local medical care
- Resources for people who need help and more knowledge of local resources
- Affordable mental health services responsive to people's unique needs
- Shelters and services for individuals experiencing homelessness
- Safe, affordable, clean housing, especially for individuals with low-incomes
- Increased community safety

Community Stakeholder Interviews Prioritized Needs

- Solutions to mental health care and substance abuse challenges, specifically those that address stigma and increase funding for treatment
- Shelters, affordable housing, transitional housing, and support services for people experiencing homelessness
- Affordable behavioral health care services, in particular a detox center and inpatient treatment center
- Access to primary care providers and specialists, as well as patient advocates to help navigate the health care system
- Support services for people experiencing domestic violence or child abuse/neglect
- Awareness and education about aging problems and services to address the aging community, such as a memory care unit and geriatric providers

Community Stakeholder Survey Prioritizd Needs

- Behavioral health challenges (includes both mental health and substance use disorder)
- Access to behavioral health
- Homelessness and housing insecurity (tied with access to behavioral health)
- Obesity
- Access to medical care
- Domestic violence

Both community members and stakeholders identified the following health-related needs as priorities. There were many overlaps in their comments and some differences, which are noted below:

Behavioral health care (access to and challenges)

Overlap	Differences
•Importance of having affordable mental health services for people with and without insurance •Need for more mental health services for youth, especially those provided in schools •Need for more competent, accepting, and supportive mental health services for individuals identifying as LGBTQ+ •Need for more mental health providers in general •Need to address and reduce stigma around seeking mental health services	•Stakeholders emphasized a need for a detox center and inpatient treatment center, focusing on substance abuse disorder more than community members

Homelessness/ safe, affordable housing

Overlap	Differences
•Need for more shelters in the Tri-Cities •Need for a place to shower, use the bathroom, and do laundry for people experiencing homelessness •Need for more low-income housing for families •Need for more affordable housing for older adults •Identified an overlap between mental health/substance abuse and homelessness	•Community members identified a need for housing that is clean and good quality for families, rather than just a roof over their head •Stakeholders identified a need for more transitional housing and wet shelters

Access to medical care

Overlap	Differences
•Need for more specialists and primary care providers •Need for faster access to appointments, such as same day appointments •Need for more convenient hours for appointments such as evenings and weekends •Need for more respectful and understanding providers for individuals identifying as LGBTQ+ and medical care for trans individuals •Need for more health care services that are affordable for people who are undocumented	•Stakeholders emphasized a need for more assistance navigating the complexity of the health care system •Community members emphasized a need for more affordable medical care, dental care, and prescriptions, particularly free or low-cost care, as well as more flexibility in payment plans and sliding fee scales •Community members noted needing a true urgent care in the Tri-Cities

Community safety and child wellbeing

Overlap	Differences
•The importance of keeping children safe and cared for in their homes and in the communities •The importance of schools in reaching children, addressing ACEs, and protecting children from negative influences	•Community members were more concerned with the presence of gangs, the selling of drugs, and community violence •Stakeholders were more concerned with domestic violence

Aging problems

Overlap	Differences
•Need for more specialists for older adults, such as neurologists and geriatric providers •Need for more support for older adults living alone in their homes •Need for more affordable housing for older adults	•Stakeholders emphasized aging problems more than community members. They specifically spoke to the need for a memory care unit and more services to address Alzheimer's and dementia

Appendix 1: Listening Session Supporting Documents

Listening Session Script—English

INTRODUCTION

Good morning/evening and welcome to our session. Thank you for taking the time to join this conversation about the health of the community. My name is [NAME], and I work with [ORGANIZATION]. For this session, I am working with Kadlec Regional Medical Center and the Benton-Franklin Health District to complete their community health needs assessments. This process is completed every three years to better understand the health needs and strengths of the communities. That's why we're talking with community members like all of you.

The information from this session will become part of the needs assessment report, which the hospitals will use to help improve the health and wellbeing of the community. Your name will remain anonymous. We may use some quotes from the session, but we will not include your name. We will not be recording the session, but two people will be taking notes during the conversation. Their names are [NAMES].

I will facilitate the conversation, but I will not be participating. I will ask some questions of the group. I may need to move the conversation to the next question to ensure we have time to cover all of the questions.

I hope that all of you can share your experiences and opinions with us during this hour together. Please feel free to get water or use the restroom. Participation today is optional and you may leave when needed. We will finish no later than [TIME].

