



## **Community Assessment for Public Health Emergency Response (CASPER) for Primary Data Collection for a Community Health Assessment, Richland County Montana, 2015**

### **Background**

Richland County is located in on the eastern side of Montana and is a rural county with 11,576 persons (4.7 persons/square mile). Richland County Health Department (RCHD), Sidney Health Center, and the Public Health and Safety Division (PHSD) collaborated to complete a Community Assessment for Public Health Emergency Response (CASPER) to gather primary data to improve the understanding of the health status of Richland County for a community health assessment, to establish a volunteer network, and to complete an emergency preparedness exercise.

### **Methods and Materials**

CASPER is an epidemiologic technique designed to provide household-level information and to be efficiently and rapidly deployed with minimum resources. CASPERs can be conducted to assess the effect of a disaster on a population, to determine the health status and basic needs of an affected population, to evaluate response and recovery efforts, to gain a better understanding of the community for community health assessments, and to practice the CASPER technique as part of a preparedness exercise. The CASPER organization includes leadership, local coordination, logistics, data management, and field teams. Field teams consist of two persons with a target of 10–15 teams. A CASPER includes seven steps: 1) define the geographic area, 2) determine sampling method, 3) select instrument(s), 4) train field personnel, 5) conduct assessment, 6) analyze data, and 7) report results.

CASPER uses a two-stage cluster design based on the World Health Organization epidemiology technique for estimating vaccine coverage from small pox eradication. In the first stage of the sampling method, 30 clusters (i.e. census blocks) with  $\geq 7$  housing units (HUs) are selected with their probability proportional to the estimated number of HUs in each cluster. In the second stage, seven HUs are randomly selected in each of the 30 clusters by the field teams for the purpose of conducting the interviews with the goal of 210 completed interviews. Eighty percent completion rates allows population needs to be estimated from the sample and the estimates are usually within 10 percent.

RCHD contacted the PHSD in June 2015 for help conducting a CASPER in August of 2015. Formal planning for the CASPER started immediately. RCHD initiated an incident command structure (ICS) for planning and execution of the CASPER. During the first call, July 29 and 30 were chosen for the exercise and duties were assigned. RCHD roles were development of the survey instrument with community stakeholders, volunteer management, exercise logistics including data collection, and the media campaign to raise awareness of the exercise. PHSD roles were coordinating the sampling and

development of cluster maps with the Centers for Disease Control and Prevention, the just-in-time training for volunteers, completion of the volunteer evaluation, and writing of the final report.

The geographic area for the CASPER included all of Richland County, which is 2,084 square miles. The main population center is Sidney with a population of 6,253. Richland County contains 1,744 total census blocks including 989 blocks with 0 HUs, 522 blocks with 1–6 HUs, and 233 blocks with  $\geq 7$  HUs for a total of 4,528 HUs. The CDC Health Studies Branch logically combined census blocks taking into account boundaries, roads, rivers, and other features to create new clusters with  $\geq 7$  HUs. In the first stage sampling, 30 clusters were randomly selected with probability proportional to the number of HUs within the merged blocks. In the second stage, field teams used a standardized method for randomization to select HUs for the seven interviews.

RCHD worked with community partners including the Sidney Health Center and Communities in Action Coalition to develop the survey instrument which was designed to capture 1) demographic information 2) health status and physical activity 3) community planning 4) access to care and preventive services 5) educational programs and 6) perceptions of community issues (Appendix A). On Wednesday July 29, a just-in-time training session for 42 volunteers provided an overview of a CASPER, household selection, interview techniques, and safety. Twenty, 2-person teams attempted to conduct seven interviews in each of the 30 clusters selected for the sample, with a goal of 210 completed interviews. Residents of households who were at least 18 years of age were considered eligible respondents. Additionally, field teams distributed information on immunizations, high blood pressure, Sidney Health Center, RCHD, Boys and Girls Club, Foundation for Community Care, Volunteer Program, and seat belt usage. Data collection occurred on Wednesday July 29 from 3:00 pm to 8:00 pm and again on Thursday July 30 from 3:00 pm to 7:00 pm. All forms used during the CASPER were from the CASPER toolkit and were modified accordingly. All volunteers completed an evaluation at the end of the exercise (Appendix B).

Epi Info 7.1.2, a free statistical software package produced by the CDC, was used for data entry and analysis. The completion rate was calculated by dividing the number of completed interviews by 210 (i.e., the goal for completed interviews in this CASPER). To account for the probability that the responding household was selected, we created sampling weights based on the total number of occupied houses according to the 2010 Census, the number of clusters selected, and the number of interviews completed in each cluster. This weight was used to calculate all weighted frequencies and percentages presented in this report.

## **Results**

On July 29 and 30, the interview teams conducted 204 interviews, yielding a completion rate of 97.1%. The 204 interviewed households were a sample of the 4,659 total households in Richland County. Unweighted frequencies, percentages, and projected population estimates based on weighted analyses can be found in Tables 1-17.

Seventy-one percent (71%) of respondents were female and 50.7% were between 25 and 54 years of age. Thirty-eight percent (38%) of respondents were employed full-time, 23% were retired, 14.7% were self-employed, and 12.3% were employed part-time. Table 1 contains complete demographic results.

Of the interviewed households, 97.6% strongly agree or agree they feel safe in their home; 95.6% strongly agree or agree they feel safe in their community; 94.1% strongly agree or agree their community is a good place to raise children; 93.2% strongly agree or agree they have enough financial resources to meet their basic needs; 88.7% strongly agree or agree there are places to be physically active near their home; 88.2% strongly agree or agree they feel prepared for an emergency; 86.8% strongly agree or agree their community is a good place to grow old; 78.4% strongly agree or agree people of all races, ethnicities, backgrounds, and beliefs are treated fairly in their community; 70.6% strongly agree or agree they can get the health care they need near their home; and 57.9% strongly agree or agree they can buy affordable healthy food near their home. Respondents identified access to health care and other services (60.8%), affordable housing (39.7%), good schools (33.3%), and good jobs and a healthy economy (32.4%) as most important aspects to a health community. Tables 2-3 contain complete results for community perceptions.

Of the interviewed households, 82.7% rated their physical health as excellent, very good, or good; 63.5% rated their day-to-day stress level as moderate or high; 21.3% haven't visited a dentist for 3 or more years; 19.3% currently smoke; and 61.1% always wear their seatbelt. Respondents identified more parks, trails, or greenways (24.5%) and more/better sidewalks (23.5%) as improvements that would help them be more physically active. Thirty-three percent (33%) of interviewed persons stated the biggest barrier to being more physically active is they are too busy or don't have time. Barriers to healthy eating included healthy foods cost too much (30.4%), takes too long to prepare and shop for healthy food (21.6%), and hard to find healthy choices outside the home (19.6%). Tables 4–8 contain complete results for health questions.

Ninety-two percent (92%) of respondents stated local health care providers and services are important to the economic well-being of the area. Thirty percent (30.2%) were unaware of programs to help pay for health care expenses and 23.8% did not get or were delayed in health care services in the past 12 months. Reasons health care services were delayed or not received included couldn't get an appointment (39.6%), costs too much (29.2%), availability of services (27.1%), and too long to wait for an appointment (20.8%). Items identified that would improve access to health care included more primary care providers (49.5%), availability of visiting specialists (42.2%), and availability of walk-in clinics (34.8%). The most common preventive services used in the past year were routine health check-up with family physician (58.3%), birthday lab work (51%), and routine blood pressure check (44.6%). Only 43% of persons interviewed received an influenza immunization within the last year. Friends/family (65%), health care provider (48%), word of mouth/reputation (43%), and the newspaper (39%) were identified as the main sources of health services or health-related information available in the community. Tables 9-14 contain complete results for access to care questions.

The most important aspects of education identified by respondents were K-12 (57.8%) and early childhood (33.3%). However, 32% of persons interviewed didn't know what areas of education lacked resources. Educational classes of interest included first aid/CPR (32%), fitness (26%), health and wellness (25%), nutrition (24%), and weight loss (22%). Tables 15-16 contain complete results to educational questions.

Issues perceived as big problems in Richland County included availability of affordable housing (58%), illegal drug use (43%), alcohol abuse (38%), obesity (30%), cancer (29%), tobacco use (28%), availability of affordable childcare (25%), prescription drug abuse (22%), and motor vehicle injuries (22%). Table 17 contains complete information on perceptions of issues within Richland County.

### **Volunteer Evaluations**

All but two volunteers would participate in a CASPER in the future. Positive experiences from the CASPER included the just-in-time training, food, cluster packets, communications, and transportation. Volunteers felt the community was generally receptive to the survey and the community cares. Volunteers had good experiences interacting with residents and conveying to them their opinions matter. Volunteers recognized surveying takes a lot of time. Some volunteers felt the survey was too long, some questions were redundant, maps were difficult to understand and read, the method targeted stay at home mothers and the elderly, more emergency preparedness questions were needed, and more time should have been spent on the tracking form during the training.

### **Discussion**

Successful collaborations occurred between the RCHD, the Sidney Health Center, PHSD, and other Richland County local public health system partners. These collaborations helped strengthen relationships and define roles of partners during a CASPER. Practicing the technique will be invaluable to the county and state in the event a CASPER will be needed during an emergency or disaster situation. Lessons learned during the process will help refine the technique for use in Richland County and in other Montana counties. RCHD was able to successfully find and utilize a volunteer network within the community. The post-exercise evaluations showed persons participating in the CASPER would volunteer again if needed. RCHD now has a list of volunteers that can be engaged if needed for future exercises or emergency events.

The CASPER met the stated purposes of improving the understanding of the health status of Richland County, developing a volunteer workforce, and completing an emergency preparedness exercise. RCHD and local public health system partners gained granular local data that can be used in addition to other data sources to direct resources and improve services. Areas for potential public health interventions include continued efforts to decrease smoking, improve seat belt usage, increase influenza vaccine coverage, and to increase routine dental care. Improvements can be made to increase awareness of programs to help pay for health care expenses and to ensure and improve access to health care services.

Overall, results show residents feel Richland County is a good place to live, work, and retire. Richland County residents identified key issues they felt required immediate attention including increasing the availability of affordable housing and addressing illegal drug use and tobacco use. The results should be shared with local leaders, planners, and other local public health system groups to start discussions about how to address these community-wide issues.

### **Limitations**

To create sampling weights, information from the 2010 Census was used to determine the household probability of being selected. Richland County has experienced significant population changes since 2010, and thus the Census data might not be representative of the current population. The discrepancy between the 2010 Census and the current status, would not, however, affect the unweighted frequencies presented in this report.

### **Lessons Learned**

- 1) CASPERs are a good method to gather local primary data for community health assessments.**  
Because of Montana's small population, granular local data can be hard to obtain. The CASPER method allows for collection of local data with population estimates. The data gained through a CASPER are invaluable to the health department and other local public health system partners for understanding the complete picture of community health.
- 2) Ensure cluster maps are adequate.**  
Some of the cluster maps created by CDC, especially the rural clusters, were not adequate. With future CASPERs, ensure both a street and topographic map are in the cluster packets with arrows designating the cluster entry point. These changes will decrease frustration for volunteer teams and ensure the correct households are being interviewed.
- 3) In addition to explaining the household tracking form, walk through an example and provide extra household tracking forms.**  
Some confusion existed with the proper way to complete the household tracking form during data collection and many teams used the one form supplied and were unable to continue tracking homes. For future CASPER trainings, each volunteer should receive a tracking form during the training to practice filling out the form properly. In addition, multiple household tracking forms should be provided to ensure teams can track household contact during the data collection.
- 4) Extend data collection times for day one to try to complete as many clusters as possible.**  
As with the previous CASPER conducted in Montana, retaining volunteers for the second day of data collection was challenging. Options to ensure enough volunteers exist to complete the CASPER is to have more teams for the first day of data collection with extended data collection hours or have a set of volunteers for each day.
- 5) Improve the survey by decreasing the number of choices for questions.**  
Volunteers felt some questions had too many choices, which created difficulty for the respondents. As with any survey, improvements to questions can always be made to ensure the appropriate data is collected.

### **Recommendations**

Based on the results of the CASPER exercise, the following actions are recommended:

- 1) Share the results of the survey with local public health system partners and use as part of the community health assessment.**  
Information gained in the CASPER will benefit local public health system partners and should be shared. RCHD should use the results in addition to other data sources to determine community

health priorities and in the development of a community health assessment and organizational strategic plan.

**2) Continue to engage partners.**

Success of a CASPER or any community-based exercise is dependent on engagement and collaboration of partners. Partners were successfully engaged for collaboration during this project. Continued engagement of the partners will strengthen public health system and emergency preparedness in Richland County.

**3) Continue to recruit and use volunteers regularly.**

CASPERs can use either a volunteer or deployable workforce. Volunteers were the basis of the field teams in this exercise. Volunteers found use in this exercise and were engaged during the process. RCHD should keep a volunteer registry and continue to use volunteers for other exercises or projects. If an emergency or disaster does occur, volunteer networks will already have been established and trained.

**4) Use the results to implement public health interventions and create targeting public health messaging.**

Information gained about the population of Richland County during this exercise should be used to implement public health interventions and targeted public health messaging, to help address issues to access to health care, and to provide information about resource allocation for issues within the county.

**5) Improve cluster maps provided to volunteers.**

The maps provided by CDC were not detailed enough for some areas within Richland County. For future CASPERs, maps should be both the street view and a map view with an arrow marking the starting point.

**6) Create and maintain randomized cluster maps for each county in Montana to be ready to be used for an exercise to practice the technique or during an emergency or disaster.**

The most time consuming portion of the CASPER was combining census blocks, randomly selecting clusters, and creating detailed maps of the selected clusters. CDC provided the cluster maps for this CASPER; as no expertise exists within PHSD to complete the cluster mapping. PHSD should develop and maintain a bank of randomly selected clusters for each county in Montana. The state then would be able to provide this expertise to the counties for an exercise or during an emergency or disaster.

## Appendix A. Data Tables

Table 1. Demographics

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
<b>Sex</b>					
Female	145	71.1	3283	70.5	69.1-71.8
Male	54	26.5	1265	27.1	25.9-28.5
<b>Race/Ethnicity</b>					
Black or African American	1	0.49	22	0.48	0.31-.073
Asian	1	0.49	22	0.48	0.31-.073
American Indian or Alaska Native	10	4.9	285	6.1	5.5-6.9
White or Caucasian	191	93.6	4371	93.8	93.1-94.5
Hispanic or Latino	6	2.9	137	2.9	2.5-3.5
<b>Age Range</b>					
18-19	1	0.5	22	0.5	0.31-0.74
20-24	14	7.0	314	6.8	6.1-7.6
25-34	34	16.9	758	16.5	15.5-17.6
35-44	33	16.4	736	16.0	15.0-17.1
45-54	35	17.4	836	18.2	17.1-19.4
55-59	15	7.5	336	7.3	6.6-8.1
60-64	15	7.5	333	7.3	6.5-8.0
65-74	36	17.9	854	18.6	17.5-19.8
75+	17	8.5	381	8.3	7.5-9.1
<b>Employment Status</b>					
Employed full time	79	38.7	1760	37.8	36.4-39.2
Employed part time	25	12.3	558	12.0	11.1-13.0
Retired	47	23	1046	22.5	21.3-23.7
Student	3	1.5	67	1.4	1.1-1.8
Armed forces/military	2	0.98	44	0.95	0.7-1.3
Self-employed	30	14.7	780	16.8	15.7-17.9
Stay at home parents	17	8.3	381	8.2	7.4-9.0
Unable to work due to illness or injury	6	2.9	133	2.9	2.4-3.4
Unemployed <1 year	3	1.5	67	1.4	1.1-1.8
Unemployed >1 year	3	1.5	67	1.4	1.1-1.8

**Table 2. Aspects of Richland County**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
<b>I can get there health care I need near my home</b>					
Strongly Agree	49	57.4	1146	24.6	23.4-25.9
Agree	117	13.2	2666	57.2	55.8-59.7
Disagree	27	1.5	603	12.9	12.0-13.9
Strongly Disagree	8	24.0	177	3.8	3.3-4.4
Don't know	3	3.9	67	1.4	1.1-1.8
<b>My community is a good place to raise children</b>					
Strongly Agree	91	44.6	2141	46.0	44.5-47.4
Agree	101	49.5	2252	48.3	46.9-49.8
Disagree	7	3.4	155	3.3	2.9-3.9
Strongly Disagree	1	0.49	22	0.5	0.3-0.7
Don't know	4	2.0	89	1.9	1.5-2.4
<b>My community is a good place to grow old</b>					
Strongly Agree	60	29.4	1446	31.0	29.7-32.4
Agree	117	57.4	2603	55.9	54.4-57.3
Disagree	15	7.4	336	7.2	6.5-8.0
Strongly Disagree	6	2.9	137	2.9	2.5-3.5
Don't know	6	2.9	137	2.9	2.5-3.5
<b>I feel safe in my home</b>					
Strongly Agree	94	46.1	2200	47.2	45.8-48.7
Agree	105	51.5	2348	50.4	49.0-51.8
Disagree	5	2.5	111	2.4	2.0-2.9
Strongly Disagree	0	0	0	0	0
Don't know	0	0	0	0	0
<b>I feel safe in my community</b>					
Strongly Agree	71	34.8	1690	36.3	34.9-37.7
Agree	124	60.8	2770	59.4	58.0-60.9
Disagree	8	3.9	177	3.8	3.3-4.4
Strongly Disagree	1	0.5	22	0.5	0.3-0.7
Don't know	0	0	0	0	0
<b>I feel prepared for an emergency</b>					
Strongly Agree	68	33.3	1575	33.8	32.5-35.2
Agree	112	54.9	2551	54.8	53.3-56.2
Disagree	21	10.3	466	10.0	9.2-10.9
Strongly Disagree	2	1.0	44	1.0	0.7-1.3
Don't know	1	0.5	22	0.5	0.3-0.7
<b>People of all races, ethnicities, backgrounds, and beliefs in my community are treated fairly</b>					
Strongly Agree	39	19.1	980	21.0	19.9-22.2
Agree	121	59.3	2688	57.7	56.3-59.1
Disagree	26	12.8	581	12.5	11.5-13.5

Strongly Disagree	2	1.0	48	1.0	0.77-1.4
Don't know	16	7.8	362	7.8	7.0-8.6
	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
<b>I can buy affordable healthy food near my home.</b>					
Strongly Agree	24	11.8	588	12.6	11.7-13.6
Agree	94	46.1	2148	46.1	44.7-47.6
Disagree	60	29.4	1335	28.7	27.4-30.0
Strongly Disagree	25	12.3	566	12.1	11.2-13.1
Don't know	1	0.5	22	0.5	0.3-0.7
<b>There are places to be physically active near my home.</b>					
Strongly Agree	50	24.5	1224	26.3	25.0-27.6
Agree	131	64.2	2917	62.6	61.2-64.0
Disagree	17	8.3	385	8.3	7.5-9.1
Strongly Disagree	4	2.0	89	1.9	1.5-2.4
Don't know	2	1.0	44	1.0	0.7-1.3
<b>I have enough financial resources to meet my basic needs.</b>					
Strongly Agree	55	27	1339	28.7	27.4-30.1
Agree	135	66.2	3010	64.6	63.2-66.0
Disagree	13	6.4	288	6.2	5.5-6.9
Strongly Disagree	1	0.5	22	0.5	0.3-0.7
Don't know	0	0	0	0	0

**Table 3. What is most important to a healthy community.**

	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
Access to health care and other services	124	60.8	2873	61.7	60.3-63.1
Affordable housing	81	39.7	1808	38.8	37.4-40.2
Good schools	68	33.3	1512	32.5	31.1-33.8
Good jobs and a healthy economy	66	32.4	1578	33.9	32.5-35.3
Clean air/water	58	28.4	1287	27.6	26.3-28.9
Strong family life	54	26.5	1209	26.0	24.7-27.2
Low crime/safe neighborhood	37	18.1	825	17.7	16.6-18.8
Religious or spiritual values	34	16.7	821	17.6	16.5-18.8
Healthy behaviors and lifestyles	23	11.3	510	11.0	10.1-11.9
Healthy food choices	17	8.3	381	8.2	7.4-9.0
Parks and recreation	15	7.4	336	7.2	6.5-8.0
Good community	10	4.9	281	6.0	5.4-6.8

involvement					
Public transportation	10	4.9	222	4.8	4.2-5.4
	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
Strong early childhood (pre-K) education system	9	4.4	200	4.3	3.7-4.9
Access to adult learning opportunities	6	2.9	133	2.9	2.4-3.4
Low levels of domestic violence	5	2.5	111	2.4	2.0-2.9
Tolerance for diversity	4	2.0	89	1.9	1.5-2.4
Low death and disease rates	3	1.5	67	1.4	1.1-1.8
Arts and cultural events	3	1.5	67	1.4	1.1-1.8

**Table 4. Health questions.**

	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
<b>Physical Health</b>					
Excellent	22	10.8	547	11.8	10.9-12.8
Very good	66	32.5	1531	33.0	31.7-34.4
Good	80	39.4	1779	38.4	37.0-39.8
Fair	24	11.8	536	11.6	10.7-12.5
Poor	10	4.9	222	4.8	4.2-5.5
Don't know	1	0.5	22	0.5	0.3-0.7
<b>Day-to-day level of stress</b>					
High	26	12.8	581	12.5	11.6-13.5
Moderate	103	50.7	2352	50.7	49.3-52.2
Low	66	32.5	1527	32.9	31.6-34.3
Don't know	3	1.5	67	1.4	1.1-1.8
Prefer not to say	5	2.5	111	2.4	2.0-2.9
<b>Physically active in the past 7 days</b>					
0 days	13	6.4	288	6.3	5.9-7.0
1-2 days	31	15.4	691	15.0	14.0-16.1
3-4 days	51	25.3	1143	24.8	23.5-26.0
5 or more days	98	48.5	2293	49.7	48.2-51.1
Don't know	9	4.5	200	4.3	3.8-5.0
Prefer not to say	0	0	0	0	0
<b>Routine dental check-up</b>					
<1 year	113	55.7	2629	56.7	55.3-58.1
1-2 years	43	21.2	954	20.6	19.4-21.8
3-5 years	11	5.4	251	5.4	4.8-6.1

>5 years	33	16.3	736	15.9	14.8-17.0
Never	2	1.0	44	1.0	0.7-1.3
Don't know	1	0.5	22	0.5	0.3-0.7
	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
<b>Currently smoke</b>					
Yes	39	19.3	928	20.1	19.0-21.3
No	163	80.7	3687	79.9	78.7-81.0
Missing	2	1.0	44	1.0	0.7-1.3
<b>Seatbelt use</b>					
Always	123	61.5	2795	61.1	59.7-62.6
Nearly always	47	23.5	1109	24.3	23.0-25.6
Sometimes	14	7.0	311	6.8	6.1-7.6
Seldom	8	4.0	177	3.9	3.4-4.5
Never	6	3.0	133	2.9	2.5-3.5
Prefer not to say	2	1.0	44	1.0	0.7-1.3
<b>Skipped meal in the past 12 months because there was not enough money for food</b>					
Yes	11	5.4	244	5.2	4.6-5.9
No	190	93.1	4348	93.3	92.6-94.0

**Table 5. If currently smoke, where would you go for help if you wanted to quit?**

	<b>Frequency (n=39)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
Quitline MT	13	33.3	292	31.5	28.5-34.6
Doctor	1	0.6	22	0.6	0.4-0.9
Don't know	4	10.3	89	9.6	7.8-11.7
Prefer not to say	2	5.1	44	4.8	3.5-6.4

**Table 6. What would help you be more physically active?**

	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
More parks, trails, or greenways	50	24.5	1113	23.9	22.7-25.2
More/better sidewalks	48	23.5	1069	22.9	21.7-24.2
Access to a gym	34	16.7	817	17.5	16.5-18.7
Walking or exercise group	22	10.8	488	10.5	9.6-11.4
More programs or events	18	8.8	399	8.6	7.8-9.4
Stores within walking distance	16	7.8	355	7.6	6.9-8.4
More sports leagues	12	5.9	270	5.8	5.2-6.5
Increased neighborhood safety	10	4.9	222	4.8	4.2-5.4

**Table 7. What gets in the way of being more physically active?**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
Too busy or don't have time	67	32.8	1501	32.2	30.9-33.6
Nothing gets in the way	48	23.5	1124	24.1	22.9-25.4
Too tired to exercise	27	13.2	603	12.9	12.0-13.9
Costs too much	20	9.8	447	9.6	8.8-10.5
Physically unable	17	8.3	377	8.1	7.3-8.9
Don't like or want to exercise	17	8.3	377	8.1	7.3-8.9
No friends or group to exercise with	15	7.4	333	7.1	6.4-7.9
No gym access					
Not important to me	5	2.5	111	2.4	2.0-2.8

**Table 8. What are the barriers to eating healthy?**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
Healthy foods cost too much	62	30.4	1387	29.8	28.5-31.1
Takes too long to prepare and shop for health food	44	21.6	980	21.0	19.9-22.2
Hard to find healthy choices outside the home	40	19.6	891	19.1	18.0-20.3
Healthy food doesn't taste good	14	6.9	366	7.9	7.1-8.7
Nobody in my family would eat it	14	6.9	311	6.7	6.0-7.4
No place to buy healthy food	11	5.4	248	5.3	4.7-6.0
Don't know how to prepare healthy food	3	1.5	67	1.4	1.1-1.8

**Table 9. Health care and health care access**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
<b>How important are health care providers and services to the economic wellbeing of the area?</b>					
A lot	185	91.6	4230	91.7	90.8-92.4
A little	7	3.5	155	3.4	2.9-3.9
Not at all	1	0.5	22	0.5	0.3-0.7
Don't know	8	4.0	185	4.0	3.5-4.6
Prefer not to say	1	0.5	22	0.5	.03-0.7
<b>Are you aware of programs to help pay for health care expenses?</b>					
Yes	137	67.8	3051	66.1	64.7-67.5
No	61	30.2	1475	32.0	30.6-33.3
Prefer not to say	4	2.0	89	1.9	1.6-2.4
<b>In the past 12 months, was there a time you couldn't get health care services?</b>					
Yes	48	23.8	1131	24.3	23.1-25.6
No	154	76.2	3483	74.8	73.5-76.0

**Table 10. Reasons why health care was not received.**

	Frequency (n=48)	% Households	Projected Households	Projected %	95% CI
Couldn't get an appointment	19	39.6	429	37.9	35.1-40.8
Costs too much	14	29.2	322	28.4	25.8-31.2
Availability of services	13	27.1	288	25.5	23.0-28.2
Too long to wait for an appointment	10	20.8	229	20.3	18.0-22.8
No insurance	8	16.7	181	16.0	14.0-18.3
Office not open when I could go	8	16.7	177	15.7	13.6-18.0
Could not get off work	4	8.3	89	7.8	6.4-9.6
Do not like doctors	3	6.3	67	5.9	4.6-7.5
Unsure if services were available	3	6.3	67	5.9	4.6-7.5
Transportation problems	3	6.3	67	5.9	4.6-7.5
Insurance did not cover	3	6.3	67	5.9	4.6-7.5
Not treated with respect	2	4.2	44	3.9	2.9-5.3
Too nervous/afraid	2	4.2	44	3.9	2.9-5.3
No one to care for children	1	2.1	22	2.0	1.3-3.0

Language barrier	0	0	0	0	0
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**Table 11. What would improve community's access to health care?**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
More primary care providers	101	49.5	2256	48.4	47.0-49.9
Availability of visiting specialists	86	42.2	1978	42.5	41.0-43.9
Availability of walk-in clinics	71	34.8	1583	34.0	32.6-35.4
Improved quality of care	34	16.7	758	16.3	15.2-17.4
Telemedicine	22	10.8	495	10.6	9.8-11.6
Health education resources	20	9.8	447	9.6	8.8-10.5
Transportation assistance	16	7.8	355	7.6	6.9-8.4
Cultural sensitivity	8	3.9	177	3.8	3.3-4.4
Interpreter services	6	2.9	133	2.9	2.4-3.4

**Table 12. Preventive services used in past year**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
Routine health check up with family physician	119	58.3	2766	59.4	57.9-60.8
Birthday lab work	104	51.0	2366	50.8	49.4-52.2
Routine blood pressure check	91	44.6	2089	44.8	43.4-46.3
Flu shot	87	42.7	1989	42.7	41.3-44.1
Cholesterol check	55	27.0	1279	27.5	26.2-28.8
Children' checkup/well baby	32	15.7	714	15.3	14.3-16.4
None	18	8.8	399	8.6	7.8-9.4
Colonoscopy	17	8.3	433	9.3	8.5-10.2
Mammography	49	24.0	1142	24.5	23.3-25.8
Pap smear	55	27.0	1279	27.5	26.2-28.8
Prostate	14	6.9	366	7.9	7.1-8.7

**Table 13. Mental health and substance abuse services**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
<b>Do you know where someone could go for mental health services?</b>					
Yes	98	48.8	2237	48.7	47.3-50.2
No	65	32.3	1509	32.9	31.5-34.2
Don't know	36	17.9	802	17.5	16.4-18.6
Prefer not to say	2	1.0	44	1.0	0.7-1.3
<b>Where would you refer someone for mental health services?</b>					
Eastern MT Community Mental Health Center	88	43.1	1960	42.1	40.6-43.5
Don't know	54	26.5	1205	25.9	24.6-27.2
Faith-based leader	37	18.1	887	19.1	17.9-20.2
Private doctor	36	17.7	862	18.5	17.4-19.6
Private Therapist/ social worker	35	17.2	780	16.8	15.7-17.9
Emergency room	28	13.7	625	13.4	12.5-14.4
Friend	11	5.4	244	5.2	4.6-5.9
<b>Do you know where someone could go for substance abuse services?</b>					
Yes	104	51.7	2378	51.8	50.4-53.3
No	66	32.8	1464	31.9	30.5-33.3
Don't know	28	13.9	680	14.8	13.8-15.9
Prefer not to say	3	1.5	67	1.5	1.1-1.9
<b>Where would you refer someone for substance services?</b>					
District II Alcohol and Drug	106	52.0	2418	51.9	50.5-53.4
Alcoholics Anonymous	62	30.4	1383	29.7	28.4-31.0
Don't know	42	20.6	939	20.1	19.0-21.4
Faith-based leader	39	19.1	932	20.0	18.9-21.2
Private doctor	28	13.7	629	13.5	12.5-14.5
Private Therapist/ social worker	20	9.8	444	9.5	8.7-10.4
Emergency room	18	8.8	399	8.6	7.8-9.4
Friend	11	5.4	244	5.2	4.6-5.9

**Table 14. How do you learn about health services and health-related information available in our community?**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
Friends/family	133	65.2	3072	66.0	64.6-67.3
Health care provider	97	47.6	2163	46.4	45.0-47.9
Word of mouth / reputation	87	42.7	1993	42.8	41.4-44.2
Newspaper	79	38.7	1767	37.9	36.5-39.4
Social media platforms	45	22.1	1013	21.8	20.6-23.0
Mailings/newsletters	43	21.1	958	20.6	19.4-21.8
Public health	39	19.1	873	18.7	17.6-19.9
Website/internet	32	15.7	714	15.3	14.3-16.4
Radio	31	15.2	695	14.9	13.9-16.0
TV	25	12.3	555	11.9	11.0-12.9
presentations	13	6.4	288	6.2	5.5-6.9

**Table 15. Education**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
<b>What aspect of education is most important?</b>					
K-12	118	57.8	2740	58.8	57.4-60.2
Early childhood	68	33.3	1509	32.4	31.0-33.8
Job training	19	9.3	429	9.2	8.4-10.1
Don't know	13	6.4	292	6.3	5.6-7.0
Adult education	13	6.4	288	6.2	5.5-6.9
Advanced education	11	5.4	244	5.2	4.6-5.9
<b>What two areas lack adequate resources?</b>					
Don't know	66	32.4	1523	32.7	31.4-34.1
Early childhood	58	28.4	1302	27.9	26.7-29.3
K-12	52	25.5	1217	26.1	24.9-27.4
Job training	43	21.1	958	20.6	19.4-21.8
Adult education	40	19.6	887	19.1	17.9-20.2
Advanced education	37	18.1	825	17.7	16.6-18.8

**Table 16. Educational classes/programs**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
First Aid/CPR	65	31.9	1560	33.5	32.1-34.9
Fitness	52	25.5	1157	24.8	23.6-26.1
Health and Wellness	51	25.0	1135	24.4	23.1-25.6
Nutrition	48	23.5	1065	22.9	21.7-24.1
Weight loss	46	22.3	1024	22.0	20.8-23.2
Parenting	33	16.2	732	15.7	14.7-16.8
Alzheimer's	31	15.2	691	14.8	13.8-15.9
Health insurance/ACA	30	14.7	669	14.4	13.4-15.4
Mental Health	27	13.2	599	12.9	11.9-13.9
Early childhood development	27	13.2	602	12.9	12.0-13.9
Diabetes	25	12.3	558	12.0	11.1-13.0
Cancer	22	10.8	488	10.5	9.6-11.4
Grief counseling	18	8.8	403	8.7	7.9-9.5
Pulmonary health	18	8.8	403	8.7	7.9-9.5
Support groups	16	7.8	355	7.6	6.9-8.4
Heart disease	14	6.9	311	6.7	6.0-7.4
Smoking cessation	12	5.9	270	5.8	5.2-6.5
Alcohol/substance abuse	11	5.4	244	5.4	4.6-5.9

**Table 17. Issues considered big problems in Richland County**

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
<b>Heart Disease</b>					
A big problem	18	8.2	399	8.6	7.8-9.4
A problem	76	37.3	1697	36.4	35.1-37.8
Not a problem	27	13.2	714	15.3	14.3-16.4
Don't know	83	40.7	1849	39.7	38.3-41.1
<b>Diabetes</b>					
A big problem	30	14.7	669	14.4	13.4-15.4
A problem	99	48.5	2263	48.6	47.1-50.0
Not a problem	24	11.8	588	12.6	11.7-13.6

Don't know	51	25.0	1139	24.4	23.2-25.7
<b>Cancer</b>					
A big problem	59	28.9	1313	28.2	26.9-29.5
A problem	84	41.2	1926	41.4	39.9-42.8
Not a problem	21	10.3	525	11.3	10.4-12.2
Don't know	40	19.6	895	19.2	18.1-20.4
	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
<b>Asthma</b>					
A big problem	29	14.4	647	14.0	13.1-15.1
A problem	76	37.6	1745	37.9	36.5-39.3
Not a problem	31	15.4	747	16.2	15.2-17.3
Don't know	66	32.7	1472	31.9	30.6-33.3
<b>COPD</b>					
A big problem	14	6.9	311	6.7	6.0-7.4
A problem	72	35.3	1716	36.8	35.4-38.2
Not a problem	34	16.7	758	16.3	15.2-17.4
Don't know	84	41.2	1875	40.2	38.8-41.7
<b>Obesity</b>					
A big problem	61	29.9	1353	29.1	27.8-30.4
A problem	96	47.1	2141	46.0	44.5-47.4
Not a problem	17	8.3	495	10.6	9.8-11.6
Don't know	30	14.7	699	14.4	13.4-15.4
<b>Alcohol abuse</b>					
A big problem	78	38.2	1745	37.5	36.1-38.9
A problem	90	44.1	2056	44.1	42.7-45.6
Not a problem	17	8.3	381	8.2	7.4-9.0
Don't know	19	9.3	477	10.2	9.4-11.2
<b>Tobacco use</b>					
A big problem	58	28.4	1294	27.8	26.5-29.1
A problem	103	50.5	2356	50.6	49.1-52.0
Not a problem	21	10.3	521	11.2	10.3-12.1
Don't know	22	10.8	488	10.5	9.6-11.4
<b>Prescription drug abuse</b>					
A big problem	45	22.4	988	21.7	20.6-23.0
A problem	69	34.3	1546	33.7	32.3-35.1
Not a problem	25	12.4	666	14.5	13.5-15.6
Don't know	62	30.9	1383	30.1	28.8-31.5
<b>Illegal drug use</b>					

A big problem	88	43.1	2015	43.3	41.8-44.7
A problem	69	33.8	1542	33.1	31.8-34.5
Not a problem	32	15.7	336	7.2	6.5-8.0
Don't know	15	7.4	765	16.4	15.4-17.5
	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
<b>Access to mental health services</b>					
A big problem	27	13.3	603	13.0	12.1-14.0
A problem	55	27.1	1228	26.5	25.2-27.8
Not a problem	45	22.2	1054	22.7	21.5-24.0
Don't know	76	37.4	1753	37.8	36.4-39.2
	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
<b>Access to substance abuse services</b>					
A big problem	23	11.3	514	11.1	10.2-12.0
A problem	52	25.6	1165	25.1	23.9-26.4
Not a problem	25	12.5	1217	26.2	25.0-27.5
Don't know	76	37.4	1742	37.6	36.2-39.0
<b>Motor vehicle injuries</b>					
A big problem	44	21.6	979	21.0	19.8-22.2
A problem	79	38.7	1849	39.1	37.7-40.5
Not a problem	36	17.7	862	18.5	17.4-19.6
Don't know	45	22.1	1002	21.5	20.3-22.7
<b>Falls resulting in injury</b>					
A big problem	9	4.4	203	4.4	3.8-5.0
A problem	54	26.5	1202	25.8	24.6-27.1
Not a problem	59	28.9	1428	30.6	29.3-32.0
Don't know	82	40.2	1827	39.2	37.8-40.6
<b>Good prenatal care</b>					
A big problem	17	8.3	385	8.3	7.5-9.1
A problem	46	22.6	1024	22.0	20.8-23.2
Not a problem	90	44.1	2115	45.4	44.0-46.8
Don't know	51	25.0	1135	24.4	23.1-25.6
<b>Availability of services for seniors</b>					
A big problem	16	7.8	362	7.8	7.0-8.6
A problem	45	22.1	1009	21.7	20.5-22.9
Not a problem	70	34.3	1608	34.5	33.1-35.9
Don't know	73	35.8	1679	36.0	34.7-37.4

<b>Availability of services for individuals with physical disabilities</b>					
A big problem	16	7.8	359	7.7	7.0-8.5
A problem	66	32.4	1479	31.8	30.4-33.1
Not a problem	46	22.6	1131	24.3	23.1-25.6
Don't know	76	37.3	1690	36.3	34.9-37.7
	<b>Frequency (n=204)</b>	<b>% Households</b>	<b>Projected Households</b>	<b>Projected %</b>	<b>95% CI</b>
<b>Access to public transportation</b>					
A big problem	9	4.4	200	4.3	3.8-4.9
A problem	47	23.2	1050	22.7	21.5-23.9
Not a problem	110	54.2	2566	55.3	53.9-59.8
Don't know	37	18.2	821	17.7	16.6-18.8
<b>Availability of affordable childcare</b>					
A big problem	50	25.3	1117	24.7	23.4-26.0
A problem	59	29.8	1320	29.2	27.9-30.5
Not a problem	41	20.7	969	21.4	20.2-22.6
Don't know	48	24.2	1120	24.8	23.5-26.0
<b>Hunger</b>					
A big problem	7	3.4	155	3.3	2.9-3.9
A problem	53	26.0	1180	25.3	24.1-26.6
Not a problem	68	33.3	1631	35.0	33.6-36.4
Don't know	76	37.3	1694	36.4	35.0-37.8
<b>Poor housing conditions</b>					
A big problem	32	15.7	714	15.3	14.3-16.4
A problem	72	35.3	1660	35.6	34.3-37.0
Not a problem	49	24.0	1154	24.8	23.5-26.0
Don't know	51	25.0	1131	24.3	23.1-25.6
<b>Availability of affordable housing</b>					
A big problem	119	58.3	2718	58.3	56.9-59.8
A problem	57	27.9	1320	28.3	27.1-29.7
Not a problem	12	5.9	266	5.7	5.1-6.4
Don't know	16	7.8	355	7.6	6.9-8.4
<b>Homelessness</b>					
A big problem	16	7.8	355	7.6	6.9-8.4
A problem	51	25.0	1139	24.4	23.2-25.7
Not a problem	53	26.0	1239	26.6	25.3-27.9
Don't know	84	41.2	1926	41.4	39.9-42.8
<b>Access to clean water</b>					

	Frequency (n=204)	% Households	Projected Households	Projected %	95% CI
A big problem	11	5.4	244	5.2	4.6-5.9
A problem	26	12.8	581	12.5	11.5-13.5
Not a problem	139	68.1	3212	69.0	67.6-70.3
Don't know	28	13.7	621	13.3	12.4-14.4
<b>Child abuse or neglect</b>					
A big problem	19	9.4	478	10.3	9.4-11.2
A problem	74	36.5	1649	35.6	34.2-37.0
Not a problem	31	15.3	695	15.0	14.0-16.1
Don't know	79	38.9	1816	39.2	37.8-40.6
<b>Domestic, dating, or sexual violence</b>					
A big problem	20	9.8	503	10.8	9.9-11.7
A problem	69	33.8	1546	33.2	31.8-34.6
Not a problem	25	12.3	555	11.9	11.0-12.9
Don't know	90	44.1	2056	44.1	42.7-45.6
<b>Unintended pregnancy including teen pregnancy</b>					
A big problem	22	10.8	492	10.6	9.7-11.5
A problem	80	39.2	1841	39.5	38.1-41.0
Not a problem	22	10.8	488	10.5	9.6-11.4
Don't know	80	39.2	1838	39.4	38.0-40.9
<b>Sexually transmitted infections</b>					
A big problem	17	8.4	381	8.2	7.5-9.1
A problem	49	24.1	1146	24.7	23.5-26.0
Not a problem	26	12.8	581	12.5	11.6-13.5
Don't know	111	55.7	2529	54.6	53.1-56.0

Statements	Projected Percent				
	Strongly agree	Agree	Disagree	Strongly disagree	Don't know
I can get the health care I need near my home.	24.6%	57.2%	12.9%	3.8%	1.4%
My community is a good place to raise children.	46.0%	48.3%	3.3%	0.5%	1.9%
My community is a good place to grow old.	31.0%	55.9%	7.2%	2.9%	2.9%
I feel safe in my home.	47.2%	50.4%	2.4%	0.0%	0.0%
I feel safe in my community.	36.3%	59.4%	3.8%	0.5%	0.0%
I feel prepared for an emergency.	33.8%	54.8%	10.0%	1.0%	0.5%
People of all races, ethnicities, backgrounds, and beliefs in my community are treated fairly.	21.0%	57.7%	12.5%	1.0%	7.8%
I can buy affordable healthy food near my home.	12.6%	46.1%	28.7%	12.1%	0.5%
There are places to be physically active near my home.	26.3%	62.6%	8.3%	1.9%	1.0%
I have enough financial resources to meet my basic needs.	28.7%	64.6%	6.2%	0.5%	0.0%

<sup>a</sup>The data presented is a population estimate.

<sup>b</sup>Confidence intervals and specific survey results can be seen in the full community health assessment report.

Issues	Projected Percent			
	A big problem	A problem	Not a problem	Don't know

Availability of affordable housing	58.3%	28.3%	5.7%	7.6%
Illegal drug use	43.3%	33.1%	7.2%	16.4%
Alcohol abuse	37.5%	44.1%	8.2%	10.2%
Obesity	29.1%	46.0%	10.6%	14.4%
Cancer	28.2%	41.4%	11.3%	19.2%
Tobacco use	27.8%	50.6%	11.2%	10.5%
Availability of affordable childcare	24.7%	29.2%	21.4%	24.8%
Prescription drug abuse	21.7%	33.7%	14.5%	30.1%
Motor vehicle injuries	21.0%	39.1%	18.5%	21.5%
Poor housing conditions	15.3%	35.6%	24.8%	24.3%
Diabetes	14.4%	48.6%	12.6%	24.4%
Asthma	14.0%	37.9%	16.2%	31.9%
Access to mental health services	13.0%	26.5%	22.7%	37.8%
Access to substance abuse services	11.1%	25.1%	26.2%	37.6%
Domestic, dating, or sexual violence	10.8%	33.2%	11.9%	44.1%
Unintended pregnancy including teen pregnancy	10.6%	39.5%	10.5%	39.4%
Child abuse or neglect	10.3%	35.6%	15.0%	39.2%
Heart Disease	8.6%	36.4%	15.3%	39.7%
Good prenatal care	8.3%	22.0%	45.4%	24.4%
Sexually transmitted infections	8.2%	24.7%	12.5%	54.6%
Availability of services for seniors	7.8%	21.7%	34.5%	36.0%
Availability of services for individuals with physical disabilities	7.7%	31.8%	24.3%	36.3%
Homelessness	7.6%	24.4%	26.6%	41.4%
COPD	6.7%	36.8%	16.3%	40.2%
Access to clean water	5.2%	12.5%	69.0%	13.3%



3. Did you think you were prepared (e.g., training, food, safety, communications, supplies) for your assignment?

4. Would you want to participate on a team in the future?

5. If we were to do this assessment again, what improvements can be made?

6. Did you learn anything from this experience?

7. Were there specific situations that you encountered that you want to tell us about relating to

a. Orientation of field teams?

b. Assessment methods?

c. Questionnaire?

d. Supplies and equipment?

e. Food?

f. Safety?

g. Communications?

h. Transportation?

8. Please provide any additional comments

**THANK YOU FOR YOUR SERVICE TO YOUR COMMUNITY**