



Grand County Public Health and Wellness Needs Assessment: 2018

Survey of Residents and Health Professionals

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PUBLIC HEALTH AND WELLNESS NEEDS ASSESSMENT 2018

RESULTS FROM SURVEYS OF RESIDENTS AND HEALTH PROFESSIONALS

BACKGROUND

Grand County Public Health (GCPH) promotes and protects the health of Grand County residents and visitors. According to the Colorado State Demography Office, this rural county has gained 500 households since 2013 and is expected to gain 800 more households by 2023. Accompanying this population growth are changes in public health issues, needs, and ability. For example, public discourse about opioids and health insurance are fundamentally different now than they were five years ago.

GCPH wants to ensure they are focusing their services to adapt to these changes and to achieve their mission. Additionally, GCPH is required by state policy to conduct a county-wide community health assessment and health issue prioritization process to update its health improvement plan. GCPH hired Corona Insights to guide the county through this process. This report documents the initial phase of the process and summarizes the findings of two surveys: one survey of local health professionals and affiliates and the other with county residents.

PURPOSE, GOALS, AND SUCCESS MEASURES

The **purpose** of needs assessment is to understand public health and wellness needs and ability, and then use that knowledge to strategically prioritize actions that GCPH and their partners can take to effectively promote and protect the health and wellness of residents for the next five years.

Goals

1. Elicit and document high-priority needs from the perspective of partners, health experts, and other stakeholders.
2. Identify the most pressing health needs from the perspective of Grand County residents.
3. Measure the gaps in services and barriers of access to public health services.
4. Understand changes in health needs, indicators, and capacity since 2012.

Success Measures

1. Public engagement facilitates equitable input from residents and stakeholders; collaboration and multiple perspectives are valued.
2. Research reveals findings and insights that inform strategic decisions and prioritize actions.

3. Quantifiable results represent the community, are reliable and defensible, and the degree of uncertainty (e.g., margin of sampling error) is clearly documented.
4. Qualitative results are rich in description, contextual, and recognize complexity.
5. Final report is readable and relevant to GCPH, local social service and health care partners, county leaders, and interested residents.
6. GCPH is confident in the information they use to make decisions.
7. Requirements outlined under the Colorado Public Health Improvement Act are satisfactorily met.

APPROACH

PROJECT PLANNING

We first held an online project kick-off meeting where we elicited the desired project outcomes from the GCHP project management team (PMT). We then formalized achievable project goals and success measures into a project goals document, which the PMT reviewed and approved.

SURVEY OF HEALTH PROFESSIONALS AND AFFILIATES

We conducted an online survey of local health professionals and affiliates, such as health care providers, County and municipality officials, school nurses, law enforcement, and others, to gauge the health system's ability to address various health and wellness needs. The survey also explored changes in issue status since 2012, vulnerability, priorities, tobacco, and desired resources. The survey instrument is in [Appendix A](#).

Grand County Public Health provided a list of 144 email addresses of local health professionals and affiliates, and we sent to each address a secured invitation to answer a questionnaire online. Four email addresses were invalid. We then sent three follow-up reminders to all non-respondents. We received a total of 82 useable responses, for a response rate of 59 percent, suggesting this population is very engaged.

Assuming the list of email addresses generally represented the complete population of health professionals and affiliates in Grand County, we checked to see if some types of respondents, based on email address domains, were more likely or less likely to respond. We found that respondents from certain organizations (reflected through the domain name of their email) were more or less likely to respond. We therefore calculated and applied corrective weights to balance the data so that the results did not overrepresent nor underrepresent any sub-group.

SURVEY OF GRAND COUNTY RESIDENTS

After initiating the survey of health professionals, we then conducted a county-wide mail survey to assess health and wellness needs among Grand County adult residents. Corona collaborated with the PMT to ensure the questionnaire asked relevant, easy to interpret, and high-value questions. The survey instrument is in [Appendix A](#).

We mailed 2,700 4-page questionnaires, printed in English and in Spanish, to a representative list of mailing addresses. Because 93 percent of all address types in Grand County are PO Boxes, this list included both traditional and only-way-to-get-mail PO Boxes, which increased our sample coverage. The list excluded addresses known to be vacant or seasonally occupied, which slightly decreased our coverage but increased survey efficiency. The questionnaire packet included a one-page cover letter, printed in English and Spanish, and it include a pre-stamped and addressed return envelope. Although we mailed this questionnaire to

addresses, we wanted the data to represent just one person who lived at each address. To reduce potential response bias, the cover letter instructed that the adult living at the address who had the next birthday should complete the questionnaire. This approach helped randomize respondents and prevent overrepresentation of people who had more time available or interest in completing the questionnaire. About ten days after mailing the initial survey packet, we mailed a postcard to each address, reminding people to reply to the survey if they had not yet done so. To further encourage residents to respond, we promoted a sweepstakes in which five randomly selected survey respondents would each receive a \$100 cash prize; 53 percent of respondents entered the sweepstakes.

Out of 2,700 questionnaires mailed, 125 questionnaires were returned as undeliverable. Almost all of these undeliverable questionnaires had street addresses, as opposed to PO Boxes, but there did not appear to be any other geographic pattern of concern. Among the 2,575 questionnaires that were delivered, we received 522 useable responses by the cut-off date, for a 20 percent response rate, which was slightly higher than expected for a community survey.

Although we received a high response rate, we did receive proportionally more responses from older adults and from females than their representation within the population. To correct for this potential bias, we calculated and applied statistical weights so that responses by age group and gender were correctly representative. We then made an additional correction to balance the representation by household size, so that people living in multiple-person households were not underrepresented. The goal of these corrections was to increase the accuracy and representativeness of the survey results.

The maximum plus or minus margin of sampling error (at 95% level) for the resident survey was ± 5.8 percentage points. If we were to conduct this survey 100 times, drawing a new random sample each time, we would expect that our estimate would be within the margin-of-error on 95 of those 100 surveys. These values account for the study's design and weighting effects, which increase the margin of error in relationship to the distribution of the weights. Margin of sampling error is just one type of potential error; total error includes other potential issues such as residents misreading questions and non-response.

THIS REPORT

This report integrates data from the health professional and affiliate survey and the resident survey. Specific details of how the data were integrated, if applicable, are discussed at the beginning of each section. The data source is noted in each chart title; with the abbreviation "HPA" indicating the data was from the health professionals and affiliates survey, while the abbreviation "RS" indicates the data was from the resident survey. The "Q#" shows the question number from that survey.

Accompanying this report is a workbook of analysis tables for each question from both surveys.

This report summarizes findings from the initial research phase of the needs assessment. Findings from additional research about access to mental health and lack of social support systems are summarized in a separate report.

MEASURING NEED AND ABILITY

The central metric derived from this needs assessment is the extent that Grand County residents' health and wellness needs differ from the community's ability to meet those needs. Measuring and indexing the difference between need and ability for specific health and wellness issues (e.g., alcohol abuse, paying for dental care, etc.) was the primary goal of the survey research phase of the needs assessment. This section explains how we measured need and then displays results and interprets findings of that process.

FACTORS OF NEED

To measure health and wellness need, we created a conceptual model that incorporated three factors: frequency of the health or wellness issue within Grand County, difficulty of addressing the issue, and ability to address the issue. We combined the frequency and difficulty factors to create a composite need score. There are numerous other factors that could influence a prioritization assessment that were not included in this model, such as the individual, social, or economic benefit of treating or addressing each issue. We considered incorporating other factors into our model, but we chose to include just these three factors due to space/time limitations on the surveys.

The conceptual model and descriptions of each factor are shown below.

Frequency represented the percentage of Grand County residents who faced or experienced each health and wellness issue included in this assessment. We conceptualized that more common issues would represent greater need, all else being equal. Frequency was one of two factors that represented need, and it was measured by asking county residents to mark, among the 38 various issues, which ones were true for them in the past 12 months.

Difficulty represented the amount of effort or resources it would take for the community's health and wellness system to produce significant improvements.

Intervention: For issues associated with personal health, such as alcohol abuse, depression, obesity, exercise and nutrition, or violent behavior, we measured difficulty as the amount of intervention needed for a typical person facing that issue to make significant improvements. A slight intervention meant few resources (effort, money, space, expertise) would be needed to see improvement, while an extreme intervention meant a lot of resources would be needed.

Complexity: Not all issues in this assessment were associated with personal health, and therefore the level of intervention scale was not always appropriate. Community or social issues, such as accessing healthy food, securing child care, or system navigation, were measured as how difficult or complex it would be to meaningfully improve, treat, prevent, educate, or otherwise directly address people facing each issue. Slightly difficult or complex meant few resources (effort, money, space, expertise) would be needed to address it, while extremely difficult or complex meant a lot of resources would be needed.

Difficulty was the second of two factors that represented need, and it was measured by asking health professionals and affiliates to score, among the issues that their organization addressed, the difficulty of each issue on a four-point scale, with a “don’t know” option.

Ability represented an organization’s current ability to serve more residents facing that issue than they currently do. Ability was defined as the combination of time and resources available, and each issue was measured on a four-point scale with a central point label of “At capacity; cannot serve more.” There was also a “don’t know” option.

The following sub-sections display results from both the resident survey and the health professionals and affiliates survey for each factor included in this conceptual model.