During this conversation I want everyone to have a chance to talk and share your thoughts. Feel free to respond to one another and give your opinion even if it is different from someone else's. Before we start I want to set some expectations for the group. First, everyone should participate, but it helps us if only one person speaks at a time. Second, there are no right or wrong answers, we must all be respectful of one another. Third, please keep what you hear from other participants confidential.

Before we begin, are the any questions?

Great, does everyone consent to participation?

INTRODUCTORY ACTIVITY

We have a little over an hour to talk, and I'd like to start with a creative activity. I'd like you to start by thinking about your community. People might think of "community" in different ways. Maybe it's family, or maybe it's neighbors, or maybe it's coworkers or friends. For the next 5 minutes, draw a picture that represents **your community**.

Pause, give people ~5 minutes to draw. Facilitator should draw too.

So let's go around in a circle—tell me your name, and tell us something about the community represented in your drawing. We will each have about thirty seconds to share. I'll start.

Facilitator introduces self, models talking about community. Then everyone goes in a circle, introducing self and saying a few words about their community.

Thank you all for sharing. That leads into what we're going to talk about next: the health of your community.

CONTEXT

What we were hoping to talk about today is: ***What makes a healthy community?***

That's a difficult question, because it involves two ideas. First, there's ***HEALTH***. What do we mean by health? Do we mean freedom from disease? Having enough to eat? Feeling generally good about life? Being financially healthy?

Then there's the idea of ***COMMUNITY***. What do we mean by community? Are we talking about each one of you, individually? Are we talking about your friends and family? Your neighborhood? Your church? Your racial or ethnic group? Your city or town?

We're not going to define these things for you. We're going to keep it open.

QUESTION 1. VISION. Now take a minute to think about your community—that community that is represented in your drawing. **How can you tell when your community is healthy?**

Probes if needed:

- *You have all spoken about physical health. What about other kinds of health and wellbeing?*
- *What does a healthy community look like for people going through a difficult time?*
- *What does a healthy community look like for families?*
- *What does a healthy community look like for your children or young people?*
- *What does a healthy community look like for older adults?*
  Instructions: write ideas on the poster.

QUESTION 2. NEEDS.

So we've talked about what a healthy community looks like. Now let's talk about what's not there or what you need more of.

What's needed? What more could be done to help your community be healthy?

Probes if needed: Consider relating probes to question one. What's needed to help community members reach their specific ideas of a healthy community? For example:

- *What's needed to help your community be physically healthy?*
- *What's needed to help your community be mentally and emotionally healthy?*
- *What's needed to help your community be safe?*
- *What's needed to ensure all members of your community can lead healthy lives?*

Instructions: write ideas on the poster.

QUESTION 3. STRENGTHS. So you've told us what a healthy community looks like and what the needs are in your community. Let's explore this idea a little more. Communities have certain **resources** that can help them be healthy. It might be programs. It might be a park or a community center. It might be a really great teacher at your local school. It might be a local business or a local organization that helps people be healthy.

My question for you is: **What's working? What are the resources that CURRENTLY help your community to be healthy?**

Probes if needed:

- *Are there people that help your community be healthy?*
- *Are there places people can go that help them be healthy?*
- *Are there programs that help your community be healthy?*
- *How do community members help each other be healthy?*

Instructions: write ideas on the poster.

Thank you all for sharing your thoughts and opinions with the group today. All of this information is really helpful. Before we finish, **is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?**

Listening Session Script—Spanish

INTRODUCCIÓN

Buenos días/ buenas noches. Bienvenidos. Gracias por tomarse el tiempo para participar en una conversación sobre la salud de la comunidad. Me llamo [NOMBRE] y trabajo con [ORGANIZACIÓN]. Para esta sesión, estoy trabajando con Kadlec Regional Medical Center y Benton-Franklin Health District para completar las evaluaciones de las necesidades de salud de la comunidad. Ellos completan este proceso cada tres años para comprender mejor las necesidades de la comunidad y las cosas positivas que hace la comunidad para mantener una buena salud. Es por eso por lo que estamos hablando con miembros de la comunidad como ustedes.

La información de esta sesión formará parte del informe de evaluación que los hospitales usaran para mejorar la salud y el bienestar de la comunidad. Sus comentarios serán anónimos. Es posible que vamos a usar algunas citas de la sesión, pero nunca vamos a incluir sus nombres. No vamos a grabar la sesión, pero hay dos personas que van a ayudarme tomando notas durante la conversación. Ellos se llaman [NOMBRES].

Yo voy a facilitar la conversación, pero no voy a participar. Voy a hacer algunas preguntas al grupo. Es posible que tenga que interrumpir la conversación para pasar a la siguiente pregunta para asegurarnos de que tenemos tiempo para cubrir todas las preguntas.

