

2019 Community Health Status Assessment



Creating a State of Health



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1. INTRODUCTION

1.1. Mobilizing for Action through Planning and Partnerships (MAPP)

The definition of health encompasses a broad range of conditions, not simply health in terms of healthcare.



Improving health is deliberate to ensure the conditions for a dynamic state of complete physical, mental, spiritual, and social well-being.

Mobilizing for Action through Planning and Partnerships (MAPP) is a community-wide strategic planning process for improving public health. This framework helps communities prioritize public health issues, identify resources for addressing them, and take action to improve conditions that support healthy living. MAPP is generally led by the local

Health Department and is completed with the input and participation of many organizations and individuals who work, learn, live, and play in the community.

1.2. The MAPP Process

The MAPP Process consists of six phases. In Phase One, community members and agencies form a partnership and learn about the MAPP Process. During Phase Two, those who work, learn, live, and play in the community create a common understanding of what it would like to achieve. During Phase Three, qualitative and quantitative data are gathered to provide a comprehensive picture of health in the community through four assessments. In Phase Four, the data are analyzed to uncover the underlying themes that need to be addressed in order for a community to achieve its vision. In Phase Five, the community identifies goals it wants to achieve and strategies it wants to implement related to strategic issues. During Phase Six, the community implements and evaluates action plans to meet goals, address strategic issues, and achieve the community's vision.

1.3. Community Health Needs Assessment (CHNA)

This report has been prepared to communicate the results of the 2019 Community Health Needs Assessment (CHNA). Provisions of the Patient Protection and Affordable Care Act require each non-profit hospital facility in the United States to conduct a CHNA and adopt an implementation strategy to meet identified community health needs. In conducting the CHNA, non-profit hospitals are required to take into account input from persons who represent the broad interests





of the community served, including those with special knowledge of or expertise in public health. The CHNA approach is strategic with eight steps. These steps include creation of a sub-committee, creation of a list of indicators, collection of data for community selected indicators, organization and analysis of data, compilation and dissemination of results, creation of a system to monitor indicators over time, creation of a list of challenges and opportunities, and finally sharing the results with the community.

History of MAPP

MAPP was developed to respond to the need to improve public health practice. In 1988, the Institute of Medicine (IOM) published the report *The Future of the Public's Health in the 21st Century*, which asserted that the public health system was in disarray. The report was the impetus for creating several types of assessments, standards, and improvement processes. In 1991, NACCHO, with support from the CDC, developed the Assessment Protocol for Excellence in Public Health (APEX PH) to help local health departments assess community health status and establish the leadership role of the health department in the community. APEX PH was continuously updated and revised through the 1990s. In 1997, the IOM published another report titled *Improving Health in the Community: A Role for Performance Monitoring*, which emphasized the importance of active community involvement in public health performance monitoring and detailed what a community health improvement plan should contain. During this time, public health practitioners were also requesting a process that was driven and owned by the community. In response, APEX PH evolved into MAPP. NACCHO, with support from the CDC, developed MAPP with substantive input from the field and careful attention to research and literature. MAPP was developed to provide structured guidance that would result in an effective strategic planning process that would be relevant to public health agencies and the communities they serve.

2. MURRAY COUNTY

2.1. Demographics

Subject	Number	Percent
SEX AND AGE		
Total population	13,488	100.0
Under 5 years	922	6.8
5 to 9 years	886	6.6
10 to 14 years	912	6.8
15 to 19 years	826	6.1
20 to 24 years	666	4.9
25 to 29 years	804	6.0
30 to 34 years	727	5.4
35 to 39 years	824	6.1
40 to 44 years	775	5.7
45 to 49 years	954	7.1
50 to 54 years	1,011	7.5
55 to 59 years	923	6.8
60 to 64 years	895	6.6
65 to 69 years	738	5.5
70 to 74 years	560	4.2
75 to 79 years	460	3.4
80 to 84 years	316	2.3
85 years and over	289	2.1
Median age (years)	41.0	(X)
Male population	6,718	49.8
Female population	6,770	50.2
RACE		
Total population	13,488	100.0
One Race	12,649	93.8
White	10,515	78.0
Black or African American	178	1.3
American Indian and Alaska Native	1,638	12.1
Asian	48	0.4
Native Hawaiian and Other Pacific Islander	8	0.1
Some Other Race	262	1.9
Two or More Races	839	6.2
White; American Indian and Alaska Native [3]	701	5.2
White; Asian [3]	11	0.1
White; Black or African American [3]	40	0.3
White; Some Other Race [3]	17	0.1

Subject	Number	Percent
HISPANIC OR LATINO		
Total population	13,488	100.0
Hispanic or Latino (of any race)	662	4.9
Not Hispanic or Latino	12,826	95.1
HISPANIC OR LATINO AND RACE		
Total population	13,488	100.0
Hispanic or Latino	662	4.9
Not Hispanic or Latino	12,826	95.1
RELATIONSHIP		
Total population	13,488	100.0
In households	13,175	97.7
In group quarters	313	2.3
HOUSEHOLDS BY TYPE		
Total households	5,350	100.0
Family households (families) [7]	3,692	69.0
Nonfamily households [7]	1,658	31.0
Households with individuals under 18 years	1,725	32.2
Households with individuals 65 years and over	1,647	30.8
Average household size	2.46	(X)
Average family size [7]	2.96	(X)
HOUSING OCCUPANCY		
Total housing units	6,746	100.0
Occupied housing units	5,350	79.3
Vacant housing units	1,396	20.7
HOUSING TENURE		
Occupied housing units	5,350	100.0

*Information obtained from U.S. Census Bureau American FactFinder on 10/01/2019 based on 2010 Demographic Profile Data.
<https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF>

2.2. Oklahoma State of the State's Health Report: Murray County Snapshot

Summary Grade County

	2005	2010	2015	2016	2017	Calc GRADE
Causes of Death	Alzheimer's Disease Deaths	B	D	D	F	
	Cerebrovascular Disease Deaths	F	D	C	B	A
	Chronic Lower Respiratory Disease Deaths	F	F	F	F	F
	Diabetes Deaths	F	F	F	D	F
	Heart Disease Deaths	F	F	F	F	F
	Influenza/Pneumonia Deaths	F	F	B	B	B
	Intentional Injury Deaths	D	C	F	F	D
	Malignant Neoplasm Deaths	F	D	F	D	F
	Nephritis Deaths	NA	C	B	B	NA
	Suicides	F	D	F	F	D
	Unintentional Injury Deaths	F	F	F	F	F
	Unintentional Poisoning Deaths	F	F	F	F	F
Disease Rates	Asthma Prevalence		C	C	C	
	Colon Cancer Incidence (excluding rectum)	D	D	D		
	Depression (Ever)			F	F	D
	Diabetes Prevalence			D	D	D
	High Blood Pressure (Ever)			C		D
	High Cholesterol Diagnosis (Ever)			A		F
	Invasive Breast Cancer Incidence (female only)	A	A	A		
	Lung Cancer Incidence	F	F	D		
	Prostate Cancer Incidence	A	C	C		
Mortality	Infant Mortality	D	C	F	F	F
	Life Expectancy at Birth	NA	NA	NA	NA	
	Total Mortality	F	F	F	F	F
Risk Factors & Behaviors	Adverse Childhood Experiences (3 or more)			NA		
	Binge Drinking			A	A	A
	Current Smoking Prevalence (Adults)			F	F	F
	Dental Visits (Adults)			F	F	
	First Trimester Prenatal Care	B		D	F	D
	Frequent Poor Health Days (≥14 days in the past 30 days) that Limited Usual Activities			F	F	F
	Frequent Poor Mental Health Days (≥14 days in the past 30 days)			F	F	F

Summary Grade County

	2005	2010	2015	2016	2017	Calc GRADE
Risk Factors & Behaviors			F	F	F	
			F	F	F	
			A	A	A	
	D	D	D	D	C	
					F	
			F			
					B	
			D			
			F	F	F	
			F	F	F	
			B	A	A	
			B	B	B	
	F	F	D	D	F	
			C	C	C	
			D	F	F	
Socio..		C	C	C	D	

Calc GRADE

A
B
C
D
F
NA

3. COMMUNITY HEALTH NEEDS ASSESSMENT

3.1. Subcommittee

The subcommittee organization began in the summer of 2018. The Cleveland County Health Department and Norman Regional Health System, including representatives from the Tobacco Settlement Endowment Trust's (TSET) Health Living Program, developed the Community Health Needs Assessment. Representative selection was based on data accessibility, data analyzation abilities, abilities to create a system for managing data, and their interest in the data.



3.2. Development

The subcommittee met at the Norman Regional Hospital in Norman to discuss question selection, question phrasing, and collection methods. Resources including Healthy People 2020, 2015 Cleveland County Health Survey, St. Catherine of Siena Medical Center Community Health Needs Assessment, and St. Francis Hospital Community Health Needs Assessment Survey were utilized in question selection.

3.3. Questions

The subcommittee reviewed and selected a list of indicators based on the twelve categories of data suggested in the Mobilizing for Action through Planning a Partnerships (MAPP): User's Handbook. Listed below is the breakdown of each question's alignment with the categories of data.

Category of Data	2019 Community Health Needs Assessment Survey Questions
Social Determinants of Health Inequity	Q1. In general, how would you rate your overall health?
Social and Mental Health	Q2. In general, how would you rate your overall mental or emotional health?
Social and Mental Health	Q3. How many days in the past month were you not able to work due to poor physical health?
Social and Mental Health	Q4. How many days in the past month have you experienced anxiety, depression or any emotional problems that affected your ability to perform daily activities?
Social and Mental Health	Q5. In the past 12 months, have you sought treatment at any of the following for anxiety, depression or any emotional problems? Check all that apply.
Health Resource Availability	Q6. In the last 12 months, how many times did you visit your healthcare provider?
Health Resource Availability	Q7. What types of health screenings and/or services are needed to keep you and your family healthy? Check all that apply.