NEED

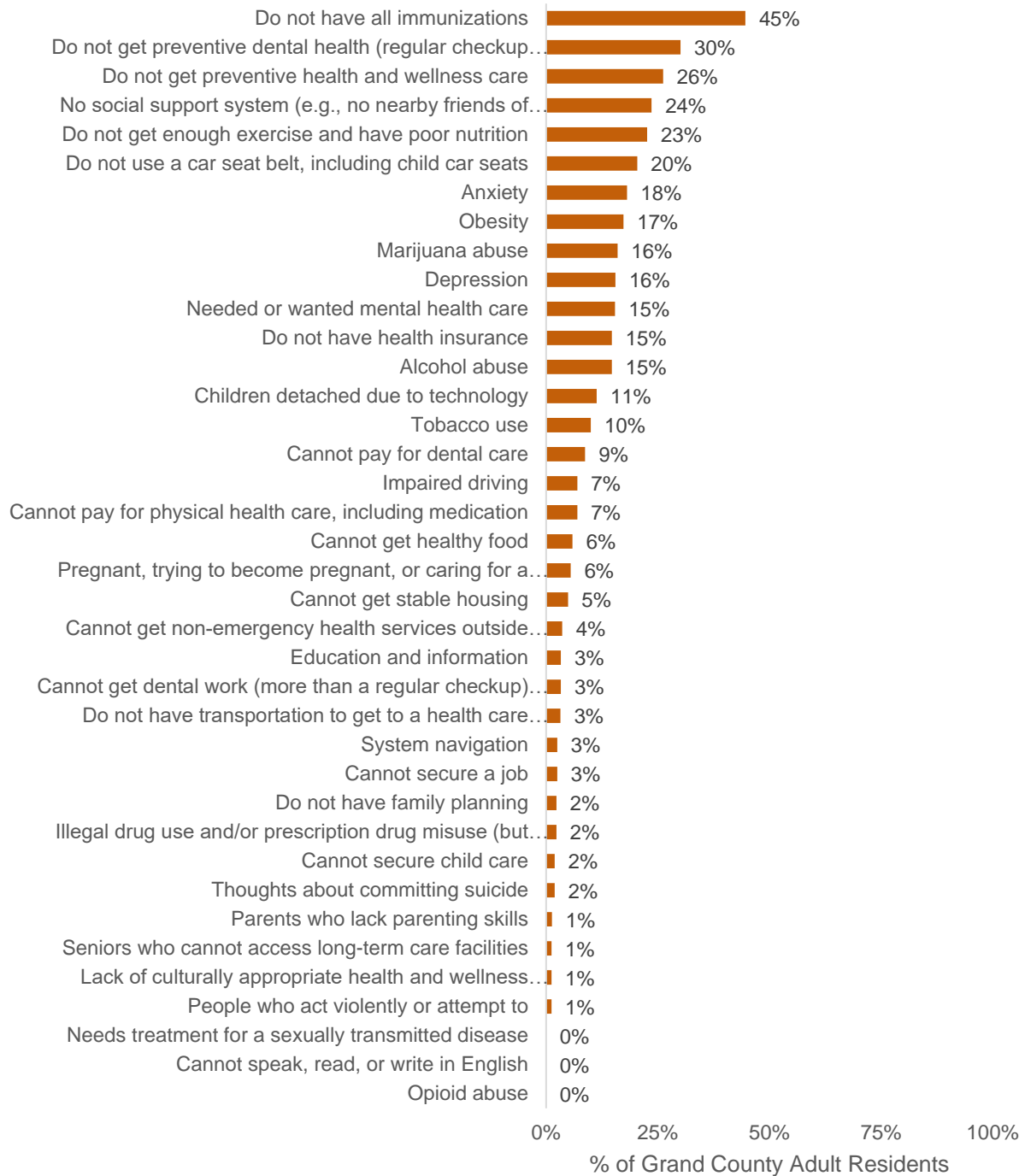
Need is composed of frequency (i.e., the percentage of residents facing the issue) and difficulty (i.e., how much time, effort, and resources are needed to make improvements). The following sections display frequency and difficulty results separately and then combined.

FREQUENCY

Frequency results were derived from the resident survey, which asked respondents to mark every statement that was true for them in the past 12 months.

The most frequent issue among residents was not having all immunizations (45%), which was based on the statement “I got a flu shot within the past 12 months” (reverse coded). More than one-quarter of residents also did not get preventive dental health care (30%) or preventive health and wellness care (26%).

Frequency of Health and Wellness Issues (RS: Q5)



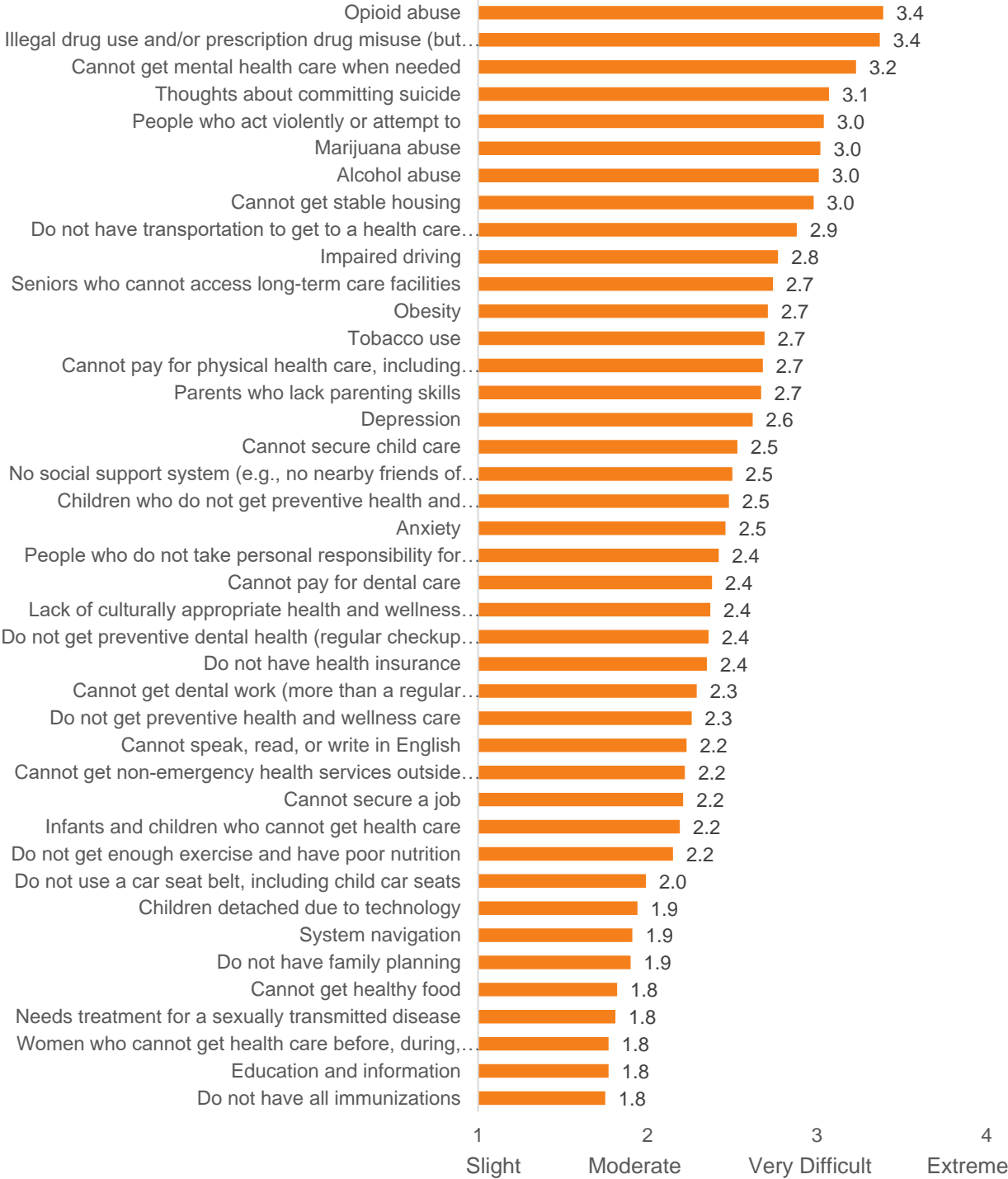
DIFFICULTY

Difficulty estimates were derived from the health professionals and affiliates survey. For health issues, respondents were asked to indicate the amount of intervention needed for a typical person facing that issue to make a significant improvement. A “slight intervention” was defined as needing few resources (effort, money, space, expertise) while a lot of resources would be needed to see improvement for an issue requiring an “extreme intervention.” For social issues, we recognized that the level of intervention was not an appropriate scale. For example, ensuring access to healthy foods was a problem broader than treating one person. Therefore, social items were asked on a scale of difficulty or complexity, from “slightly difficult or complex” to “extremely difficult or complex.” Whichever scale was used, the goal of these questions was to measure the resources (e.g., effort, time, money, space) necessary to achieve improvements.

To ease comparability and simplify graphics, we calculated a “difficulty” score for each issue by assigning the following numbers to the response scale and then calculating an average: slightly difficult = 1, moderately difficult = 2, very difficult = 3, and extremely difficult = 4. Replies of “don’t know” were excluded from the average score.

On average, the most difficult issues to address were opioid abuse and illegal drug use/prescription drug (besides opioids) misuse, followed by inability to get mental health care when needed and thoughts of suicide.

Average Difficulty to Address (HPA: Q3, Q4)



ABILITY

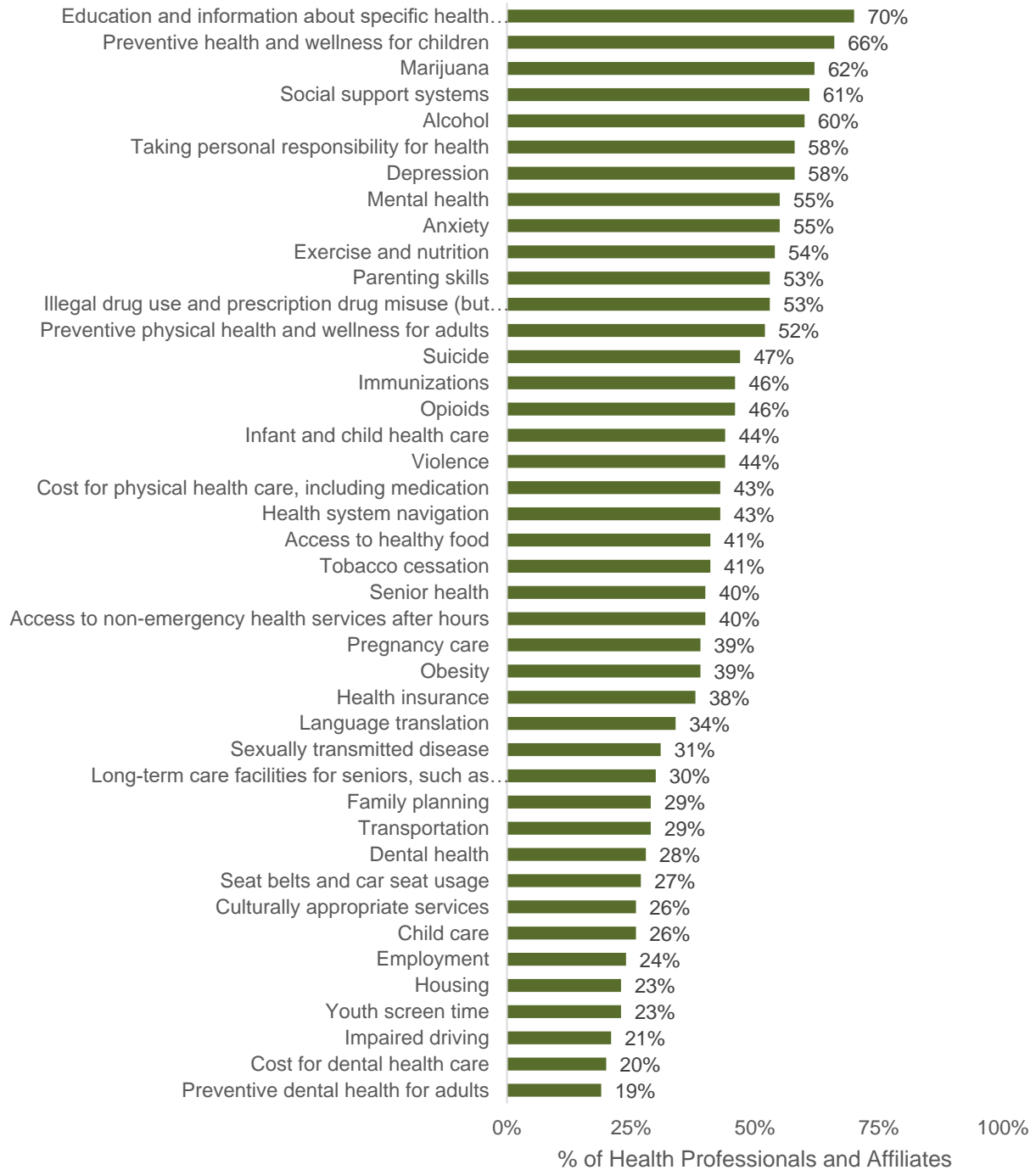
PEOPLE OR ORGANIZATIONS ADDRESSING EACH ISSUE

Questions 1 and 2 on the health professional and affiliate survey asked respondents to mark each item that they, or their organization, addressed, improved, treated, prevented, or otherwise helped residents experiencing that issue.

Results from these questions were not directly used to calculate index scores, rather, these questions were used to filter out issues that the respondent (or the organization they worked for) did not address. Therefore, health professionals and affiliates only answered questions about the health and wellness issues that they addressed in their work, and they were not asked about issues that were likely to be unfamiliar. For example, if a respondent did not indicate that they, or their organization, addressed the cost for dental health care, they were not asked about the difficulty of that issue or their ability to address it.

The greatest number of people or organizations were addressing “education and information about specific health issues” (70%), followed by preventive health and wellness for children, marijuana, and social support systems.

People or Organizations Addressing Each Issue (HPA: Q1, Q2)



ABILITY TO MEET DEMAND

Ability was measured from the health professionals and affiliates survey as the extent that organizations addressing each issue were able to meet the current demand or serve additional people. For this question, ability was defined as the combination of time and resources available.

To ease comparability and simplify graphics, we calculated an “ability” score for each issue by assigning the following numbers to the response scale and then calculating an average:

Question Scale	<u>Well over capacity</u> ; cannot meet current demand	<u>Slightly over capacity</u> ; cannot meet current demand	<u>At capacity</u> ; cannot serve more	Able to serve <u>some</u> additional people	Able to serve <u>many</u> additional people	<i>Don't know</i>
Numeric Code	-2	-1	0	1	2	-

Based on this coding scheme, negative scores suggest the health and wellness community overall does not have enough capacity to meet the current demand. Scores close to zero suggest the community is meeting the current demand but cannot serve more. Positive scores suggest there is room for the community to serve more people than it currently does.

On average, organizations could not meet the current demand for addressing residents needing stable housing, needing transportation to get health care, and providing long-term care facilities to seniors.

Average Ability to Serve Residents (HPA: Q5, Q6)



INDEX SCORES

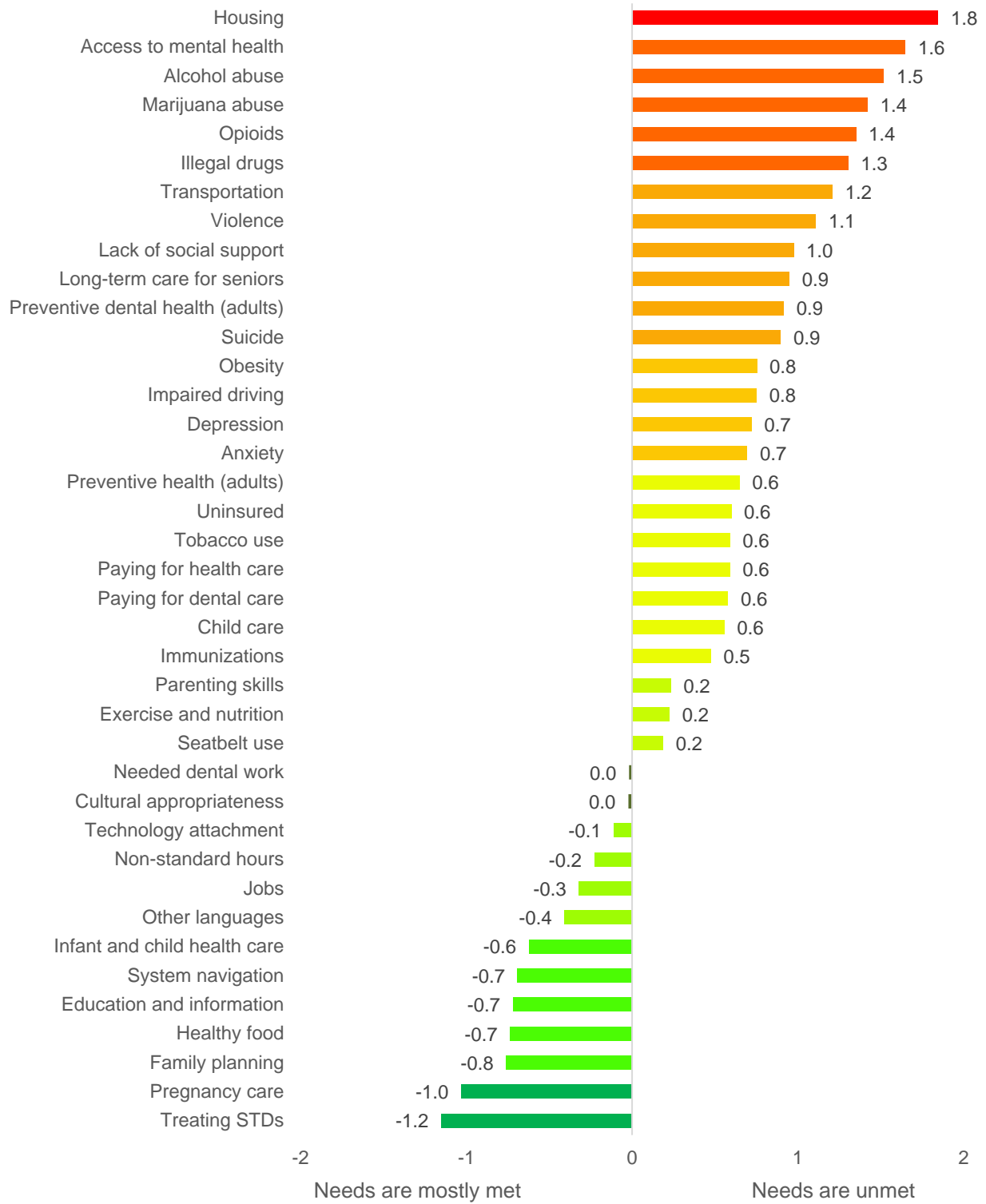
Using the factors of frequency, difficulty, and ability, we calculated an index score for each issue. We first transformed the frequency percentage for each issue into a numeric score. Scores ranged from zero to four, with zero representing zero percent frequency and four representing 100 percent frequency. Then we added that frequency score to the averaged difficulty score (see previous Difficulty section), which produced our need score. Next, we transformed the average ability for each issue into a numeric score. Scores ranged from zero to four, with zero representing “well over capacity; cannot meet current demand,” and four representing “ability to serve many additional people.” Finally, we subtracted the ability score for each issue from its need score to calculate an index value for each issue. Responses of “don’t know” were excluded from all calculations.

Technically, the minimum possible score was negative three (zero frequency plus one difficulty minus four ability), which would indicate much more ability than need. Technically, the maximum possible score was eight (four frequency plus four difficulty minus zero ability), which would indicate much more need than ability. However, the actual range of need scores was much smaller: -1.2 to 1.8.

The table below shows the twelve greatest index issues in Grand County, and the subsequent chart shows the index score for all issues.

Issue	Rank	Index Scores
Housing	1	1.85
Access to mental health	2	1.65
Alcohol abuse	3	1.52
Marijuana abuse	4	1.42
Opioids	5	1.35
Illegal drugs	6	1.30
Transportation	7	1.21
Violence	8	1.11
Lack of social support	9	0.97
Long-term care for seniors	10	0.95
Preventive dental health (adults)	11	0.91
Suicide	12	0.90

Index Scores



It is insightful to examine these issues by their specific factor scores. The table below compiles frequency, difficulty, and ability scores along with index scores, to see which factor for each issue seems to be driving the index score. The colors highlight the values for each column, with highest values in dark red, medium values in orange and yellow, and the lowest values in dark green.

An important pattern to notice is when colors are inconsistent across the row (i.e., for one issue). For example, few residents reported using opioids (we acknowledge actual use is higher than zero percent), but according to local professionals, the difficulty (i.e., level of intervention needed) to treat a typical opioid user was very high, and the community’s ability (i.e., capacity and resources) to treat users was relatively low. Therefore, high difficulty and low ability was driving the high index score for the opioid issue. Conversely, the index score for “lack of social support” issue was driven primarily from its relatively high frequency, rather than difficulty or lack of ability.

Issue	Frequency	Difficulty	Need	Ability	Index
Housing	5%	3.0	3.2	1.3	1.8
Access to mental health ¹	8%	3.2	3.6	1.9	1.6
Alcohol abuse	15%	3.0	3.6	2.1	1.5
Marijuana abuse	16%	3.0	3.7	2.2	1.4
Opioids	0%	3.4	3.4	2.0	1.4
Illegal drugs	2%	3.4	3.5	2.2	1.3
Transportation	3%	2.9	3.0	1.8	1.2
Violence	1%	3.0	3.1	2.0	1.1
Lack of social support	24%	2.5	3.4	2.5	1.0
Long-term care for seniors	1%	2.7	2.8	1.8	0.9
Preventive dental health (adults)	30%	2.4	3.6	2.7	0.9
Suicide	2%	3.1	3.1	2.3	0.9
Obesity	17%	2.7	3.4	2.7	0.8
Impaired driving	7%	2.8	3.1	2.3	0.8
Depression	16%	2.6	3.2	2.5	0.7
Anxiety	18%	2.5	3.2	2.5	0.7
Preventive health (adults)	26%	2.3	3.3	2.7	0.6
Uninsured	15%	2.4	2.9	2.3	0.6
Paying for health care	7%	2.7	3.0	2.4	0.6
Tobacco use	10%	2.7	3.1	2.5	0.6
Paying for dental care	9%	2.4	2.7	2.2	0.6
Child care	2%	2.5	2.6	2.1	0.6
Immunizations ²	45%	1.8	3.5	3.1	0.5
Parenting skills	1%	2.7	2.7	2.5	0.2
Exercise and nutrition	23%	2.2	3.1	2.8	0.2

¹ Frequency represented the proportion of the population that needed or wanted mental health care but did not receive it. Difficulty and ability questions were operationalized as “cannot get mental health care when needed.”

² Frequency was measured as the inverse of "I got a flu shot," which is probably a bit low compared to "all immunizations."

Seatbelt use	20%	2.0	2.8	2.6	0.2
Needed dental work	3%	2.3	2.4	2.4	0.0
Cultural appropriateness	1%	2.4	2.4	2.4	0.0
Technology attachment	11%	1.9	2.4	2.5	-0.1
Non-standard hours	4%	2.2	2.4	2.6	-0.2
Jobs	3%	2.2	2.3	2.6	-0.3
Other languages ³	3%	2.2	2.3	2.8	-0.4
Infant and child health care ⁴	3%	2.2	2.3	2.9	-0.6
System navigation	3%	1.9	2.0	2.7	-0.7
Education and information	3%	1.8	1.9	2.6	-0.7
Healthy food	6%	1.8	2.1	2.8	-0.7
Family planning	2%	1.9	2.0	2.8	-0.8
Pregnancy care ⁵	6%	1.8	2.0	3.0	-1.0
Treating STDs	0%	1.8	1.8	3.0	-1.2

³ Frequency was derived from the American Community Survey (2016 5-year estimate), and shows the percentage of adults in Grand County who did not speak English “very well.”

⁴ Frequency represented the proportion of the population caring for a newborn child. Difficulty and ability were operationalized as “infants and children who cannot get health care.”

⁵ Frequency represented the proportion of the population that was trying to become pregnant, was pregnant, or was caring for a newborn. Difficulty and ability were operationalized as “women who could not get health care before, during, or after pregnancy.”

STATED PRIORITIES

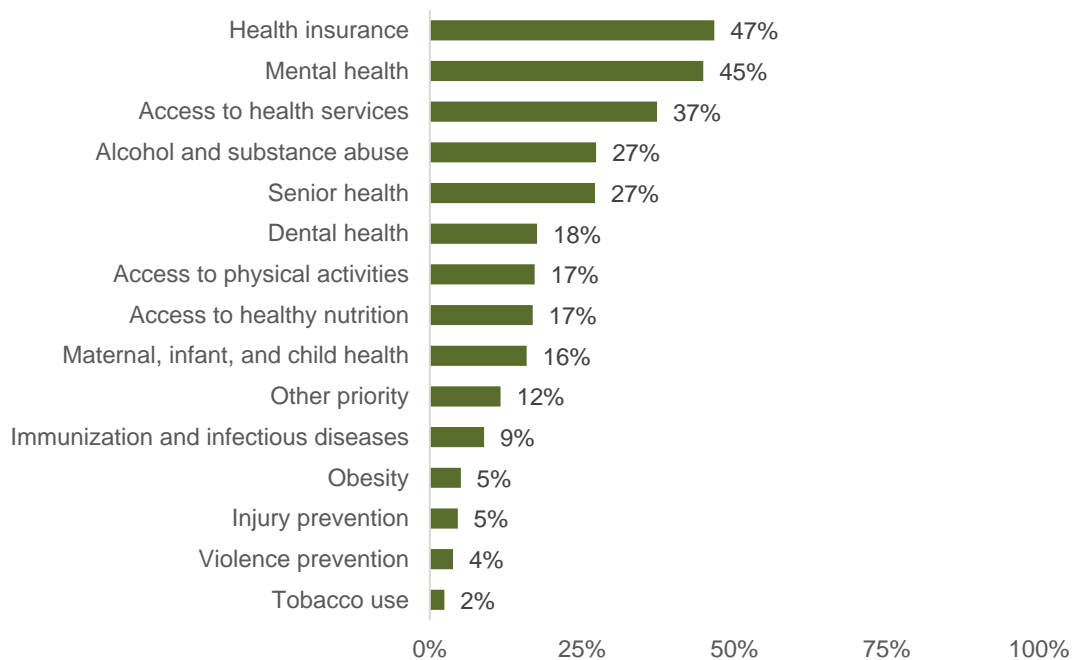
We asked Grand County residents and health professionals and affiliates to mark their top community health and wellness issues that they think should be addressed. This section documents and compares stated priorities between residents and health professionals and affiliates.

RESIDENT PRIORITIES

Grand County residents were asked to indicate⁶ their top three health and wellness issues (from a list of 14 general issues) that they thought Grand County Public Health should prioritize. The chart below shows the proportion of residents who indicated the issues should be a top-three priority.

Health insurance, mental health, and access to health services were the most common top priorities among residents. While health insurance was the most common top priority, over 90 percent of residents were covered by health insurance or a health coverage plan. Beliefs that Grand County should prioritize health insurance is probably unlikely to be related to being covered and possibly related to quality or value of insurance.

Issues Grand County Public Health Should Prioritize
(RS: Q6)

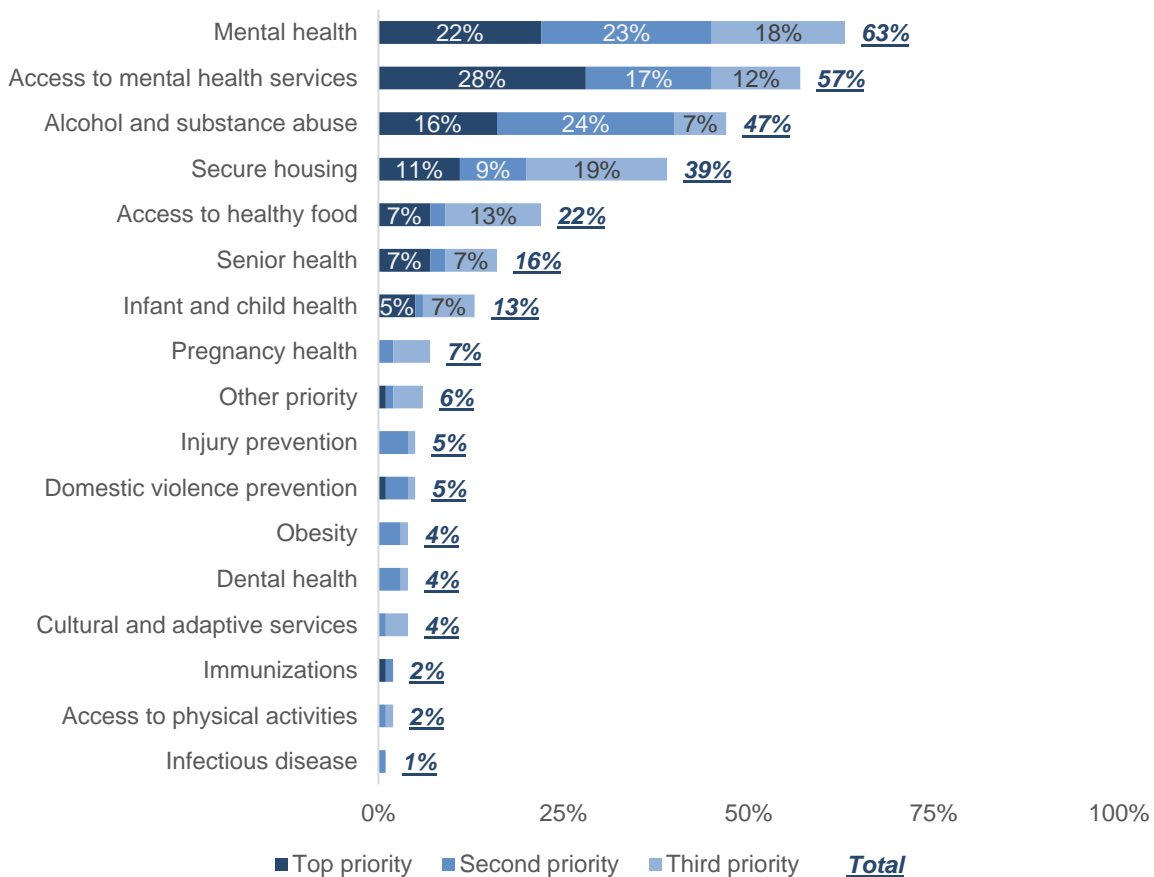


⁶ Residents were asked to rank issues using the numbers 1, 2, and 3; however, a significant proportion of respondents marked three issues without ranking them (e.g., using an “X” to mark the issue instead of a number). Therefore, we tallied all marked issues together, regardless of ranking.

HEALTH PROFESSIONAL AND AFFILIATE PRIORITIES

Health professionals and affiliates were also asked to rank their top-three general issue priorities, out of a list of 17 issues (this list was slightly different than the list of issues asked of residents). Mental health and access to mental health services were the issues most commonly ranked as a top-three priority, followed by alcohol and substance abuse, secure housing, and access to healthy food.

Top Priorities to Improve Resident Health (HPA: Q12)



It is interesting to note that the top-rated priorities in 2018 do not all align with index scores. The four top priorities (i.e., mental health, alcohol and substance abuse, and housing) did align well; they all had high index scores. However, access to healthy food, which 22 percent of respondents indicated was a top-three priority, had a low index score of -0.7. Conversely, domestic violence prevention, which only five percent of respondents indicated was a top-three priority, had a relatively high index score of 1.1. Further, while only four percent of respondents indicated obesity was a top-three priority, it had a moderately high index score of 0.8.

Comparing results of the current survey to results from 2012 survey of health professionals and affiliates, the largest trends we noticed were increases in priority of access to healthy food and senior health. We noticed the largest decreases for dental health and obesity. Note that four issues asked in 2018 were not asked in 2012.

Priority Area	Rank in 2012	Rank in 2018	Rank Change
Mental health	1	1	0
Access to mental health services	3	2	+1
Alcohol and substance abuse	2	3	-1
Access to healthy food	8	4	+4
Senior health	7	5	+2
Infant and child health ⁷	5	6	-1
Other priority	10	7	+3
Domestic violence prevention	9	8	+1
Injury prevention	10	8	+2
Dental health	4	10	-6
Obesity	6	10	-4
Immunizations ⁸	10	12	-2
Access to physical activities	13	12	+1

⁷ Asked as “Maternal, infant, and child health” in 2012

⁸ Asked as “Immunizations and infectious diseases” in 2012

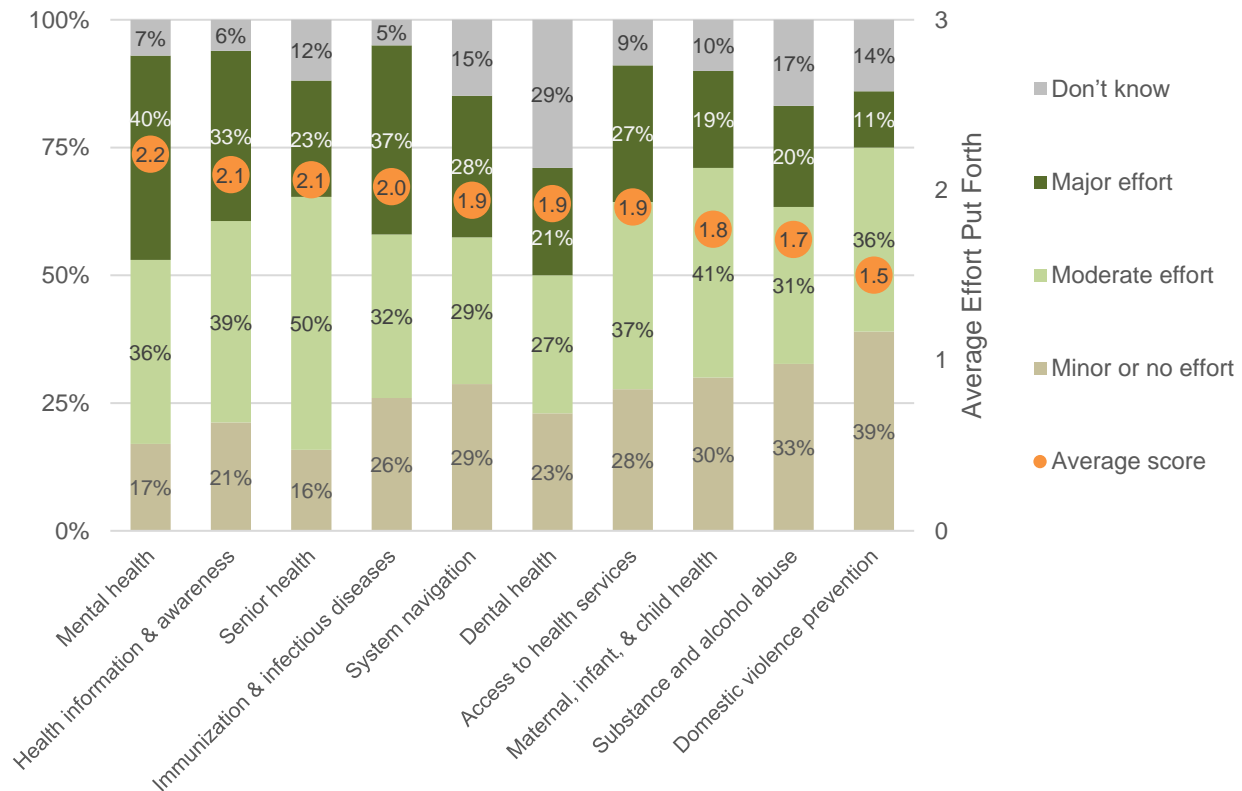
PROGRESS SINCE 2012

One goal of this needs assessment was to understand how health and wellness issues have changed since the 2012 needs assessment. Specifically, we wanted to know if progress was made on the top-ten priority areas identified in 2012. Additionally, we wanted to see if effort (i.e., resources invested, such as time and money) put towards those areas was related to progress. Effort translating into progress would indicate success. Effort not relating to progress would indicate challenges with addressing that issue.

To achieve this goal, we first asked health professionals and affiliates to rate how much effort their organization put towards addressing up to ten of the top priority areas from the 2012 plan. Respondents were only asked to answer about issues that they had previously (i.e., on question 1 and 2) indicated their organization helped address. In the chart below, average scores were calculated by assigning the following numbers to each response option: no effort = 0, minor effort =1, moderate effort = 2, major effort =3. Don't know responses were excluded from the average calculation.

Among the top ten priorities from 2012, the most individual organizations put the greatest effort, on average, into addressing mental health, followed by health information and awareness, and senior health. Domestic violence and prevention received the least effort, on average. Note that almost 30 percent of respondents did not know how much effort their organization put into addressing dental health care.

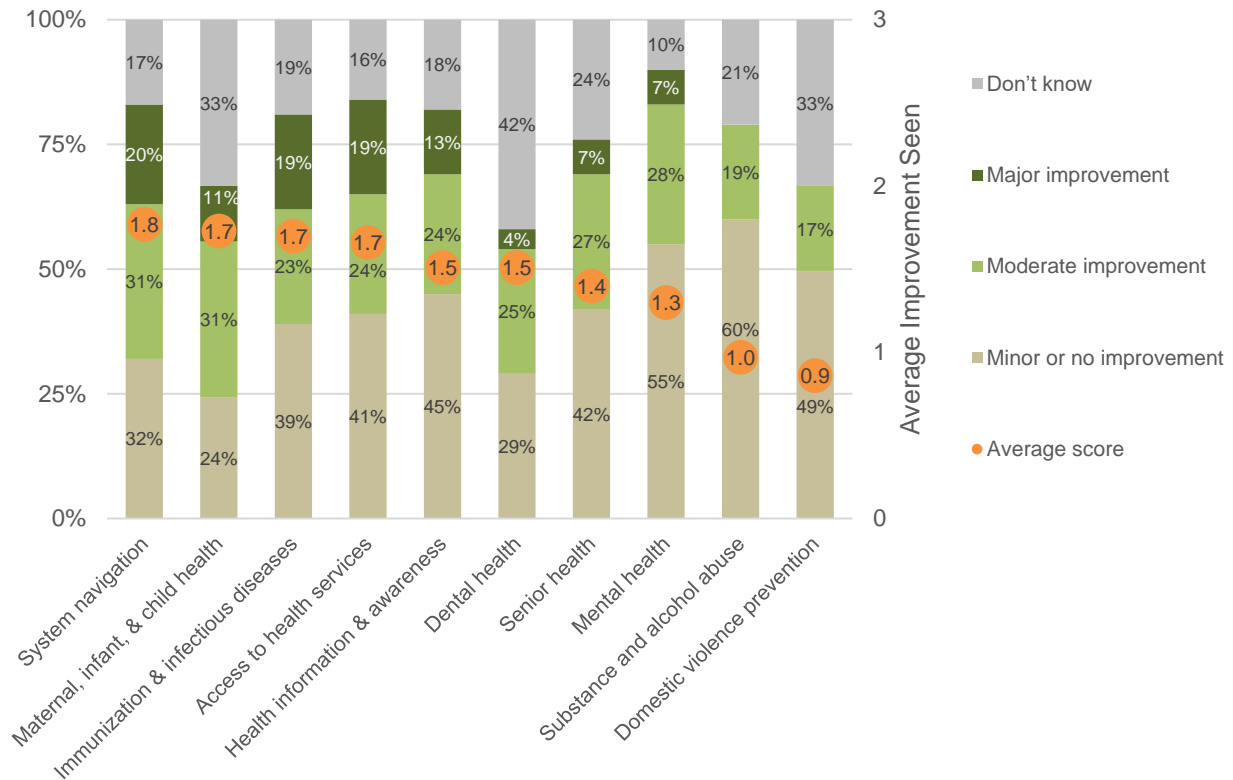
Effort Put Towards 2012 Priorities (HPA: Q7)



Paralleling the question about effort, we asked health professionals and affiliates to rate the community-wide improvement they have seen in the past five years, specifically regarding programs or systems. Again, respondents were only asked about issues that their organization addressed. In the chart below, average scores were calculated by assigning the following numbers to each response option: no improvement = 0, minor improvement = 1, moderate improvement = 2, major improvement = 3. Don't know responses were excluded from the average calculation.

Among the top ten priorities from 2012, the most respondents saw the greatest community-wide improvement in system navigation, followed by maternal, infant, and child health; immunizations and infectious disease; and access to health services. Note that across many of the 2012 priority areas, many respondents did not know how to rate community-wide improvement. For example, 42 percent did not know about improvement in dental health, and one third did not know about improvements in maternal, infant, and child health or domestic violence prevention, even though their organization addressed those issues.

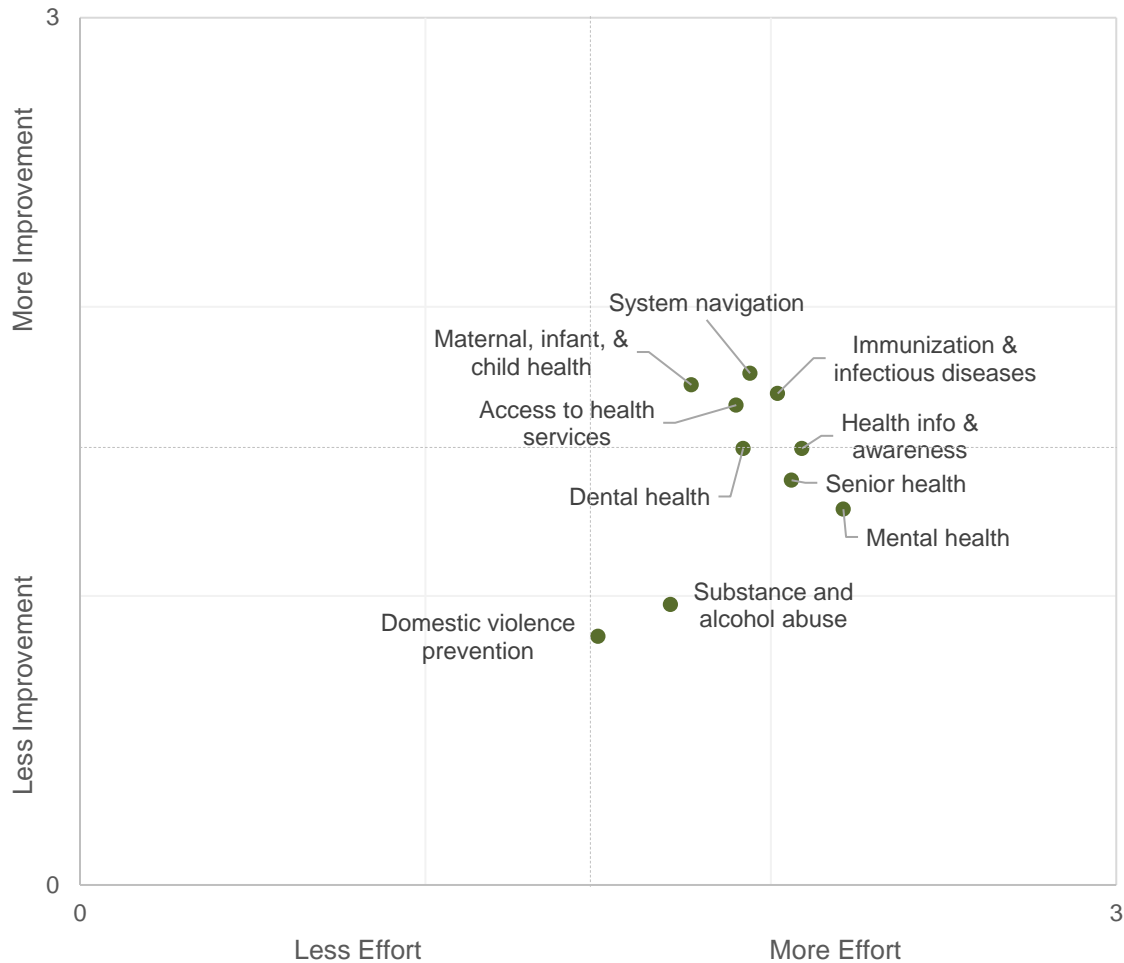
Improvement Seen Since 2012 (HPA: Q8)



One way to evaluate progress and challenges since 2012 is to see if community-wide effort was related to community-wide improvement. We would hope to see priorities that received the most effort also improved the most, and we would expect that priorities that received the least effort also improved the least. The latter is evident, with domestic violence prevention receiving the least effort, and it was rated as least improved (although one third of respondents were unsure the extent it changed). Substance and alcohol abuse received the second least amount of effort, and it was rated second least improved. However, we did not see this relationship at the other end of the scale (i.e., most effort and most improved). Indeed, mental health received the most effort, with three quarters of organizations putting forth major or moderate effort to address this issue, but only one third of health professionals and affiliates saw major or moderate improvement.

This finding suggests that on a community-wide level, more effort is not translating into equivalent improvement for each priority issue. While this could reflect differences in efficiency or efficacy, it is likely that external forces are changing as well, and that some areas may be seeing a rise in prevalence and seriousness.

Average Improvement by Effort (HPA: Q7 & Q8)



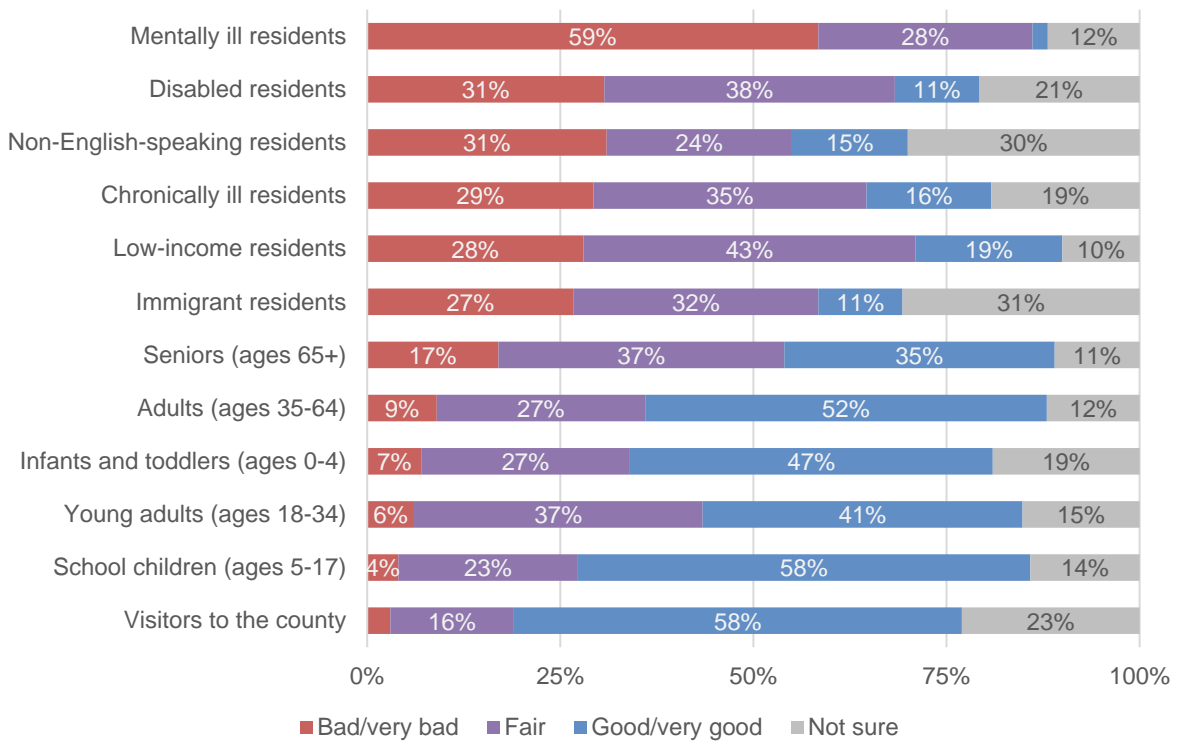
A second way to evaluate progress on addressing 2012 priorities is to look at the individual respondent level, to see if their own organization's level of effort was related to improvements they saw. In other words, was effort correlated to improvement? In this analysis, the findings are a bit different than above. Individual respondents whose organization put more effort towards addressing senior health were very likely to see improvement in senior health. This was also true for immunizations and infectious disease. Improvement in most of the other 2012 priorities were moderately correlated to effort. However, mental health was the one priority with very little correlation between organizational effort and observed improvement. The table below shows the correlation scores for each of the 2012 priorities, on a scale of zero to one, with zero representing no correlation and one representing perfect correlation.

2012 Priority Areas	Correlation Score
Senior health	0.6
Immunization & infectious diseases	0.5
Health information & awareness	0.4
Domestic violence prevention	0.4
Access to health services	0.4
Maternal, infant, & child health	0.3
Substance and alcohol abuse	0.3
Dental health	0.2
System navigation	0.2
Mental health	0.1

VULNERABILITY

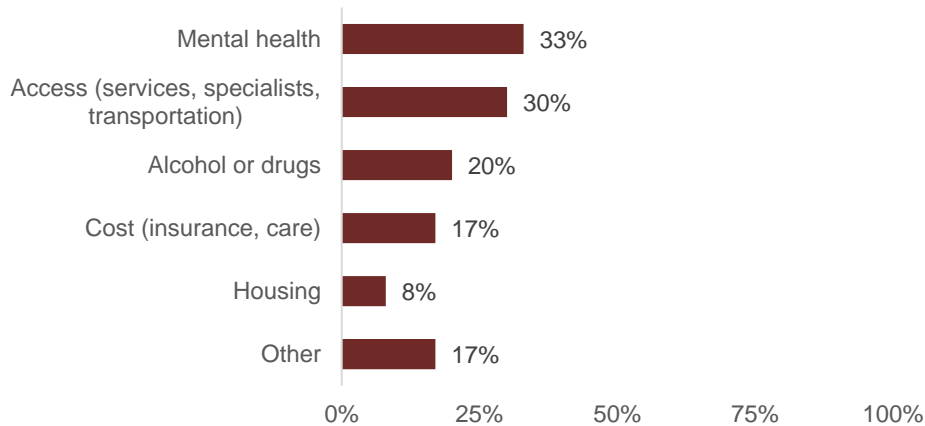
In addition to addressing the most common and difficult needs, this study also evaluated the extent that the health community is currently able to meet the needs of vulnerable residents. The chart below shows that almost 60 percent of health professionals and affiliates believed that health and wellness services were bad or very bad at meeting the needs of mentally ill residents, with fewer than three percent rating good or very good. Health professionals and affiliates tended to give lower ratings for ability to meet the health needs of residents with vulnerable circumstances such as being low-income, disabled, chronically ill, non-English speaking, or an immigrant. Comparatively, there was generally neutral or positive ratings for meeting the needs of residents regardless of their age group.

Meeting Needs of Vulnerable Populations (HPA: Q9)



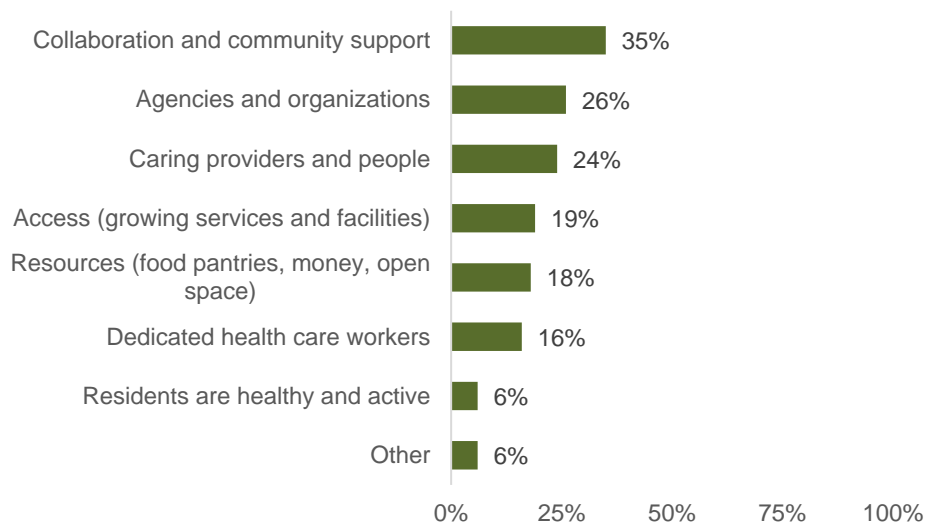
One third of health professionals and affiliates indicated mental health care is the community’s greatest health and wellness challenge, and close to one third said access (to health services, to health specialists, or to transportation) was the greatest challenge.

Greatest Health and Wellness Challenges (HPA: Q10)



Health professionals and affiliates varied slightly in their descriptions about the health and wellness community’s greatest strength. About one third of respondents described collaboration and internal support as the community’s greatest strength, while about one quarter mentioned local agencies and organizations themselves and another quarter mentioned how providers and residents are caring.

Greatest Health and Wellness Strengths (HPA: Q11)



MENTAL HEALTH

MENTAL HEALTH CARE PROCESS

For residents who need or want mental health care, there are several steps and potential barriers in the process to better mental wellbeing. This research sought to understand how many residents made it all the way through the process and to identify which steps were associated with the most residents abandoning the process. Future resources and efforts should help residents across each step, with the most focus on the steps where the greatest proportion of residents abandon the process.

As seen in the chart below, about 15 percent of all residents indicated they needed or wanted mental health care in the past 12 months. This percentage could be an underestimate, as other research has found that survey respondents are less likely to answer yes to stigmatized issues, such as mental health needs.

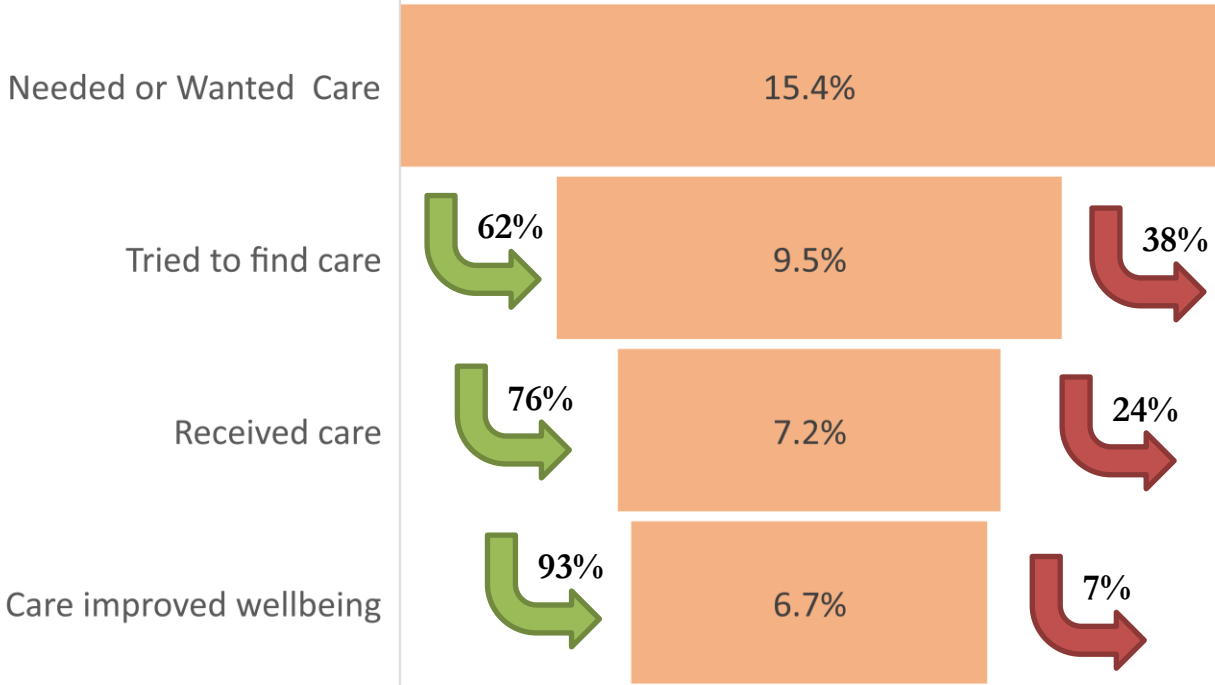
Among all residents, about 10 percent tried to find mental health care, which means about 38 percent of those residents who needed or wanted care dropped out of the process at the first step, not even trying to find care. Analysis of open-ended comments suggest that some common reasons why people did not seek care included expected high cost of service, not knowing where to go for help, wanting to protect personal privacy, feeling intimidated or stigmatized, lack of time, lack of transportation, bad experiences previously, and beliefs that services were not available locally.

Among all residents, just over seven percent received mental health care in the past 12 months; about 24 percent of those who tried to find care dropped out of the process before receiving care. Some reasons for not receiving care included not finding affordable care, stress of looking for care, scheduling issues, and lack of nearby providers.

Among all residents, slightly less than seven percent indicated that the mental health care they received improved their wellbeing. Consider slightly more than seven percent of all residents received mental health care, almost all of these residents believed that the mental health care they received improved their wellbeing. When residents did get mental health care, it was very likely to help them. Those who received care that did not improve their wellbeing mentioned various reasons why, including a provider leaving the community, needing to travel to Denver for specialty treatment that was not locally available, and feeling that care was not helping.

Among the residents who wanted or needed mental health care, 44 percent successfully proceeded through the entire process: seeking care, getting care, and improving wellbeing. This means 56 percent of residents who wanted or needed mental health care exited the process prematurely.

Mental Health Care Process (RS: Q7-Q10)



Green Arrows = Stayed in Process

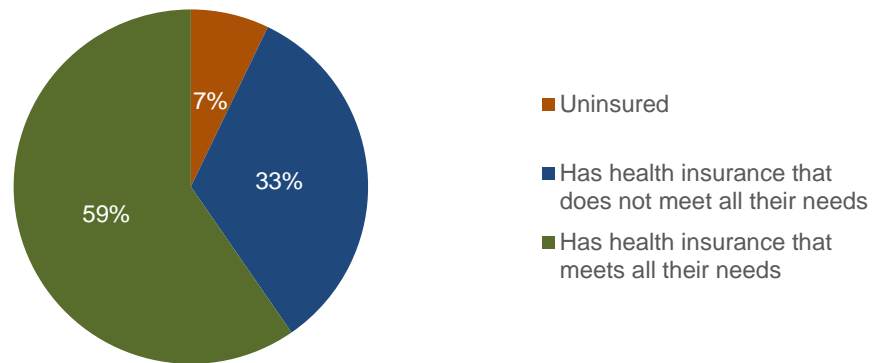
Red Arrows = Exited Process

HEALTH INSURANCE

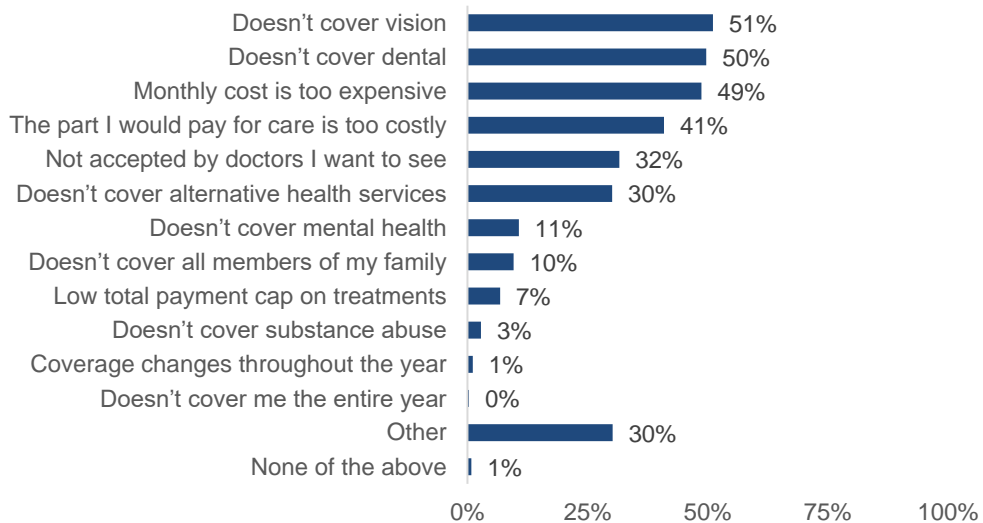
HEALTH INSURANCE COVERAGE

While most residents had health insurance coverage, one third of all respondents reported that their health insurance coverage was inadequate for their needs. Residents who reported having inadequate health insurance coverage most often indicated that their health insurance did not cover vision or dental, that the costs were too high, that it was not accepted by their preferred doctors, or that it did not cover alternative health services. Similarly, health professionals and affiliates in Grand County noted that the issue of residents being unable to afford healthcare was more difficult to address than the issue of residents lacking health insurance.

Health Insurance Coverage (RS: Q12, Q13)



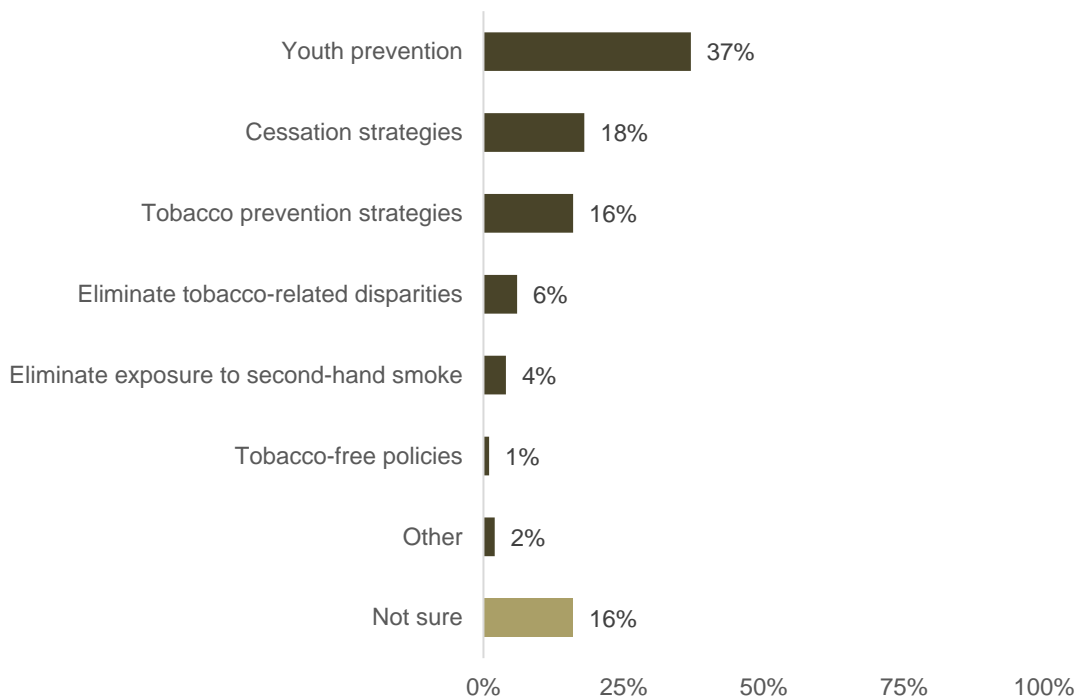
Reasons Health Insurance Coverage is Inadequate (RS: Q14)



TOBACCO

In total, more than half of health professionals and affiliates believed prevention strategies were the most important tobacco-use prevention components, with 37 percent answering “youth prevention, such as policies to prevent young people from starting to use tobacco” and 16 percent answering the more general “tobacco prevention strategies, such as retail licensing, increased age for tobacco purchasing, or increased pricing.” About one in ten suggested cessation strategies. Note that about 16 percent were not sure of the most important component.

Most Important Tobacco Prevention Component
(HPA: Q13)



APPENDIX A: SURVEY INSTRUMENTS

- Survey of Grand County health professionals and affiliates
- Survey of Grand County residents