Espero que todos ustedes puedan compartir sus experiencias y opiniones con nosotros durante esta hora juntos. Siéntase libre de obtener agua o ir al baño durante la sesión. La participación de hoy es opcional y pueden salir cuando necesitan. Vamos a terminar a las [TIEMPO].

Durante la conversación, quiero que todos tengan la oportunidad de hablar y compartir sus pensamientos. Siéntase libre de responder el uno al otro y dar su opinión, incluso si es diferente a la de otra persona. Antes de comenzar quiero establecer algunas expectativas para el grupo. Primero, todos deben participar, pero nos ayuda si solo una persona habla a la vez. Segundo, no hay respuestas correctas o incorrectas, todos debemos ser respetuosos unos con otros. Tercero, por favor mantengan confidencial lo que escuchan de otros participantes.

Antes de comenzar, ¿alguien tiene alguna pregunta? ¿Todo está claro?

Bueno, ¿Están listos para participar? ¿A alguien le gustaría irse?

ACTIVIDAD INTRODUCTORIA

Vamos a hacer una actividad creativa. Me gustaría comenzar esta charla escuchando sus descripciones de sus comunidades porque yo sé que todos tenemos diferentes maneras de pensar sobre nuestras comunidades y todas las ideas son válidas. Comunidad puede incluir familia, vecinos, compañeros, y amigos. Puede ser donde vivimos, trabajamos, o pasamos tiempo. Por favor, tómense cinco minutos para hacer un dibujo que represente a su comunidad.

Todos los participantes dibujan durante cinco minutos. El facilitador debe dibujar también.

Por favor compartan sus primeros nombres y algo sobre su comunidad representado en su dibujo. Yo puedo empezar.

El facilitado comparte la descripción de su comunidad.

Gracias por compartir con el grupo. Eso nos lleva a lo que vamos a hablar a continuación: la salud de la comunidad.

CONTEXTO

Durante la sesión, me gustaría discutir la siguiente pregunta: **¿Que hace a una comunidad sana?**

Esta es una pregunta grande porque incluye dos ideas. Primero está la idea de la **SALUD**. ¿Que entendemos por salud? Tal vez la liberación de las enfermedades. O suficiente comida para comer. Tal vez sentirse generalmente bien con la vida. Teniendo ingresos suficientes para cubrir sus necesidades.

Segundo esta la idea de **COMUNIDAD**. ¿Que entendemos por comunidad? ¿Estamos hablando de cada uno de ustedes, individualmente? ¿Estamos hablando de sus amigos y familiares? ¿Su vecindario? ¿Su iglesia? ¿Su grupo racial o étnico? ¿Su ciudad o pueblo?

No vamos a definir esas cosas para ustedes. Vamos a mantenerlas abiertas.

PREGUNTA 1. VISION. Tómense un momento para pensar en su comunidad. **¿Cómo puede saber cuándo su comunidad esta saludable?**

Pregunta si es necesario:

- Todos han hablado de la salud física. ¿Qué pasa con otros tipos de salud y bienestar?
- ¿Cómo se ve una comunidad saludable para las personas que atraviesan un momento difícil?
- ¿Cómo se ve una comunidad saludable para las familias?
- ¿Cómo se ve una comunidad saludable para sus hijos o jóvenes?
- ¿Cómo se ve una comunidad saludable para los adultos mayores?

Escribe las ideas en el poster.

PREGUNTA 2. NECESIDADES. Hemos hablado sobre cómo se ve una comunidad saludable. Ahora hablemos de lo que necesitan.

¿Cuáles son sus necesidades? ¿Qué más se podría hacer por su comunidad para que sea saludable?

Pregunta si es necesario:

- ¿Qué se necesita para ayudar a su comunidad para que sea físicamente saludable?
- ¿Qué se necesita para ayudar a su comunidad para que sea mental y emocionalmente saludable?
- ¿Qué se necesita para ayudar a su comunidad para que sea segura?
- ¿Qué se necesita para garantizar que todos los miembros de su comunidad puedan llevar una vida saludable?

Escribe las ideas en el poster.

PREGUNTA 3. FORTALEZAS. Nos ha dicho como se ve una comunidad saludable y cuáles son las necesidades en su comunidad. Exploremos esta idea un poco más. Las comunidades tienen ciertos recursos que pueden ayudarles a ser saludables. Podrían ser programas, un parque, o un centro comunitario. Podría ser que sea un gran maestro en su escuela local. Podría ser un negocio local. O una organización local que ayude a las personas a ser saludables.