Social Determinants of Health Inequity	Q8. Have you been told you have any of the following health conditions? Check all that apply.
Behavioral Risk Factors	Q9. If you have been diagnosed with a chronic illness, are you taking medication and/or making lifestyle changes?
Behavioral Risk Factors	Q10. Please check all the health behaviors that apply to you.
Social Determinants of Health Inequity	Q11. How do you prefer to receive health information? Check all that apply.
Social Determinants of Health Inequity	Q12. In your opinion, what are the major health concerns in your community? Check all that apply.
Health Resource Availability	Q13. In the past 12 months, did any of the following keep you or your family from receiving needed medical care? Check all that apply.
Quality of Life	Q14. What is needed to improve the health of your family and neighbors? Check all that apply
Health Resource Availability	Q15. Where would you go for emergency medical services if you were able to take yourself?
Health Resource Availability	Q16. Which of the following preventive procedures have you had in the past 12 months? Check all that apply.
Health Resource Availability	Q17. How likely are you to seek care using a Virtual Care provider on your smart phone or computer for yourself or child?
Health Resource Availability	Q18. Do you have health insurance?
Social Determinants of Health Inequity	Q19. Have you had regular access to food in the past year?
Social Determinants of Health Inequity	Q20. What food services has your household participated in during the past year? Check all that apply.
Demographic Characteristics	Q21. What is the zip code of your current residence?
Demographic Characteristics	Q22. What is your current housing situation?
Demographic Characteristics	Q23. Do you feel safe in your neighborhood?
Demographic Characteristics	Q24. How many days the past 30 days have you used public transportation?
Demographic Characteristics	Q25. What is your age?
Demographic Characteristics	Q26. What racial or ethnic group do you identify with?
Demographic Characteristics	Q27. What gender do you identify with?
Social Determinants of Health Inequity	Q28. Please indicate your highest level of education.
Social Determinants of Health Inequity	Q29. Are you a Veteran?
Social Determinants of Health Inequity	Q30. How many people live in your household?
Social Determinants of Health Inequity	Q31. What is your average annual household income?
Social Determinants of Health Inequity	Q32. What is your current employment status?

3.4. Timeline

The initial timeline included finalization of question selection by December 2018, distribution of surveys to the public beginning in April 2019, and collection completion by July 2019. Due to available sample size based on the number of respondents, the extension of the completion date to August 31, 2019 occurred.

4. DATA COLLECTION

4.1. Methods

The 2019 Community Health Needs Assessment Survey was distributed to the public in electronic and paper formats. English and Spanish version were available. The Office of Minority Services at the Oklahoma State Department of Health provided Spanish translation services. The subcommittee utilized Survey Monkey to provide the electronic format platform.



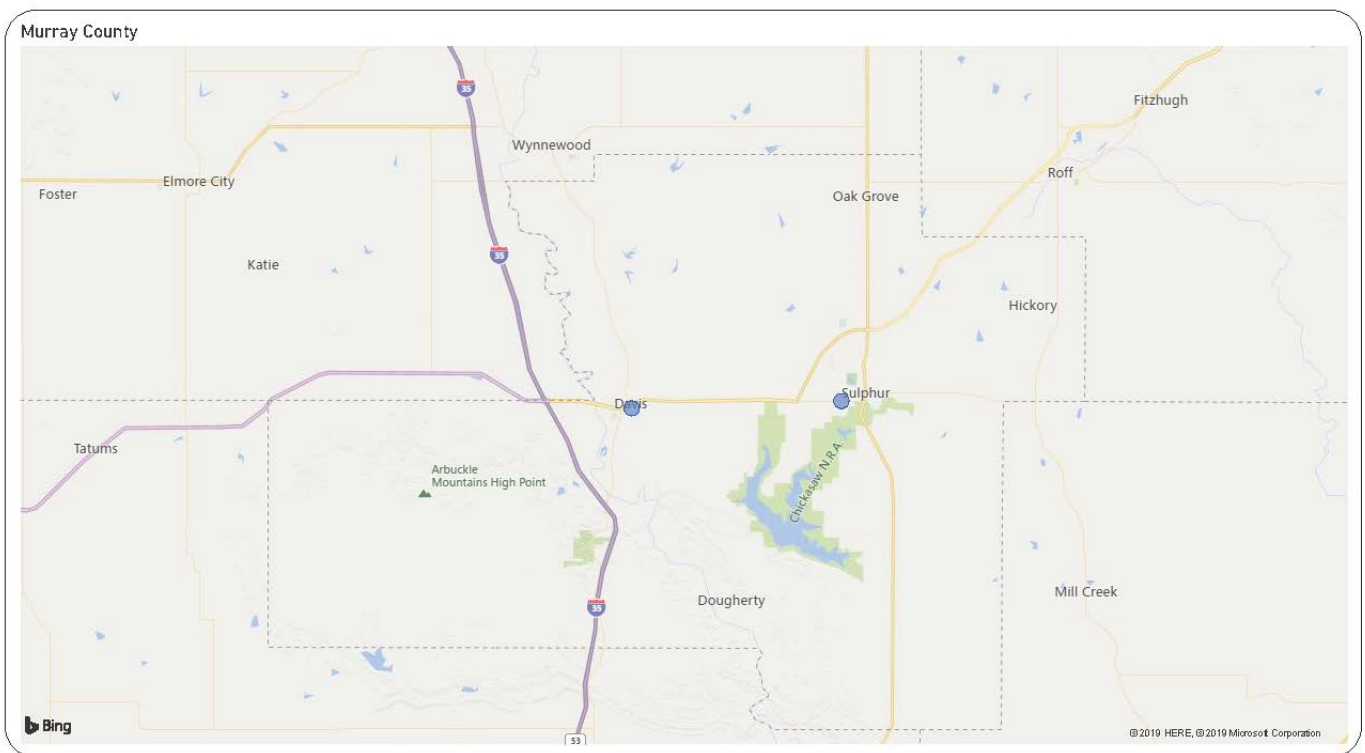
4.2. Community Partners

Local community partners included the Arbuckle Memorial Hospital and the Mary Parker Memorial Library.

4.3. Locations

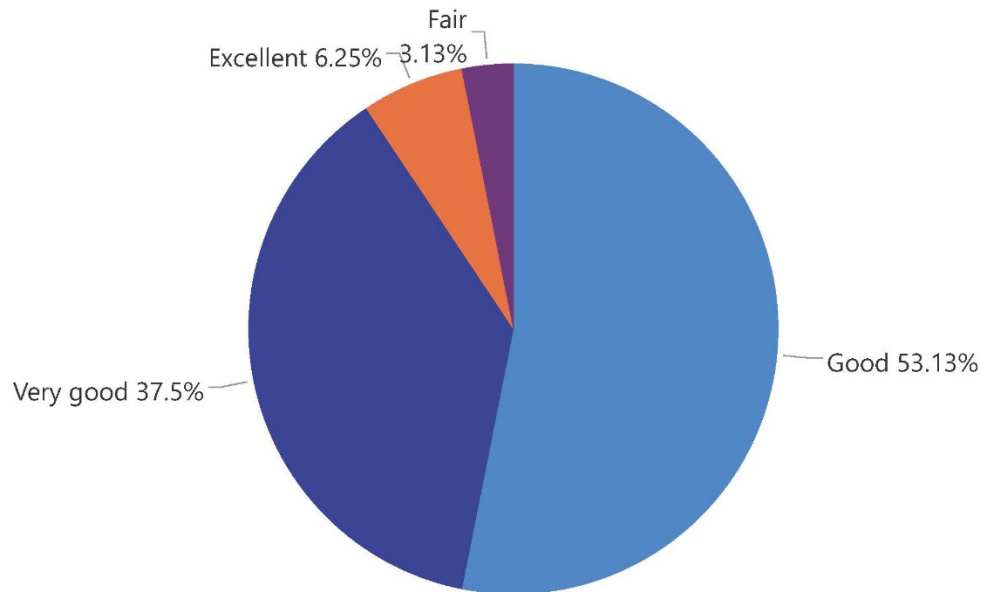
Paper surveys and collection boxes were available to the public at the Mary Parker Memorial Library from June 27, 2019 until September 5, 2019. They were available at the Arbuckle Memorial Hospitals from July 17, 2019 to August 1, 2019.

The zip codes represented in the survey responses: 73030 and 73086.

