

**Gila County
Community Health
Assessment (CHA) and
Community Health
Improvement Plan (CHIP)**



Overview

- Community Health Assessment (CHA)
 - Understanding the CHA Process
 - Gila CHA Highlights
- Community Health Improvement Planning (CHIP)
 - Understanding the CHIP Process
 - Gila CHIP Highlights
- CHA/CHIP Opportunities

The Community Health Assessment Process

- Domain 1: Conduct and disseminate assessments focused on population health status and public health issues facing the community.
- Domain 4: Engage with the community to identify and address health problems, and
- Domain 10: Contribute to and apply the evidence-base of public health.

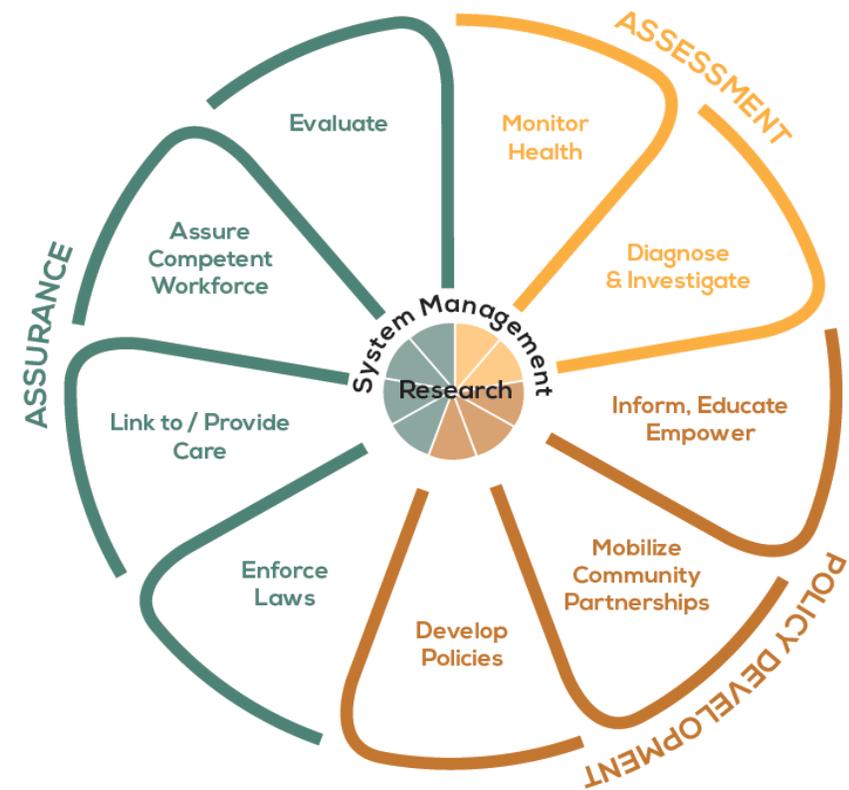


Figure 1: The 10 Essential Public Health Services

CHA Methodology

- Mobilizing for Action through Planning and Partnerships (MAPP)
 - Emphasizes a community-driven approach
- Collection of primary and secondary data
 - 36 priority health indicators
 - Community engagement:
 - Community survey (N = 637)
 - Focus groups (N= 49/6 Groups)
 - Key informant interviews (N = 14)

Criteria for Indicator Selection

- Is the indicator easily understood by both professionals and public residents?
- Is the data readily accessible and publishable?
- Is the data available at the county level and consistently available throughout the entire county?
- Is the data source for the indicator recent, preferably within the last three years?
- Does the indicator mix include the physical and social environment?

