Blue Mountain Hospital District

2022 COMMUNITY HEALTH NEEDS ASSESSMENT

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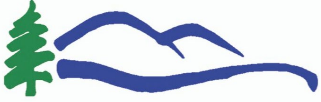


INTRODUCTION AND OVERVIEW

LETTER FROM THE CEO

Dear Grant County Resident:

On behalf of all involved in creating this 2022 Community Health Needs Assessment (CHNA), I invite you to review this document as we collaboratively strive to meet the health and medical needs in our county.

The 2022 CHNA process identifies local health and medical needs, and the subsequent implementation plan communicates how Blue Mountain Hospital District (BMHD) plans to respond to the prioritized needs. This 2022 CHNA also reports the efforts regarding the four focus areas identified in the 2019 CHNA.

As you review this 2022 CHNA document, please consider how, together, we can further improve the health and medical services our area needs. BMHD does not have adequate resources to solve all the problems identified. Some issues are beyond the mission of BMHD, and action is best suited for a response by others. Some improvements will require personal actions by individuals rather than the response of an organization. We view this as a process for how we, along with other organizations and agencies, can collaborate to bring the best each has to offer to address the more pressing, identified needs.

We invite you to review the CHNA documents, provide feedback and join us in creating a healthier county. We all live and work in this county together, and our collective efforts can make living here a more enjoyable and healthier experience.

Derek Daly, CEO

ABOUT BLUE MOUNTAIN HOSPITAL DISTRICT

Blue Mountain Hospital District (BMHD) is located in John Day, Oregon. The hospital was originally located in Prairie City and rebuilt in John Day in 1960. A new seven-million-dollar replacement facility began in 2001 opened to the public in August of 2003.

The facility is a 25-bed critical access hospital and includes a Family Practice Rural Health Clinic, a General Surgery Clinic, and a Pain Management Clinic. In addition, BMHD operates Blue Mountain Care Center, a 40-bed intermediate care facility in Prairie City, a Home Health and Hospice agency and ambulance services.

MISSION, VISION, AND VALUES

OUR MISSION/PURPOSE (WHY WE'RE HERE.)

To provide quality healthcare close to home

OUR VISION (WHERE WE'RE GOING.)

Blue Mountain Hospital District will be the primary choice for compassionate, caring, quality healthcare

WE VALUE (HOW WE ACT.)

Integrity, trust, honesty, kindness, consideration, concern for the community, dignified, comfortable and competent patient care, patient safety and customer satisfaction

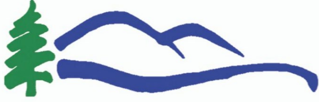
APPROVAL

BMHD Board of Directors approved and adopted the 2022 CHNA on June 22, 2022.

AVAILABILITY TO THE PUBLIC

This report will be made available to the public on the BMHD website, www.bluemountainhospital.org. Paper copies may be obtained at no charge from either Administration or the Public Relations department by calling 541-575-1311 or contacting the hospital at the following address.

Blue Mountain Hospital District, 170 Ford Road, John Day, Oregon 97845



ACKNOWLEDGMENTS AND STEERING COMMITTEE

STEERING COMMITTEE

The CHNA steering committee established the methodology for conducting the CHNA and provided guidance and direction through the process.

The steering committee members include:

- Derek Daly, Chief Executive Officer
- Paul McGinnis, CHNA Facilitator
- Eric Price, CFO
- Kelly McNitt, DNS
- Amy Kreger, Board Chair
- Lori Lane, Compliance Officer
- Shawna Clark, Board Member
- Vardan Rigby, HR Director
- Joan Sonnenburg, Director of Outpatient & Provider Services
- Jena Knowles, Foundation and Public Relations Director

COMMUNITY STAKEHOLDERS

The following Community Stakeholders participated in either Focus Groups or at the Priority Setting meeting. BMHD is grateful for their thoughtful and important contributions to this Community Health Needs Assessment document.

- Rebekah Rand, BMHD
- Linda Watson, GOBHI
- Tracey Blood, Community Health Improvement Coalition
- Lisa Weigum, Community Counseling Solutions
- Mark Mahoney, Care Center Administrator
- Michelle Gibson, BMHD
- Jessica Winegar, Grant County Health Department
- Thad Labhart, Community Counseling Solutions
- Tilli Slusarenko, Lens Pharmacy
- Jenna Hendriksen, BMHD
- Robyn Jennings, BMHD
- Angie Uptmor, Senior Services

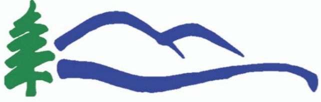
OVERVIEW OF PROCESS

The Affordable Care Act requires nonprofit hospitals to complete a community health needs assessment (CHNA) process every three years. While CHNAs are a recent requirement, community health assessments (CHAs) have long been used as a tool by hospitals, public health departments, and other social service agencies to identify key community health concerns. A CHNA is a systematic process involving the community to identify and analyze community health needs and assets, prioritize those needs, and then implement a plan to address significant unmet needs.[1] Upon completing the assessment, BMHD will develop implementation strategies to address the significant community health needs identified in the CHNA.

Community Health Needs Assessment Process Graph:

SOURCE: http://www.healthycommunities.org/Resources/toolkit.shtml

Catholic Health Association of the United States. (2015). Assessing and addressing community health needs. Retrieved from https://www.chausa.org/communitybenefit/assessing-and-addressing-communityhealth-needs



DATA COLLECTION METHODOLOGY

A multi–faceted approach was used to gather information about the health needs of the community and to develop priorities for health improvement. The process focused on gathering and analyzing secondary data as well as obtaining input from key stakeholders and the community to identify and define significant health needs, issues, and concerns.

Both quantitative and qualitative methods were utilized to gather data.

SECONDARY DATA

A variety of secondary data sources were used to obtain data about both health trends and health disparities. Every effort was made to obtain the most current data. Data was analyzed for comparison purposes with the United States, the state of Oregon, counties within the state, when comparative data was available.

COUNTY SURVEY

A county survey was conducted in April 2022. The county survey was distributed in various public locations and was also made available electronically. There were a total of 286 survey respondents. The results are included in Appendix B.

FOCUS GROUPS

Additional information from key stakeholders included two Focus Groups conducted April 21, 2022. Results on page 23.

REGULATORY REQUIREMENTS

The Patient Protection and Affordable Care Act (ACA), enacted on March 23, 2010, added a requirement that hospitals covered under section §501(r) of the Internal Revenue Code conduct a Community Health Needs Assessment (CHNA) and adopt an implementation strategy to meet the community health needs identified through the CHNA at least once every three years.

The CHNA defines priorities for health improvement, with an emphasis on the needs of populations that are at risk for poor health outcomes due to geographic, language, financial, or other barriers; commonly referred to as social determinants of health. The CHNA process creates a platform to engage community stakeholders and to understand the needs of the community.

GAP ANALYSIS

Data was obtained from all required sources in completing the 2022 CHNA and identifying community health priorities. The assessment was designed to provide a comprehensive and broad picture of the health in the overall community served. However, there may be a number of medical conditions that are not specifically addressed in this report due to various factors, including but not limited to, publicly available information or limited community input. In addition, certain population groups might not be identifiable or might not be represented in numbers sufficient for independent analysis. Examples include homeless, institutionalized persons, undocumented residents and members of certain ethnic groups who do not speak English. Efforts were made to obtain input regarding these specific populations through key stakeholder surveys.

SERVICE AREA DEFINED

Grant County was used as the geographic defined service area for BMHD's CHNA. For the calendar year 2021, the overwhelming majority of hospital inpatients, outpatients, and/or admissions to the Blue Mountain Care Center were from the ZIP Codes in Grant County. It is therefore reasonable to utilize Grant County as the CHNA geographic area.

BMHD'S CHNA SERVICE AREA AT COUNTY LEVEL
Grant County

When ZIP Code level data was available and used, the following ZIP Codes in Grant County are reflected.

BMHD'S CHNA SERVICE AREA AT ZIP CODE LEVEL	
ZIP CODE	CITY NAME
97817	Bates
97820	Canyon City
97825	Dayville
97845	John Day
97848	Kimberly

97856	Fox, Long Creek and Ritter
97864	Monument
97865	Mount Vernon
97869	Prairie City
97873	Seneca

Since ZIP Code and county boundaries do not always match, it is important to note the Sumpter ZIP Code (97877) is not in BMHD's CHNA service area. A small portion of the Sumpter ZIP Code (97877) is in Grant County while the remainder is in Baker County. Hence,when data was available at a ZIP Code level, data associated with the Sumpter ZIP Code is not included in the data provided within this report. Grant County includes medically underserved, low-income and minority populations. All patients were used to determine BMHD's CHNA geographic area.

DEMOGRAPHIC SNAPSHOT

The following tables provide a summary regarding the demographics of Grant County. Data tables show total population of the community, as well as the breakout of the population between male and female, age distribution and race/ethnicity. Because Grant County has a higher percentage of veterans as compared to the state of Oregon and United States, a table with the statistics is included below. Also below are population density figures.

POPULATION 2020	GRANT COUNTY		OREGON	UNITED STATES
Male Population	3,644	50.8%	49.6%	49.2%
Female Population	3,530	49.2%	50.4%	50.8%
Total	7,174	100%	100%	100%

SOURCE: Claritas 2021

2020 POPULATION DISTRIBUTION BY AGE			
	GRANT COUNTY	OREGON	UNITED STATES
Under 5 years	4.2%	5.5%	6%
5 to 9 years	5.5%	5.8%	6.1%
10 to 14 years	4.2%	6.0%	6.5%
15 to 19 years	4.1%	5.9%	6.5%
20 to 24 years	4.4%	6.4%	6.7%
25 to 29 years	4.5%	6.9%	7.0%
30 to 34 years	5%	7.1%	6.8%
35 to 39 years	5%	6.9%	6.5%
40 to 44 years	4.9%	6.5%	6.1%
45 to 49 years	4.6%	6.3%	6.3%
50 to 54 years	6.7%	6%	6.4%
55 to 59 years	6.6%	6.3%	6.7%
60 to 64 years	9.9%	6.8%	6.0%
65 to 69 years	8.9%	6.2%	5.3%
70 to 74 years	7.4%	4.4%	4.1%
75 to 79 years	6.1%	2.9%	2.8%
80 to 84 years	4.4%	1.9%	1.9%
85 years and over	3.8%	2.1%	2%

SOURCE: Claritas 2021

2020 POPULATION BY RACE/ETHNICITY				
	GRANT COUNTY		OREGON	UNITED STATES
Amer. Ind. (Non- Hispanic)	110	1.53%	1.09%	0.82%
Asian (Non-Hispanic)	49	0.68%	4.50%	5.64%
Black (Non-Hispanic)	0	0.0%	1.89%	12.62%
White (Non-Hispanic)	6,713	93.57%	82.59%	70.42%
Other (Non-Hispanic)	302	4.21%	9.93%	10.49 %
Hispanic	291	4.06%	13.22%	18.2%
Total	7,174	100.00%	100.00%	100.00%

SOURCE:Claritas 2021

PERCENTAGE OF POPULATION THAT ARE VETERANS	
Grant County	13%
Oregon	8.30%
United States	7.10%

SOURCE: U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates

POPULATION DENSITY (PER SQUARE MILE)	
Grant County	2.57
Oregon	43.16
United States	87.42

SOURCE: United States Census Bureau, American Community Survey. 2015-2019 Source geography: Tract

SOCIOECONOMIC SNAPSHOT (2015-2019 American Community Survey)

	SERVICE AREA	COUNTY	RURAL	OREGON
Population below Poverty Level	17.4%	18.1%	14.2%	13.2%
Population below 200% of Poverty Level	37.5%	38.3%	35.2%	30.8%
Population <18 below Poverty Level	21.8%	24.0%	19.4%	16.5%
Unemployed Labor Force Population	8.7%	8.7%	6.2%	5.5%
Population 18-64 with Disability	19.1%	19.2%	15.1%	11.8%
Population 65+ with Disability	44.3%	43.8%	37.7%	35.7%
Households receiving Cash Public Assistance	2.9%	2.9%	3.5%	3.5%
Population 25+ w/o High School Diploma	11.3%	11.2%	11.1%	9.3%
Population >5 who speak English less than “very well”	1.0%	0.9%	3.8%	5.6%
Uninsured	5.6%	5.5%	7.1%	6.7%
Total Oregon Health Plan (Dec 2021)	32.5%	32.3%	35.7%	31.4%

	GRANT	OREGON
Receiving Temporary Assistance for Needy Families (5/2020)	0.4%	1.0%
Children Eligible Free/Reduces Lunch (19-20 School Year)	53.8%	49.2%
Receiving Food Stamps (5/2020)	18.3%	16.5%
Government Employees as % of Total Employment	40.9%	14.2%
Medicare Enrollees (1/ 2021-CMS)	32.4%	20.8%

MATERNAL HEALTH SNAPSHOT

Birth outcomes and maternal health are often seen as measures of how well the health delivery system is operating. Inadequate prenatal care leads to low birthweight which leads to longer term health struggles and developmental delays. Low Birthweight is less than 5.5 pounds. 60% of all infant deaths are related to Low Birthweight. Low Birthweight infants who survive are 3 times more likely than others to experience mental retardation, breathing problems, sight and hearing problems and learning difficulties.

This measure is the basis of the widely used Kessner index, in which a woman's prenatal care is classified as "adequate" if it begins in the first trimester and includes nine or more visits for a pregnancy of 36 or more weeks, “intermediate” if it begins in the second trimester or includes five to eight visits “Inadequate” prenatal care is less than 5 visits or care that did not begin until the 3rd Trimester.

2016-2020 (AVG PER YEAR-RATES PER 1,000 BIRTHS)		
	GRANT	**OREGON**
Average Births per Year	62	42,605
Low Birth Weight Rate	83.9	66.7
Inadequate Prenatal Care Rate	80.6	60.7
Infant Mortality Rate	9.7	4.7
Teen (15-19) Birth Rate	32.3	38.0

Source: Oregon Health Authority – Center for Health Statistics

COUNTY HEALTH RANKINGS

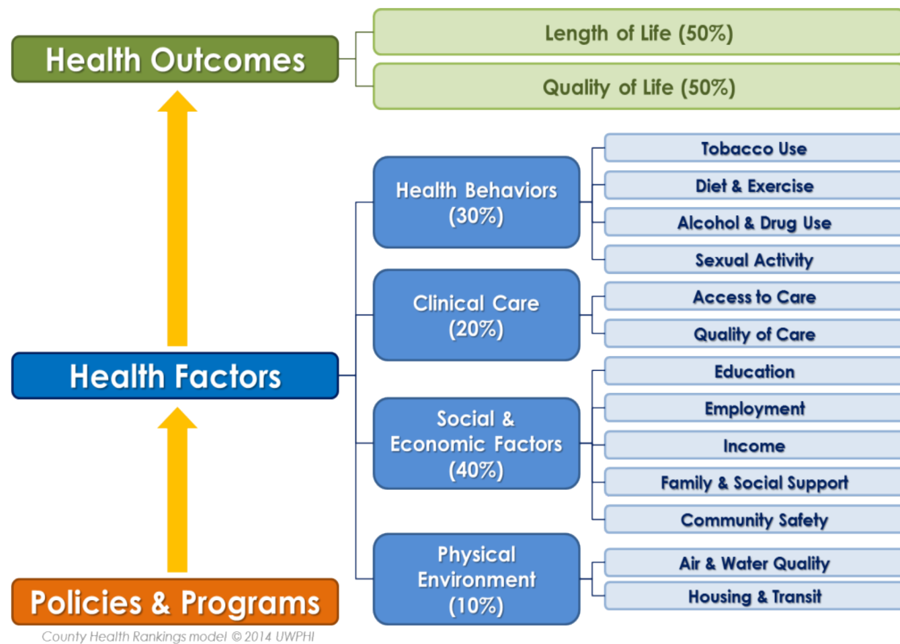
The County Health Rankings & Roadmaps Program is a collaborative between the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The rankings are determined by the following factors:

HEALTH OUTCOMES: "The overall rankings in health outcomes represent how healthy counties are within the state. The healthiest county in the state is ranked #1. The ranks are based on two types of measures: how long people live and how healthy people feel while alive."

HEALTH FACTORS: "The overall rankings in health factors represent what influences the health of a county. They are an estimate of the future health of counties as compared to other counties within a state. The ranks are based on four types of measures: health behaviors, clinical care, social and economic, and physical environment factors."[2]

The rankings are based on a model of population health that emphasizes the many factors that, if improved, can help make communities healthier places to live, learn, work, and play.

To learn more about the County Health Rankings data sources and methodology use the following link. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources



The table on the next page shows how Grant County ranks out of the 35 counties in Oregon. A ranking of one (1) represents the healthiest county. Overall, Grant County is ranked 26th in the state of Oregon (3rd quartile), as compared to the other 35 counties in Oregon.

	Grant County's rank out of 35 counties in Oregon	Grant County's Quartile
Health Outcomes	29	4th
Length of Life	31	4th
Quality of Life	22	3rd
Health Factors	22	3rd
Health Behaviors	12	2nd
Clinical Care	12	2nd
Social & Economic Factors	34	4th
Physical Environment	5	1st

Ranking quartiles: 1 - 9, 10 - 18, 19 - 26, 27 - 35
Source: www.countyhealthrankings.org; May 2022

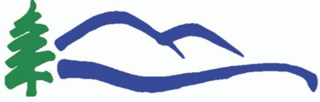
	Grant County	Error Margin	Top U.S. Performers	Oregon
Health Outcomes				29
Length of Life				31
Premature death	7,400	4,700 – 10,100	5,600	6,100
Quality of Life				20
Poor or fair health	21%	18-23%	15%	17%
Poor physical health days	4.6		4.2-4.9	3.4
Low birthweight	7%	5-10%	6%	7%
Additional Health Outcomes (not included in overall ranking)				
COVID-19 age-adjusted mortality			43	36
Life expectancy	80.1	77.7-82.5	80.6	79.7
Premature age-adjusted mortality	360	280-440	290	310
	Grant County	Error Margin	Top U.S. Performers	Oregon

Child mortality			40	40
Infant mortality			4	5
Frequent physical distress	14%	13-16%	10%	12%
Frequent mental distress	18%	16-19%	13%	15%
Diabetes prevalence	9%	9-10%	8%	8%
HIV prevalence			38	202
Health Factors				22
Health Behaviors				12
Adult smoking	20%	17-23%	15%	15%
Adult obesity	31%	29-32%	30%	29%
Food environment index	6.2		8.8	8.1
Physical inactivity	28%	25-30%	23%	24%
Access to exercise opportunities	52%		86%	84%
Excessive drinking	21%	20-22%	15%	21%
Alcohol-impaired driving deaths	20%	5-39%	10%	28%
Sexually transmitted infections	125		161.8	457.1
Teen births	14	9-23	11	15
Additional Health Behaviors (not included in overall ranking)				
Food insecurity	17%		9%	12%
Limited access to healthy foods	15%		2%	5%
Drug overdose deaths			11	16

	Grant County	Error Margin	Top U.S. Performers	Oregon
Motor vehicle crash deaths			9	11
Insufficient sleep	34%	32-36%	32%	33%
Clinical Care				6
Uninsured	10% (Better)	8-11%	6%	7%
Primary care physicians	1,200:1 (Worse)	1,010:1	1,060:1	
Dentists	1,440:1 Same	1,210:1	1,210:1	
Mental health providers	240:1	250:1	170:1	
Preventable hospital stays	458 (Better)		2,233	2,903
Mammography screening	42% (Better)		52%	43%
Flu vaccinations	26% (Better)		55%	44%
Additional Clinical Care (not included in overall ranking)				
Uninsured adults	11% (Better)	9-13%	7%	10%
Uninsured children	5% (Better)	4-7%	3%	4%
Other primary care providers	1,440:1		580:1	1,000:1
Social & Economic Factors				34
High school completion	89%	86-92%	96%	81%
Some college	54%	44-63%	74%	70%
Unemployment	8.3%		2.90%	4.10%
Children in poverty	20% (Worse)	11-28%	9%	12%
Income inequality	4.1	3.3-4.8	3.7	4.4

	Grant County	Error Margin	Top U.S. Performers	Oregon
Children in single-parent households	13%	4-21%	14%	21%
Social associations	9.7		18.1	10.1
Violent crime	69		63	249
Injury deaths	139	103-184	61	77
Additional Social & Economic Factors (not included in overall ranking)				
Disconnected youth			96%	81%
Median household income	$50,800	$43,000 to $58,600	$75,100	$67,800
Children eligible for free or reduced price lunch	52%		32%	48%
Residential segregation - black/white			23	63
Residential segregation - non-white/white	14		15	33
Homicides			2	3
Suicides	38	18-70	11	19
Firearm fatalities			8	13
Juvenile arrests	43			28
Physical Environment				5
Air pollution - particulate matter	6.5		5.9	9.0
Drinking water violations	Yes			

	Grant County	Error Margin	Top U.S. Performers	Oregon	
Severe housing problems	15%	11-19%	9%	19%	
Driving alone to work	74%	69-79%	72%	70%	
Long commute - driving alone	20%	14-26%	16%	30%	
Additional Physical Environment (not included in overall ranking)					
Traffic volume					75
Homeownership	75%	71-79%	81%	63%	
Severe housing cost burden	14%	9-19%	7%	15%	
Broadband access	80%	75-85%	88%	88%	
Note: Blank values reflect unreliable or missing data					
Source: http://www.countyhealthrankings.org; May 2022					
Color Legend					
Areas of strength					
Areas to explore					



OREGON'S STATE HEALTH IMPROVEMENT PLANS (SHIP) AND PRIORITIES

The purpose of Oregon's State Health Improvement Plan (SHIP) is to identify population-wide priorities and strategies for improving the health of people in Oregon. The SHIP serves as the basis for taking collective action on key health issues in Oregon.
Healthier Together Oregon (HTO) is Oregon's 2020-2024 State Health Improvement Plan. The five-year identifies the state's priority strategies the will lead to improved outcomes. HTO's primary goal is to achieve health equity. BMHD includes the results of the HTO in the 2022 CHNA to allow those who create a "plan" in response to this assessment to understand where Oregon is headed as state. HTO informs community health improvement plans.
The HTO identifies strategies in five priority areas.

- Institutional bias
- Adversity and toxic stress
- Behavioral health
- Economic drivers of health
- Access to equitable preventive health services

INSTITUTIONAL BIAS

Institutional bias is defined as the tendency for resources, policies and practices of institutions to operate in ways that advantage white, heterosexual, cis-gendered, able-bodied individuals and communities. This discrimination results in adverse health consequences for underrepresented groups, such as people of color, people with low incomes, people with disabilities and people who identify as LGBTQ+.

GOALS:

Expose and reduce the impact of institutional biases that influence health, by
Identifying and championing work across systems, structures, polices, communities and generations, so that
All people in Oregon are empowered and have the opportunity to participate fully in decisions to achieve optimal health.

ADVERSITY, TRAUMA AND TOXIC STRESS

Conditions that cause adversity, trauma and toxic stress include abuse and neglect, living in poverty, incarceration, family separation, and exposure to racism and discrimination. These events have a lifelong effect on health and are correlated with things such as substance use, suicide and heart disease.

GOALS:

Prevent trauma, toxic stress and adversity through data-driven policy, system and environmental change.
Increase resilience by promoting safe, connected and strengths-based individuals, families, caregivers and communities.
Mitigate trauma by promoting trauma-informed systems and services that assure safety and equitable access to services and avoid re-traumatization.

BEHAVIORAL HEALTH

Behavioral health includes mental health and substance use. Oregon has one of the highest rates of mental illness in the country. Mental distress can lead to lower quality of life, unemployment and increased rates of suicide. Use of alcohol, opioids, methamphetamine and other substances have a significant impact on many families. Although described as behavioral health, these strategies are specific to mental health. While all of the priorities impact substance use, strategies related to alcohol and drug use can be found in the Alcohol and Drug Policy Commission Strategic Plan.

GOALS:

Reduce stigma and increase community awareness that behavioral health issues are common and widely experienced.
Increase individual, community and systemic resilience for behavioral health through a coordinated system of prevention, treatment and recovery.

ECONOMIC DRIVERS OF HEALTH, SUCH AS HOUSING, TRANSPORTATION AND LIVING WAGE JOBS

Economic drivers of health include housing, living wage, food security and transportation. Poverty is a strong predictor of poor health. Many people who have a job are struggling to get out of poverty due to the high cost of living or raising a family. People living in poverty experience higher rates of premature death, houselessness, mental distress and food insecurity.

GOALS:

Increase the percentage of Oregonians earning a livable wage by raising public awareness of the correlation between health and economic sufficiency and advocating for evidence-based policies to improve economic sufficiency.

Ensure that all people in Oregon live, work and play in a safe and healthy environment and have equitable access to stable, safe, affordable housing, transportation and other essential infrastructure so that they may live a healthy resilient life.
Increase equitable access to culturally appropriate nutritious food regardless of social or structural barriers by addressing the underlying issues in food availability.

ACCESS TO EQUITABLE PREVENTIVE HEALTH CARE

Despite an increasing number of people with health insurance, many are challenged to get to a health care provider or see a dentist due to provider shortages, transportation barriers or health care costs. They also may not feel comfortable with their provider due to language or other cultural difference.
Goals:
Increase equitable access to and uptake of community-based preventive services.
Increase equitable access to and uptake of clinical preventive services.
Implement systemic and cross-collaborative changes to clinical and community-based health-related service delivery to improve quality, equity, efficiency and effectiveness of services and intervention

DESIGNATIONS OF SHORTAGE AND CLINIC RESOURCES

The US Health Resources Services Administration (HRSA) designates geographic and populations as "health professional shortage areas (HPSA)." Designation allows for access to special resources suck the National Health Service Corp, federally recognized Rural Health Clinic status among others.

Grant County is a Geographic/Population HPSA through its Frontier (six people or less per square mile) designation as well as for Low Income population. The county is also a Mental Health professional shortage area and a Low Income designation for Dental shortage.

There are three primary care clinics in Grant County (Grant County Health Department, Strawberry Wilderness Clinic and Canyon Creek Clinic) two of which are federally certified Rural Health Clinics. There is also a School-based Health Clinic providing primary care in the county.

COMMUNITY SURVEY – KEY FINDINGS

In April of 2022, BMHD conducted a Community Survey. The entire results of the 286 respondents can be found in Appendix B. Here are selected highlights.

- 90.4% reported excellent or good physical health
- 94.7% reported excellent or good mental health
- 7% do not have housing or are worried about losing housing
- 59% have private insurance
- 10.2% have Medicaid
- 18.6% have Medicare
- 14.2% reported having difficulty getting a Doctor's appointment when "really needed"
- 13.7% reported being worried about food running out in the past 12 months
- 16.1% had trouble getting child care
- 34.4% reported having more times available for doctor's appointments would help them and their families be healthy
- Alcohol use (75%) and illegal drug use (79.3%) are felt to be the behaviors that put adults (18+) at most risk
- Alcohol use (76.7%) and illegal drug use (75.2%) are felt to be the behaviors that put people under 18 at most risk
- 25.2% said quality of care in Grant County is why they seek health services out of the community
- 95.1% of respondents reported having access to the internet in their household
- The highest percentages for what BMHD should focus on in the next three years include increasing the number of specialists, increasing the number of family physicians, helping people get mental health and supporting caregivers

BLUE MOUNTAIN HOSPITAL DISTRICT
2022 COMMUNITY HEALTH NEEDS ASSESSMENT
FOCUS GROUP RESULTS

On April 21, 2022 two separate focus groups were conducted at noon and 3:00 at the Fire Hall in John Day.

At the focus groups participants were asked to introduce themselves and say which part(s) of the community they represented. There were a variety of stakeholder groups represented including the education system, health care, business, and social service providers.

For the purposes of these focus groups, community was defined as the Blue Mountain Hospital District's service area which is Grant County.

All attempts have been made to maintain the confidentiality of the participants. Anecdotal stories which illustrated the speakers statements and personal experiences were not used in this report.

The results shared here are statements of opinions and beliefs. **They are not to be intended as facts.**

Focus group participants were given $25 worth of Grant Greenbacks as a thank you for their time and thoughts.

FOCUS GROUP FINDINGS

Community:

What do you consider the most positive aspects of Grant County? Prompt: What do you like best?

- The great outdoors, geographic location, four seasons and multiple outdoor activities are available.
- The community welcoming to new residents.
- People can rely on their neighbors and friends. Close-knit with people looking out for one another. Tightness and connection sometimes good and bad.
- People have lots of ways to be involved in community life in meaningful ways. Lots of ways to expand into other portions of society beyond your family and work.
- There are opportunities for personal and community growth.

What do you consider the most negative aspects of Grant County? Prompt: What do you like the least?

- Internet and cell service are limited in many areas throughout Grant County.
- It is hard to get specialized health care. Have to leave the community.
- The community (population) is shrinking.
- There is a lack of diversity among the population.
- Small communities lack a voice in the affairs of the State of Oregon.
- The need to go to Bend or Boise for basic consumer items like clothing.
- People seem closed to change and it is hard to embrace new ideas and concepts.
- Limited activities for children (movie theatre, skating rink etc.)
- Poverty seems to be on the increase.
- Lack of an adequate workforce.
- People who are not afraid to grab the microphone and yell the loudest get heard.
- Poor or inadequate access to childcare.

What do you believe are the 2 or 3 most important characteristics of a "healthy" community? Prompt: What community characteristics help people stay healthy? Be healthy?

- Having indoor and outdoor physical activities available with connections to other people.
- Having a sense of being physically safe.
- Having a sense of well-being.
- Access to health care-some specialists.
- Strong workforce with living wage jobs.
- Having health insurance.
- A safe and reliable childcare system.
- Access to nutritious food.

Tell me about some concerns you have about the health and well being of in your community? Prompt: What do you believe are the most important issues that need to be addressed to improve health and quality of life?

- The town is shrinking- wood products industry has declined.
- Vaccine resistance.
- Lack of interest in receiving preventative health care services.
- It is hard for a newcomer to find information about the health system and what is going on until you figure out the system.
- A robust communication system to connect people to services. Sometimes you need to know someone to connect and access services.
- Negative stigma about mental health services.
- Resistance to change.
- Generational poverty and trauma- untreated mental health issues are a barrier to getting out of these cycles.

What are challenges in your community that get in the way of people having healthy lives? Prompt: What do you believe is keeping your community from doing what needs to be done to improve quality of life?

- People are welcoming but not necessarily inclusive.
- People do not like government or federal employees. Need to separate "people" who implement from the "policy" directives.
- High resistance to change and opening up to new ideas.
- Culture of accepting generational poverty.

- Toxic political environment combined with a lack of leadership vision. Leaders are not on the same page.
- Local government is involved and looking at health access, childcare, internet access and other issues but no common answer surfaces.

Health System:

What are your perceptions of Blue Mountain Hospital in terms of quality of care and scope of services provided? Prompts: What gives you these perceptions? What do you think the broader community thinks of the hospital? Prompts: Why do you think they feel that way?

- There is distrust in the health care system (COVID driven).
- The quality is excellent but is under communicated with the public.
- There is a broad scope of service at the hospital: 3D mammo, MRI, fully staffed Emergency Room.
- The rebuild of the hospital might have over promised the increase in scope of service.
- High quality- people do the best they can with the resources available.
- System is working hard to recruit providers at all levels of care.
- Sexual assault resources are limited.
- There is a lack of communication about what is going on in the health system.
- Sometimes it is hard to understand the accents of the Emergency Room doctors (language barriers).
- Some level of lack of confidentially (NOT HIPAA violations).
- It would be nice to have dialysis and cancer treatments (chemotherapy).

What are your perceptions of the local physicians and clinicians in terms of quality, scope of care, number of providers and accessibility? Prompt: What gives you these impressions?

- System is always recruiting more providers.
- The clinicians are of high quality.
- People have trouble getting through to anybody at the clinic and there is lack of return calls.
- People seem to struggle to see their doctor. When dealing with a chronic illness, continuity of care is important.
- Having a one-on-one relationship with a provider is incredibly important to people and improves care.
- Access to care is present. People say “I can’t get in, when the truth is, they could get in, but they couldn’t see the doctor they wanted.”

What are your perceptions regarding local mental health and substance abuse in terms of quality, accessibility and adequacy? Prompt: What gives you these impressions?

- Lacking. Not enough counselors. Constantly recruiting. High turnover rate.
- New clinicians are strained and over worked.
- Difficult to get access at Community Counseling Solutions. Long waits to get service for substance use disorders.
- Prescription therapies (adjustments) for substance use disorders need to be managed at the physical health clinic and communicated.
- Many will not go to Community Counseling Solutions.
- High community stigma about seeking help for mental health. Rugged individualism.
- Families refusing services that are offered to them.
- Pain management services are lacking.
- Nowhere to send people after suicide attempts.
- Need for evidence-based childcare therapies.

What are any perceptions about other health care services such as dental, vision, ambulance, pharmacy, public health or complimentary medicine (chiropractors, massage therapists etc.)? Prompt: What gives you these impressions?

- Insurance coverage for school and federal employees limits services for vision and dental. Need to leave the community for these.
- Emergency Medical Technicians are great. "One of our gold stars."
- The services are available and accessible.
- Some lack of emergency dental care.
- Pharmacy works well and Emergency Department is able to provide prescriptions when the pharmacy in town is closed.
- Public Health has stepped up even when being abused (COVID). Does a good job working with the schools through the School Based Health Clinic. Provides another avenue of access for many who might otherwise not get in.

Disparities:

Thinking about neighborhoods and groups in your community, do some people have more health problems and poorer health than others? Prompt: What causes this?

- Those with lower socio-economic status.
- Low income without health insurance.
- "Just say the trailer park." Inadequate housing. Hard to stay healthy in bad physical environments.
- Seniors trying to live alone without technology. "it takes a village to care for the elderly as well as children."
- People with children who use drugs and are afraid to seek help for fear of having their children removed from the home."
- Veteran's and those that are homeless.
- Fierce independence of people. Not seeking help or wanting it.
- "People need help, but also need to help themselves."
- Need to pull out of groups which negatively influence their health decisions. Hard to do when it involves your family.
- Constant stress lowers the brain's ability to work correctly.

Now think in reverse, in neighborhood and groups of people, why do some people in your community have less health issues than others? Prompt: Better health?

- Educated.
- Use preventative services.
- Willing to ask questions and speak up.
- People who can think about the future beyond getting through the day.
- Volunteer. Serving others.
- Stable family life.
- Willingness to seek and accept help.

Social Determinants of Health:

SDOH is defined as the settings/places where people live, learn, work and play that can shape overall health of an individual or community. Examples include education, food insecurity, housing, employment, social stressors (hostility, sexism, racism etc.), working conditions and transportation.

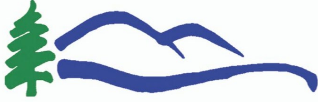
What are specific examples of SDOH from above that are being addressed well in the community? Prompt: What is working? What needs more attention? Prompt: What is keeping this issue from being addressed?

- Transportation – The People Mover has been welcome. It is not perfect, but better than nothing and what happened in the past.

- Housing and workforce need improvement. But who is responsible for this? It is a public or private effort? A combination of both?
- People can be recruited but then have trouble finding housing. If they have children, they are concerned with the schools and the trauma that occurs within them.
- Social stressors are huge. You don't want to be the odd man out of the pack. It is risky for people who have different thoughts. It is not safe to stick your neck out.
- Well attended Farmer's Market.

Anything else?

- Not having a hospital here would be a terrible thing. People can throw stones but it is supported by the public. It is important to the community and beneficial.



EVALUATION OF THE 2019 CHNA IMPLEMENTATION PLAN

Every year BMHD CHNA committees report on a summary of the progress made in the preceding year. For the purposes of evaluating our 2019 Implementation Plan, a final report summarizing our progress was completed. Please see Appendix B for the 2019-2022 CHNA Final Report.

The Community Survey participants and Focus Groups were asked about how the 2019 Community Health Improvement Plan was being implemented. Below are responses to the Focus Group and Community Survey questions about the effort.

In the 2019 BMHD Community Health Improvement Plan, the following activities were prioritized.

- ***Education on substance abuse including tobacco, drugs and alcohol***
- ***Improving access to care***
- ***Improve care for persons with chronic disease especially diabetes and obesity***
- ***Improving mental health including suicide prevention***

Have you noticed any differences in any of these areas? Prompt: What changes occurred? Are they still relevant?

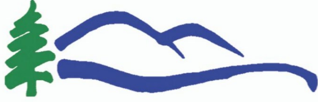
- "I think it is unfair to judge because I think COVID messed everything up and unfortunately some of those issues are probably worse off now."
- It is difficult to see and measure change (especially preventative / education services) in a short time period.
- These issues are still very relevant. The action steps did not feel like there was a lot of fresh, large substantial initiatives that would bring meaningful change.
- The Fast Track system for patient access does provide openings, but not necessarily to their doctor.
- People need to understand that the clinicians have two days in clinic and 2 Emergency Room shifts.
- There is intensive Behavioral Health therapy for people with a Body Mass Index of >30.
- Because the efforts to implement involved multi-organizations, it is difficult to know who is doing what under this plan.
- Access to care got funding from the hospital and was improved. Substance use disorder and mental health did not.

The following data was taken from the 2022 Community Survey. It requested evaluation of the 2019 priority efforts conducted by Blue Mountain Hospital District and multiple community partners.

60
50
40
30
20
10
0

We educated people about substance abuse, including tobacco, drugs & alcohol
We improved access to care
We helped improve chronic disease, especially obesity and diabetes
We helped improve mental health including suicide

Strongly Agree · Agree · Undecided · Disagree · Strongly Disagree



PRIORITY SETTING MEETING

On June 2, 2022 a meeting took place at the Grant County Regional Airport. Attendance was a mix of in-person and via the internet. During the meeting the Community Health Needs Assessment results were shared with the participants. The quantitative and qualitative findings were highlighted as the groups reviewed the entire document.

The following potential issue areas were shared and discussed by the group. They included:

- **Substance Abuse**
- **Care Giver Support**
- **Chronic Disease**
- **Access to Care**
- **Economic Drivers of Health (Social Determinants of Health)**
- **Mental Health**
- **Behavioral Health**
- **Using Preventive Services**
- **Adversity / Toxic Stress**
- **Early Childhood**

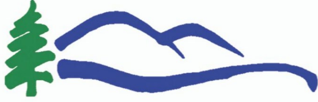
The group then prioritized the list to recommend to the Blue Mountain Hospital District Board of Directors. The group recognized that many of the issues overlap one another and determined to blend some together. Here are the three issue areas the group selected.

- **Mental/Behavioral Health**
- **Access to Care**
- **Social Determinants of Health**

There were no specific recommendations from the group about objectives under each priority area. These were felt to be best addressed around working groups that will be formed to develop a Community Health Implementation Plan.

NEXT STEPS

Over the next several months, BMHD in collaboration with community partners, will develop an implementation plan for each of the priority health needs. The implementation plan will be published in a separate report.



APPENDIX A (2019-2022 CHNA FINAL REPORT)

Community Health Needs Assessment
2019-2022 Final Progress Report
June 2022

Background:

- As a component of federal Affordable Care Act regulations, Tax-exempt hospitals are required to conduct a Community Health Needs Assessment (CHNA) every three years.
- Blue Mountain Hospital District completed its current CHNA survey process in June of 2019 with the assistance of the citizens of Grant County, internal stakeholders and community partners.
- Following the assessment process, four priorities were identified through an implementation planning process that concluded in October of 2019.
    - Access to Care
    - Chronic Disease
    - Mental Health
    - Substance Abuse
- Two CHNA Committees were established at the time of implementation planning and have executed on the CHNA implementation plan since 2019.
    - Mental Health/Substance Abuse
    - Access to Care/Chronic Disease
- This report serves as Blue Mountain Hospital District's final CHNA report summarizing our CHNA implementation work completed over the course of 2019-2022.
- Please see below for a progress report for the four identified priorities and corresponding strategies for each.

CHNA Priority Progress:

Access to Care

- Strategy 1**-** Improve patient access including extended hours, additional same day and fast track, and coordinated services with community partners.
    - Continued and re-energized resident physician program through Klamath Falls and OHSU Residency Program, in addition to scheduling medical students through end of 2022.
    - Increased education, communication, and coordination of same day appointment program.
    - Expanded access to same day appointments through hiring of a nurse practitioner, James Cook, FNP, and a locum nurse practitioner (Cris Rodriguez).

- Evaluated and implemented expansion of provider hours by having more than one provider available for early morning and/or late afternoon appointments.
- Conducted an access analysis for SWCC in order to develop a plan to improve access and growth, and have moved forward with implementation.

- Strategy 2- Addition of provider to meet patient volumes.
  - Hired three family practice physicians and two nurse practitioners in the clinic who started in 2020 and 2021 (Dr. Brian Jennings, Dr. Robyn Jennings, Dr. Caitlin MacCoun, Erica Adams, NP, and James Cook, NP).
  - Hired a nurse practitioner (James Cook) and locum nurse practitioner (Cris Rodriguez to solidify our same day appointment program.
  - Hired another family practice physician to start in August of 2022 (Dr. Charlie Price).

- Strategy 3- Improve patient communication to include access, response time, triage nurse access, referrals, prescription refills, and test results.
  - Referrals:
    - Completed audit of Q4 2021 referrals to assess improvements from process changes put in place in prior months.
  - Access:
    - Daily same day provider access for acute symptoms.
    - Adjusted clinic hours to better fit community needs.
    - Implementation of Chronic Disease Management software program to assist with patient outreach and access.
    - Daily nurse triage available, as well as our after-hours nurse triage hotline.
  - Prescription Refills:
    - Daily prescription queue now being fulfilled prior to end of day.
  - Call Backs/Test Result
    - Initiated Medical Assistant call back pool.
    - All call backs received by the provider are completed in the same business day.

- Strategy 4- Pursue additional visiting specialty services (pulmonologist, otolaryngologist (ENT), urologist, dermatologist, rheumatologist, oncologist, orthopedist) via collaboration with specialty providers.
  - Dermatology
    - Finalized agreement to have dermatologist and two dermatology PAs begin part-time work with BMHD in the spring of 2021.
    - Jill Ollinger, MD began providing increased appointments for patient access in 2022.
    - Research is underway to implement MOHS procedures.
  - Ophthalmology

    - Hired Daniel Hanson, Ophthalmologist in addition to Dr. Mitchell Brinks providing ophthalmology services.
  - Cardiology
    - Brought in new visiting cardiologist, Dr. Michael Sultan and PA Becky Sultan from St. Charles
    - Approved privileges for St. Charles Health System, Inc. Cardiology Group for telecardiology services supporting and growing BMHD echocardiogram services.
  - Pulmonology
    - Approved privileges for St. Charles Health System, Inc. Pulmonology Group for telepulmonology services supporting and growing BMHD respiratory therapy services.
  - Rheumatology
    - Contracted with Saint Alphonsus for telerheumatology services and invested in our telemedicine capabilities.
    - Unfortunately, the rheumatologist accepted a new position and we were not able to go live.
  - Orthopedics
    - Began orthopedic surgical procedures with Dr. Lilley from The Center.
    - Evaluating further orthopedic surgery program expansion opportunities.
- Strategy 5**-** Collaboration with partner facilities and providers to implement telemedicine program and expansion of specialty services.
  - During the COVID-19 pandemic we were able to build a telemedicine infrastructure to aid with current (primary care, rehabilitation, home health) and future telemedicine opportunities.
  - Initiated discussions with St. Charles and Saint Alphonsus surrounding telemedicine specialty opportunities.

- Strategy 6**-** Develop public relations and education campaign with community partners to promote the availability and awareness of clinic providers, visiting specialist, telemedicine services and coordinated services with community partners.
  - Updating the electronic community resource packet (New Path to a Healthier Grant County) for citizens.
  - Public Relations Director has implemented the strategic marketing plan targeting awareness, education, information, and communication of services provided.
  - Collaborated with community partners on outreach activities within COVID regulations improving public relations and education campaign.
  - Implemented Walk-with-a-Doc program.

Chronic Disease

- Strategy 1**-** Develop robust care coordination program to include community health workers (CHW's) and chronic care management.
  - Launched robust care coordination program to include community health workers (CHW's).
  - Working through continual staffing and training of community health workers (CHW's).

    - Partnered and implemented ChartSpan, a program to assist with chronic care management and patient outreach.
    - Completed 3 month Medicare chronic care management pilot with a limited patient panel.

- Strategy 2- Launch community health worker (CHW) home outreach as an extension of care coordination.
    - Implemented community health worker home outreach program.
    - Daily communication with Chartspan for patient access and coordination to community resources.
    - CHW outreach to patients with chronic disease to schedule follow-up appointments for patient compliance.

- Strategy 3- Enhance internal and external data tracking and monitoring patient compliance.
    - Continuing to track EOCCO metrics and exploring more robust reporting through eMDs.
    - ChartSpan is tracking CCM focus areas for improvements, partnering with public relations to develop community education plan.
    - Provided education to DHS staff on ChartSpan and CHWs.
    - Collaboration internally between quality and clinic on data review.

- Strategy 4- Promote education and awareness of nutrition and healthy lifestyle programs.
    - Continuing to promote education and awareness of nutrition and healthy lifestyle programs though Family Fun Day, Healthy N Fit, the creation of a "Go Outside" campaign, Walk-with-a- Doc, and other COVID modified activities.
    - Implemented a vibrant Health & Wellness Program for BMHD staff promoting education and awareness of nutrition and healthy lifestyles.
    - Facilitated volunteer time-off program for BMHD staff to deliver food monthly to community members.
    - Investigated Frontier Veggie RX Program for Grant County.

Mental Health

- Strategy 1- Facilitate access to behavioral and mental health services on the BMHD campus (Annex and/or main hospital building).
    - Initiated discussions internally and externally surrounding opportunities to bring behavioral health services in-house.
    - Educated internal team members on Prime Plus Program & COVID Outreach Programs following implementation.
    - Partnered with Community Counseling Solutions to facilitate access to behavioral and mental health services on BMHD campus (Annex building).

- Strategy 2- Collaborate with community partners to enhance education of available mental health services.
    - Implementing QPR First Responder Program training by CCS and BMHD staff.
    - Walk-with-a-Doc program implemented in the summer and will resume in the spring 2022.

- Successful partnership with John Day Parks & Rec and CCS on "Go Outside" Campaign and events.
- Collaboration with CCS staff and other community partners on development of a Trauma Informed Care initiative.

- Strategy 3- Work with community partners surrounding crisis prevention/intervention and resource strategies to combat suicide.
    - Collaborated with community partners surrounding youth programs that promote mental health, suicide prevention and social/emotional development such as Youth to Youth, QPR Training, Youth Mental Health First Aid Training, and Safe Talk programs.
    - Partnered with community partners surrounding crisis prevention/intervention and resource strategies to combat suicide with QPR Training, Mental Health First Aid, First Responder Training, Trauma Informed Care Training, and Child Sexual Abuse Training for leaders in our community.
    - Evade de-escalation trainer education occurred for two BMHD team members, initial training rolled out in June 2022.

Substance Abuse

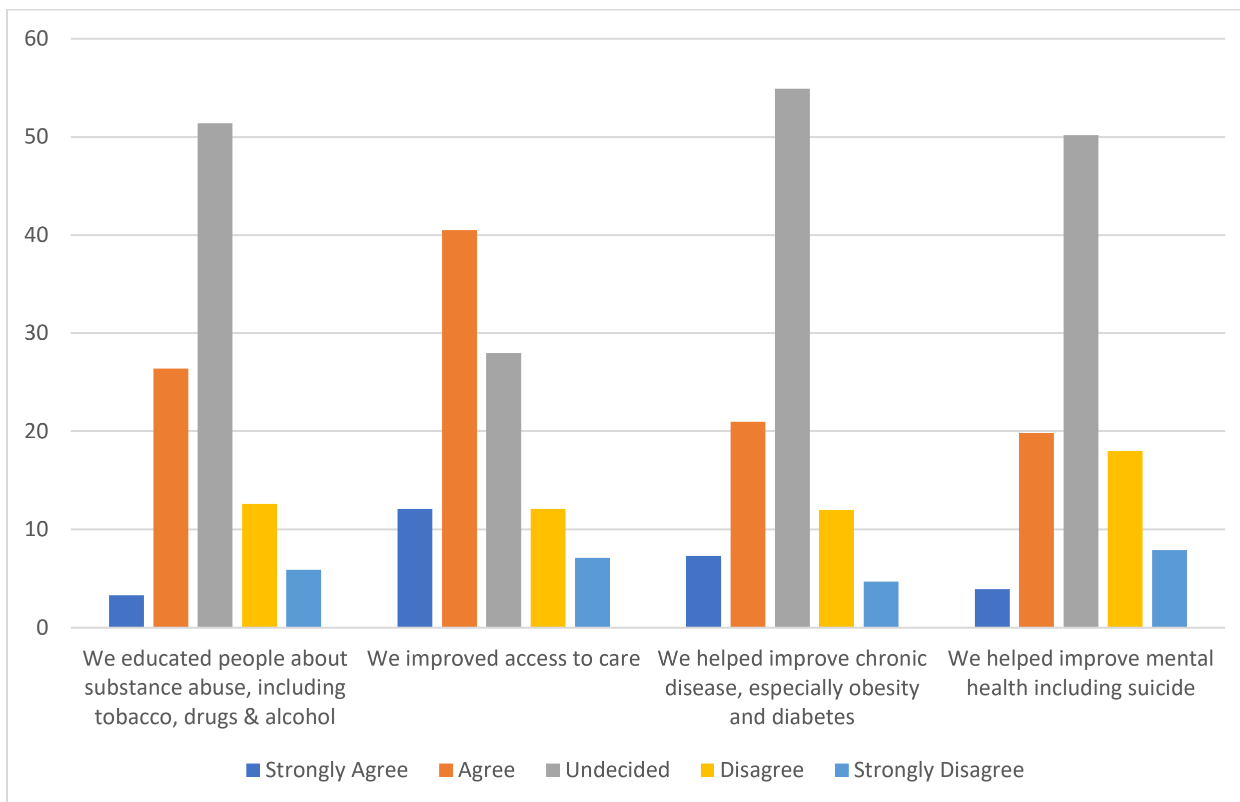
- Strategy 1- Continue building collaborative education with community partners surrounding awareness for K-12 population throughout Grant County.
    - Distributed mental health & wellness kits to Grant County schools grades 3 – 12.
    - Integrated resources at Family Fun Day.
    - Worked through communications with CCS and Long Creek, Dayville, and Monument to meet clinical staff needs.
    - Partnered with Community Counseling Solutions providing several trainings for school staff and community members and youth/community engagement activities.

- Strategy 2- Expand education and support for healthy alternatives to substance use for the adult population throughout Grant County.
    - Partnered with Community Counseling Solutions and completed First Responder Training at BMHD and community.
    - Successful summer "Go Outside" campaign through partnership with John Day Parks & Rec.; continuing campaign.
    - Walk-with-a-Doc program implemented in the summer of 2021 with revamped Dine and Walk with a Doc schedule for summer of 2022.
    - Distributed 2020 EOCCO data to committee.
    - 1 Physician and 2 Nurse Practitioners participate in the Medication Assisted Treatment which helps patients lead to a smoother transition to a drug-free lifestyle in the early stages of recovery.

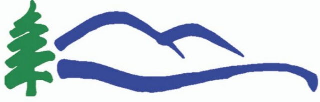
- Strategy 3**-** Increase access to reliable and/or accurate data surrounding substance abuse.
    - Reviewed data related to substance abuse within Grant County and Grant County schools Oregon Healthy Teens Survey.
    - Identified cannabis as the topic for a Community Readiness Assessment.

2022 CHNA Survey Feedback:

- During the 2022 CHNA Survey process, BMHD solicited input from community members regarding the 2019 CHNA initiatives and our progress.
- Survey respondents were asked the question: “BMHD chose several initiatives to work on from 2019 through 2021. How do you think we did since then?”
- A summary of the responses for the four priority initiatives can be seen in the chart below.



APPENDIX B (Community Survey Questions & Results)



BMHD requested input from community members regarding the health needs of Grant County. County survey distribution methods include the following. A list of the questions asked and the responses provided are below.

Electronic survey was available via BMHD Facebook Page, targeted Facebook and Instagram ads, Blue Mountain Eagle Facebook Page, BMHD Website, emailed to stakeholders for distribution, emailed to hospital district employees, emailed to Chamber of Commerce email list, and QR codes linked to the survey were hung in post offices throughout the county as well.

Paper copies were available throughout BMHD, Home Health & Hospice, Strawberry Wilderness Community Clinic, Grant County Health Department, Canyon Creek Clinic and at the Monument Senior Center.

Question 1: Tell us about your physical health. Please choose only one.
Question 2: Tell us about your mental health. Please choose only one.
Question 3: How many people, including yourself, live in the same household? Please choose only one.
Question 4: What is your housing situation today? Please choose only one.
Question 5:Think about the place you live. Do you have problems with any of the following? (Check all that apply)
Question 6: Tell us if you are providing care for someone in your family.
Question 7: What is your work situation? Please choose only one.
Question 8: What is your main insurance? Please choose only one.
Question 9: In the past year, have you or the people that you live with been unable to get any of the following when "really needed?" Choose all that apply.
Question 10: Within the past 12 months, you worried that your food would run out before you got money to buy more?
Question 11: Within the past 12 months, the food you bought just didn't last and you don't have money to get more.
Question 12: In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work or from getting things you need for daily living? Choose all that apply.
Question 13: In the past 12 months has the electric, gas, oil, or water company threatened to shut off services to your home?
Question 14: In the past 12 months have you had trouble getting child care services?
Question 15: What do you think would help you and your family improve your health? Please choose all that apply.
Question 16: What behaviors put adults over age 18 at risk in Grant County?
Question 17: What behaviors put youth and teens under age 18 at risk in Grant County?
Question 18: In your opinion, what is the biggest mental health or addiction issue that you see in this community?

Question 19: What stressors do you see in the community that contribute to problems with mental health or addiction? Check all that apply.
Question 20: What are the reasons you or your family don't use available healthcare services in Grant County? Please choose all that apply.
Question 21: The following doctors or providers are available in Grant County. Please tell us if you have any trouble getting an appointment or accessing care. Please choose all that apply.
Question 22: What doctors or providers do you or your family travel outside of Grant County to see? Please choose all that apply.
Question 23: In the past six months, have you used a Smart application on your phone, computer or tablet to do any of the following? Check all that apply.
Question 24: At your house, apartment or mobile home – do you or any member of your household own or use any of the following types of computers? Check all that apply
Question 25: At your house, apartment or mobile home – do you or any member of your household have access to the internet? Check all that apply
**Question 26: Do you or any member of your household have access to the internet using a –
(Check all that apply)**
Question 27: Individual health statements. Check all that apply to you.
Question 28: What would you like to see Blue Mountain Hospital District, in cooperation with community partners, focus on over the next three years? Please choose up to three (3).
Question 29: If you think one of the priorities should be chronic disease, what chronic diseases would you recommend the Hospital and community partners focus on?
Question 30: If you think one of the priorities should be Supporting Caregivers, what would you recommend the Hospital and community partners focus on?
Question 31: If you think one of the priorities should be Drugs, Alcohol or Tobacco should be a priority, what would you recommend the Hospital and community partners focus on?
Question 32: If you think Domestic Violence, Abuse, or Neglect should be a priority, what would you recommend the Hospital and community partners focus on?
Question 33: BMHD chose several initiatives to work on from 2019 through 2021. How do you think we did since then?
Question 34: What community do you live in? Please choose only one.
Question 35: What is your race or ethnicity? Please choose only one.
Question 36: What is your age?
Question 37: What language do you speak?
Question 38: What is the highest level of school you attended? Please choose only one.
Question 39: Any other comments are welcome and appreciated.

ATTACHMENT (2022 CHNA COMMUNITY SURVEY RESULTS)