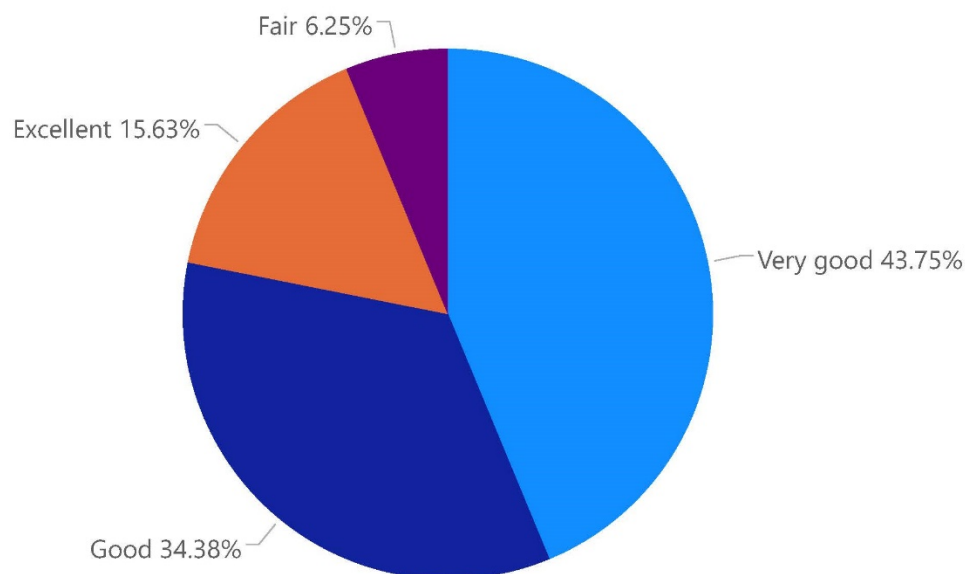


4. RESULTS

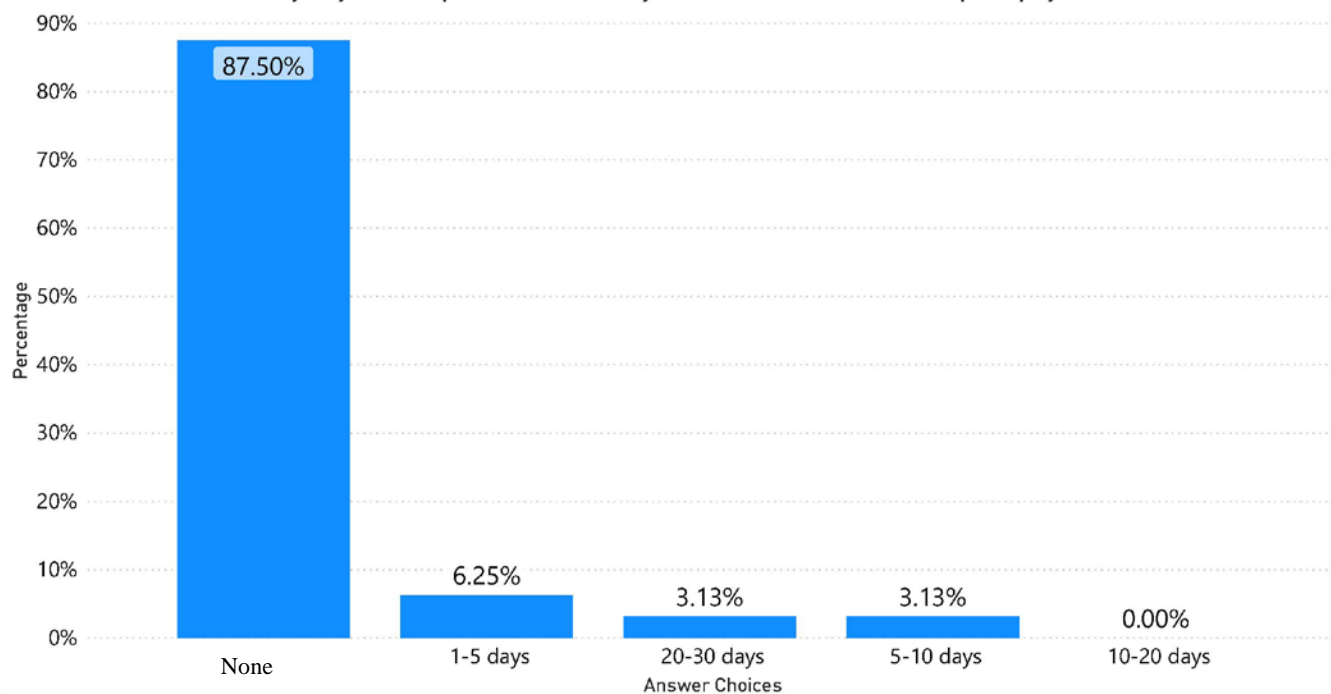
Q1. In general, how would you rate your overall health?



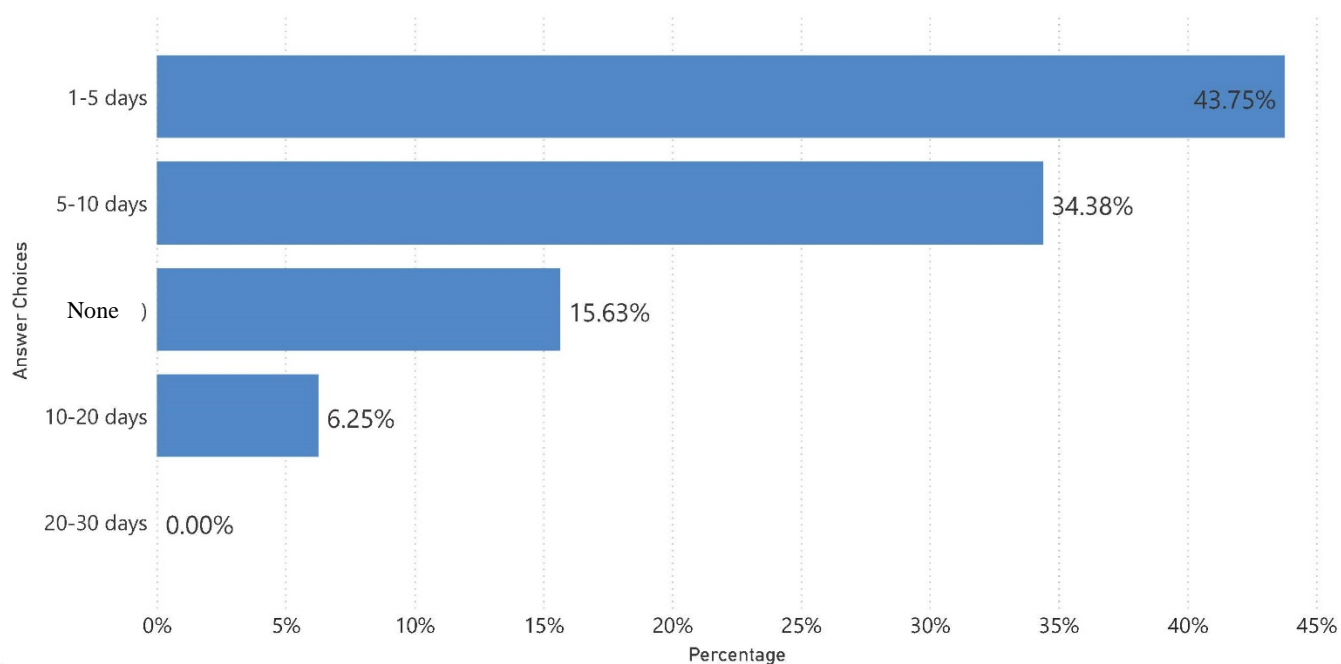
Q2. In general, how would you rate your overall mental or emotional health?



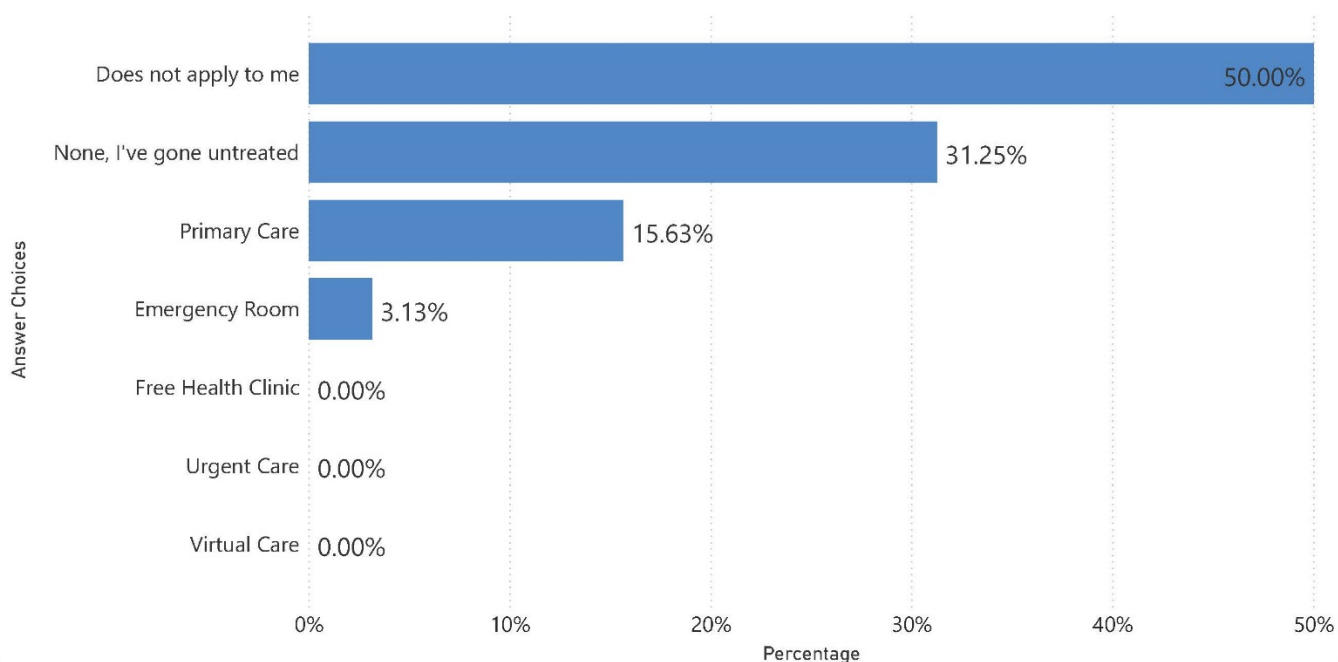
Q3. How many days in the past month were you not able to work due to poor physical health?



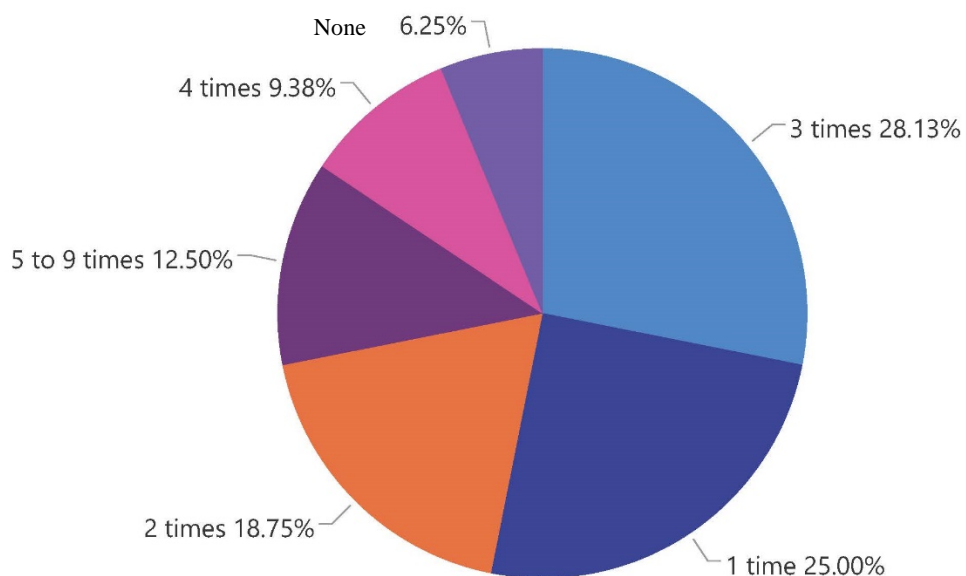
Q4. How many days in the past month have you experienced anxiety, depression or any emotional problems that affected your ability to perform daily activities?



Q5. In the past 12 months, have you sought treatment at any of the following for anxiety, depression or any emotional problems? Check all that apply.