Health Indicators

- Mortality
 - Morbidity
 - Healthcare Access and Quality
 - Health Behaviors
 - Social Factors
 - Physical Environment
- Comparison reflections by:
 - Incidence – number of newly diagnosed cases of disease
 - Prevalence – number of cases of the disease that exist in a population
 - Morbidity - illness
 - Mortality - death

CDC Community Health Status Indicators (CHSI)

Identifies peer communities (those similar to Gila County) for comparison by the following characteristics:

- Population size
- Population growth
- Population density
- Population mobility
- Percent children
- Percent elderly
- Sex ratio
- Percent foreign born
- Percent high school graduates
- Unemployment
- Single parent households
- Median home value
- Housing stress
- Percent owner-occupied housing units
- Median household income
- Receipt of government income
- Household income
- Overall poverty
- Elderly poverty

Indicator Report Features

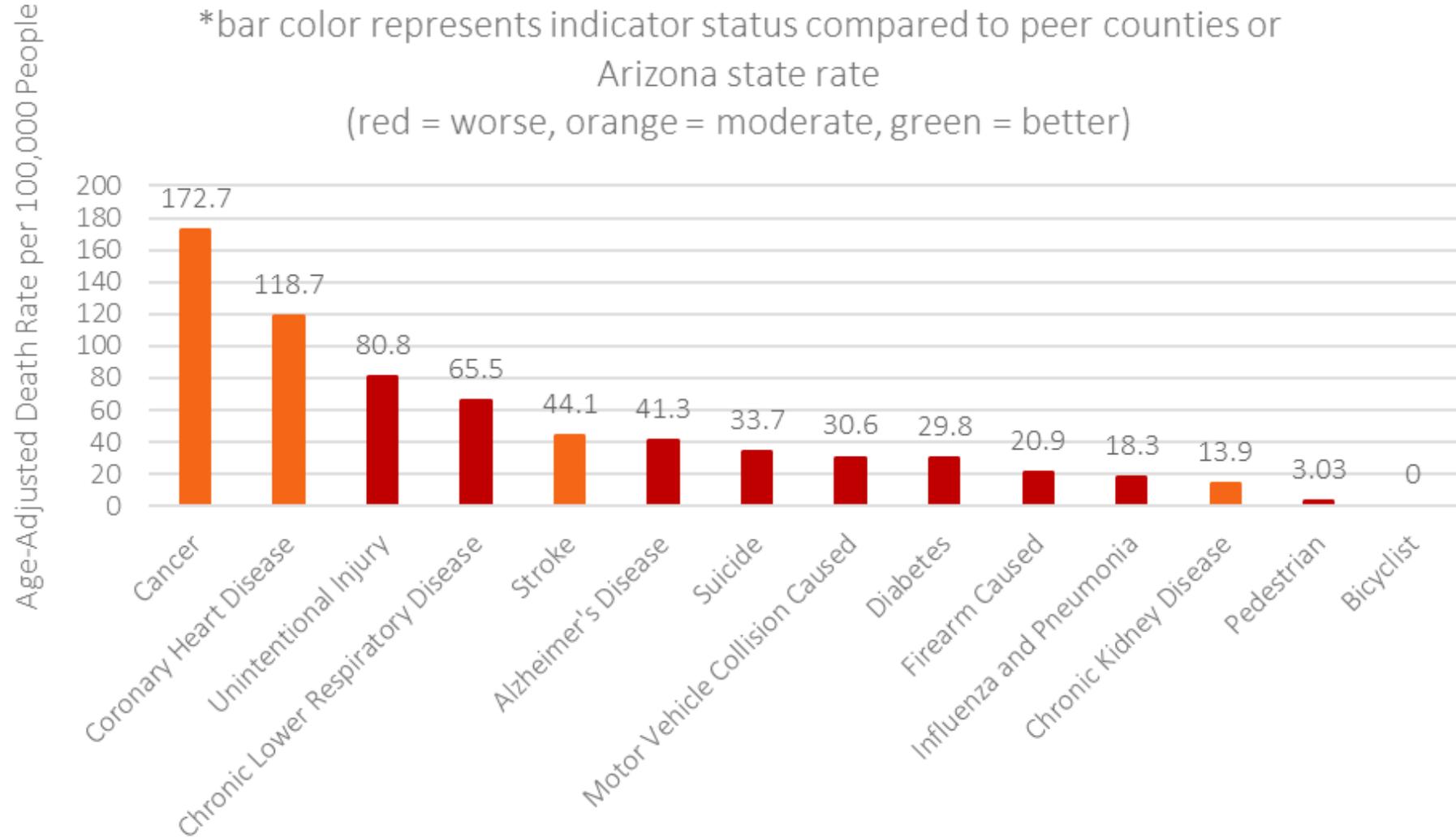
- Provides an “at a glance” summary of how Gila county compares with peer counties.
 - **Green** = Better in comparison
 - **Orange** = Moderate in comparison
 - **Red** = Worse in comparison