La pregunta es: **¿Que está funcionando? ¿Cuáles son los recursos que actualmente ayudan a que su comunidad sea saludable?**

Pregunta si es necesario:

- ¿Hay personas que ayuden a su comunidad a ser saludable?
- ¿Hay lugares donde la gente pueda ir para que los ayuden a ser saludables?
- ¿Existen programas que ayuden a su comunidad para que sea saludable?
- ¿Cómo se ayudan los miembros de la comunidad para ser saludables?

CIERRE. Gracias a todos por compartir sus pensamientos y opiniones con el grupo hoy. Toda esta información es útil. Antes de que terminemos, **¿hay algo más relacionado con los temas que discutimos hoy? ¿Qué piensan que yo debería saber que no haya preguntado o que no hayan compartido?**

Listening Session Codebook

Code	Definition	Example
Access to healthcare	References to accessing medical, vision, and/or dental care. Includes references to insurance, cost of care, clinic hours, urgent care, number of providers, specialists, and preventative care.	Free clinics needed for those who can't afford services—free screenings and vaccinations.
Activities for children	References the importance of activities specifically for children, such as sports or after school programs. Includes references to engaging children in positive activities to prevent future negative behaviors.	Need things (activities) for kids so they don't turn to drugs/ gangs.
Caring for one another	References community members being willing to help their neighbors and other community members. Includes comments about volunteerism, smiling, and a lack of conflict.	People working together towards the same goals
Collaboration/ cooperation	References to people working together, common goals, and unity.	People working together towards the same goals, people helping each other.
Communication	References communication among community members and community organizations. Includes references to needing to share more information and have spaces where people can have a dialogue.	Communication with in the community, between neighbors and between organizations.
Diversity/ equity	Includes references to inclusion, openness/honesty about who you are, respect for others, awareness of other cultures, and meeting the unique needs of all people.	Understanding of each other's' challenges. Respect and compassion.
Education	References comments related to formal and informal education opportunities for children and adults.	Opportunities for higher education (Columbia Basin College).
Employment/ economic opportunity	References job opportunities and comments related to the local economy.	Strong economy: people shopping, stores busy, unemployment low.
Family dynamics	References to relationships between family members, domestic violence, and parent engagement.	Parents caring for their kids and servicing as role models. Give attention to their kids, paying attention to what's going on with them.
Food security	References to food banks, food donations, grocery stores, school lunch programs, Summer meals, and farmers markets. Includes references to having enough food or having access to good food.	Community gardens: share vegetables in our community.
Green spaces/ environmental conservation	References parks, rivers, natural resources, hiking trails, and efforts to conserve or protect nature.	Good parks, trails, outdoor activities.
Healthy/ unhealthy behaviors	References to nutrition, physical activity, and smoking.	People spending time outside (riding bikes, walking).
Housing/ homelessness	References to housing, homelessness, shelters, homeless services, and evictions.	Housing access: not just a roof, but adequate size for family and affordable.
Information/ awareness	Includes references to sharing of information, health information/ education, and increased awareness about resources and health topics.	Information in the fields about themes of health, including importance of vaccines.

Mental health services	References to emotional wellbeing, mental health and substance use treatment, support groups, counseling, and accessing mental health care.	More accessible therapy and less expensive.
Neighborhood condition	References to cleanliness and general appearance of the neighborhood. Includes references to trash, water quality, and air quality.	Clean: community is free of garbage.
Other	References to any comments that do not fit into existing categories.	Participation in local government: activism.
Population: People with disabilities	Tags comments related to the needs of people with disabilities.	Social security isn't sufficient to pay rent and doctor's co-payments.
Population: English as a second language/ limited English proficiency	Tags comments related to the needs of people who speak English as a second language or have limited or no English proficiency.	More information in Spanish (that's clearer) about health and other themes.
Population: Farmworkers	Tags comments related to the needs of farmworkers.	Personal hygiene: change clothes when you arrive home from work, especially if you've been working in the fields. Protection from chemicals/ pesticides for field workers.
Population: LGBTQ+ identifying individuals	Tags comments related to the needs of people who identify as LGBTQ+.	More acceptance of and discussion of gender spectrum.
Population: People with low incomes	Tags comments related to the needs of people with low incomes.	Pay scale for medical and dental care.
Population: Older adults	Tags comments related to the needs of older adults.	Financial support for seniors who can't afford internet access, cable, cell phone, etc.
Population health	References to number of sick people, amount of disease, and number of people hospitalized.	Decrease rates of infectious diseases.
Q1 Vision	Tags all responses that answer question 1: "How can you tell when your community is healthy?"	Coverage for dental, vision, and hearing for those not on Medicaid.
Q2 Needs	Tags all responses that answer question 2: "What's needed? What more could be done to help your community be healthy?"	Someone to help navigate resources.
Q3 Strengths	Tags all responses that answer question 3: "What's working? What are the resources that currently help your community be healthy?"	Churches help with rent, clothes, and food.
Quality of care	References to characteristics of good or bad health care services and providers.	Consistent doctors: Doctors who stay in the community.
Resources/ support services	References rent and utility assistance, coupons, discounts, secondhand stores, and showers/ bathrooms for people experiencing homelessness. Also includes references to specific services needed	More services/ resources for low income individuals.