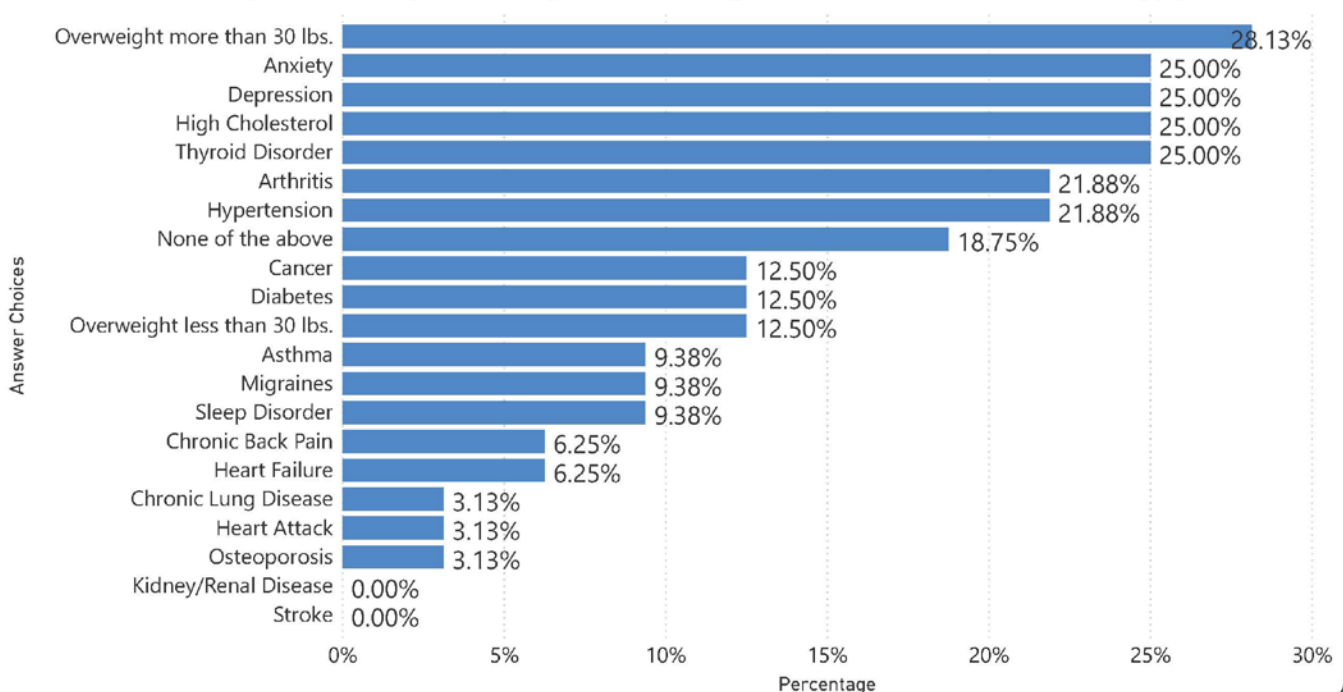
Q6. In the last 12 months, how many times did you visit your healthcare provider?



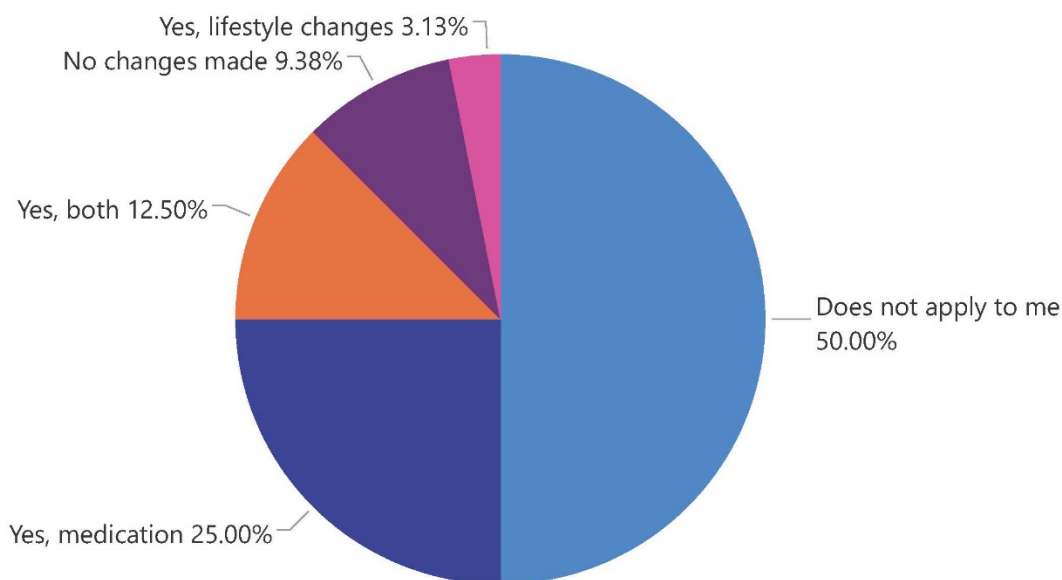
Q7. What types of health screenings and/or services are needed to keep you and your family healthy? Check all that apply.

Answer Choices	Percentage
Blood pressure	59.38%
Routine well checkups	59.38%
Dental Screenings	46.88%
Cholesterol	40.63%
Heart disease	34.38%
Exercise/physical activity	31.25%
Diabetes	25.00%
Weight loss help	25.00%
Mental Health/depression	21.88%
Cancer	18.75%
Vaccination/immunizations	12.50%
Nutrition	9.38%
Drug and alcohol abuse	6.25%
Falls prevention for the elderly/disabled	6.25%
Memory loss	6.25%
Quitting smoking	6.25%
Eating disorders	3.13%
Emergency preparedness	3.13%
Infection outbreak prevention	3.13%
Prenatal care	3.13%
Suicide prevention	3.13%
HIV/AIDs & STDs	0.00%

Q8. Have you been told you have any of the following health conditions? Check all that apply.



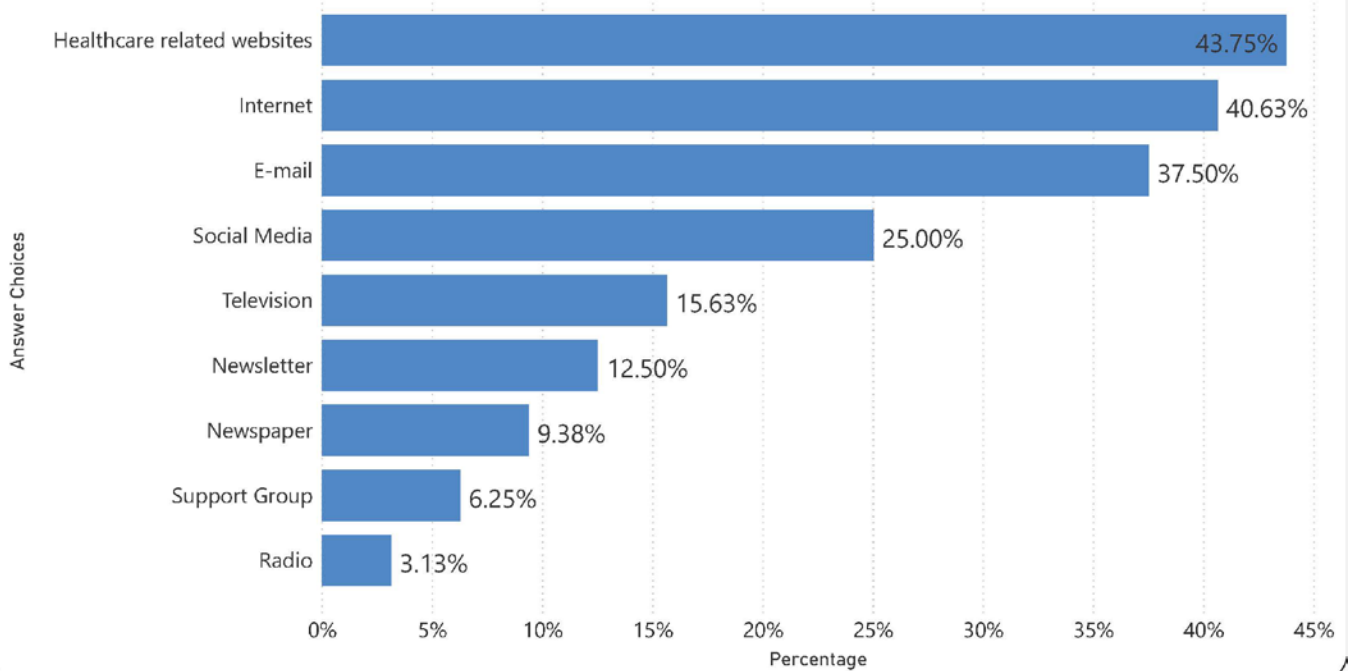
Q9. If you have been diagnosed with a chronic illness, are you taking medication and/or making lifestyle changes?



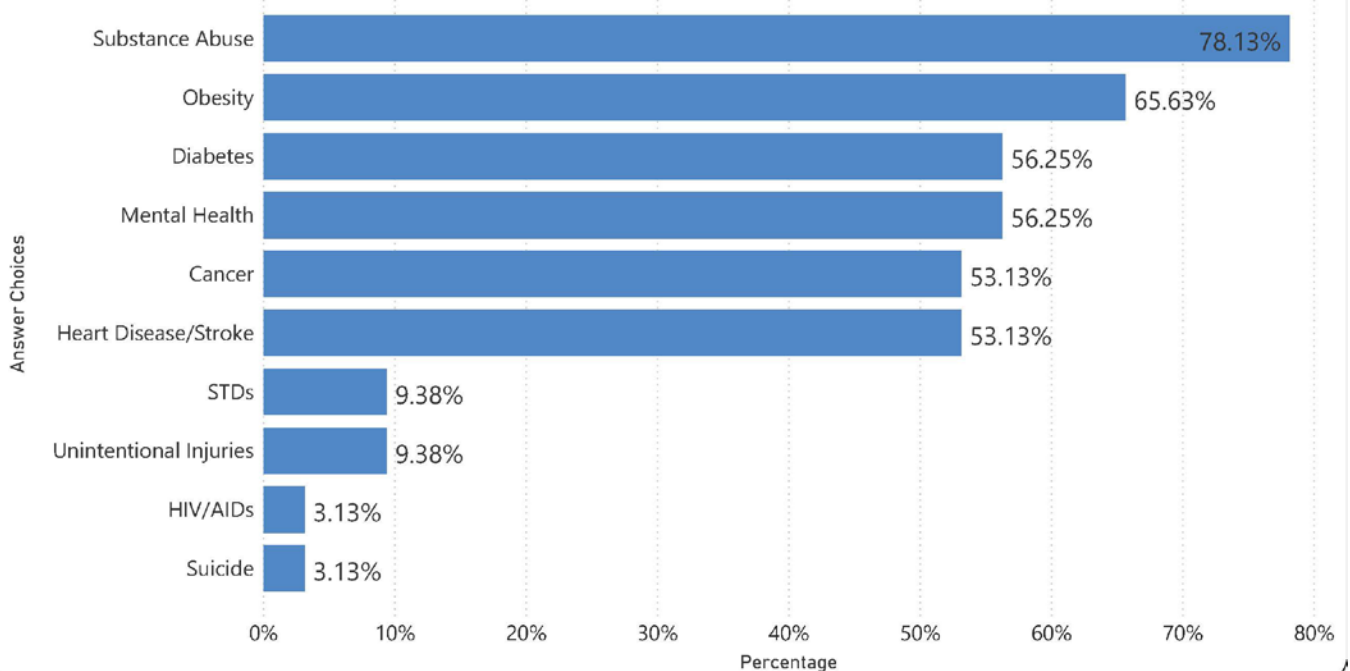
Q10. Please check all the health behaviors that apply to you.