County Demographics

Gila County Demographics		
	Arizona	Gila County
Population	6,731,484	53,119
% Under 18 Years of Age	24.4	20.4
% 65 Years of Age or Older	15.4	26.6
% White Alone (Not Hispanic or Latino)	56.2	63.2
% Black	4.7	0.9
% American Indian	5.3	16.5
% Asian	3.3	0.8
% Native Hawaiian or Other Pacific Islander	0.3	0.1
% Hispanic or Latino	30.5	18.8
% Less than High School Degree	14.56	15.4
% Bachelor's Degree or Higher	26.9	16.1
% Below Federal Poverty Level (FPL)	17.9	21.6
% Unemployed	6.3	8.0

Comparison of Mortality Causes in Gila County by Rate per 100,000 people

*bar color represents indicator status compared to peer counties or Arizona state rate
(red = worse, orange = moderate, green = better)



Morbidity Indicators Summary - Worse	Rate
Gonorrhea incidence	35.8 per 100,000
Chlamydia incidence	493.8 per 100,000
Adult diabetes	9.3%
Adult obesity	32.5%
Obesity in low-income children participating in WIC ages 2-5 years	14.6%
Adult overall poor health status	21.4%
Preterm births	15.0%
Babies with low birth weight	8.3%
Mothers who received early prenatal care	68.3%
Low-income mothers participating in WIC whose pre-pregnancy BMI was underweight	5.6%
Low-income mothers participating in WIC whose weight gain in pregnancy was greater than ideal	53.2%
Breastfeeding initiation among low-income infants participating in WIC	62.2%
Low-income infants participating in WIC breastfed at least 12 months	14.2%
Older adult asthma	5.4%
Chronic kidney disease in the Medicare population	16.3%

Morbidity Indicators Summary - Moderate	Rate
Liver and bile duct cancer	6.9 per 100,000
HIV incidence	67.4 per 100,000
Heart failure in the Medicare population	16.1%
Stroke in the Medicare population	3.4%
COPD in the Medicare population	12.0%
Rheumatoid arthritis or osteoarthritis in the Medicare population	29.7%

Morbidity Indicators Summary - Better	Rate
Alzheimer's disease or dementia	6.6%
All Cancers	346.1 per 100,000
Cancer in the Medicare population	6.5%
Bladder cancer	17.5 per 100,000
Breast cancer	88.3 per 100,000
Colorectal cancer	31.7 per 100,000
Lung and bronchus cancer	53.5 per 100,000
Melanoma	12.5 per 100,000
Non-Hodgkin's lymphoma	10.6 per 100,000
Oral cavity and pharynx cancer	7.0 per 100,000
Ovarian cancer	11.7 per 100,000
Prostate cancer	58.9 per 100,000
Syphilis incidence	0 per 100,000
Tuberculosis incidence	0 per 100,000
Atrial fibrillation in the Medicare population	6.6%
Hyperlipidemia in the Medicare population	39.4%
Hypertension in the Medicare population	50.3%
Ischemic heart disease in the Medicare population	28.0%
<i>E. coli</i> infection incidence	0 per 100,000
<i>Salmonella</i> infection incidence	11.2 per 100,000
Diabetes in the Medicare population	23.7%
Overweight in low-income children participating in WIC ages 2-5 years	12.6%
Anemia in low-income children participating in WIC ages 6 months to 5 years	3.0%
Low-income babies participating in WIC with high birth weight	4.5%
Low-income mothers participating in WIC whose pre-pregnancy BMI was overweight	22.9%
Low-income mothers participating in WIC whose pre-pregnancy BMI was obese	27.5%
Low-income mothers participating in WIC whose weight gain in pregnancy was less than ideal	20.3%
Low-income infants participating in WIC breastfed at least 6 months	33.7%
Low-income infants participating in WIC exclusively breastfed at least 3 months	19.3%
Low-income infants participating in WIC exclusively breastfed at least 6 months	10.3%
Depression in the Medicare population	8.3%
Hospitalization rate due to asthma	48.6 per 10,000
Osteoporosis in the Medicare population	5.0%