	for people with low incomes or disabilities, and older adults.	
Safety	References to crime, violence, gangs, sidewalks, lighting, law enforcement, and emergency response.	Increased safety: Reduced gang violence and murders.
Social connection	References to community events, community centers, spaces for people to spend time together, social isolation, and mentorship.	Weekly dinner where people can come together.
Specific organizations	Tags the names of community organizations and programs.	Second Harvest: brings fruits and vegetables for seniors.
Spirituality	References to spirituality, churches, ministry, and faith. Does not include references to financial assistance received from churches (includes in resources/ support services).	Churches create community and belonging.
Substance abuse	References to drug use, needle exchanges, and detox centers.	Don't have detox center—need to leave the community for those services.
Transportation	References to public transportation, the airport, buses, and Dial-A-Ride.	Public transportation, especially for people with limited access or unable to drive.

Appendix 2: Stakeholder Interview Supporting Documents

Stakeholder Interview Facilitator Guide

Key Community Stakeholder	**Hospital Representatives**
Date and Time of Interview **Location**	**(Please list all attendees)**
Key Community Stakeholder Names/Titles (please list all attendees)	
Organization Name	
Preferred Contact	

Interview Questions	
Purpose	**Question**
To understand the role of the stakeholder's organization and community served	**1. How would you describe your organization's role within the community?**
	2. How would you describe the community your organization serves? Please include the geographic area.
To identify and prioritize unmet health related needs in the community, including the social determinants of health	**3. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health, such as housing, transportation, and access to care, just to name a few.**
	4. **Can you prioritize these issues? What are your top concerns*? [Note to interviewer: encourage ranking of at least top three health needs in order of priority]***
	5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
To identify populations disproportionately affected by the unmet health-related needs	**6. Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs? We have a particular concern for those that are low income, vulnerable or are experiencing health inequities.**
To identify gaps in services that contribute to unmet health-related needs	7. **Please identify and discuss specific gaps in community services for the persons you serve that contribute to the unmet health-related needs you identified earlier.**
To identify barriers that contribute to unmet health-related needs	**8. Please identify and discuss specific barriers for the persons you serve that contribute to the unmet health-related needs you identified earlier.**
To identify community assets that can be leveraged, such as initiatives that are already addressing	**9. What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health related needs you identified earlier? Can you rank them in terms of effectiveness?**

these health-related needs	
To identify opportunities for collaboration between organizations	**10. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?**
Anything else	**11. What other things do you think we should hear about?**
Other comments:	

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).			
	Aging problems (e.g. memory loss/hearing/vision loss)		Access to oral health providers
	Air quality, e.g. pollution, smoke		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/recreation
	Gang activity/violence		Behavioral health challenges (includes both mental health and substance use disorder)
	HIV/AIDS		Poor schools
	Homelessness/lack of safe, affordable housing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to medical care		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Access to behavioral health care		Other:

Stakeholder Interview Codebook

Code	Definition	Example
Access to behavioral health care	References to mental health and substance use treatment, support groups, counseling, insurance coverage, provider availability, and detox centers.	"Well, the unmet needs are we don't have a detoxification center and we are the largest metro in the state that doesn't have one and areas much smaller than Benton and Franklin counties have them."
Access to medical care	References to insurance, cost of care, clinic hours, urgent care, number of providers, specialists, and preventative care.	"I really feel that it is very hard for our population to get into specialists."
Access to oral health providers	References to accessing dental care, including dental providers, cost of care, and location of dental clinics.	"I think another thing is lack of affordable dental care for a lot of these folks that are, you know, they can't really get a job if they don't have a smile."
Access to services/ resources	References knowing and being able to use community resources, such as social services. Does not include accessing behavioral, medical, or oral health care.	"I feel that the transgender community, very specifically, does not get served enough or have enough consistent service. Adolescent and younger youth don't have services or everts. And elder LGBTQ+ community members."
Aging problems	Includes references to memory loss, such as dementia and Alzheimer's. Includes references to hearing and vision loss and decreases mobility.	"Aging problems: not having facilities equipped to handle dementia and outbursts."
Air quality	Includes references to pollution and smoke.	"Air quality, pollution, and smoke. I mean, the smoke in the Summer is horrific."
Behavioral health challenges	References to mental illness, behaviors related to mental illness, substance abuse, and addiction. Does not include references to treatment or behavioral health services, which are included in "Access to behavioral health care."	"And then the mental health piece where not only the professional mental health piece, but identifying those social emotional needs for the students while they're in school."
Coalition/ collaboration	References working together, communication between organizations, joining efforts, and forming coalitions.	"We could sit here all day and name off all the organizations we have in the Tri-Cities or Benton Franklin Counties that help, but the coalitions help us meet, network, help us get on the same page."
Community awareness of resources	References the sharing of resources and services between organizations and with community members. Includes references to awareness of available services.	"Because I said it before, I'll say it again. We, I've never seen a community such as Benton and Franklin counties that has the services or the people who care enough to back those services up. Like it is insanely awesome how many services we do have. Yeah. But it's extremely frustrating that not everybody knows about them."
Community centers/ social connection	References to meeting spaces and opportunities for people to meet one another. Includes references to community support networks.	"Why can't we give our community members the ability to form their own groups, to lean on each other, to help each other out to do that? So yeah, I think, and once you do that, I think

		you'll see a lot more empowerment throughout the community because we see it with our clients."
Complexity navigating systems	References challenges navigating documentation, referrals, and complicated health care and social service systems. Includes references to health literacy.	"Well yeah and navigating the system is really difficult. It is. And when you don't understand the system, when you understand the terminology, it's next to impossible."
Domestic violence, child abuse/ neglect	References to violence within families and the home. Includes violence against children or a lack of parenting.	"I put domestic violence, which I think is, and child abuse and neglect, which is somewhat related to substance abuse, not always, but certainly related."
Education	References to schools and early learning.	"I'd say the early learning alliance too is, it has been, we have staff that kind of rotate and attend that, but that's been helpful, um, initiative for us to be plugged into."
Food security	References to food banks, food donations, grocery stores, school lunch programs, Summer meals, and farmers markets. Includes references to having enough food or having access to good food.	"Food. Huge one. I can't tell you how many kids I see out there that aren't engaged in school that aren't doing anything just because they're worried about their next meal. It's Maslow's Hierarchy and they, they just, they, they can't concentrate. They're in survival mode. And if you're in survival mode all the time, you're, you play school or anything else for that matter on the back burner as far as your hierarchy of needs go. I mean, if you're hungry, if your stomach's growling."
Funding	References to public and private sources of funding, including grants.	"The other is of course, financial. We just have, the counties here have been sitting on money and they are not spending it and they could spend it to fund detox and inpatient services."
Gang activity/ violence	Reference to gang activity and violence in the community. Does not include references to domestic violence.	"Third priority would be gang activity and violence. See it everywhere. I've been to elementary schools where I've, I've seen, not profiling, I've seen gang members walking around the school waiting for the kids to get out of school, waiting to be there for them and suck them into the gang life."
Good Quote	Tags quotes that are particularly insightful or well-representative of a theme.	"Having a stable place to live is really important to be able to meet any other needs. If they're jumping around from place to place they're never going to fully be able to participate in any other programs."
Housing/ homelessness	References to housing, homelessness, shelters, homeless services, housing stability, and evictions.	"I mean it will always come back to housing. The lack of resources to be able to keep a family housed. I think there's been a little bit of improvement there as far as the housing resource center, availability of funds is concerned, but it's still, you know, oftentimes people have to be being evicted before they can receive any assistance."