Answer Choices	Percentage
I receive a flu shot each year	93.75%
I eat fast food at least once a week	71.88%
I have access to a wellness program through my employer	59.38%
I exercise at least three times per week	56.25%
I use sunscreen or protective clothing for planned time in sun	53.13%
I eat at least 5 servings of fruits or vegetables daily	18.75%
I have used opioids that have not been prescribed to me	6.25%
I use cannabis or marijuana products to relax or to ease pain	6.25%
I have more than four drinks (if female) of alcohol or five drinks (if male) per day	3.13%
I use tobacco or tobacco products	3.13%
I use cannabis or marijuana on a recreational basis	0.00%
None of the above apply to me	0.00%

Q11. How do you prefer to receive health information? Check all that apply.



Q12. In your opinion, what are the major health concerns in your community? Check all that apply.



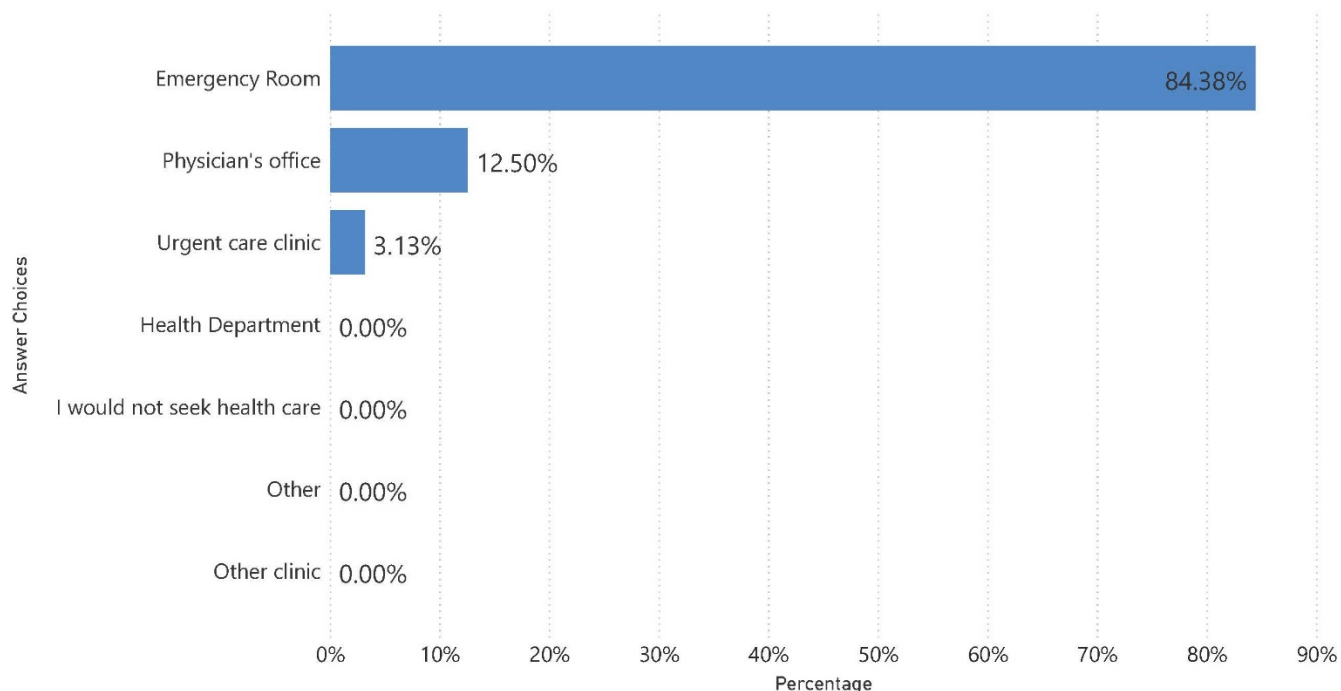
Q13. In the past 12 months, did any of the following keep you or your family from receiving needed medical care?
Check all that apply.

Answer Choices	Percentage
None apply	81.25%
Could not afford the co-pay	12.50%
Could not afford to fill the prescription	12.50%
Could not afford glasses or hearing aids	9.38%
Do not have health insurance	9.38%
Office hours were not convenient	9.38%
Could not get an appointment	6.25%
Do not have a primary care provider	6.25%
Do not have dental insurance	6.25%
Do not have vision insurance	6.25%
Fearful of what might be found on an exam	3.13%
Provider did not accept my child's insurance	3.13%
Provider did not accept my insurance	3.13%
Transportation	3.13%
Language barrier	0.00%

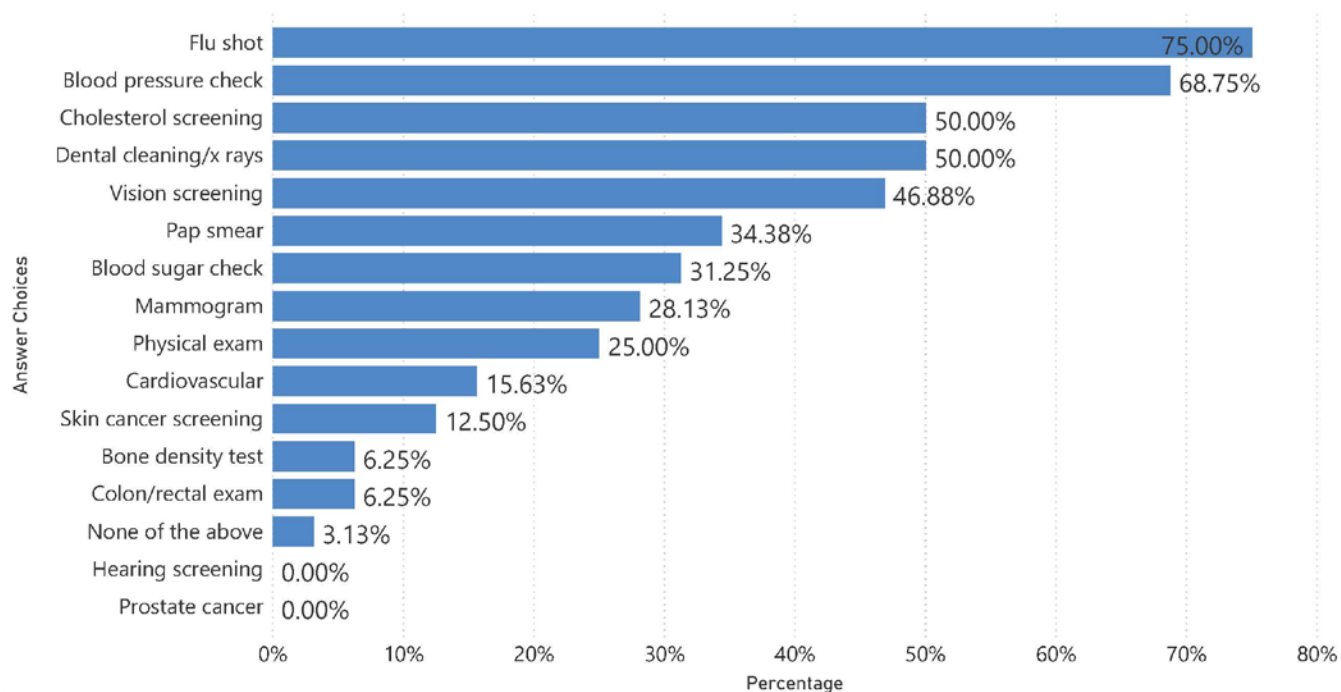
Q14. What is needed to improve the health of your family and neighbors? Check all that apply

Answer Choices	Percentage
Healthier Food	50.00%
Free or affordable health screenings	40.63%
Wellness services	31.25%
Mental health services	28.13%
Recreation facilities	28.13%
Substance abuse rehabilitation	28.13%
I don't know	25.00%
Safe places to walk/play	25.00%
Specialty physicians	18.75%
Job Opportunities	9.38%
Transportation	6.25%
Other	3.13%

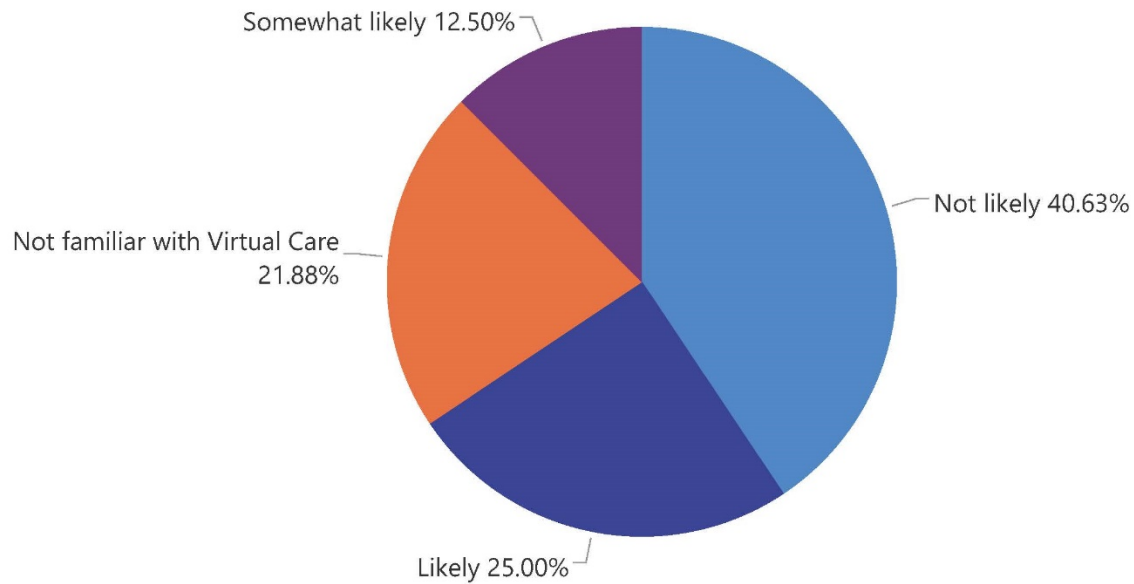
Q15. Where would you go for emergency medical services if you were able to take yourself?