Health-Care Access and Quality Indicators Summary	Rate
Older adult preventable hospitalizations	64.9 per 1,000
Cost barrier to care	19.0%
Primary care provider access	67.7 per 100,000
Uninsured	19.6%

Health Behaviors Indicators Summary	Rate
Teens who have smoked tobacco	39.8%
Teens who currently smoke tobacco	18.2%
Teens who have used methamphetamines	1.7%
Teens who use alcohol	30.8%
Teens who use marijuana	19.3%
Adults who eat 5 or more fruits and vegetables per day	13.9%
Adult women who receive routine Pap Tests	68.8%
Adult physical inactivity	24.9%
Teen birth rate	78.8 per 1,000
Adult binge drinking	15.7%
Cigarette smoking by adults	25.6%

Social Factors Indicators Summary	Rate
Gender: female	50.3%
Gender: male	49.7%
Population over 65 years old	25.8%
Population under 18 years old	20.4%
People living in poverty	21.3%
Children living in poverty	37.0%
Homeownership	45.8%
School dropouts	5.1%
Single-parent households	39.0%
Linguistic isolation	2.1%
Inadequate social support	24.0%
Violent crime	338.9 per 100,000
People facing high housing costs	31.6%
Median household income	\$40,042
Families living in poverty	14.9%
Households with cash public assistance	2.2%
On-time high school graduation	72.6%
People 25 years and older with a bachelor's degree or higher	17.1%
Unemployment	8.0%
Income inequality index	0.427
People 65 years and older living in poverty	7.9%

Physical Environment Indicators Summary	Rate
Child food insecurity	32.1%
Food insecurity	18.4%
Limited access to healthy foods	11.6%
People 65 years and older with low access to a grocery store	5.7%
People who live within half a mile of a park	3.0%
People living in stressed housing	35.1%
Annual ozone air quality grade	5 (F)
Children with low access to a grocery store	5.0%
Households with no car and low access to a grocery store	3.5%
People living near highways	2.3%
Annual particle pollution (PM2.5)	8.0 µg/m ³
Liquor store density	5.7 per 100,000
Recognized carcinogens released into air	20,910 pounds
Persistent, bioaccumulative and toxic chemicals released	3,787,204 pounds

Community Engagement - Survey

Age	%
<17	0.3
18-24	2.9
25-34	12.6
35-44	13.7
45-54	17.8
55-64	29.4
65-74	18.4
75 or older	4.9