Obesity/ Nutrition	References to obesity, healthy eating, physical activity.	But really obesity. I mean it's gonna, they're gonna have a lower life expectancy and certainly a lower quality of life than previous generations, but it really just relates to chronic diseases and really a huge, huge impact on the health care system and you know, just quality of life and mental health and all the things that are connected. It's totally systemic."
Other	References to any comments that do not fit into existing categories. Includes information shared when participants were asked if they had anything else to share.	"My second priority to back that up would be coming up with some ways we can hold parents accountable, put their feet to the fire."
Parks/ recreation	References to green space, opportunities for people to be outside and active.	"I think about our lovely trails and parks that we have in the area, a little bit more education on where older people can go and safely walk and get outside."
Population: Caregivers	Tags comments related to caregivers.	"I think family caregivers are another population that are affected that they often don't even self-identify as caregivers and they certainly don't take care of themselves as well as they should."
Population: Farmworkers	Tags comments related to farmworkers.	"I know transportation is a big one as well, especially within the Tri-Cities area, it can be pretty difficult. Just with people's schedules, especially like farm workers for example that work really tight schedules. I know transportation can often be a barrier."
Population: Individuals slightly above income threshold for services	Tags comments related to individuals with incomes above threshold for services.	"I think a gap that I see a lot is between the poverty and the middle class, right? So you make too much to use the federal relief fund. You make too much to qualify for these programs. But at the same time, you're still struggling."
Population: LGBTQ+ identifying individuals	Tags comments related to individuals who identify as LGBTQ+.	"And even just with the LGBTQ community, I've heard from a lot of people that it's difficult to find just medical providers in general that have any superficial awareness of the LGBTQ community."
Population: Limited English proficiency	Tags comments related to people with limited English proficiency.	"And then we've talked about, you know, really limiting English proficiency is going to be a barrier. Um, we are, have a huge amount of folks that speak a whole lot of languages in our community because of our resettlement and just the demographics of the community. And so LEP clients just have more general barriers because when you don't speak the language and don't read the language, the things that are available you're not aware of."
Population: Older adults	Tags comments related to older adults.	"Um, I think we need, um, a friendly environment for the aging population. I don't believe our community is friendly towards the

		aging population. We have curbs to trip over. We have, um, heavy doors. We have just things that are barriers for the, for the older population that I think could be addressed in a perfect world and with all the money in the world."
Population: People experiencing homelessness	Tags comments related to people experiencing homelessness.	"And I mean homeless individuals as well. I know that I've heard from some partner organizations that it can be difficult to get in to see a medical provider for homeless individuals who maybe don't have forms of identification."
Population: People in rural areas	Tags comments related to people living in rural areas.	"And when I say access, it's not just access to healthcare, it's access to services, access to transportation, access to assistance or funding mechanisms to help people survive. You know, if you're living in a rural area and you're barely getting by and your sewage system fails, how are you going to deal with that new challenge if you don't have access?"
Population: People of color	Tags comments related to people of color.	"Well I mean, just looking at it even nationally, mortality rates for pregnant black woman are on the rise. Research also finds that the women of color are more often sent away from doctors in emergency rooms and their pain is often dismissed."
Population: People who are undocumented	Tags comments related to people who are undocumented.	"I would definitely say our undocumented population in this community are left kind of by the wayside, especially after we lost the NCFP grant, the non-citizen family planning grant that I feel that disproportionately affected our Hispanic population here."
Population: People with criminal background	Tags comments related to people with criminal backgrounds.	"All of these are difficult with clients with criminal background: housing, employment."
Population: People with disabilities	Tags comments related to people with disabilities (developmental or physical)	"I've heard as well about accessibility for people with disabilities. Something I've can think of recently was, when we got snowed in, people who need accessibility literally could not use the sidewalks or go anywhere if they use that mode of transportation. So I know that was a big one as well."
Population: People with low-incomes	Tags comments related to people with low-incomes.	"I think it's pretty clear that those that are in poverty, living below the poverty level and really quite frankly, 300% above the poverty level, um, are those that are definitely disproportionately affected by almost every issue that we've referenced."
Population: Survivors of domestic violence	Tags comments related to survivors of domestic violence.	"You know, if you got to worry about where you're going to live with your three kids and how you're going to get there and do that, you may just suck it up and stay with the abuser