Q16. Which of the following preventive procedures have you had in the past 12 months? Check all that apply.

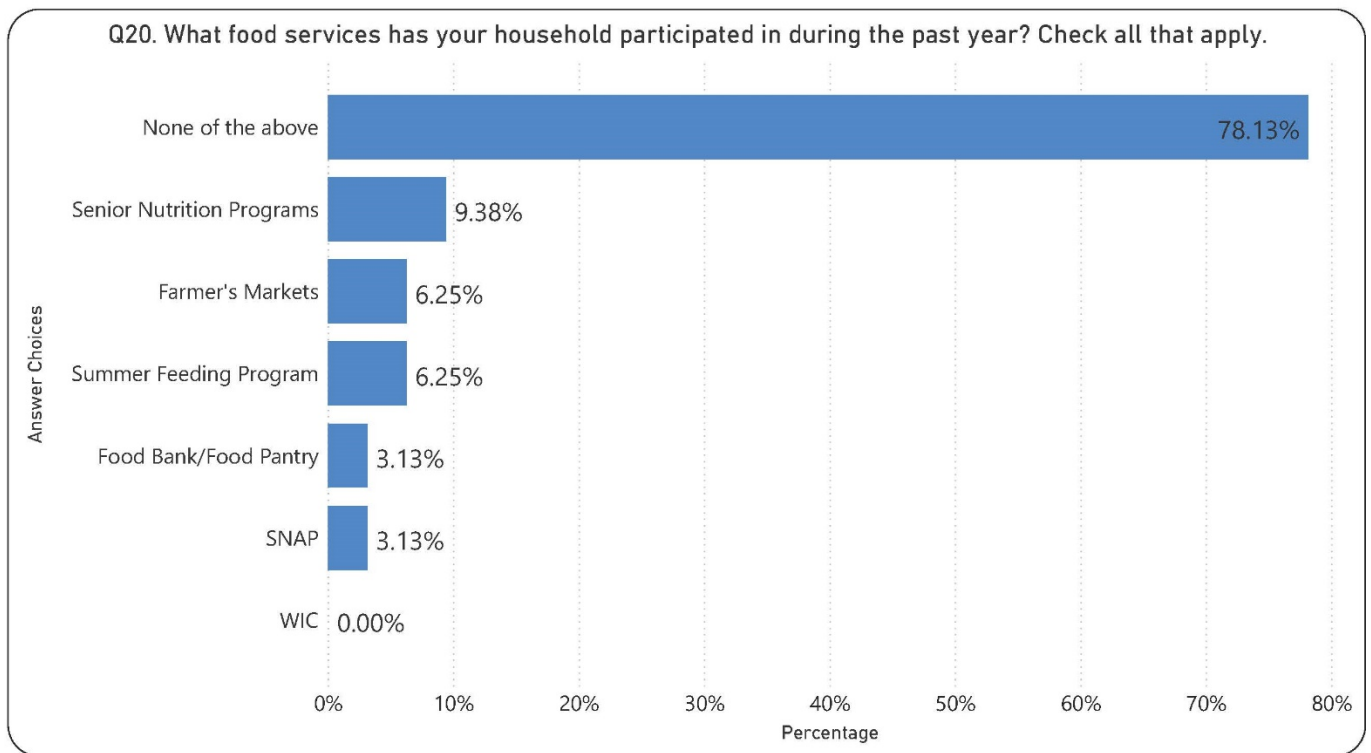
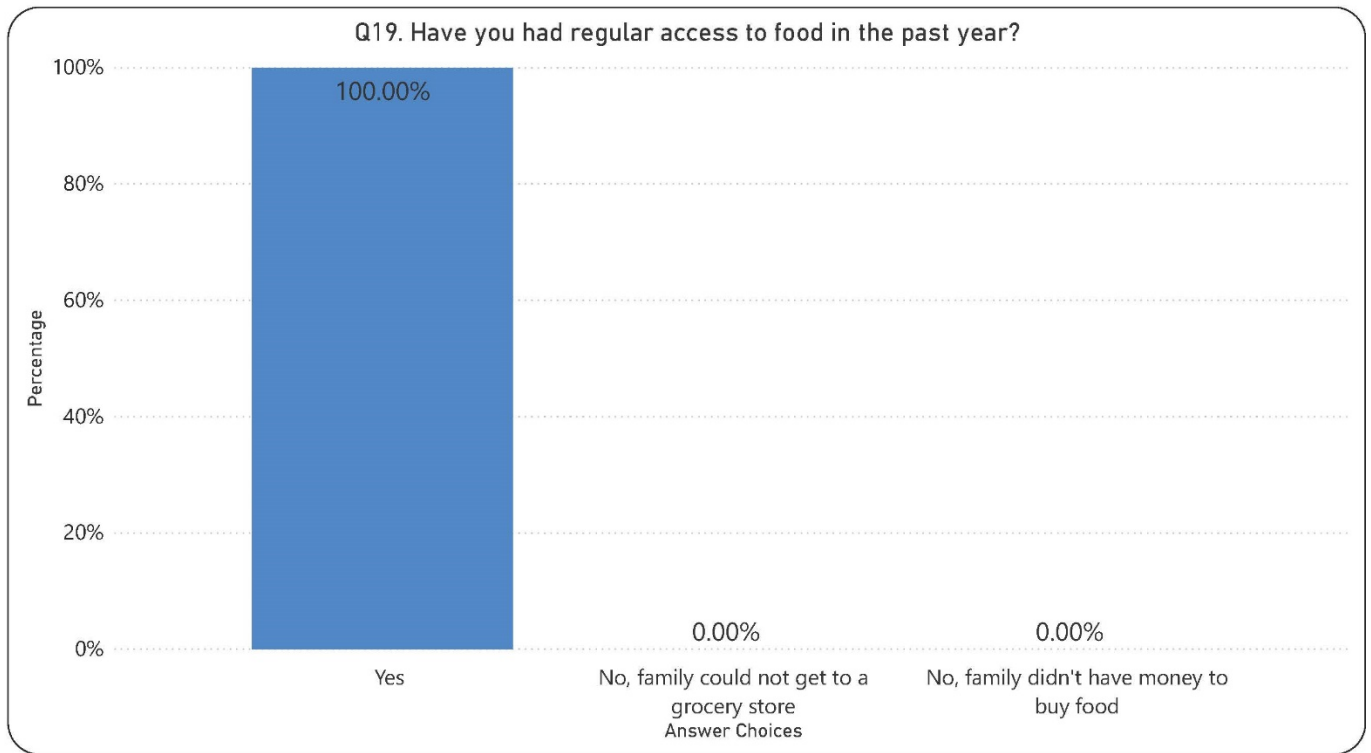