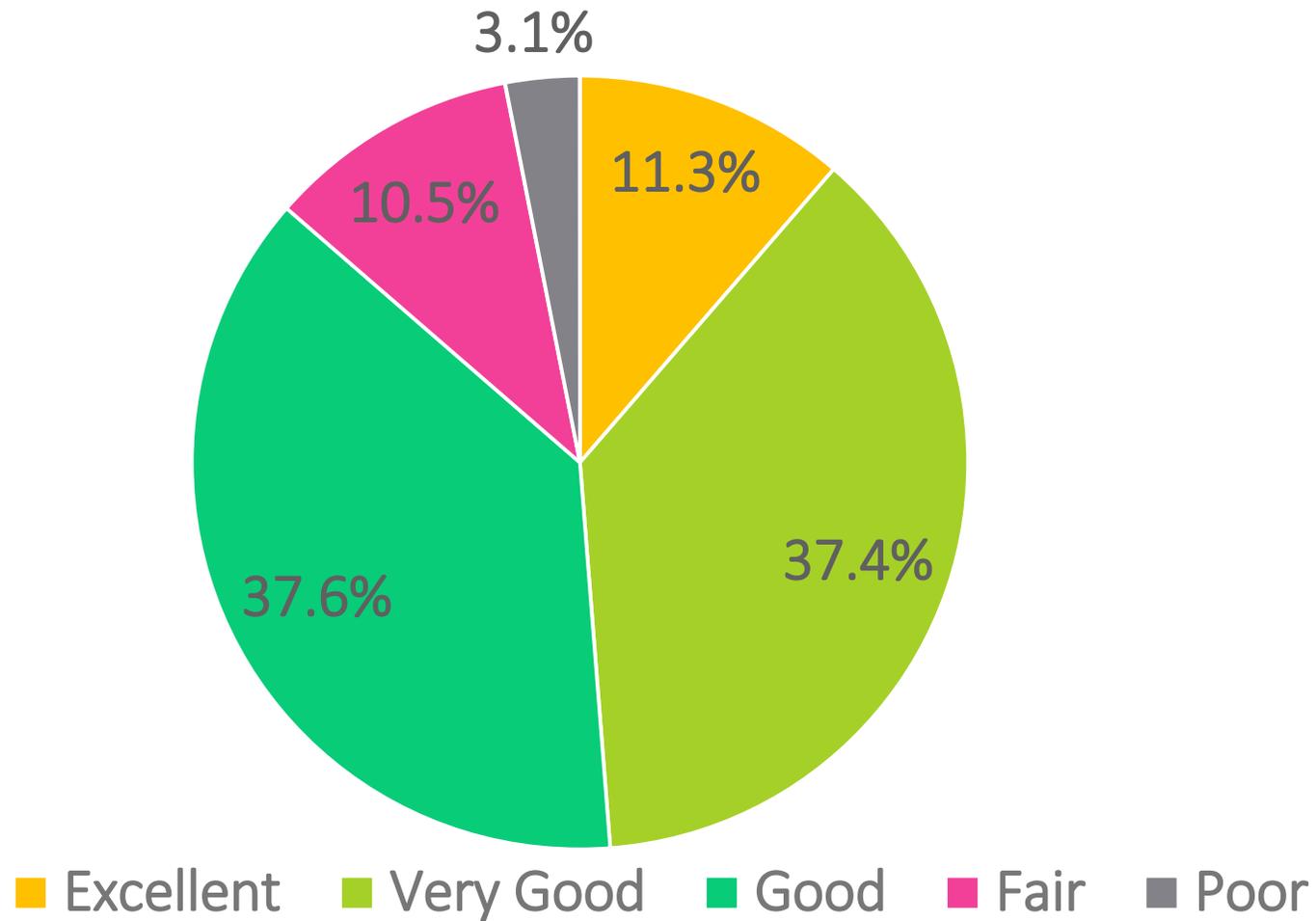
Race/Ethnicity	%
White	76
Black/African American	0.3
Asian/Pacific Islander	0.7
Hispanic	15.8
Multiple Race/Ethnicity	3.3

Gender	%
Male	27.2
Female	72.8

Education	%
Less than HS Degree	3.3
HS Degree or Equiv.	14.9
Some College, No Degree	37.1
Associate Degree	13.2
Bachelor's Degree	17.6
Graduate Degree or Higher	13.9

Town of Residence	%
Payson	25
Globe	36.3
Miami	6.3
Hayden/Winkelman	0.5
Claypool	2.9
Star Valley	1.1
San Carlos	0.7
Roosevelt	2.4
Tonto Basin	12.2
Young	4.6
Gisela	0.2
Pine	2.0
Strawberry	0.8
Other	5.0

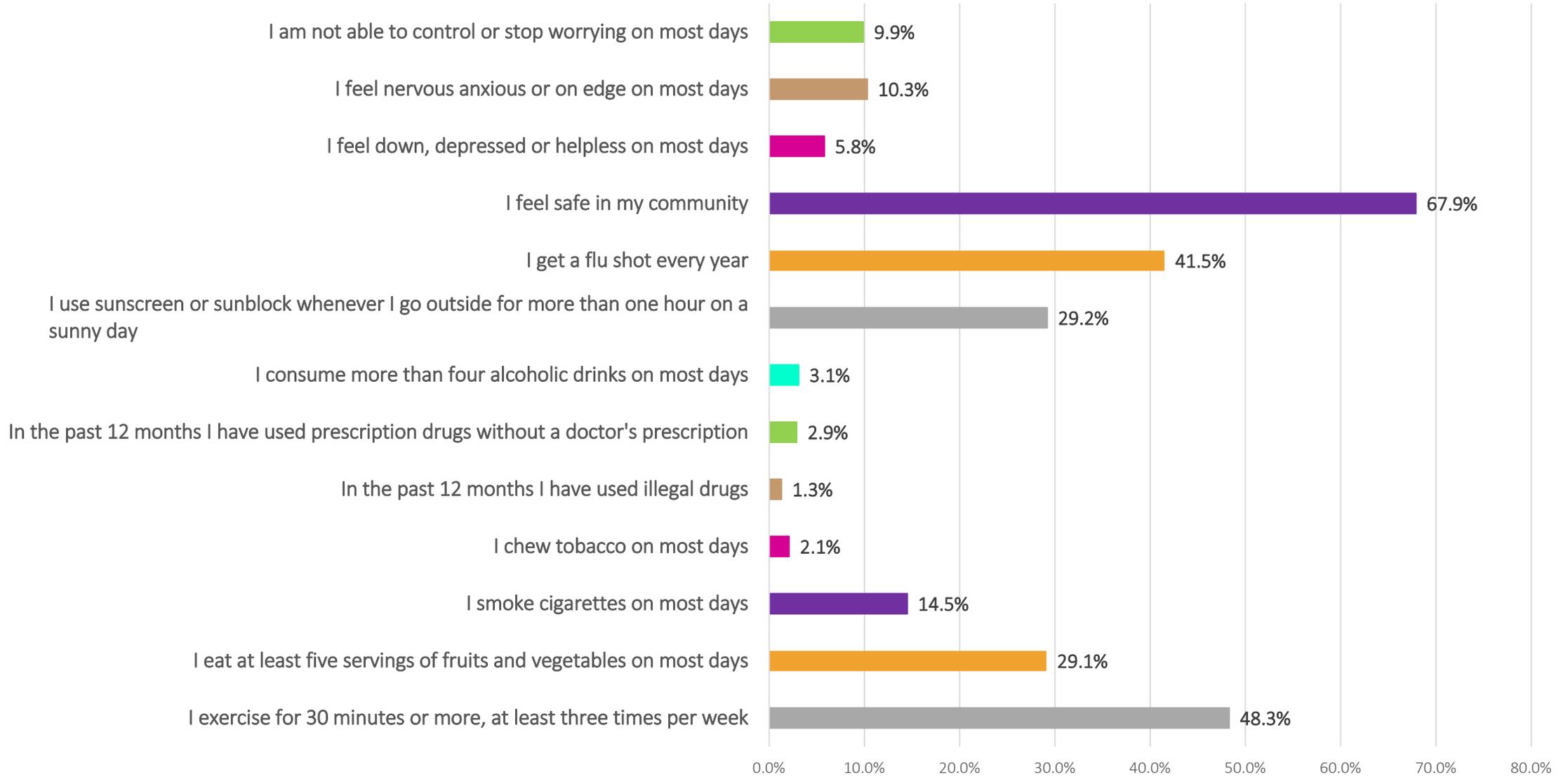
How would you describe your overall health?



Survey - Community Perceptions

- Survey respondents cited **overweight/obesity** as the top health challenge they face.
- Survey respondents believed the following to be the top three health issues for Gila County:
 - Drug addiction
 - Overweight/obesity
 - Diabetes

General Health: Which statements below describe you?



Community Engagement - Focus Groups

- **Theme 1: Strengths and opportunities embedded in small, close-knit communities across Gila County and the CVRMC service region**
 - “Small,” “quiet,” and “everyone knows each other” were three themes that emerged repeatedly in each focus group.
 - Many participants identified a connection with family or neighbors in their community that enabled them to feel connected.

“AS A SMALL TOWN
THERE IS A REAL SENSE
OF COMMUNITY WHEN
YOU’RE IN NEED.” -
PAYSON FOCUS GROUP
PARTICIPANT

“WE NEED MORE
COMMUNITY POOLS AND
BIGGER PARKS. THAT WOULD
MAKE ME WANT TO GO OUT
AND DO HEALTHY THINGS.” —
GLOBE FOCUS GROUP
PARTICIPANT

- **Theme 2: Lack of coordinated recreational opportunities**
 - The most evident theme related to poor health outcomes was the desire for increased recreational opportunities and options for all ages.
 - Participants cited a lack of recreational opportunities for all age groups and highlighted the stress related to social isolation and economic challenges of having to travel to another town to find recreational opportunities for children.
 - Social connection and mental health benefits associated with recreational opportunities were repeatedly cited as important to focus group participants.

- **Theme 3: Need for improved access to specialty health-care services**

- Focus group participants repeatedly mentioned a strong connection with the health-care providers in their communities.
- Participants requested urgent care and extended-hour pharmacy services to help meet their most immediate needs.
- Participants in all focus groups also identified a need for mental health support services.

“I HAVE TO TRAVEL TO MESA TO SEE A SPECIALIST. I DON’T HAVE THE TIME OR TRANSPORTATION TO DO THIS.” —KEARNY FOCUS GROUP PARTICIPANT

Key Informant Interviews

Participating Organizations

	Organization
1	City of Globe
2	Cobre Valley Regional Medical Center (CVRMC)
3	First Things First, Gila Regional Council
4	Freeport-McMoRan
5	Globe Active Adults
6	Heritage Healthcare
7	Horizon Human Services
8	Miami Senior Center
9	Miami Unified School District
10	Miami/Globe Head Start
11	Payson Unified School District
12	Resolution Copper
13	Southwest Behavioral Health Services
14	Tonto Apache Tribe

Key Informant Themes

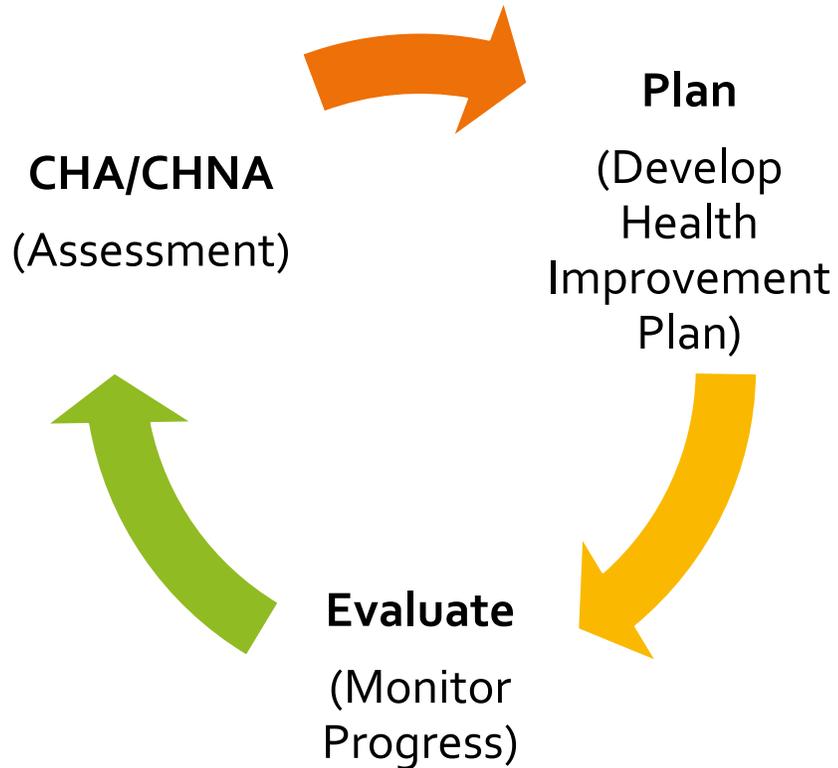
“IT’S HARD TO BE HEALTHY WHEN PEOPLE ARE LIVING IN POVERTY. HEALTH IS NOT THE NORM. I KNOW WE CAN BREAK THIS CYCLE. WE WILL GET THERE EVENTUALLY.” —
KEY INFORMANT

- Theme 1: Strong Sense of Community
- Theme 2: Need for improved access to specialty health-care services with an emphasis on mental and behavioral health services
- Theme 3: Need for improved access to substance abuse support services

Community Health Improvement Plan (CHIP)



The CHIP Process



- Purpose: Provides guidance to GCDHEM and CVRMC, partners, and stakeholders, on improving the health of the population within the county.
- The plan is critical for developing policies and defining actions to target efforts that promote health.
- Government agencies, including those related to health, human services, and education, use the CHIP to set priorities and coordinate and target resources.

CHIP Methodology

- Review CHA findings
- Engage partners
- Determine health priorities
- Develop the 5-year plan
 - Strategies
 - Measures



CHIP Advisory Committee

- GCDHEM
- CVRMC
- Capstone Pinto Valley
- Head Start
- Heritage Healthcare
- Community Bridges
- Resolution Copper
- Teen Outreach Pregnancy Services (TOPS)
- Pinto Valley Mining Corporation
- Young Public Schools
- Miami Unified School District
- Tonto Apache Tribe
- Globe Active Adult
- Globe Fire
- Southwest Behavioral Health
- University of Arizona Cooperative Extension
- Globe Unified School District
- Carlota Mine
- Elder Quality of Life
- Banner Payson
- Southeastern Arizona Behavioral Health Services (SEABHS)
- KGHM Mines

Criteria for Identifying Health Priorities

- **Size** – Are there a high number of people affected?
- **Seriousness** – Do the health issues cause severe impacts to people's quality of life and costs to the healthcare system?
- **Feasibility** – Can we realistically address the issues? Are potential solutions cost effective, actionable, and achievable?
- **Potential for Collective Impact** – Are there opportunities to leverage existing efforts and resources to address this issues?
- **Influence** – Does the issue represent a significant risk factor for other diseases? Can preventative measures have a high impact?

Health Priorities

- Committee identified 12 key health issues from the CHA, after consensus narrowed to the following 4 health priorities:
 1. Obesity
 2. Substance Abuse
 3. Access to Quality Health Care, including Mental Health Services
 4. Sexual Health



ROAD MAP TOWARDS SUCCESS 2015-16

EARLY JANUARY

Results of the Community Health Needs Assessment were presented to the CHIP Advisory Group.



EARLY FEBRUARY

Top 4 Priority Health Issues were identified:

1. Obesity
2. Substance Abuse
3. Access to Quality Health Care, including Mental Health Services
4. Sexual Health

MARCH

Cobre Valley Regional Medical Center and Gila County adopted the 2015 Community Health Improvement Plan.



SEPT - NOV

- 15 Key Informant Interviews, 637 Surveys and 6 Focus Groups were conducted with Gila County Residents.
- Data from secondary sources such as X, Y, Z were analyzed

LATE JANUARY

The Advisory Group identified 5 criteria to prioritize health needs and issues from the assessment:

- Size
- Seriousness
- Feasibility
- Potential for Collective Impact
- Influence

LATE FEBRUARY

The Advisory Group identify long-term and 5 year goals for each priority, as well as targeted strategies to accomplish those goals.



PREVENT. PROMOTE. PROTECT

Questions?

adrienneudarbe@pinnacleprevention.org