		because that's easiest route, see what I'm saying."
Population: Veterans	Tags comments related to veterans.	"And one of the biggest unmet needs for our veterans is an ER for emergency services. If we have, if I needed to go to an ER, I have to call the VA first to, to let them know that I need to go to the ER."
Population: Women	Tags comments related to women.	"I think we have a special need for female veteran mental health counselors. We used to have a female veteran counselor available and she had a female local support group. Yeah. And that's gone now."
Population: Young parents	Tags comments related to young parents.	'Also, pregnancy, there's nowhere for teen moms. They have, they can do WIC and TANF and all that, like there's resources but not housing."
Population: Young people	Tags comments related to young people.	"I don't think we realize how many of our teenagers suffer with mental health disorders. And I think they slip under the radar a lot."
Q1 Organization role	Tags responses to question 1: "How would you describe your organization's role within the community?"	"We work with teens, so we house and provide resources for teenagers ages 13, up until the 18th birthday, most specifically non-state involved teenagers."
Q2 Population served	Tags responses to question 2: "How would you describe the community your organization serves? Please include geographic area."	"Well, the geographic area, Benton Franklin counties and Burbank, just kind of part of the greater Tri-Cities and the community we served as low-income uninsured residents of that geographic area."
Q3: Unmet health needs	Tags responses to questions 3: "Please identify and discuss unmet health-related needs in your community for the persons you serve." Tags responses to question 4: "Can you prioritize these issues? What are your top concerns?" Tags responses to question 5: "Using the table, please identify the five most important issues that need to be addressed to make your community healthy (1 being the most important)."	"Number two would be access to behavioral healthcare, specifically substance abuse treatment."
Q6 Disproportionately affected populations	Tags responses to question 6: "Are there specific populations or groups in your community who are disproportionately affected by these unmet health-related needs?"	"I don't think there's enough mental health providers in our community. I think that's just a huge, huge need. I think it's a great need for adolescents and teens and especially those that have really severe behavioral challenges."
Q7 Gaps in services	Tags responses to question 7: "Please identify and discuss specific gaps in community services for the persons you serve that contribute to the	"I don't really see anyone stepping up and meeting the addict as he, as he exists, you know, in any kind of a walk in basis or telephone. 'Come on in. We're here to help you.' I don't see that happening."

	unmet health-related needs you identified earlier."	
Q8 Barriers for those serviced	Tags responses to question 8: "Please identify and discuss specific barriers for the persons you serve that contribute to the unmet health-related needs you identified earlier."	"One barrier is stigma and shame and secrecy, which has historical, that's always been true. You know, the anonymous movements came up because people wouldn't go into a group if they thought they couldn't be anonymous. So anonymity is fine except why do we need to be ashamed of this if it's a disease and we know it is a disease. So stigma's one barrier."
Q9 Existing assets	Tags responses to question 9: "What existing community health initiatives or programs in your community are helpful in addressing the health-related needs of the persons you serve, especially in relation to the health related needs you identified earlier?"	"I think it was originally called the True Blood Program. Getting mental health providers in law enforcement. That's huge. And hopefully will start to impact our legal and mental health systems in more favorable ways because as we all know, people often get incarcerated when they really have mental health issues that aren't addressed."
Q10 Opportunities to work together	Tags responses to question 10: "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?"	"The only thing that I can really think of off the top of my head is just the willingness to work together and not feel like one organization is trying to poach the patients from the other organization, but looking at it as a collective whole and we're all working towards a healthier community."
Racism/ discrimination	References to racism and discrimination. Includes references to feelings of anxiety or fear by people experiencing discrimination.	"I don't, I mean I'm not quite sure here which one would it would apply for, HIV/AIDS or racism/discrimination. But I know that it's been brought up. Just like a lack of support in general for and in people's like native language around the topic of HIV and aids."
Safe streets	References to safe sidewalks, roads, bike lanes, lights, and speed limits.	"If I'm in Kennewick getting to the trail system in Kennewick on a bicycle might lead to your death because the safe street program generally stops when you cross the interstate and then starts back up on the other side."
Specific organization or program	References to specific organizations, programs, community services.	"I mentioned WISe earlier as being a program that we access as often as we can,"
Stigma	References to stigma and shame.	"So I think stigma for mental health issues. People talk about it like it's everybody else, but that's not true. So really doing what we can to reduce the stigma about having mental health challenges would be really good."
Transportation	References to public transportation, buses, and other types of transportation.	"We find transportation can be a struggle because our transportation system here in the tri cities when it comes to public transportation is very limited. So it makes it very difficult sometimes for families to get to jobs or to even be able to go out and apply for positions or different training opportunities because of that lack of transportation piece."

Appendix 3: Stakeholder Survey Supporting Documents

Stakeholder Prioritization of Health-Related Needs Survey

Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important).			
	Aging problems (e.g. memory loss/hearing/vision loss)		Access to oral health providers
	Air quality, e.g. pollution, smoke		Access to safe, nearby transportation
	Obesity		Lack of community involvement
	Bullying/verbal abuse		Affordable daycare and preschools
	Domestic violence, child abuse/neglect		Job skills training
	Few arts and cultural events		Accessibility for people with disabilities
	Firearm-related injuries		Safe and accessible parks/recreation
	Gang activity/violence		Behavioral health challenges (includes both mental health and substance use disorder)
	HIV/AIDS		Poor schools
	Homelessness/lack of safe, affordable housing		Racism/discrimination
	Food insecurity		Unemployment/lack of living wage jobs
	Access to medical care		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Access to behavioral health care		Other: