KADLEC
REGIONAL
MEDICAL CENTER

I am pleased to share the Community Health Needs Assessment (CHNA) of Kadlec Regional Medical Center and the greater Tri-Cities community. Kadlec is an active partner in an organization called the Benton-Franklin Community Health Alliance. This group comes together to coordinate the health priorities of our region and produce a CHNA every three years. Members of the alliance include hospitals, medical providers, public health district, insurance providers, educational institutions and other organizations in our community committed to improving health.

The Kadlec Board of Directors formally adopted the 2016 CHNA on August 30, 2016. From this work, Kadlec will formulate its community health improvement plan for the next three years.

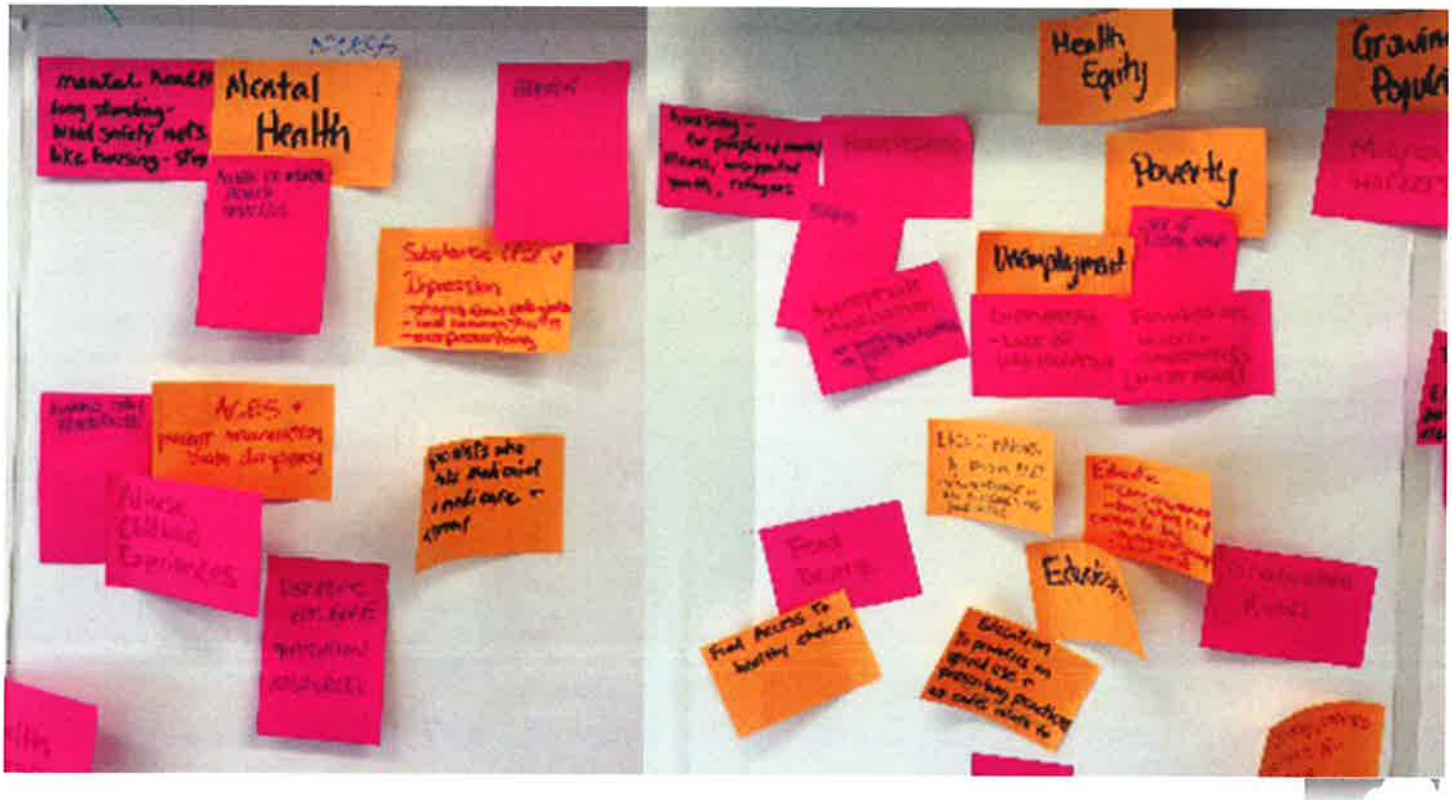
Thank you for your interest in our community's health. Our team of more than 3,500 caregivers is committed to providing this community safe and compassionate care.

Sincerely,

Lane Savitch
Chief Operating Officer
Eastern Washington/Montana Market
Southeast Washington Service Area

2016 Community Health Needs Assessment

Benton and Franklin Counties, Washington



Benton-Franklin Community HEALTH ALLIANCE

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

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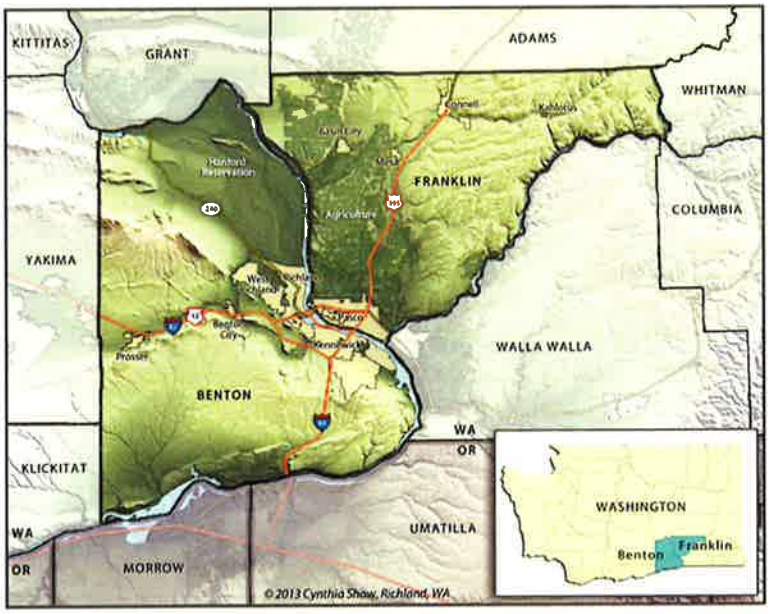
Invitation for Public Comment

Comments, ideas, or suggestions? Please click here.



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2016 CHNA Executive Summary

Purpose:

In 2015, the Benton-Franklin Community Health Alliance (BFCHA) undertook the community-driven process to update the 2012 Community Health Needs Assessment (CHNA). Community members confirmed that the 2016 CHNA should retain the 2012 CHNA two strategic issues of:

- Improve access to health care services
- Reducing obesity

The 2016 CHNA is different because it focused on **healthy equity** and **root causes** and added a third strategic issue **- *mental health***.

National Association of County and City Health Officials

Methods:

BFCHA used the evidence-based community health planning process from the National Association of County and City Health Officials (NACCHO) called Mobilizing for Action through Planning and Partnerships (MAPP).

Throughout the assessment process, BFCHA invited community members and organizations to meetings to discuss social determinants of health and to inform BFCHA members on how lack of health equity has impacted the effectiveness of the Community Health Improvement Plan (CHIP).

BFCHA studied the makeup of the populations within Benton and Franklin counties to understand social and economic barriers to health care access and healthy weight. For example, this predominantly rural area presents a geographic barrier to accessing resources. Lack of education and income also created health disparities.

Results:

In March 2016, community leaders identified health equity and poverty as important themes and significant barriers to achieving our health

CHNA 2016 Executive Summary, cont.

goals. Mental health remained a recurring theme. Mental health had been partially addressed in the 2012 CHNA and CHIP through tactics under the strategic issues of health care access and obesity. It became clear that mental illness was impacting many areas in the community beyond health care such as public safety and education. Many of the causal factors that impact mental health such as Adverse Childhood Experiences (ACEs), affordable housing, social stigma, homelessness, drug abuse are the same factors affecting health equity. When both data and community concerns were considered, it was clear that mental health needed to be a separate strategic issue.