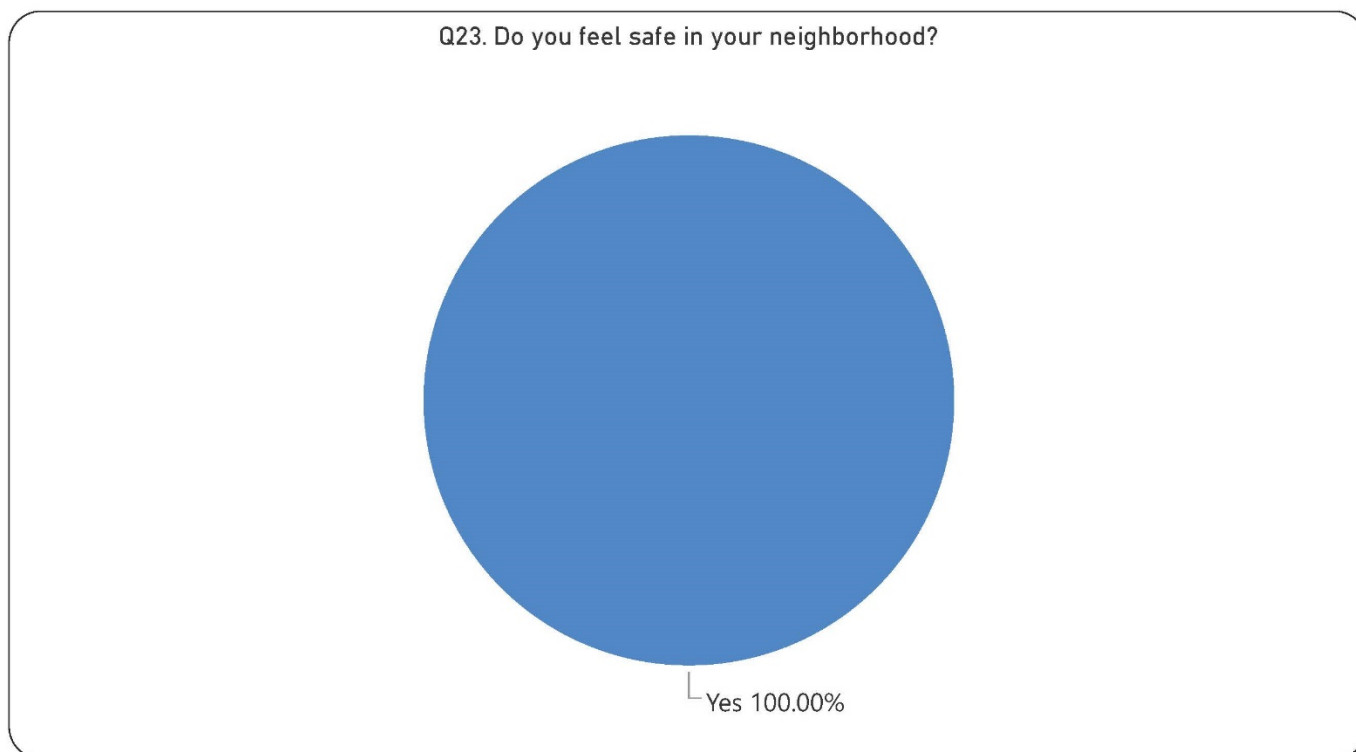
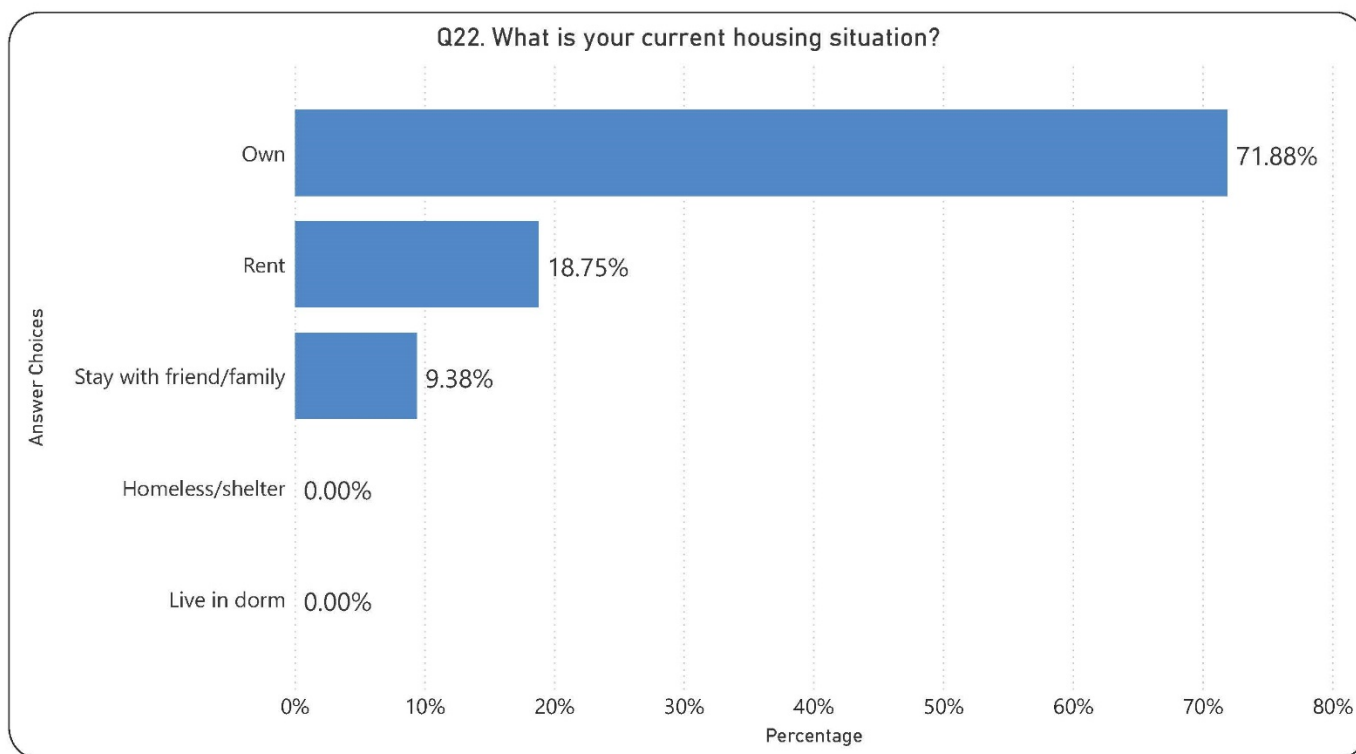
Q17. How likely are you to seek care using a Virtual Care provider on your smart phone or computer for yourself or child?

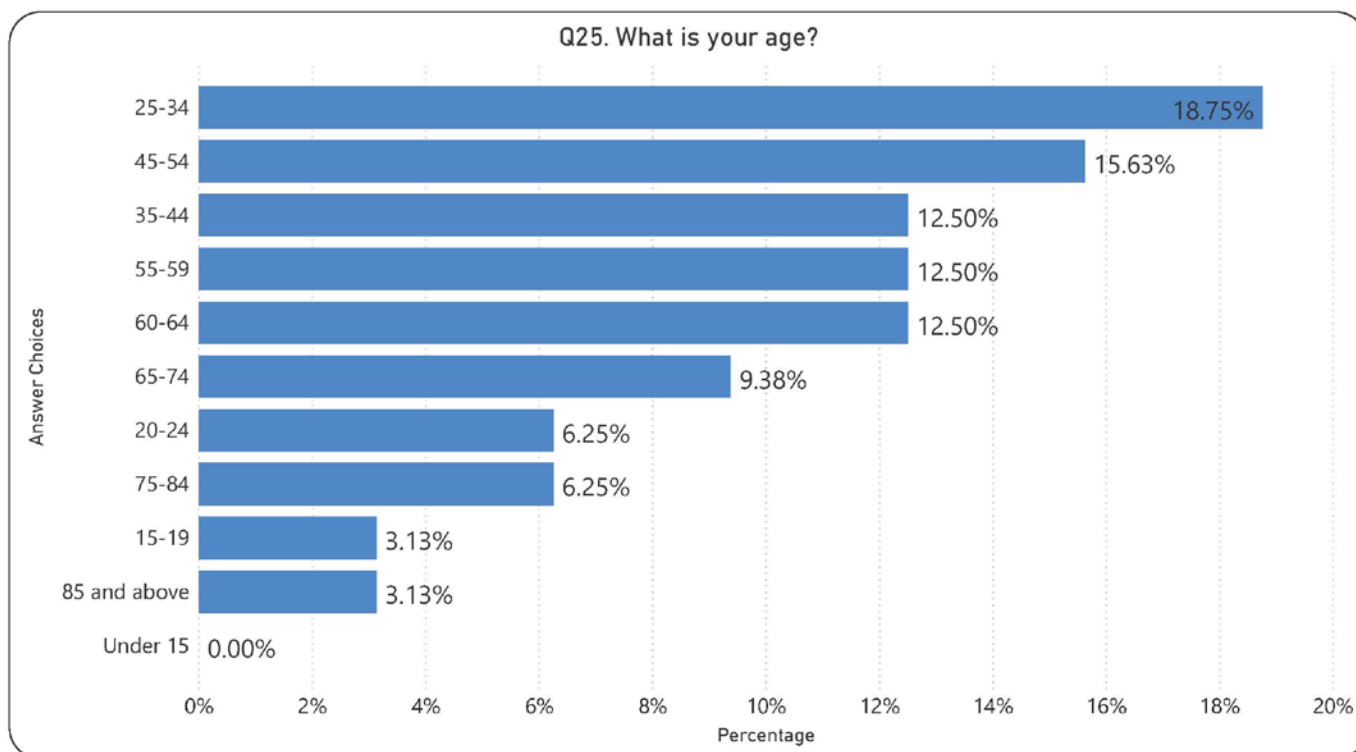
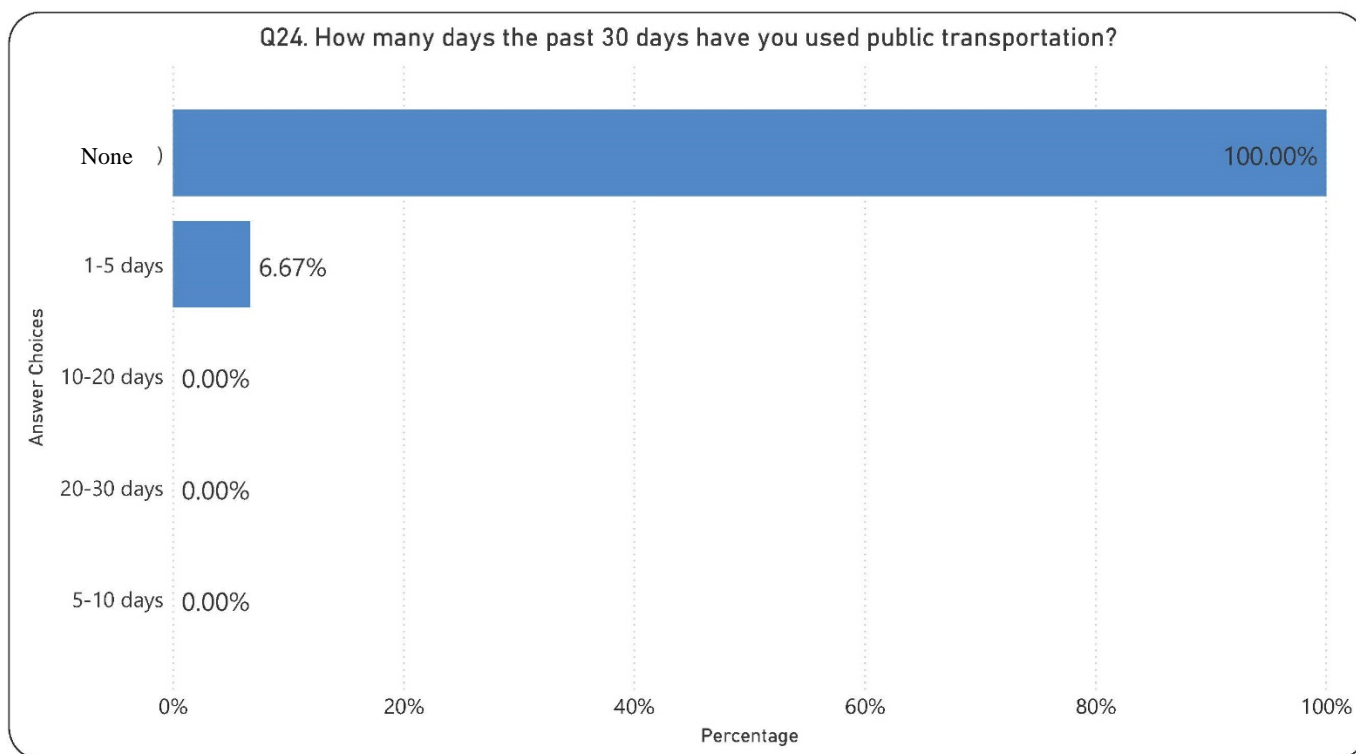


Q18. Do you have health insurance?

Answer Choices	Percentage
Yes, Employer Based Program	62.50%
Yes, Indian Health	12.50%
Yes, Commercial/Individual Policy	9.38%
Yes, Medicare	9.38%
No	3.13%
Yes, Medicaid	3.13%
Yes, Health Insurance Market Plan/Federal Exchange Policy	0.00%
Yes, VA	0.00%



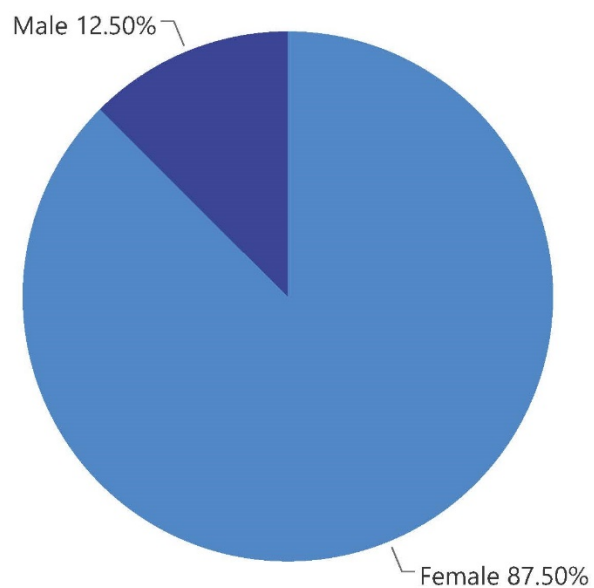




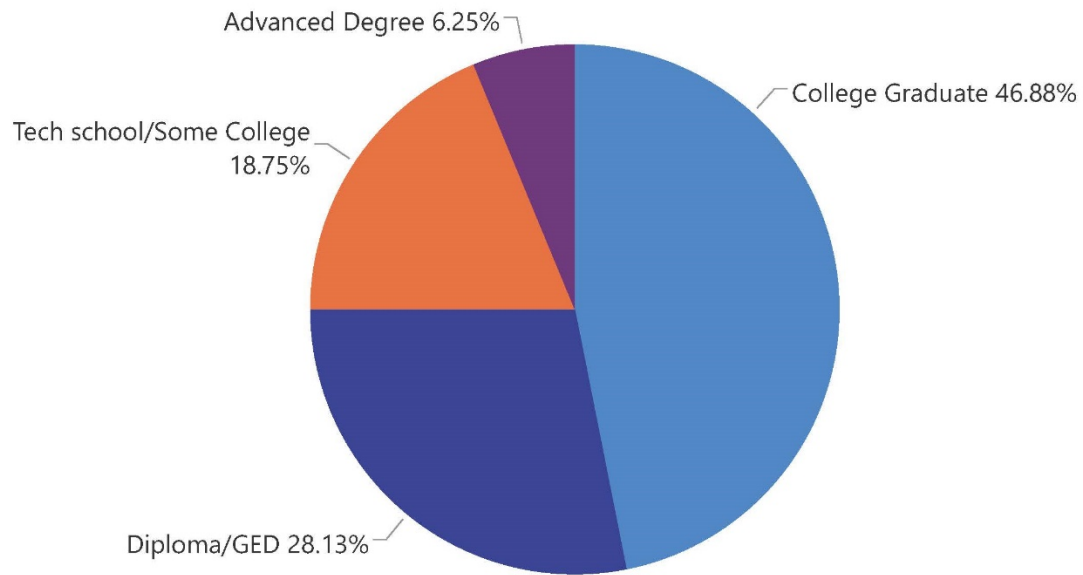
Q26. What racial or ethnic group do you identify with?

Answer Choices	Percentage
White	81.25%
American Indian or Alaska Native	15.63%
Hispanic or Latino	3.13%
Asian	0.00%
Black or African American	0.00%
Native Hawaiian or other Pacific Islander	0.00%
Other	0.00%

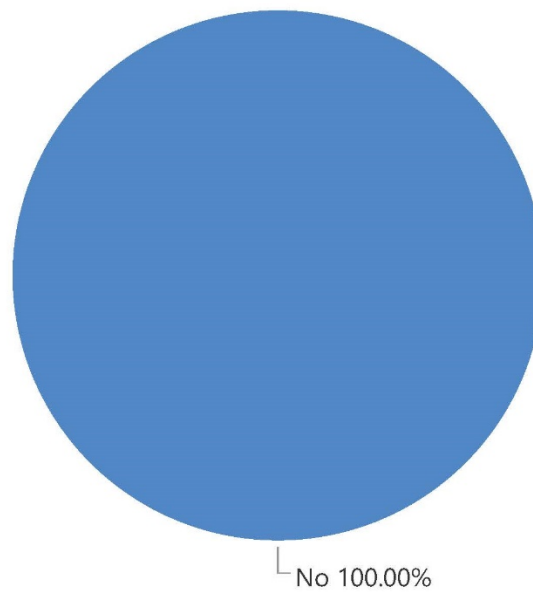
Q27. What gender do you identify with?



Q28. Please indicate your highest level of education.



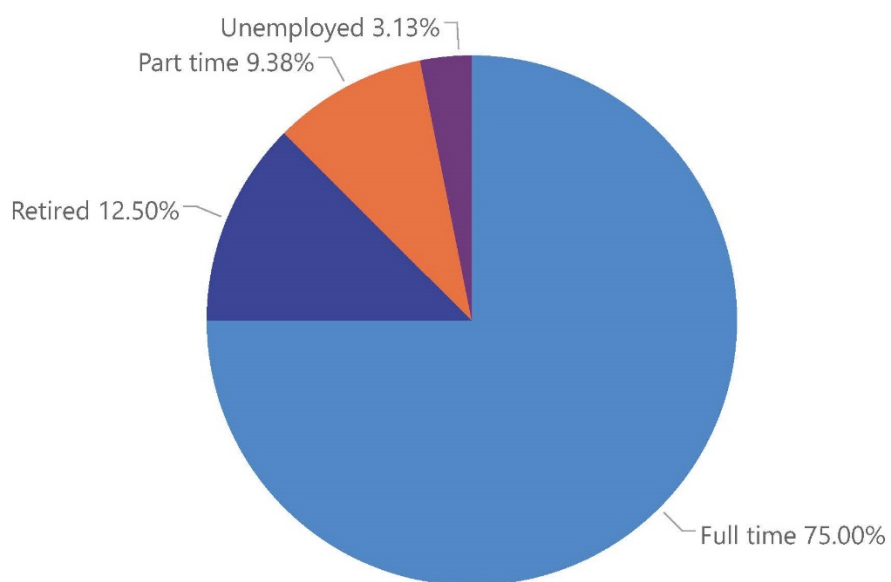
Q29. Are you a Veteran?



Q31. What is your average annual household income?

Answer Choices	Percentage
\$40,001 to \$60,000	40.63%
\$60,001 to \$80,000	18.75%
\$25,001 to \$40,000	12.50%
\$100,001 or more	9.38%
\$80,001 to \$100,000	9.38%
\$10,000 to \$25,000	6.25%
Less than \$10,000	3.13%

Q32. What is your current employment status?



5. CONCLUSION

5.1. Data Analysis

Most Notable:

- 63% of respondents reported insurance through an employer based program, 13% reported insurance with Indian Health Services, and only 3% reported not having health insurance.
- 3% of respondents reported being unemployed, with 75% reporting being employed full time.
- 19% of respondents needed or sought treatment for anxiety, depression, or emotional concerns with 31% reporting they went untreated.
- Free or affordable health screenings, healthier food, wellness services, and mental health services were selected as the highest needs for improving the health of family members and neighbors.

Needs Attention:

- 44% of respondents experienced anxiety, depression or other emotional problems that affected their ability to perform daily activities for 1-5 days in the last month and 40% reported 5-30 days that were affected.
- Barriers to receiving comprehensive medical care included not having health insurance, not being able to afford co-pays, prescriptions, or pay for glasses, and hearing aids.
- 78% reported substance abuse as a major health concern in the community

By the Numbers:

- The demographics of the respondents were
 - 87.5% female and 12.5% male
 - The highest percentage of respondents fell between 25-34 years of age
 - 81% of respondents were white, 16% American Indian or Alaska Native, 3% Hispanic or Latino
- 72% own their home, 19% rent their home, and 9% report staying with friends or family
- 53% of those responding rate their overall health as good, with 44% reporting their overall health as very good to excellent, and 3% as fair.
- 34% rate their overall mental or emotional health as good, with 59% reporting their overall mental or emotional health as very good to excellent.
- 88% of those surveyed reported zero days in the past month where they were unable to work due to poor health, 6% reported being unable to work due to poor physical health 1-5 days in the past month.
- 72% visited their healthcare provider 1-3 times in the last 12 months, 22% visited their healthcare provider 4-10 times or more in the last 12 months, and 6% did not visit their healthcare provider at all.
- Most of those surveyed prefer to receive health information by the internet, email, or social media.
- Substance abuse, obesity, diabetes, and mental health were selected as the top major health concerns in the community.
- Flu shots, blood pressure checks, cholesterol screenings, dental cleanings/x-rays, and vision screenings were the most highly utilized preventive procedures in the past 12 months.

- Prostate cancer, hearing, colon/rectal exam, and bone density screenings were the least utilized preventive procedures in the past 12 months.
- 38% of respondents said they were somewhat likely to use virtual care, with 40% reporting they are not likely to use virtual care, 22% were not familiar with virtual care.
- 100% of those surveyed said they feel safe their neighborhood.
- The top four health screening and/or services needed to keep families health are:
 - Blood Pressure Screenings
 - Routine Well Checkups
 - Dental Screenings
 - Cholesterol Checks
- The top four reported health conditions experienced by respondents are:
 - Overweight by more than 30 pounds
 - Anxiety
 - Depression
 - High Cholesterol
- Respondents reported participating in the following health behaviors the most:
 - Receiving an annual flu shot
 - Consume fast food at least once a week
 - Wellness program through employer
 - Exercise at least 3 time per week



5.2. Data Correlations

A total of 32 surveys were received from Murray County residents. This sample is approximately .2% of the population based on the 2010 census. Based on demographic information the sample represents the general population for statistical relevance. The majority of respondent reporting is consistent with the State of the State's County Report Card for Murray County in all aspects except mental or emotional identification and support.

5.3. Synopsis

More research is indicated for the population of Murray County for mental health indicators and access to fresh fruits and vegetables. The residents of Murray County are requesting more mental health services, recreation facilities, substance abuse rehabilitation, and safe places to walk and play.

6. NEXT STEPS

The data from the 2019 Community Health Needs Assessment Survey will be compiled with data from additional assessments. All of this information will be presented to the community leaders. They will select two to three priority areas of focus for community health improvement for the next three years.

The selected priorities and the associated objectives and strategies will be available to the public through the Murray County Health Improvement Plan.