Successes and Lessons Learned:

Since implementing the CHIP there have been many successes and early wins. Programs like the Community Gardens and "Good Health is Good Business" have blossomed. The hospitals have expanded facilities, services, and participated in community education. The lessons learned are that every strategy needs a champion in order to get things going and keep things moving. Strategies that were less successful served as a reminder that accountability needs to be more than simply assigning an agency to be responsible.

Current events and media proved to be important for creating a mindset of change in the community. During the 2012 CHNA cycle, the Tri-Cities made national news as the ninth most obese metropolitan statistical area in the nation. More recently, mental health issues have dominated the news and consciousness of the community.

Finally, the power of collective impact was demonstrated repeatedly in those projects that proved successful, and gives a framework to duplicate in the future. The updated CHIP will benefit from the experiences learned over the past eighteen months and will focus on upstream interventions and addressing health disparities to reduce obesity, improve access to health care and improve the mental/behavioral health system.

The CHNA Vision:

Benton and Franklin Counties are vibrant communities in which all individuals, regardless of their circumstances experience good health.

Introduction

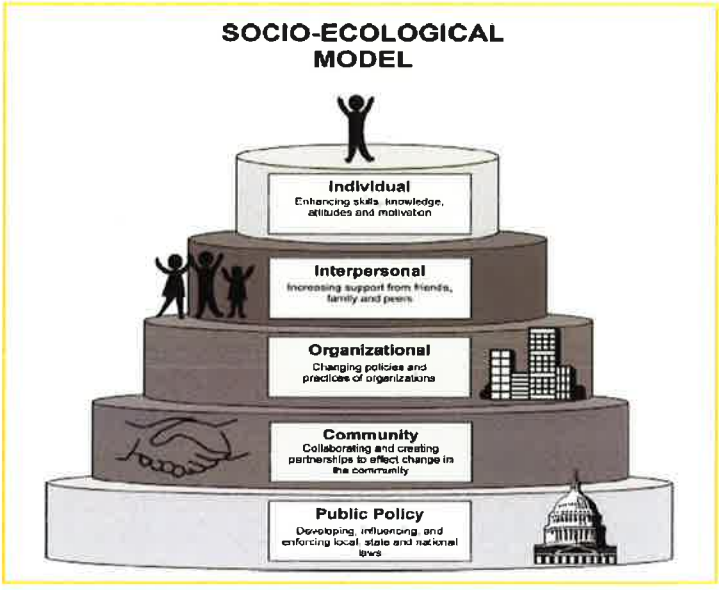
The 2016 CHNA kicked off with a retreat in May 2015, gathering old and new community partners together to renew the thoughtful and energetic process of identifying where we can make a difference in the health of our community. The three-year cycle was chosen to maintain alignment with hospital IRS requirements and to capitalize on current partnership momentum. Since it's only been 18 months since the work of the CHIP started, the Benton-Franklin Community Health Alliance (BFCHA) decided to maintain the prior strategic community health issues of improve health care access and reduce obesity, with emphasis on enhancing health equity and sustainability. By maintaining focus on health care access and obesity, the 2016 CHNA has been able to dig deeper into the reasons "why" we are seeing these issues in the community. This deeper understanding will improve our ability to make meaningful changes in the community's health.

Multiple effective, evidence-based health models were incorporated in the second CHNA for Benton & Franklin Counties. We used the National Association of County and City Health Officials Mobilizing for Action through Planning and Partnerships (MAPP) Model to maintain continuity with the first CHNA and because of its emphasis on partnerships and on action.

The socio-ecological model outlines the relationships between individuals, family, community and society and how those interactions affect health. We used this model to understand and assess issues pertaining to health equity (see below).

From partnership building and confirmation of the existing vision to conducting the four-pronged assessment process, there was a lot to accomplish in a short period of time. In addition, a separate ten-county regional assessment was occurring through the Greater Columbia Accountable Community of Health (GCACH) in parallel to the 2016 CHNA for Benton and Franklin Counties.

It is more effective to prevent health problems from occurring than to just treat disease. The analogy of moving upstream is often used to describe the difference between primary



Kendrick et al. Adapted from McLeroy et al.; Bronfenbrenner

Introduction, cont.

prevention, using safety barriers and education to keep people from falling in the river, and tertiary prevention, rescuing them after they have fallen in. Effective upstream prevention begins with a basic understanding of the social determinants of health. From geographic location and environmental factors to educational and vocational opportunities, we are shaped by these social determinants of health. The socio-ecological model illustrates how an individual can be influenced by surrounding attitudes, knowledge and beliefs throughout their life course. This assessment document outlines population demographics, the four MAPP assessments, and the social determinants of health and what goals need to be implemented to improve access to healthcare and reduce obesity.

Health Equity

Health means so much more than just the absence of illness and any discussion or assessment of health must consider the social, economic and physical environment. Increasingly, where we live influences how long we live. Significant differences in life expectancy can be found between neighborhoods just a few blocks apart and they often parallel differences in social and economic factors such as income and education.

Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people." The second Community Health Needs Assessment focused on the preventable barriers that keep people from reaching their highest level of health.

Those barriers are health disparities or health inequities; they are obstacles to attaining health that are the result of social, economic or environmental disadvantage. Health outcomes resulting from health inequities are preventable, but the changes needed to improve health outcomes must occur at the community or society level.

"Lack of adequate coverage makes it difficult for many people to get the healthcare they need and when they do get care, burdens them with large medical bills."

-community partner

"The essence of global health equity is the idea that something so precious as health might be viewed as a right."

-Paul Farmer

In order to create social and physical environments that promote health equity, it is necessary to understand the social determinants of health. "Social determinants of health are the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics" (World Health Organization). These can include early childhood development, globalization, health systems, measurement and evidence, urbanization, employment conditions, social exclusion, priority public health conditions, and gender equity.

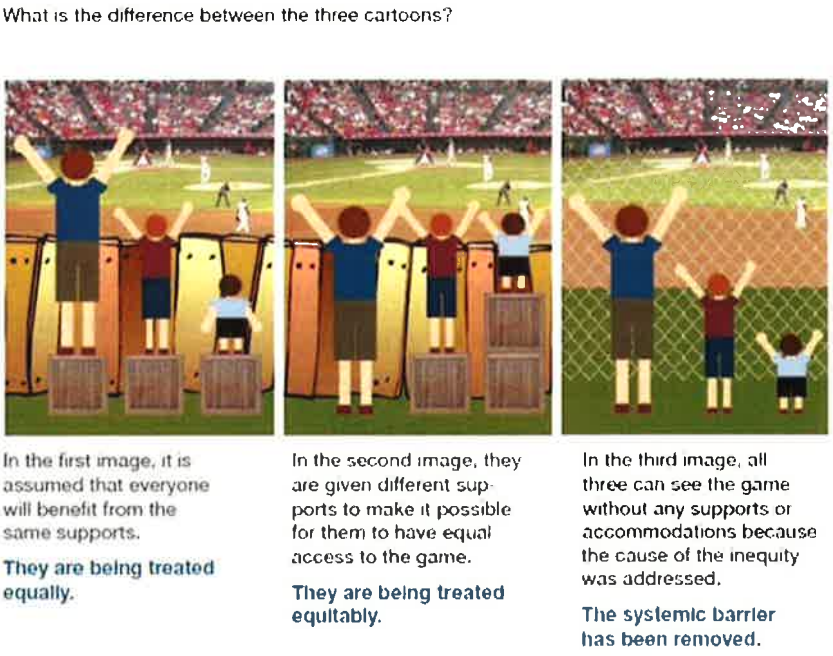
According to the Office of Disease Prevention and Health Promotion, disparities in access to health services affect individuals and society. Limited access to health care impacts people's ability to reach their full health potential,

Health Equity, cont.

negatively affecting their quality of life.

At the March 2016 meeting of the Benton-Franklin Community Health Alliance, a mini-compression and consensus session occurred. Vital information obtained previously was reviewed by small groups and key points were highlighted to summarize current community themes and strengths. New ideas were also generated and using the "all on the wall" technique, all ideas were placed in the front of the room and then arranged by similarity for further analysis. Health equity and poverty were major themes identified as they pertain to cultural/linguistic diversity, language barriers, health literacy, food deserts and perceived or actual lack of access to nutritious foods, and understanding how to navigate community systems.

Through education about the social determinants of health, the BFCHA learned more about root causes of different health outcomes. Church pastors and chaplains, local World Relief leaders, social services and housing agencies, educators, school-based site coordinators, action council leaders, community health workers, economists, hospital administrators, mental health counselors, attorneys, law enforcement representatives, other health professionals, and consumers were invited to inform BFCHA about the barriers to health and healthcare faced by their clients and communities.



Equity is treating everyone fairly by acknowledging their unique situation and addressing systemic barriers. The aim of equity is to ensure that everyone has access to equal results and benefits.

Source: The City of Ottawa and CAMI

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Our Community

Benton and Franklin Counties are geographically located along the central portion of the southern edge of Washington State. Combined, the two counties are home to about 274,000 individuals (2014 U.S. Census estimates), which accounts for 3.9% of the state's population. In this predominantly rural area, farms, ranches, rivers and open spaces are a few of the multitude of assets.

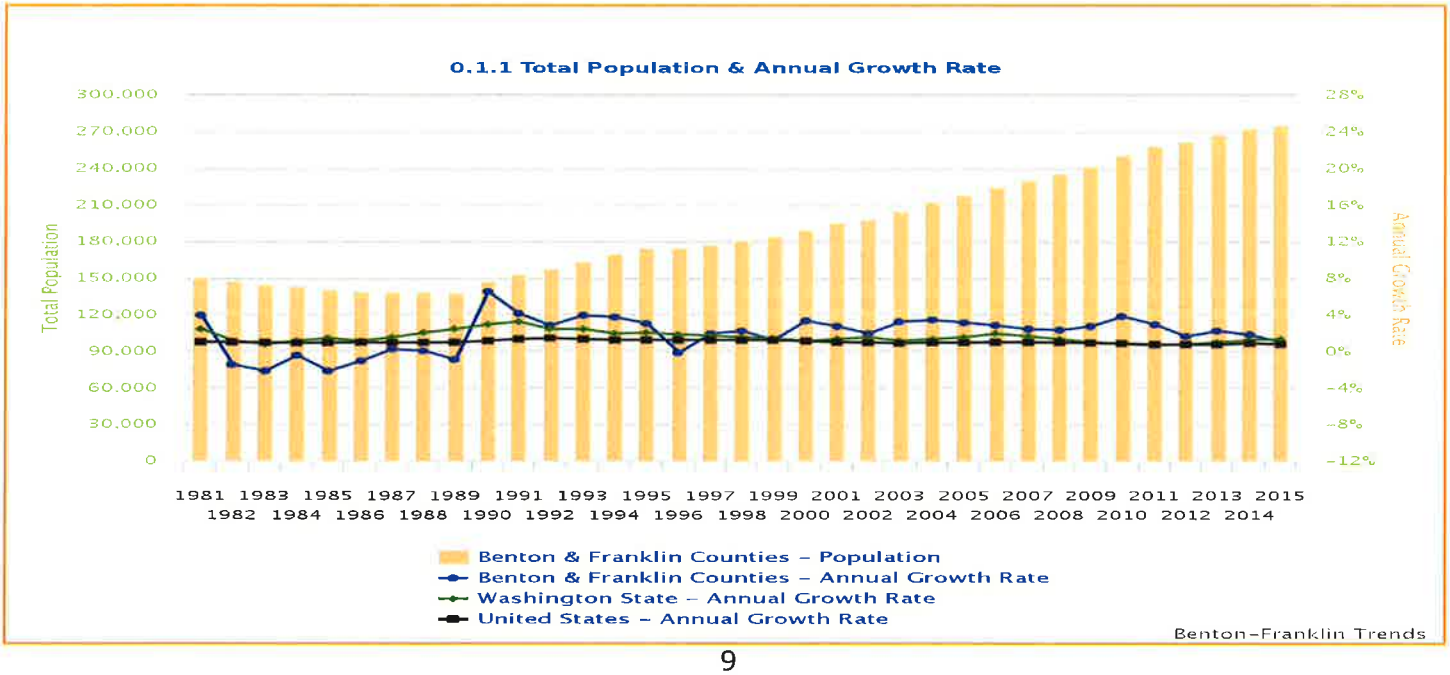
Home ownership, veteran status, country of origin and disability are general population characteristics which can help to identify social and economic barriers to healthcare access and health outcomes.

Health education and communication are a challenge when people are unable to understand the primary spoken language. Approximately 17.5% of the people in Benton County and 46.7% in Franklin County speak a language other than English. Of this population, 75% in Benton County and 93% in Franklin County speak Spanish. This diversity requires consideration when working to improve health equity.

As the community is increasing in language and cultural diversity, it is challenging to

POPULATION		
	Benton	Franklin
Population per square mile (2010 Census)	103	63
Housing: Share of House-holds who own their home	65.9%	67.5%
Veterans (2010-2014 Estimates)	14,136	3,610
Foreign born persons, per-cent, (2010-2014 Esti-mates)	10.2%	23.7%
Percent of population with a disability, under age 65 (2010-2014)	8.5%	6.2%

Source: U.S. Census Bureau, American Community Survey, Census Quick Facts 2014
*Benton-Franklin Trends Dashboard



Our Community, cont.

RACE & ETHNICITY			
		Benton	Franklin
Total Population		186,486	87,809
RACE	Caucasian/White	91.0%	90.9%
	African American/Black	1.6%	2.8%
	American Indian/Alaska Native	1.3%	1.4%
	Asian	3.0%	2.1%
	Native Hawaiian & Other Pacific Islander	0.2%	0.4%
	Two or more races	2.9%	2.4%
ETHNICITY	Hispanic/Latino (of any race)	20.4%	51.9%
Source: U.S. Census Bureau, American Community Survey, Census Quick Facts 2014			

provide information accessible in all languages, literacy levels, and for all disabilities. However, materials and information should be made available in the largely spoken languages within our community.

Nationally, higher educational attainment is associated with better employment and higher income. These factors are also associated with better health outcomes, while lower education often correlates with negative health outcomes. This correlation is due, in part, to higher literacy among those who have obtained a higher education and health literacy is critical to being able to navigate the system successfully. However, in this community, even among highly educated residents, health problems like obesity occur.

Locally, 14% of adults over the age of 25 have obtained less than a high school education. This population is at higher risk of poverty, unemployment, adverse health outcomes, and other negative conditions. In

EDUCATION		
	Benton	Franklin
Population 25 years and over	119,546	49,591
Less than 9th grade	4%	15%
9th through 12th grade, no diploma	5%	11%
High School graduate	24%	28%
Some college, no degree	26%	21%
Associate's degree	12%	9%
Bachelor's degree	18%	11%
Graduate or professional degree	11%	5%
Source: U.S. Census: American Community Survey Five-Year Estimates 2009-2013		

Our Community, cont.

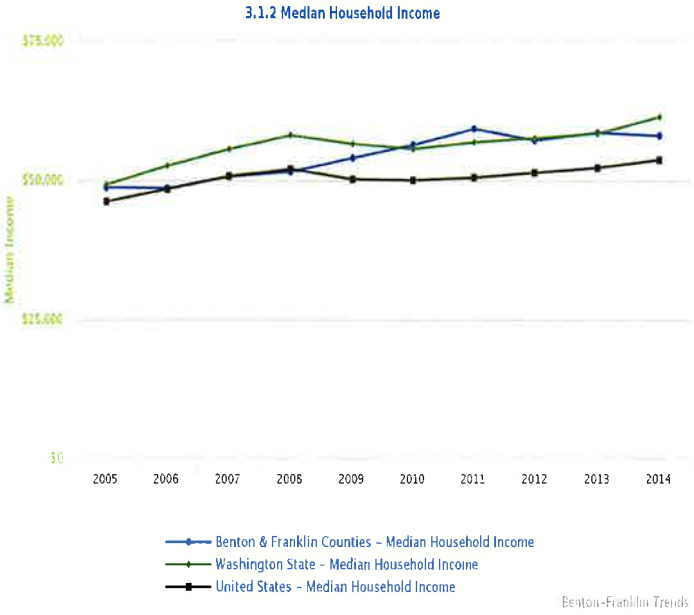
Benton County, 29% of adults over the age of 25 have achieved a baccalaureate degree or higher. In Franklin County, the percentage is significantly lower (16%), reflecting the larger agricultural and rural base of the community.

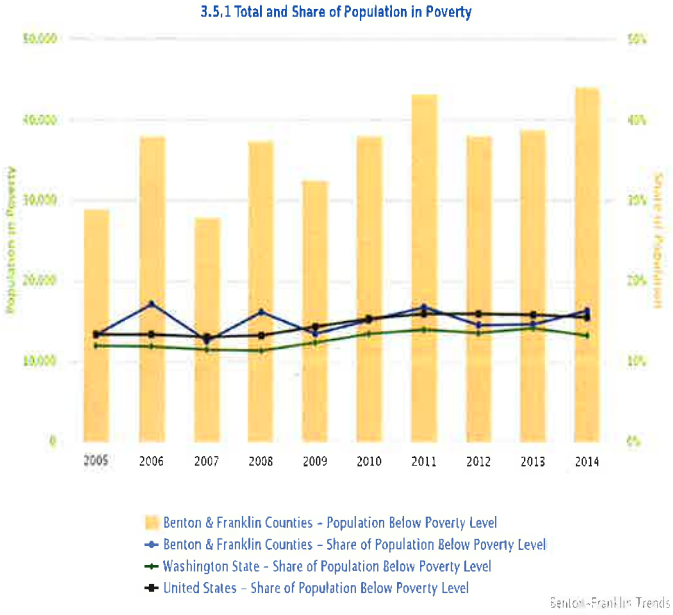
Over half of the population in both counties are employed. Between 2012 to 2014, the local unemployment rate dropped from 8.9% to 7.9%. Despite the decrease, the unemployment rate in Benton and Franklin Counties is higher than the rate in Washington, and the U.S (6.2%) and has been since 2012.

Local poverty increased by 2% between 2013 and 2014. The combined rate for Benton & Franklin Counties is 16.3%, United States is 15.5%, and Washington is 13.2%.

EMPLOYMENT	Benton	Franklin
Population 16 years and over	135,936	56,534
In labor force	64%	66%
Civilian labor force	64%	66%
Employed	60%	60%
Unemployed	5%	6%
Not in labor force	35%	34%
Population living in poverty	15.6%	17.8%

Source: U.S. Census: American Community Survey Five-Year Estimates 2009-2013





Local Public Health Systems Assessment

The Local Public Health System Assessment (LPHSA) focuses on all of the organizations and entities that contribute to the public's health. The LPHSA answers the questions: "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

There are many agencies that provide the community with portions of the 10 essential services of public health in Benton and Franklin Counties. Some of the gaps identified by the assessment include that Benton and Franklin Counties continue to be geographic areas with medical and dental provider shortages and to have a low number of mental health support agencies and programs, substance abuse prevention and intervention agencies, and services connecting people to all needed community resources.

Sector/Type of Agency Participating in the CHNA	Number of Agencies
Hospitals/Emergency Depts.	5
Healthcare Providers	21
Health Insurance Companies	6
Faith Based/Community-Based Organizations	35
Local/State Government	10
Emergency Services	7
Social Services (Housing, etc.)	13
Businesses	13
Education (K-12, Higher Ed)	19
Transportation System	2
Food Systems	6
Philanthropy	7

This list based on the list presented at 2016 CHNA Retreat in May 2015 and BFCHA participant records.

In addition to this community-wide identification of assets and resources, the Benton-Franklin Health District is undergoing the voluntary national public health accreditation process and is building more accountability, transparency, and quality improvement to better serve the community.

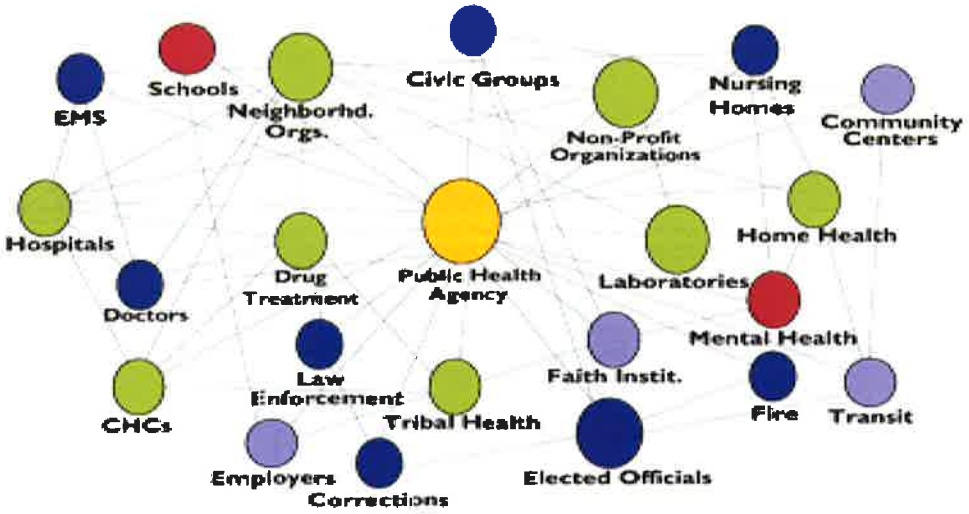


Figure: CDC's Public Health System Model

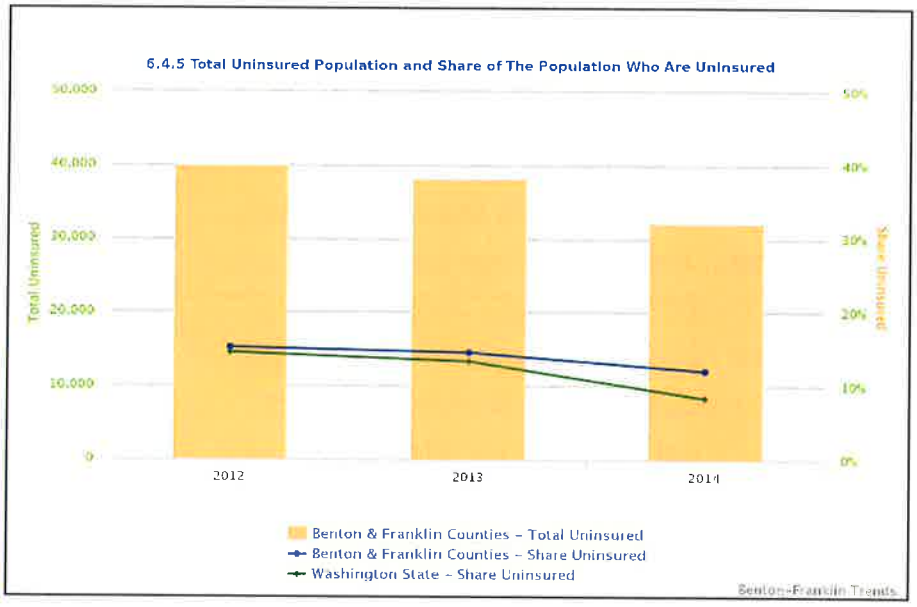
Community Health Status Assessment

In the 2012 CHNA, over 108 health indicators were proposed to the Health Alliance. Of those, 80 had data or outcomes that were currently measured. On thirty of those indicators, Benton and Franklin Counties identified as worse than Washington State or Healthy People 2020 benchmarks. Since the 2012 assessment, new and improved data sources have emerged, creating opportunities to obtain more timely, reliable information regarding the

Uninsured Population

Access to health insurance was identified as a priority in the 2012 CHNA as it aligned with federal healthcare reform and was seen as an opportunity to decrease costs. More than 2,400 people in Benton & Franklin Counties were enrolled through the Washington Health Benefit Exchange between 2012-2014. (See appendices for additional access-related measures).

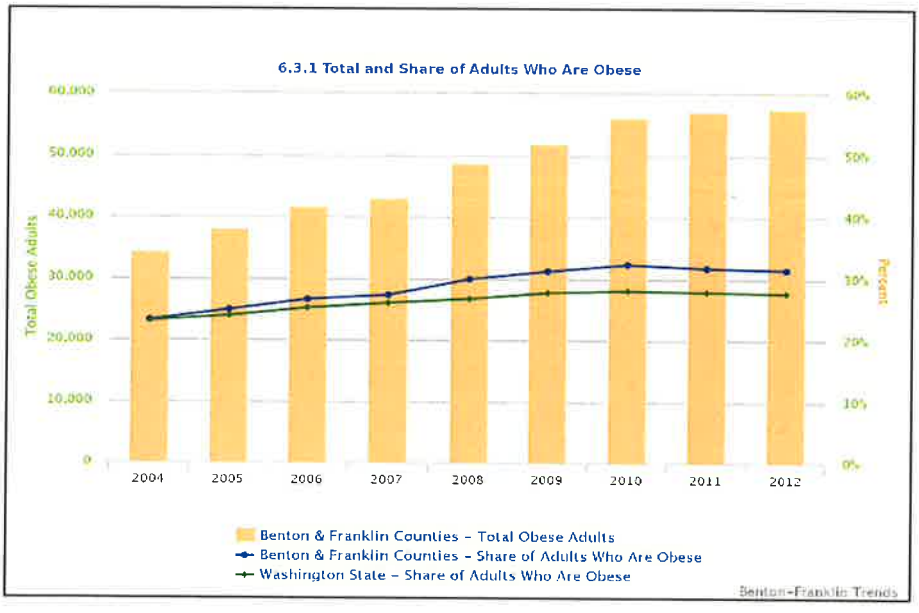
	2012	2014
Benton County	13.0%	11.6%
Franklin County	20.1%	12.7%
Washington State	14.5%	8.3%



Obesity

Obesity is defined as having a Body Mass Index (BMI) greater than or equal to 30 (BMI is calculated using height and weight). The following data are from the 2009 through 2012 Behavioral Risk Factor Surveillance Survey (BRFSS). (See appendices for additional obesity-related measures).

	2009-2010	2011-2012
Benton County	31.8%	30.0%
Franklin County	31.6%	34.9%
Washington State	27.8%	27.7%

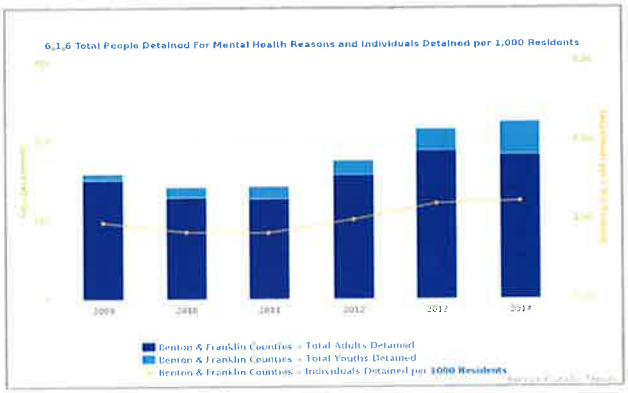


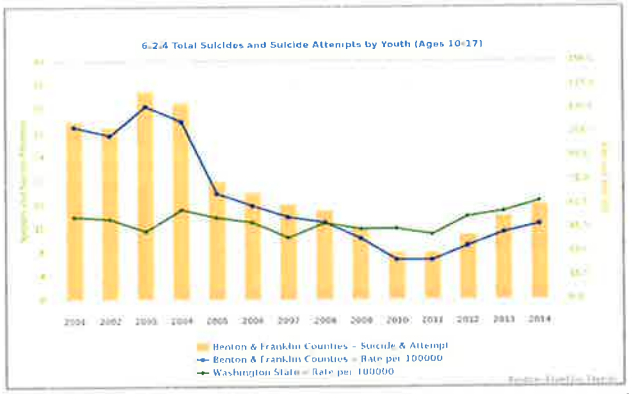
Community Health Status Assessment, cont.

health of our communities. In 2015, the Health Alliance formed a workgroup to address the community health status assessment. This process began with a presentation to The Alliance outlining ways in which the community demographics and socio-economic status have shifted over the three-year period since the last CHNA. Measures that most closely aligned with healthcare access and obesity were selected and agreed upon by BFCHA (see appendix for more details on these measures). In most cases, trends were not possible to detect due to changes in data methodology; however, the successful launch of the Benton-Franklin Trends Dashboard created a way to use and share data and trends wherever possible. The graphs to the right illustrate data trends pertaining to the overarching strategic issues.

In addition to the continued emphasis on improving healthcare access and reducing obesity, a scan of other health-related measures was done to identify any other potential critical issues that might have arisen since the last community health assessment. Due to the lag in data availability and the fast-paced changes occurring with data, healthcare access, and other measures, there is likely to be newer data by the time this CHNA is completed. These measures are to be interpreted as a snapshot, unless otherwise described. Some measures can be found in the appendices of this report and more information can be found at the Benton-Franklin Trends Dashboard.

Top causes of death in Benton and Franklin Counties reflect top causes in Washington and the United States. The top four causes of death are cancer, heart disease, Alzheimer's disease and stroke. The leading causes of hospitalizations are circulatory disease, digestive disease, respiratory disease, and injury or poisoning. The top three reasons for hospital readmissions are heart attack, heart





For more on the health status of the community go to pages 16-17 in the appendix or to the Benton Franklin Trends Website: http://www.bentonfranklintrends.ewu.edu/

Community Health Status Assessment, cont.

failure, and pneumonia. The most prevalent cancer types include breast, prostate, lung, colorectal and thyroid. The overall cancer rate is lower in Benton and Franklin Counties (435.9 per 100,000) compared to the rate statewide (555.4 per 100,000).

While defining access to healthcare is complex, certain measures have been established to identify when progress is made. For example, it is clear that the uninsured population decreased from 14.5% in 2013 to 12% in 2014 (Benton & Franklin Counties combined). The share of uninsured at the local level is higher than that of Washington State (8.3% uninsured). In Benton County, 11.6% were still uninsured in 2014, while in Franklin County, 12.7% remained uninsured. The share of uninsured population under the age of 18 has steadily declined since 2009, and as of 2014, is lower in Benton and Franklin Counties (4.5%) than the state (4.7%) and national (6%) percentages.

Obesity rates have stayed relatively the same for adults and youth since the 2012 assessment, (BF 31.4%) but remain higher than the state rate (27.6%). It is expected to take longer than three years to see measurable changes in obesity rates considering the complex and chronic nature of the problem.

From 2010-2012, a slight decrease in the rate of adults diagnosed with diabetes was measured. As of 2012, diagnosed diabetes remained higher in Benton and Franklin Counties (8.7%) compared to the state (8.2%) as it has been for the past nine years. In 2012, the local rate of diabetes dropped below the national rate (9%).

Adults visiting the dentist, hygienist or dental clinic in the past year decreased between 2008 (78%) through 2012 (66%), which mirrored the trend at the state and national levels.

The total number of people detained for mental health reasons and individuals detained per 1,000 residents has been tracked at the local level and is now publically available on the Benton-Franklin Trends dashboard website. Between 2011 and 2014, the rate of detainments has trended upwards from 0.83 per 1,000 in 2011 to 1.23 per 1,000 in 2014.

While youth suicides and suicide attempts have increased locally over the past three years, local rates remain lower than the rate statewide.

The BFCHA will continue to monitor health data and emerging information over time and use it to better inform CHIP objectives.

Forces of Change Assessment

Current political, economic, social, technological, environmental, ethical and scientific factors were examined with strengths, opportunities and threats identified by participants attending the 2016 CHNA kickoff retreat in May 2015. These factors were further analyzed and summarized by the core team.

Forces of Change play a critical role in the ability of a community to introduce and sustain change. When a community correctly identifies key factors influencing change, projects are more successful and sustainable.

Overall, findings were similar to that of the 2012 CHNA. However a few different forces emerged. For example, the scientific evidence behind Adverse Childhood Experiences (ACEs) and the oral-systemic link are gaining awareness and acceptance as mainstream knowledge. Data sharing and tracking may improve as hospitals move closer to an integrated electronic medical records management system. Regional and state efforts are becoming more aligned with population health and wellness (Washington Health Care Authority's Accountable Communities of Health (ACH); local Greater

Category	Forces of Change
Political	Healthier Washington Initiatives Medicaid Transformation waiver Public Safety sales tax passed in 2014
Economic	Shift toward population health to help decrease high costs of healthcare
Social	Perception that preserving individual liberties outweighs the greater good Increasing social consciousness about whole person health Public Safety sales tax funding Mental Health Court, Nurse-Family Partnership The number of people in poverty has grown by almost 2% since 2013
Technological	Benton-Franklin Trends Dashboard Hospitals moving to use of electronic medical records
Legal	Non-profit hospitals required to conduct CHNAs and CHIPs Washington Supreme Court justices banned "psychiatric boarding" Legal Financial Obligations (LFOs) used in Benton County being challenged
Environmental	Climate change (drought) impacts local economy Built environment creating sprawl •High density of fast food restaurants
Ethical	Large employers driving policies that impact health of community
Scientific	Science behind ACEs, oral-systemic link becoming more mainstream
Organizational	Hospitals changing organizational structures •Group Health purchased by Kaiser

Forces of Change Assessment, cont.

Columbia ACH or GCACH).

Current healthcare transformation in Washington State is a driving force of change in many aspects of the health system. The state is leading this change through legislation; "Healthier Washington" is transforming the purchasing, delivering, prioritizing and analyzing processes of delivering care at the state and local levels. Like icebergs in an ocean, the effects of unseen events, experiences or emerging infections and organisms on health will require providers to expand their knowledge about factors that often seem unrelated to symptoms.

Key Forces of Change that have impacted the healthcare delivery system through local hospital systems organizational changes. Kadlec Regional Medical Center is now affiliated with Providence Health & Services. Kennewick General changed its name to Trios Health and has expanded needed specialties and outpatient services.

A technological success in alignment with MAPP occurred in 2014 with Eastern Washington University's launch of the Benton-Franklin Trends, a community dashboard with online data resources highlighting key informational measures for Benton and Franklin Counties. Public access to this website increases our capacity to inform the community with scientifically sound information about trends across multiple sectors and key factors pertaining to population, agriculture, culture, economic vitality, education, environmental sustainability, health, housing, public safety and transportation.

Research findings about Adverse Childhood Experiences (ACEs) and the oral-systemic link have provided health professionals with additional information about possible causal links between the mind and the body, especially chronic disease development.

The community health impact of the three-tenths percent tax on retail sales in Benton County passed in 2014 has yet to be seen since the funding has only recently become available. Beyond additional resources to the jails and local police forces, funds were designated for a mental health court and expansion of the evidence-based Nurse-Family Partnership Program at the Benton-Franklin Health District. These prevention efforts will be monitored and evaluated for their effect on crime rates and health in the community.

Community Themes & Strengths Assessment

The 2016 CHNA was driven by a conscious decision to increase community engagement and strengthen partnerships and to focus on health equity and sustainability. Rather than re-create a community survey which formed the basis of our Themes and Strengths Assessment in 2012, we enhanced the year-long process through reviewing and understanding existing surveys conducted by other community agencies and organizations, and also by inviting community members to share key information about the diverse populations they serve.

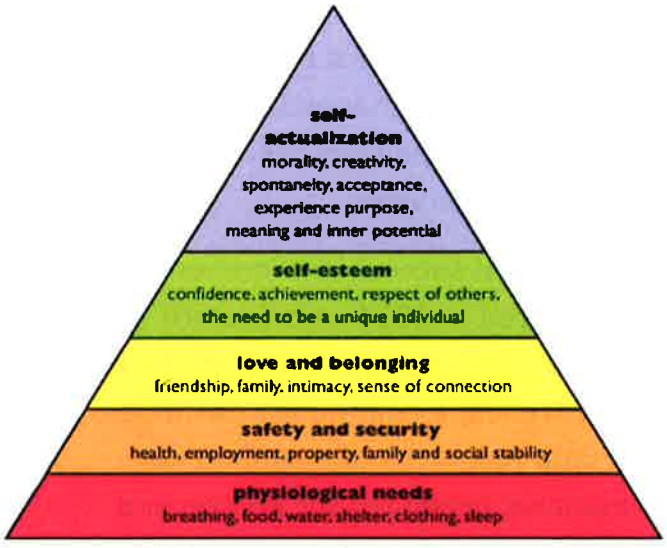
> *"Barriers come down to very basic needs that we need to address before we impact health outcomes."*
> *-concerned citizen*

The benefits of this approach were multifold; we gained new community partners to the BFCHA, we heard compelling stories about the unmet needs of residents, and we were able understand how the socioeconomic factors were impacting our ability to improve population health.

Qualitative data was obtained by conducting key informant interviews and listening sessions at various community meetings, and asking participants, many of whom serve vulnerable, at-risk populations within our community, to share from the perspective of their clients. A multitude of individuals representing various social service agencies were invited, beyond the usual BFCHA partners, and rich discussions and sharing resulted in the Summary.

The themes heard time and again were that basic needs have to be met before individuals are able to respond to new information or change their behavior.

Messaging about better nutrition, health literacy, or appropriate use of the hospitals' emergency rooms does not reach a person's cognitive level if they are homeless, hungry, or socially isolated as demonstrated by Maslow's Hierarchy of Needs pyramid. For those leading population health improvement efforts, this realization means a more targeted approach



Source: Maslow's Hierarchy of Needs

Community Themes & Strengths Assessment, cont.

within our CHIP.

The theme of mental illness also surfaced repeatedly throughout the process. The scope of the issue however, expanded beyond access and obesity as characterized in the 2012 CHNA. The scope of behavioral health includes housing, stigma, substance abuse, social and peer supports, more resources and programs, services, youth suicide, referrals, unemployment, transportation, depression, integration with physical care, lack of needed facilities, and care coordination.

An insight about our current strategic issue of reducing obesity was that the community has to believe that health should be a shared value. If the community has a mindset that obesity is not a healthy condition, then they are more likely to envision health and well-being as a shared responsibility. An effort to better understand how to change the cultural environment around obesity may be necessary before moving the needle on this issue.

Improving access to health care services remains a strategic issue for our community, but "affordability" took on new meaning since the implementation of the Affordable Care Act. Despite its availability, there are still thousands of people without insurance or whose insurance is not adequate to meet their medical needs, due in part to the high deductibles in the subsidized plans.

The Washington State Supreme Court's Civil Legal Needs Study Update, June 2015 found that low-income respondents surveyed in 2014 reported the greatest percentage of problems in the areas of health care, consumer-finance and employment.

The good news is that our community has come a long way since the 2012 assessment. We have built more partnerships, and expanded the depth of the BFCHA membership to better represent populations experiencing health disparities. Community partners are starting to understand and coalesce around our strategic issues.

We have access to parks, open spaces, and trails. We have a community volunteer system connecting students to valuable real-world experiences. Our schools are connecting with parents and families to offer more education on nutrition, drug awareness and substance abuse prevention, and there are dozens of programs focusing on youth development.

Collective impact is taking root, and a better understanding of the causal factors underlying our strategic issues will enable the community to improve its approach and effectiveness.

Partners and Collective Impact

The saying "many hands make light work" reflects the dedication of our team of professionals and community members as they worked to reassess community health needs and as they continue to implement tactics to improve health. Community health needs assessments are built into the Benton-Franklin Community Health Alliance bylaws, reflecting the value of the work. It is integral to implement community mobilization and prevent unnecessary duplication of effort. Agencies and organizations listed in the appendix represent different sectors in our community and, in many cases, they are represented by multiple individuals. Collectively, the group is constantly assessing whether new partners need to be invited to the table.

The Work Together model below illustrates the importance of working as a team through the duration of next steps as we take action to revise and implement the CHIP over the next three to five years. This model, created by the Robert Wood Johnson Foundation, was developed to give communities a tool to mobilize community health improvement.

It includes references to scientific evidence for different interventions, indicators likely to reduce disparities, and how to create sustainability.

While we will continue to grow our partnerships, we will also work to maintain existing ones. With more partners on board, we are able to extend our reach and impact on health outcomes in our community and ultimately to improve opportunities for everyone to have a better quality of life.

See Appendix 1 on page 22 for a full list of agencies who actively participated in the 2015 -2016 CHNA process.

RWJF County Health Rankings & Roadmaps Action Center: Work Together Model: http://www.countyhealthrankings.org/roadmaps/action-center

Summary and Call to Action

It is evident that there is still work to be done to equitably and sustainably improve access to healthcare and to reduce obesity in our community. During this assessment process, mental health has risen to the top in the MAPP Assessments as a third priority strategic issue and will be addressed through the work of the Benton-Franklin Community Health Alliance's Mental Health Committee and other local subject matter experts in mental and behavioral health.

Health disparities exist in our community and need to be reviewed more closely as part of the CHIP. Although data limitations are a barrier in identifying all inequities in the community, there is enough information to help identify those populations at greatest risk or in greatest need.

CHIP revisions will include evidence-based interventions and promising practices to improve health equity and promote sustainability for lasting community health improvement on these three strategic issues. Buy-in and accountability of partnering agencies must also be clear to maintain capacity to implement the activities, tactics and interventions necessary to meet the goals and SMART (Specific, Measurable, Attainable, Realistic and Time-Bound) objectives established by the BFCHA.

The process does not end even when the revision is complete. Progress on CHIP implementation efforts will be monitored and tracked, measures will be reviewed at least annually for possible revisions and a process evaluation will occur to further improve the next CHNA cycle.

Community engagement will reshape our CHIP by giving us a better understanding of the socioeconomic factors that affect health, we will be better able to move the needle toward improved population health.

The findings of the 2016 CHNA identified during our 18 months of community engagement and inquiry will undoubtedly change the goals and tactics of our current CHIP. Understanding that we need to address the socioeconomic factors and cultural barriers that affect health will challenge us to shift our focus and efforts in new directions. Attempts to reduce obesity rates and improve health access and behavioral health are likely to fall short unless we to go upstream to address the underlying conditions and causal factors.

Strategic Issues:

- ⇒ Reduce obesity/promote healthy weight
- ⇒ Improve access to health care services
- ⇒ Improve the mental/Behavioral health system-*NEW*

Appendix 1: Partnering Agencies

The following agencies and organizations have one or more staff who have engaged in and supported the success of this process.

Aging and Long-Term Care Group Health Cooperative

Alliance for a Livable and Sustainable Community

American Diabetes Association

Amerigroup Insurance

Benton-Franklin Community Health Alliance + Sub committees:

- Alliance Consistent Care Program
- Healthy Lifestyles Committee
- Health Access Team
- Mental Health Committee
- Oral Health Coalition

Benton-Franklin County Medical Society

Benton-Franklin Domestic Violence Services

Benton-Franklin Health District

Bike Tri-Cities (Formerly 3 Rivers Bicycle Coalition)

Catholic Family & Child Services

The Chaplaincy

Children's Reading Foundation of the Mid-Columbia

Columbia Basin College

Community Action Connections

Community Health Program of Washington (CHPW)

Community Members/Concerned Citizens

Consistent Care Program of Southeast Washington

Department of Social and Health Services (DSHS)

Educational Service District 123

Emmaus Counseling CenterGrace Clinic

Kadlec Regional Medical Center

League of Women Voters

Lourdes Counseling Center

Lourdes Health Network

Mental Health Ombuds, Inc.

National Alliance for the Mentally Ill (NAMI)

Pacific Northwest National Laboratory

Pasco Discovery Coalition

Pasco Ephesus Seventh-day Adventist Church

Pasco Latino Lutheran Ministry

Pasco Police Department

Physicians

Planned Parenthood

PMH Medical Center

Promotor a de Salud

Prosser Community Involvement Action Coalition

Southgate Elementary School

Tri-Cities Cancer Center

Tri-Cities Community Health

Tri-Cities Diabetes Coalition

Tri-City Regional Chamber of Commerce

Trios Health (formerly Kennewick General Hospital)

Washington State Employment Security Department

Washington State University Tri-Cities

Washington State University Extension Master Gardeners

World Relief

Appendix 2: Information Resources

National Association of County and City Health Officials (NACCHO)

- Mobilizing for Action Through Planning and Partnerships Model (MAPP)

Local Public Health System Assessment

- National Public Health Performance Standards (NPHPS)
- Local agency resource guides

Community Health Status Assessment

- Behavioral Risk Factor Surveillance System (BRFSS) Survey Data
- Healthy Youth Survey Data
- Washington State Department of Health Center for Health Statistics
- Benton-Franklin Trends Dashboard
- Robert Wood Johnson Foundation (RWJF) County Health Rankings & Roadmaps

Community Themes & Strengths Assessment

- CHNA focused discussions at bi-monthly meetings May 2015 through May 2016
- Key informants who serve vulnerable populations
- Special Presentations (alphabetical order by presenter's last name):

  Jeff Clark, VP Support Services, Kadlec Regional Medical Center Service, "Area Trends," September 16, 2015

  Jefferson Coulter, Sr. Attorney, NW Justice Project, "Civil Legal Needs Study Update," September 16, 2015

  Jennifer Dorsett, Community Prevention Wellness Initiative Coordinator," Prosser Community Involvement and Action Coalition," July 22, 2015

  Kelly Larsen, Community Coordinator, Pasco Discovery Coalition, "2014 Community Survey," July 22, 2015

  Carol Moser, Executive Director, Benton-Franklin Community Health Alliance, "Community Action Connections Survey Results," September 16, 2015

Information Resources, cont.

John Roach, Vice President, Information, Communication, & Technology, TiLite, "Servant-Leadership," May 11, 2015

Ajsa Sulic, Regional Labor Economist at Employment Security Department (ESD), Washington State "Update on Regional Demographics," September 16, 2015

Forces of Change Assessment

- Local, State and National Media
- Community Partners

Population Demographic Data & Information Sources

- U.S. Census Bureau
- Washington Office of Financial Management

Appendix 3: Terms and Definitions

Behavioral Health: an interdisciplinary field dedication to promoting a philosophy of health that stresses individual responsibility in the application of behavioral and biomedical science knowledge and techniques to the maintenance of health and prevention of illness and dysfunction by a variety of self-initiated individual and shared activities. See Mental Health.

Body Mass Index (BMI): A number calculated from a person's weight and height. BMI is a fairly reliable indicator of body fat for most people. Formula: weight (kg) / [height (m)]^2 or Formula: weight (lb.) / [height (in)]^2 x 703

CHNA: Community Health Needs Assessment is a systematic examination of the health status within a given population, through data and community perception, which helps to identify key problems and assets in a community

CHIP: Community Health Improvement Plan, community wide plan to improve population health status

Community Health Status Assessment: Identifies health status through review of available data

Community Themes & Strengths Assessment: Identifies community perceptions and opinions about health needs

Determinants of health: Social, genetic, environmental, socioeconomic and other factors that can contribute to health status or outcomes

Forces of Change Assessment: Identifies current community factors (political, economic, social, etc.) that could pose strengths, weaknesses, opportunities, or threats to the ability to implement change

Goals: under each strategic issue, a general target to work towards

Health: a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity (World Health Organization)

Health equity: attainment of the highest level of health for all people (Source: Healthy People 2020)

Local Public Health System Assessment: Identifies local capacity of what agencies support any or all of the 10 essential public health services through provision of preventive health services to the community

MAPP: Mobilizing for Action Through Planning and Partnerships (Source: National Association of County and City Health Officials)

Terms and Definitions, cont.

Mental health: emotional, behavioral, and social maturity or normality; the absence of a mental or behavioral disorder, a state of psychological wellbeing in which one has achieved a satisfactory integration of one's instinctual drives acceptable to both oneself and one's social milieu; an approprfiate balance of love, work, and leisure pursuits. See Behavioral Health.

Needs Assessment (CHNA): every three years and adopt an implementation strategy to meet the identified needs

Obesity: Having a BMI of 30 or greater

Patient Protection and Affordable Care Act: signed into law imposing new requirements that charitable hospitals must meet to continue to qualify for exemption under Section 501(c)(3) of the Internal Revenue Code. Included were requirements that charitable hospitals conduct a Community Health

Root causes: a factor that caused a nonconformance and should be permanently eliminated through process improvement. Root cause analysis is a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems.

Social determinants of health: the circumstances in which people are born, grow up, live, work and age and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics (World Health Organization)

SMART Objectives: measurable components created under each goal that are Specific, Measurable, Achievable, Realistic and Time-bound (will be included in the CHIP)

Strategic Issues: overarching health related concepts identified as priority areas for improvement

Tactics: an activity or action that supports and works towards achieving the SMART objectives of the CHIP

Community Health Status: Access to Healthcare

Health Indicator Measures	Data Sources	Benton & Franklin Counties	Washington State
Share of hospitalizations by four leading causes	Benton-Franklin Trends Dashboard, DOH & hospital statistics (2013)	Circulatory Diseases: 11.4% Digestive Diseases: 8% Respiratory Diseases: 6.5% Injury or Poisoning: 6.8%	Circulatory Diseases: 9.1%Digestive Diseases: 10.1% Respiratory Diseases 7.7% Injury or Poisoning: 20.9%
Children under 18 without health insurance	Benton-Franklin Trends Dashboard, DOH statistics (2014)	4.5%	4.7%
Adults aged 18-64 without health insurance	Benton-Franklin Trends Dashboard, DOH statistics (2014)	18.3%	12.8%
Adults aged 64 plus without health insurance	Benton-Franklin Trends Dashboard, DOH statistics (2014)	1.1%	0.7%
Adults with dental checkup within past year	Benton-Franklin Trends Dashboard, DOH statistics (2012)	66%	67%
Percent of 3rd grade students who have had a cavity	DOH Smile Survey (every five years) (2010, 2015 data expected soon)	62.1%	58.0%
Child immunizations	DOH Statistics (2012)-as reported to the Washington State Immunization Information System	63% (CI: 62,64)	53% (CI: 53,54)
Adult preventive cancer screening–colorectal	CDC Behavioral Risk Factor Surveillance Survey (BRFSS) (2012)	61% (CI: 53,68)	67% (CI: 65,68)
Percent of women giving birth who received Prenatal Care in the first trimester of pregnancy	Benton-Franklin Trends Dashboard, DOH statistics (2014)	73.4%	75.1%
Teen birth rate: The number of births to women aged 15-19 per 1,000	Benton-Franklin Trends Dashboard, DOH statistics (2014)	34.9 per 1,000	18.9 per 1,000
Chlamydia rate (newly diagnosed, reportable STD)	County Health Rankings (2012), DOH statistics (cases per 100,000)	Benton: 337 per 100,000 Franklin: 375 per 100,000	357 per 100,000 (U.S. 138 per 100,000)
Adult nonfatal unintentional poisoning	DOH statistics (2013), Hospital data (rate per 100,000)	Benton: 40.3 per 100,000 Franklin: 29.5 per 100,000	41.2
Adult nonfatal intentional (self-inflicted) poisoning hospitalizations	DOH statistics (2013), Hospital data (rate per 100,000)	Benton: 38.7 per 100,000 Franklin: 16.5 per 100,000	43.6
Adult fatal intentional (self-inflicted) poisoning	DOH statistics (2013), Hospital data (rate per 100,000)	Benton: 9.8 per 100,000 Franklin: 5.9 per 100,000	11.9
Youth in the 10th grade who report use of prescription drugs to get high in the past 30 days	2014 Healthy Youth Survey (HYS) (Students surveyed in the fall of every even year)	5.8%	8th: 2.3% 10th: 4.6% 12th: 5.6%
Percent of adults age 18 or older who report 14 or more days of poor mental health in the past month	CDC Behavioral Risk Factor Surveillance Survey (BRFSS)	Benton: 3.1 Franklin: 2.6	3.3
Total people detained for mental health reasons and individuals detained per 1,000 residents	Benton-Franklin Trends Dashboard (local data source) (2014)	1.23 per 1,000 residents (273 adults, 63 youths)	NA
Youth Depression: The percent of youth in the 8th, 10th and 12th grade 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.	2014 Healthy Youth Survey (HYS) (Students surveyed in the fall of every even year)	34.8%	8th: 27.3% 10th: 35.0% 12th: 34.0%
Total Suicides and Suicide Attempts by Youth (ages 10-17)	Benton-Franklin Trends Dashboard, DOH statistics (2013)	42 per 100,000 (14 total youth suicides in BF counties)	55.3 per 100,000

CI=Confidence Interval

Community Health Status: Reduce Obesity/Promote Healthy Weight

Health Indicator Measures	Data Sources	Benton & Franklin Counties combined	Washington State
Adults Obesity Prevalence	Benton-Franklin Trends Dashboard (2012), CDC Behavioral Risk Factor Surveillance Survey (BRFSS)	31.4%	27.6%
Adult Diabetes Prevalence	Benton-Franklin Trends Dashboard (2012), CDC Behavioral Risk Factor Surveillance Survey (BRFSS)	8.7%	8.2%
Commercially Insured Adult Diabetes Blood Sugar screening (HbA1C)The percentage of patients ages 18 to 75 diagnosed with diabetes (type 1 and type 2) whose blood sugar was tested using an HbA1c test by a doctor or other health care provider at least once in the one-year measurement period.	Washington Health Alliance/Health Care Authority (CORE Providence) Community Checkup (Commercial)	Benton: 84% (n=1,928) Franklin: 90% (n=192) (both average compared to WA)	87% (n=65,511)
Medicaid Insured Adult Diabetes Blood Sugar screening (HbA1C)The percentage of patients ages 18 to 75 diagnosed with diabetes (type 1 and type 2) whose blood sugar was tested using an HbA1c test by a doctor or other health care provider at least once in the one-year measurement period.	Washington Health Alliance/Health Care Authority (CORE Providence) Community Checkup (Medicaid)	Benton: 59% (n=235) Franklin: 59% (n=78) (both average compared to WA)	53% (n=9,416)
Obesity among youths in the10th grade	2014 Healthy Youth Survey (HYS) (Students surveyed in the fall of every even year)	12.9%	11.3%
Youth Diabetes: The percent of youth who report they have been told by a doctor or other health professional that they have diabetes (new in 2014)	2014 Healthy Youth Survey (HYS) (Students surveyed in the fall of every even year)	3.6%	3.2%
Consumption of the CDC recommended 5+ fruits and vegetables daily—percent of 10th grade students	2014 Healthy Youth Survey (HYS) computed question (Students surveyed in the fall of every even year)	20.3%	21.3%
Adult Fruit/Vegetable consumption	CDC Behavioral Risk Factor Surveillance Survey (BRFSS) (2009)	22% (19,26)	25% (24,26)
Breastfeeding Duration >= 6 months	WIC data (BFHD and TCCH), DOH WIC report (2014)	Benton: 39.5% Franklin: 40.9%	49.0%
Adult Physical Activity (BRFSS) Percent of adults age 18 or older who report moderate physical activity (30 minutes a day 5 times a week) or vigorous activity (20 minutes a day 3 times a week) in work or leisure	RWJF County Health Rankings (2011), CDC Behavioral Risk Factor Surveillance Survey (BRFSS)	82%	82%
Youth Physical Activity (Percent of 10th graders who report physical activity 60 minutes a day, 5 or more days a week (LPHI-HYS))	Washington Healthy Youth Survey (HYS) and DOH Local Public Health Indicators (LPHI) (Students surveyed in the fall of every even year)	58.1%	52.1%
Access to exercise opportunities (new measure)	RWJF County Health Rankings (CHR)	Benton: 83% Franklin: 59%	89%
Food Environment Index (0-worst, 10-best): Index of factors that contribute to a healthy food environment (new measure)	RWJF County Health Rankings (CHR)	Benton: 7.8 Franklin: 6.9	7.5
Percent of Population with food insecurity	County Health Rankings (CHR)	Benton: 13% Franklin: 14%	15%
Percent of youth aged 0-17 receiving Temporary Assistance to Needy Families (TANF) benefits	Benton-Franklin Trends Dashboard (2013) Washington State Department of Social and Health Services: Risk and Protection Profiles for Substance Abuse Prevention Planning	Benton: 8.9% Franklin: 9.4%	8.2%