2022

COMMUNITY HEALTH NEEDS ASSESSMENT

Benton & Franklin Counties, WA

This CHNA was conducted as a collaboration between Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Prosser Memorial Health, and Kadlec Regional Medical Center. To provide feedback on this CHNA or obtain a printed copy free of charge, email info@BFCHA.org or CHI@providence.org.

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EXECUTIVE SUMMARY

Purpose

The Community Health Needs Assessment (CHNA) helps determine which critical health needs the community will focus on over the next three to five years. It is a systematic and shared process for identifying and analyzing community needs and assets throughout Benton and Franklin Counties.

Methods

The CHNA steering committee began meeting weekly in January of 2022. The committee includes representatives of Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH). Providence Community Health Investment staff provided invaluable technical assistance and qualitative data analysis.

Quantitative and qualitative data were used to identify community needs through a mixed-methods approach. Quantitative data sources include a community survey, Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), and the Healthy Youth Survey (HYS) as well as Centers for Disease Control and Prevention (CDC), Child Care Aware of America, County Health Rankings and Roadmaps, Washington State Department of Children, Youth & Families (WA DCYF), Washington Statistical Analysis Center (WA SAC), Washington Association of Sheriffs and Police Chiefs (WASPC), and Washington Tracking Network (WTN). Quantitative data is presented through a life course perspective.

Qualitative data includes twenty-one interviews with working partners and community collaborators (partners), ten listening sessions, two behavioral health forums, two housing and homelessness forums, and two general forums.

The COVID-19 pandemic impacted our nation and communities. The focus became one of crisis response that required the concentration of resources and resulted in pandemic-related challenges that impacted data collection causing data limitations and information gaps.

Results

CHNA steering committee members met weekly in July and August 2022 to apply the prioritization criteria to the identified needs. Criteria included worsening trend over time, disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities, community rates worse than state average, the opportunity to impact based on community partnerships, severity of the need and/or scale of need. The following Community Health Improvement Plan Guiding Concepts also informed the prioritization process: Equity, Life-course wellness, Health in All Policies (HiAP), Evidenced-based, and Collective Impact. The list below summarizes the significant health needs identified through the 2022 Community Health Needs Assessment process in no particular order:

BEHAVIORAL HEALTH

The 2019 Benton & Franklin Counties Community Health Needs Assessment (CHNA) identified that our community needed to better understand the behavioral health gaps and needs within the community. An assessment was completed in the spring of 2022 through a partnership with Eastern Washington University (EWU). The assessment identified significant needs for behavioral health response and prevention. Behavioral health, which encompasses mental health and substance use/misuse, was identified as a need in all areas of this CHNA. With the serious behavioral health workforce shortage, increase in need, and existing coalitions working towards solutions, our steering committee identified behavioral health as a priority area.

HOUSING AND HOMELESSNESS

The 2019 CHNA also identified that our community needed to better understand the housing and homelessness gaps and needs within the community. The assessment was completed in the spring of 2022 through a partnership with EWU. On housing, the assessment identified a low supply of affordable housing, low supply of multi-family units, low vacancy rates for rentals, and increased rental costs. Housing increases in Benton and Franklin Counties are not keeping up with population growth and demand. Regarding homelessness, the assessment identified a shortage of low-barrier housing options for residents experiencing homelessness. Additionally, there has been a greater than two-fold increase in the average number of days a person experiences homelessness in Benton and Franklin Counties. Stable housing has consistently been shown to improve both physical and mental health outcomes. For this reason and because the Benton and Franklin regions are experiencing rapid growth, a lack of affordable housing, a lack of low-barrier solutions to homelessness, and the complexity of solving these issues through effective community partnerships, our steering committee identified these issues as priorities for the upcoming Community Health Improvement Plan (CHIP).

ACCESS TO HEALTH

This 2022 CHNA identified a need for access to not only healthcare, but also access to community supports that enable health. It is understood that optimal health is influenced by access and quality of healthcare, health promoting behaviors, the physical environment, and socioeconomic factors. Access to Health will include a focus on addressing barriers to medical care, including healthcare provider to patient ratios and linguistically appropriate, culturally responsive, and accessible care. In addition, the steering committee broadened this priority to include needs identified in the CHNA, such as access to safe and nutritious food; transportation; safe, licensed, and affordable childcare; health education; chronic disease prevention; and resource awareness.

COMMUNITY PARTNERSHIP DEVELOPMENT

Benton and Franklin Counties are fortunate to have numerous community coalitions and committees aimed at improving and supporting community health. This region also has a business community which is quite supportive of promoting local health and social initiatives. However, this CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources. This priority area will impact the other three priority areas by improving communications, clarifying coalition functions, and expanding the work of community health improvement to non-traditional partnerships.

These priorities were approved by the Kadlec Community Mission Board on October 19, 2022; the Benton Franklin Health District on October 20, 2022; the Benton-Franklin Health Alliance on October 21; and Prosser Memorial Health on October 28, 2022.

Benton-Franklin Health District, Benton-Franklin Community Health Alliance, Kadlec Regional Medical Center, and Prosser Memorial Health, in collaboration with community partners will develop a three-year Community Health Improvement Plan (CHIP) to respond to these prioritized needs.

Kadlec will also develop its three-year CHIP to respond to these prioritized needs in collaboration with community partners. The 2023-2025 Kadlec CHIP will be approved and made publicly available no later than May 15, 2023.

Measuring Our Success: Results from the 2020 Benton & Franklin Counties CHIP

While striving to achieve the goals outlined in the 2020 CHIP, the COVID-19 pandemic impacted our community and the focus became one of crisis response. In spite of the pandemic, outcomes were achieved, and a few key outcomes are listed below:

- Benton-Franklin Health District, Kadlec Regional Medical Center, Prosser Memorial Health, the Hispanic Chamber of Commerce, and many other community partners came together to expand access to health care services related to the COVID-19 pandemic.
- In the spring of 2022, a sales tax in Benton and Franklin Counties went into effect, providing one penny per every $10 to go towards behavioral healthcare and access in the two counties.
- Columbia Basin Health Associates established primary care facilities in rural areas of north Franklin County. Prosser Memorial Health (PMH) hired multiple new providers in urgent/after-hours care, pediatrics, family practice, obstetrics and women's health, emergency medicine, and behavioral health. PMH also expanded clinic hours where appropriate.
- Benton-Franklin Health District established the Food Access and Security Coalition which began meeting in April of 2022.
- Benton-Franklin Health District contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a more comprehensive needs assessment regarding homelessness and behavioral health. The report was completed in June of 2022 completing two CHIP objectives and providing data to inform the 2022 CHNA and 2023 CHIP.

To read the Benton & Franklin Counties 2020 CHIP, click here.

Measuring Our Success: Results from the 2020-2022 Kadlec Regional Medical Center CHIP

The priorities identified in the 2019 Benton & Franklin Counties CHNA were behavioral health challenges, access and cost of health care, and social determinants of health. While striving to achieve the goals outlined in the 2020-2022 Kadlec CHIP, the COVID-19 pandemic impacted our community and therefore responding to COVID-19 became Kadlec's priority. A few key outcomes are listed below:

- Telemedicine services expanded rapidly in response to the pandemic, and 48,291 telemedicine visits were completed in 2020 and 37,260 telemedicine visits were completed in 2021.
- Kadlec established the Community Resource Desk (CRD), which is a free service that connects people with community resources they need, including establishing a primary care provider, dental care, medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and basic needs such as food, transportation, clothing, work, or housing aid. The CRD was instrumental in helping community members access COVID-19 vaccines and testing.
- Four of the eight of Kadlec's Family Medicine Residency program residents that graduated in 2022 are staying within Kadlec.
- Kadlec integrated behavioral health in primary care by embedding social workers in three clinics.
- Between January 2020 and September 2022, 669 people were trained in Mental Health First Aid and other mental health and suicide prevention programs.
- As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking Community Health Workers (CHW) were hired in 2021 to be frontline agents of change, helping to reduce health disparities in underserved communities, working alongside their clients as they navigate health care services and access resources.

To read the Kadlec Regional Medical Center 2020-2022 CHIP, click here.

INTRODUCTION

As a collaboration between Benton-Franklin Health District (BFHD), Benton-Franklin Community Health Alliance (BFCHA), Kadlec Regional Medical Center (Kadlec), and Prosser Memorial Health (PMH), this CHNA covers Benton and Franklin Counties.

Who We Are: Benton-Franklin Health District

The Benton-Franklin Health District (BFHD) has been serving the growing community of Benton and Franklin counties for over 75 years. Made up of more than one hundred dedicated staff members, BFHD serves the bi-county population of over 300,000 residents, thousands of visitors, and covers almost 3,000 square miles within its jurisdiction. BFHD is poised and ready to address current and emerging public health concerns. In addition to providing many services directly, BFHD works collaboratively with dozens of community partners and organizations to address health needs of people living, working, and visiting the bi-county region.

Mission BFHD provides all people in our community the opportunity to live full, productive lives by promoting healthy lifestyles, preventing disease and injury, advancing equity, and protecting our environment.

Vision BFHD is a proactive leader uniting knowledgeable staff and proven practices with strong partners and informed residents to form a resilient, healthy community where all of us can learn, work, play, and thrive to our greatest potential.

Values Excellence – Diversity – Communication and Collaboration – Integrity and Accountability – Effectiveness

Equity BFHD believes everyone in the community should have the opportunity to attain their highest level of health. BFHD values and serves all people regardless of age, race, ethnicity, gender identity, sexual orientation, religion, socioeconomic status, or physical and mental abilities.

Who We Are: Benton-Franklin Community Health Alliance

The Benton Franklin Community Health Alliance (BFCHA) began in 1993 as a task force of community leaders from Benton and Franklin Counties who believed that the community needed a cancer treatment facility, but that funding needs were too large for any one hospital to absorb alone. The hospitals worked together to finance and operate the Tri-Cities Cancer Center, which has become a world class cancer treatment facility associated with the Seattle Cancer Care Alliance. Today, BFCHA serves as a "neutral convener" bringing healthcare and community leaders together to address a variety of issues related to health and quality of life in Benton and Franklin Counties.

Who We Are: Kadlec Regional Medical Center

Our Mission Provide safe, compassionate care.
Our Vision Health for a better world.
Our Promise "Know me, care for me, ease my way."
Our Values Safety—Compassion—Respect—Integrity—Stewardship—Excellence—Collaboration

Kadlec Regional Medical Center (KRMC) is a not-for-profit serving residents in Southeast Washington and Northeast Oregon. Founded in 1944, KRMC is an acute-care hospital located in Richland, Washington. The hospital has 337 licensed beds and is approximately eleven acres in size.
More than 3600 employees work in the hospital, the freestanding Emergency Department, and in primary and specialty care clinics throughout the region. Kadlec is part of the family of mission-driven organizations that make up Providence, serving communities across a seven-state footprint.
Major programs and services offered to the community include the following: comprehensive, award-winning cardiac care program; neurosurgery and neurology; all-digital outpatient imaging center; pediatrics, rural and emergency care; telehealth services in partnership with clinics and hospitals in Southeast Washington and Northeast Oregon and is the region's only Level III Neonatal Intensive Care Unit. KRMC is a Level III Trauma Center.

Kadlec dedicates resources to improve the health and quality of life for the communities they serve. During 2021, Kadlec provided $63,900,000 in Community Benefit[1] in response to unmet needs and to improve the health and well-being of those we serve in Benton and Franklin Counties and beyond. Kadlec further demonstrates organizational commitment to community health through the allocation of staff time, financial resources, participation, and collaboration to address community identified needs.

[1] Per federal reporting and guidelines from the Catholic Health Association.

Who We Are: Prosser Memorial Health

For 75 years, Prosser Memorial Health has provided high-quality, compassionate, and comprehensive healthcare services to our communities. Service lines include: 24/7 Emergency Department; Orthopedics; Cardiology; Dermatology; General Surgery and ENT/Allergy; Gastroenterology; Urology; Obstetrics and Family Birthplace; Therapy Services; and Primary Care through our local clinics.

Prosser has also expanded their Community Health Programs to include a Community Paramedic Program which helps to provide care the vulnerable, promote health and wellness, and lower the cost of healthcare.

Prosser Memorial Health's Mission is to "improve the health of our community," and they further demonstrate this by offering the best quality medical care using their six organizational Values: Accountability, Services, Promote Teamwork, Integrity, Respect and Excellence.

Prosser's Chief Quality and Compliance Officer participated in this CHNA process.

Health Equity

We acknowledge that all people do not have equal opportunities and access to living their fullest, healthiest lives due to systems of oppression and inequities. We are committed to ensuring health equity for all by striving to address the underlying causes of racial and economic inequities and health disparities. We believe we must address not only the clinical care factors that determine a person's length and quality of life, but also the social and economic factors, the physical environment, and the health behaviors that all play an active role in determining health outcomes (see Figure 1[2]).

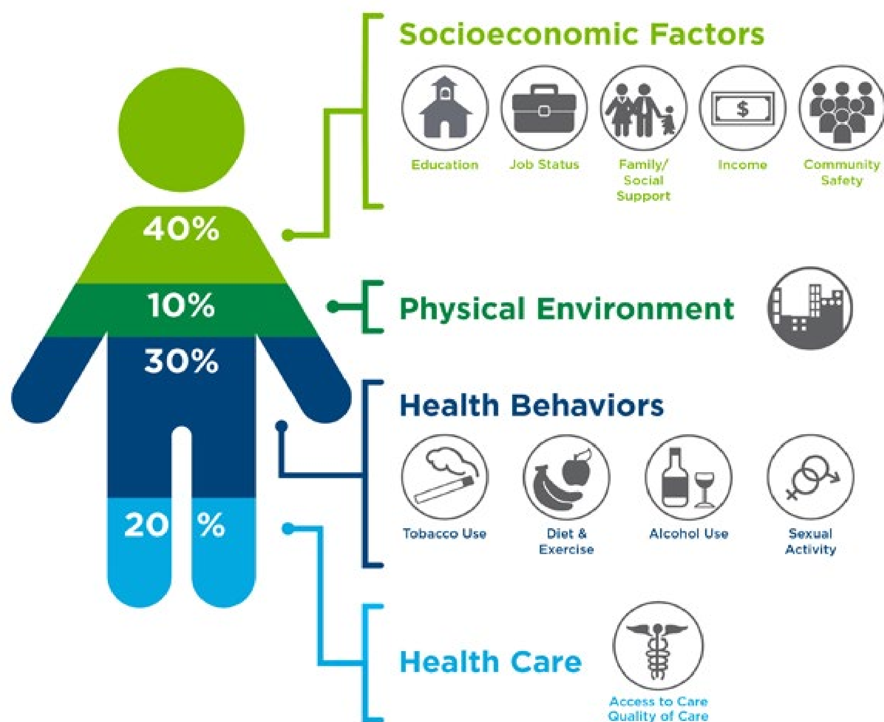


Figure 1. Factors contributing to overall health and well-being

[2] Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2013)

The CHNA is a valuable tool we use to better understand health disparities and inequities within the communities we serve, as well as community strengths and assets (see Figure 2 for definition of terms[3]). Through the literature and our community partners, we know that racism and discrimination have detrimental effects on community health and well-being. We recognize that racism and discrimination prevent equitable access to opportunities and the ability of all community members to thrive. We name racism as contributing to the inequitable access to all the determinants of health that help people live their best lives, such as safe housing, nutritious food, responsive health care, and more.

Health Equity

A principle meaning that "everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care. For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups." (Braverman, et al., 2017)

Health Disparities

Preventable differences in the burden of disease or health outcomes as a result of systemic inequities.

Figure 2. Definitions of key terms

Efforts taken to center equity in community engagement included interviewing stakeholders who represent organizations serving various demographic groups that are historically marginalized. Populations included were aging adults, people experiencing homelessness, Spanish-speaking communities, immigrants, and families of those living with disabilities. Listening sessions were designed to include participants from under-represented groups and included family members and caregivers of those living with disabilities, aging community members, veterans, and youth and adults experiencing homelessness. The community survey was distributed in English and Spanish.

When possible, data categories were broken down into more specific sub-groups to better identify unique differences. Restrictions in data sharing and small numbers limited the range of data available for disaggregation.

[3] Braverman P, Arkin E, Orleans T, Proctor D, and Plough A. *What is Health Equity? And what Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation, 2017.

OUR COMMUNITY

Description of Community Served

Benton and Franklin Counties are located in south central Washington just west of the confluence of the Columbia and Snake Rivers. Pasco is the county seat of Franklin County while Prosser, located 30 miles west, is the Benton County seat. Many county facilities are located in Kennewick. With a combined population of more than 300,000, the area is Washington's third largest metro area and among of the fastest growing. The area's three largest cities, Kennewick, Pasco, and Richland became known as the "Tri-Cities" not long after WWII. Other principal cities in Benton County are West Richland and Benton City. Outside of Pasco, Franklin County's small towns support some of the country's most productive farmland irrigated by the Columbia Basin Project. They include Eltopia, Basin City, Mesa, Connell, and Kahlotus. The rich agricultural opportunities provide residents with access to fresh and locally grown food. In fact, for five months of the year, there are farmers' markets open throughout the region nearly daily. Additionally, multiple local farms offer you-pick and roadside produce sales. With over 300 days of sunshine per year, multiple paved and natural trails, and numerous community parks, this region offers opportunities for outdoor recreation for all ages and ability levels in a high-desert climate.

Hospital systems serving Benton and Franklin Counties and beyond include Kadlec Regional Medical Center, Trios Health, Lourdes Health, and Prosser Memorial Health. Federally Qualified Health Centers serving the area are Miramar Health Centers, Tri-Cities Community Health, and Columbia Basin Health Association. Based on the availability of data, geographic access to these facilities, and other hospitals in neighboring counties, Benton and Franklin Counties serve as the boundary for the service area.

Community Demographics

The tables below provide basic demographic and socioeconomic information about Benton and Franklin Counties and how they compare to Washington State.

POPULATION TOTALS

Table 1. Population Totals

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
2020 Total Population	205,700	96,760	302,460	7,656,200
Female Population	102,198	47,071	149,269	3,835,105
Male Population	103,502	49,689	153,191	3,821,095

Source: WA OFM, 2020

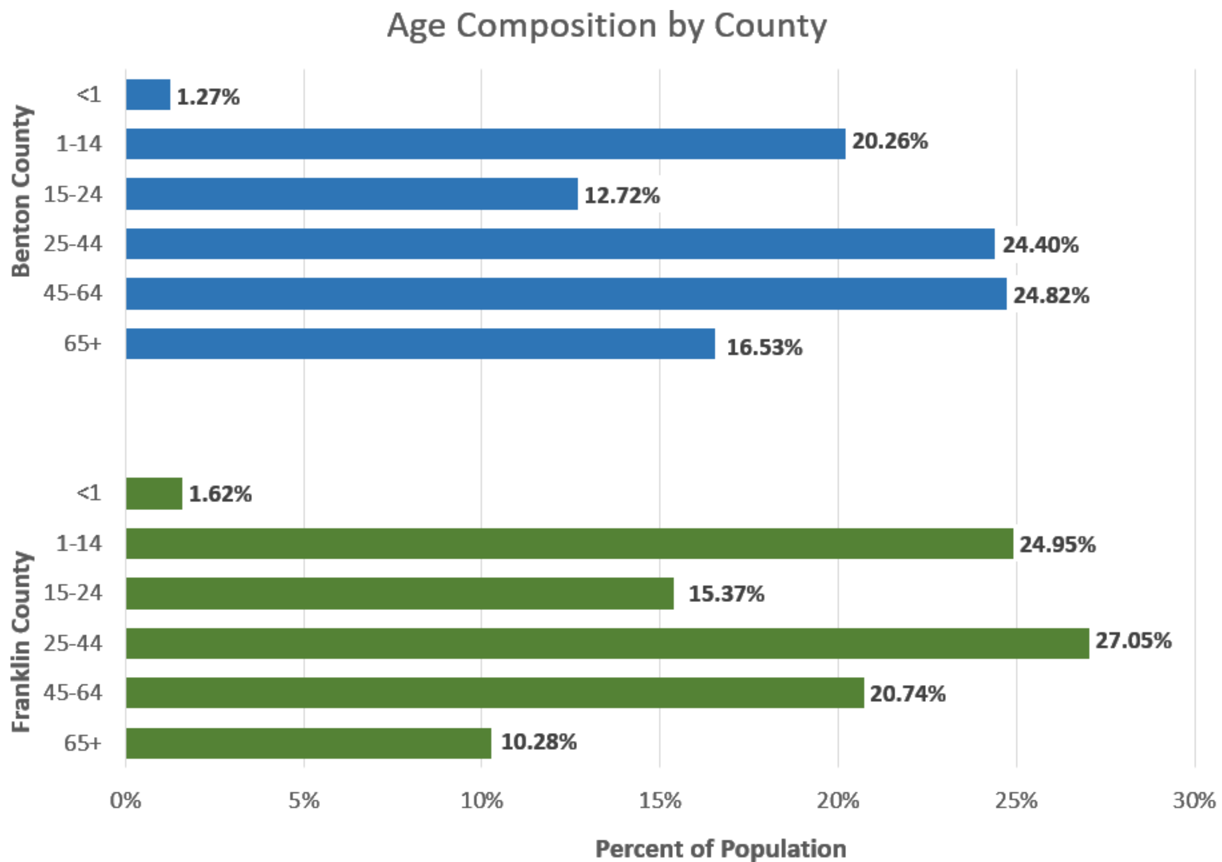
POPULATION BY AGE

Table 2. Population by Age

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Population that is <1 Years Old	1.27%	1.62%	1.38%	1.16%
Population that is 1-14 Years Old	20.26%	24.95%	21.76%	17.35%
Population that is 15-24 Years Old	12.72%	15.37%	13.57%	12.61%
Population that is 25-44 Years Old	24.40%	27.05%	25.25%	27.25%
Population that is 45-64 Years Old	24.82%	20.74%	23.52%	24.89%
Population that is 65+ Years Old	16.53%	10.28%	14.53%	16.74%

Source: WA OFM, 2020

Figure 3. Age Composition by County



Source: WA OFM, 2020

POPULATION BY RACE AND ETHNICITY

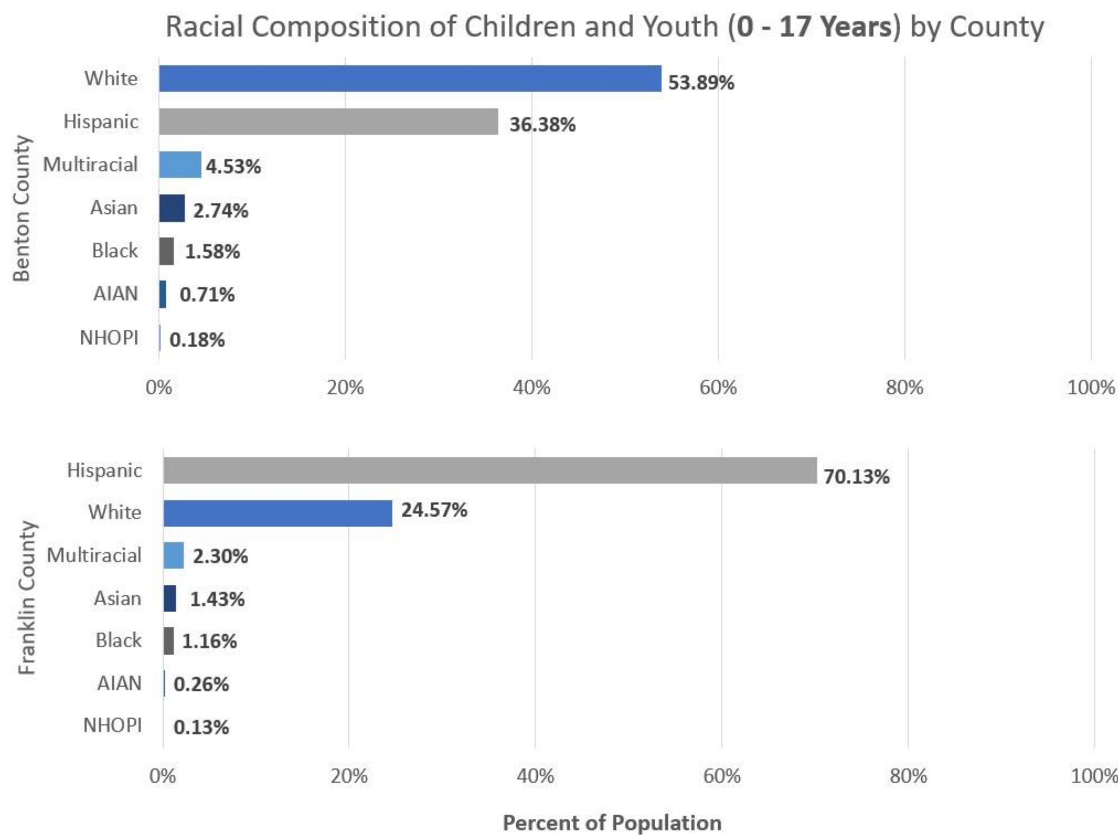
Table 3. Population by Race and Ethnicity

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Youth (0-17) who identify as American Indian & Alaska Native, Not Hispanic	0.71%	0.26%	0.55%	1.40%
Youth (0-17) who identify as Asian, not Hispanic	2.74%	1.43%	2.26%	8.22%
Youth (0-17) who identify as Black, not Hispanic	1.58%	1.16%	1.43%	4.45%
Youth (0-17) who identify as Hispanic	36.38%	70.13%	48.77%	22.71%
Youth (0-17) who identify as Multiracial, not Hispanic	4.53%	2.30%	3.71%	9.15%
Youth (0-17) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.18%	0.13%	0.16%	0.97%
Youth (0-17) who identify as White, not Hispanic	53.89%	24.57%	43.13%	53.10%
Adults (18-64) who identify as American Indian & Alaska Native, Not Hispanic	0.79%	0.56%	0.72%	1.28%
Adults (18-64) who identify as Asian, not Hispanic	3.62%	2.34%	3.21%	10.44%
Adults (18-64) who identify as Black, not Hispanic	1.50%	1.97%	1.65%	4.27%
Adults (18-64) who identify as Hispanic	21.96%	53.77%	32.17%	12.60%
Adults (18-64) who identify as Multiracial, not Hispanic	2.05%	1.36%	1.83%	3.51%
Adults (18-64) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.17%	0.18%	0.18%	0.77%
Adults (18-64) who identify as White, not Hispanic	69.90%	53.77%	60.25%	67.13%

Adults (65+) who identify as American Indian & Alaska Native, Not Hispanic	0.44%	0.36%	0.42%	0.89%
Adults (65+) who identify as Asian, not Hispanic	3.26%	2.90%	3.17%	7.09%
Adults (65+) who identify as Black, not Hispanic	0.67%	1.86%	0.94%	2.11%
Adults (65+) who identify as Hispanic	6.22%	24.07%	10.26%	3.71%
Adults (65+) who identify as Multiracial, not Hispanic	1.29%	.088%	1.20%	1.37%
Adults (65+) who identify as Native Hawaiian or Pacific Islander, not Hispanic	0.10%	0.04%	0.08%	0.27%
Adults (65+) who identify as White, not Hispanic	88.02%	69.88%	83.92%	84.56%

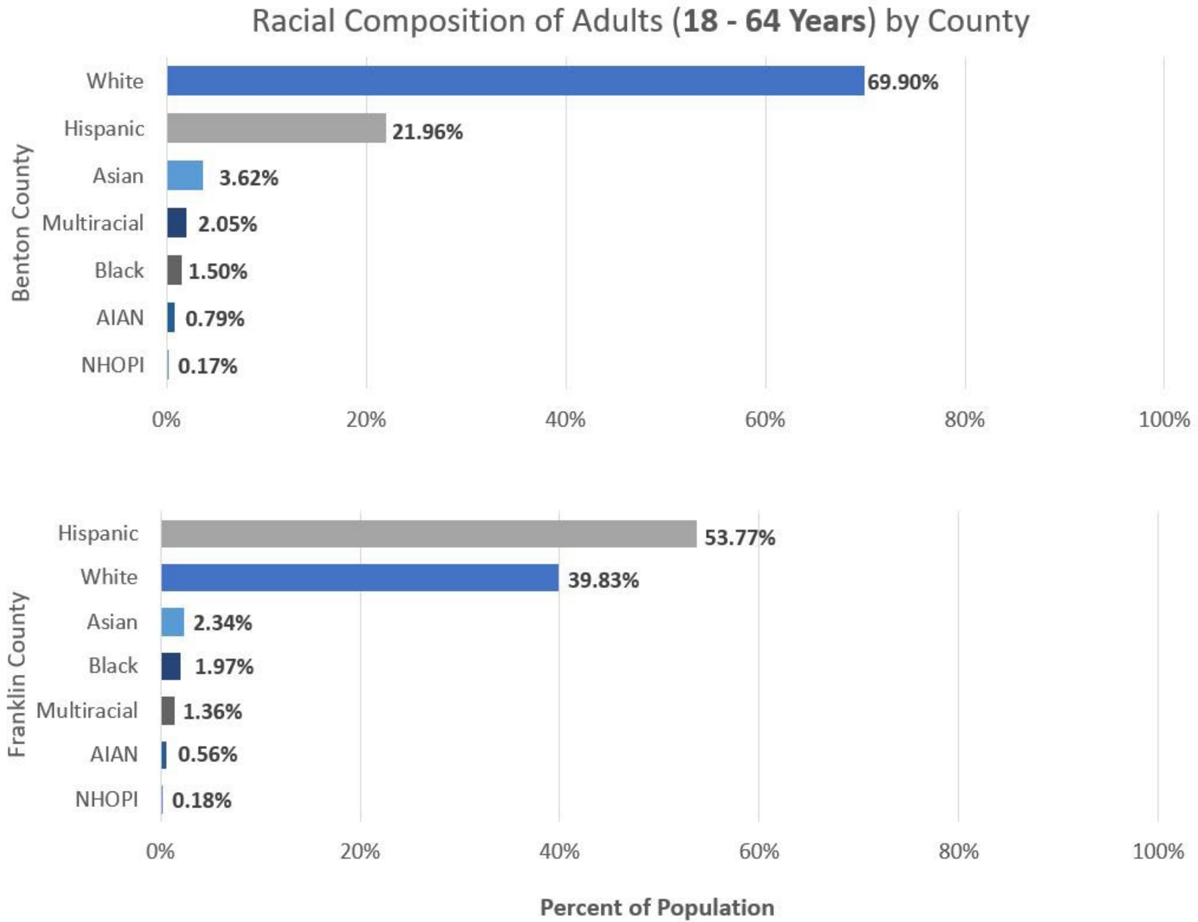
Source: WA OFM, 2020

Figure 4. Racial Composition of Children and Youth (0-17 Years) by County



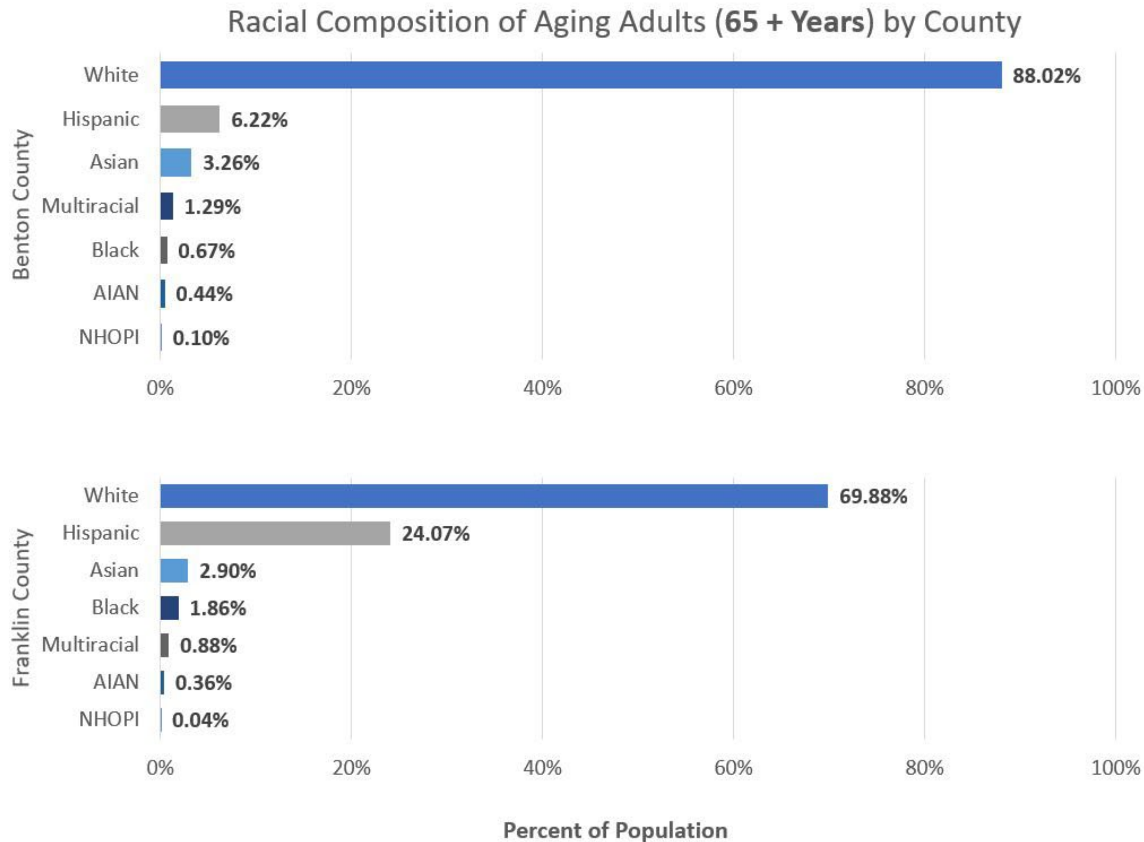
Source: WA OFM, 2020
AIAN—American Indian and Alaska Native
NHOPI—Native Hawaiian or Pacific Islander

Figure 3. Racial Composition of Adults (18-64 Years) by County



Source: WA OFM, 2020
AIAN—American Indian and Alaska Native
NHOPI—Native Hawaiian or Pacific Islander

Figure 6. Racial Composition of Older Adults (65+ Years) by County



Source: WA OFM, 2020
AIAN—American Indian and Alaska Native
NHOPI—Native Hawaiian or Pacific Islander

MEDIAN INCOME

Table 4. Median Household Income

Indicator	Benton County	Franklin County	Washington State
Median Household Income*	$72,847	$63,575	$80,319
Median Household Income (Preliminary Estimate)**	$75,882	$73,656	$81,998

**Source: WA OFM, 2019*
***Source: WA OFM, 2020*
BentonFranklinTrends.org, 2019—no owners paying 50%+ metric

HOUSING COST BURDEN

Table 5. Percent of Residents with Severe Housing Cost Burden

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Renters Paying 30%+ of Income on Shelter	44.1%	42.7%	43.7%	45.3%
Renters Paying 50%+ of Income on Shelter	20.7%	16.2%	19.4%	20.5%
Owners Paying 30%+ of Income on Shelter	15.5%	19.2%	16.5%	23%

INCOME BELOW FEDERAL POVERTY LEVEL (FPL)

Table 6. Percent of Residents with Income Below FPL by Age Group

Indicator	Benton County	Franklin County	Washington State
Total Residents Living Below FPL	10.2%	14.2%	10.2%
<5 Years	15.80%	15.20%	13.40%
5-17 Years	14.20%	20.60%	12.30%
18-34 Years	11.90%	12.80%	13.10%
35-64 Years	7.30%	11%	8.20%
65+ Years	7.10%	11.70%	7.50%

Source: US Census, 2020

INSURANCE ESTIMATES

Table 7. Residents Uninsured and Residents with Medicaid

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Percent Residents Uninsured*	7.1%	14.1%	9.3%	6.2%
Percent Residents with Medicaid**				23.98%
Percent Residents with Medicaid***	21.9%	36.1%	26.4%	19.8%

**US Census Bureau, 2020*
***Data.medicaid.gov, 2020*
****BentonFranklinTrends.org, 2019*

HEALTH PROFESSIONAL SHORTAGE AREA

Benton and Franklin Counties are designated by the Health Resources & Services Administration (HRSA) as Health Professional Shortage Areas (HPSA) having shortages of primary care, dental, and mental health providers meaning there are not enough providers for the population, service area, or facilities.

Franklin County is also designated by HRSA as a Medically Underserved Area (MUA) having too few primary care providers, high infant mortality, high poverty or a high elderly population.

Definitions and additional information can be on the HRSA website.

See Appendix 1 for additional details on HPSA and Medically Underserved Areas and Medically Underserved Populations.

OVERVIEW OF CHNA FRAMEWORK AND PROCESS

The CHNA process is based on the understanding that health and wellness are influenced by factors within our communities, not only within medical facilities. In gathering community information, we looked not only at the health conditions of the population, but also at socioeconomic factors, the physical environment, and health behaviors. Additionally, we invited working partners, community collaborators, and community members to provide additional context to the quantitative data through qualitative data in the form of interviews and listening sessions.

Quantitative and qualitative data were used to identify community needs through a mixed-methods approach. Quantitative data sources include Behavioral Risk Factor Surveillance System (BRFSS), Community Health Assessment Tool (CHAT), and the Healthy Youth Survey (HYS) as well as Centers for Disease Control and Prevention (CDC), Child Care Aware of America, County Health Rankings and Roadmaps, Washington State Department of Children, Youth & Families (WA DCYF), Washington Statistical Analysis Center (WA SAC), Washington Association of Sheriffs and Police Chiefs (WASPC), and Washington Tracking Network (WTN). Quantitative data is presented through a life course perspective.

Qualitative data includes twenty-one interviews with working partners and community collaborators (partners) were conducted, ten listening sessions, a community survey, two behavioral health forums, two housing/homelessness forums, and two general forums. Partners interviewed and listening session participants represent members of medically underserved, low-income, and minority populations in the community.

Process for Gathering Comments on CHNA and Summary of Comments Received

The 2019 Benton & Franklin Counties CHNA, Kadlec Executive Summary, and the 2020-2022 Kadlec CHIP were made widely available to the public via posting on the internet in December 2019 (CHNA) and May 2020 (CHIP) as well as through various channels with our community-based organization partners. Two requests for hard copies were made to Kadlec and copies were sent via United States Postal Service mail at no charge. No comments were received. The CHNA will be posted on Kadlec’s website and remain there through two subsequent CHNA cycles.

HEALTH INDICATORS

The 2022 CHNA health indicators were primarily selected based on four factors: one or both Benton and Franklin Counties' values were significantly higher than Washington State's value; a significant disparity between Benton County and Franklin County was identified; there was a significant change from previous years in Benton or Franklin Counties; or the indicator was identified in the 2020 CHIP as a goal metric to measure.

Pregnancy, Birth & Sexual Health

PRENATAL CARE INITIATION

Table 8. First Prenatal Care Visit

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Pregnancies with First Prenatal Care Visit in the 1st Trimester	74.85%	76.36%	75.39%	81.82%
Pregnancies with First Prenatal Care Visit in the 2nd Trimester	17.61%	16%	17.03%	13.19%
Pregnancies with First Prenatal Care Visit in the 3rd Trimester	5.29%	4.71%	5.08%	4.38%
Pregnancies Receiving No Prenatal Care	2.25%	2.93%	2.19%	1.18%

Source: Community Health Assessment Tool (CHAT), 2020

BIRTH STATISTICS

Table 9. Birth Rates and Infant Mortality

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Birth Rate (per 1,000 Population)	12.09	15.26	13.10	10.85
Birth Rate (per 1,000 Population) to Women Aged 10-19 Years	12.15	14.33	12.95	8.7
Births with a Low Birthweight (<2500g)	6.31%	6.77%		6.71%
Infant Mortality Rate (per 1,000 Births)			6.56	4.49

Source: CHAT, 2020

YOUTH CONDOM USE

Table 10. Youth Condom Use

Indicator	Benton & Franklin Counties Combined	Washington State
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 8th Grade	34.54%	31.24%
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 10th Grade	62.25%	58.43%
Sexually Active Youth Reporting Condom Use During Last Sexual Encounter – 12th Grade	62.91%	54.72%

Source: Healthy Youth Survey (HYS), 2021

Family & Community

CHILD CARE COSTS AND AVAILABILITY

Table 11. Child Care Cost and Need Met

Indicator	Benton County	Franklin County	Washington State
Average Child Care Cost per Child per Month	$894	$899	$1,044
Average Child Care Cost per Child per Month as Percentage of Median Household Income	17%	19%	18%
Estimated Percent Child Care Need met by Licensed Child Care (<35 Months)	11%	14%	17%
Estimated Percent Child Care Need met by Licensed Child Care (35 Months to School Aged)	25%	34%	53.30%

Source: Child Care Aware of America, 2021

YOUTH PHYSICAL AND VERBAL ABUSE

Table 12. Youth Surveyed Report Physical and Verbal Abuse

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 8th grade	30.70%	31.20%
Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 10th grade	33%	30.80%

Youth Surveyed Report they are Sworn at, Humiliated, or Insulted by an Adult in their Home Often or Very Often – 12th grade	32.10%	34%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 8th grade	15.80%	17.50%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 10th grade	20.90%	21.60%
Youth Surveyed Report Having Ever Been Physically Abused by an Adult – 12th grade	19%	19.90%

Source: HYS, 2021

Activity, Nutrition & Weight

YOUTH PHYSICAL ACTIVITY

Table 13. Youth Physical Activity

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Reporting Not Meeting Physical Activity Recommendations – 6th Grade	82.40%	81.30%
Youth Reporting Not Meeting Physical Activity Recommendations – 8th Grade	78.20%	80.90%
Youth Reporting Not Meeting Physical Activity Recommendations – 10th Grade	76.70%	78%
Youth Reporting Not Meeting Physical Activity Recommendations – 12th Grade	77.80%	77.30%

Source: HYS, 2021

YOUTH BMI

Table 14. Youth BMI

Indicator	Benton & Franklin Counties Combined	Washington State
Youth in Top 15% BMI by Reported Height and Weight – 8th Grade	16.60%	17.30%
Youth in Top 15% BMI by Reported Height and Weight –10th Grade	18.10%	15.80%
Youth in Top 15% BMI by Reported Height and Weight – 12th Grade	17.70%	15.30%

Source: HYS, 2021

Access to Healthcare & Use of Preventative Services

ACCESS TO HEALTHCARE

Table 15. Access to Healthcare Resources

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Adults (18-64) Reporting Having Any Kind of Medical Coverage*	88.05%	68.54%	80.31%	88.45%
Adults (18-64) Reporting Having a Primary Care Provider*	77.22%	61.83%	71.10%	73.96%
Primary Care Provider to Population Ratio**	1430:1	4720:1		1180:1
Dentist to Population Ratio**	1390:1	2030:1		1200:1
Mental Health Providers to Population Ratio**	350:1	720:1		250:1

**Source: Behavioral Risk Factor Surveillance System (BRFSS), 2020*
***Source: County Health Rankings and Roadmaps, 2021*

Mental & Behavioral Health

ADULT AND YOUTH MENTAL HEALTH

Table 16. Adult and Youth Mental Health

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Adults Reporting Poor Mental Health for 14+ Days for the Last 30 Days*	13.38%	10.90%	12.63%	14.23%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 8th Grade**			35.80%	35.30%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 10th Grade*			41.60%	38.20%
Youth Reporting Ever Feeling Sad or Hopeless Almost Every Day for 2 Weeks or More in a Row – 12th Grade*			48.60%	44.50%

**Source: BRFSS, 2020*
**Source: HYS, 2021*

YOUTH MENTAL HEALTH (SUICIDE)

Table 17. Youth Mental Health (Suicide)

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 8th Grade	18.80%	19.30%
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 10th Grade	20.40%	19.50%
Youth Reporting Having Seriously Contemplated Suicide in the Last Year – 12th Grade	21.30%	20.20%

Source: HYS, 2021

Substance Use

OPIOID STATISTICS

Table 18. Opioid Statistics

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Opioid Prescriptions per 100 Residents*	72.9	12.4		39.5
Opioid Overdose Hospitalization Rate (per 100,000 Population)**			14.18	14.47
Opioid Overdose Mortality Rate (per 100,000 Population)**			15.71	15.30

**Source: Center for Disease Control and Prevention (CDC), 2020*
***Source: CHAT, 2019*

YOUTH VAPING

Table 19. Youth Vaping

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Report Using E-Cigarettes in Past 30 Days – 6th Grade	3.80%	3.20%
Youth Report Using E-Cigarettes in Past 30 Days – 8th Grade	6.50%	5.10%

Youth Report Using E-Cigarettes in Past 30 Days – 10th Grade	9.40%	8%
Youth Report Using E-Cigarettes in Past 30 Days – 12th Grade	11.70%	15.50%

Source: HYS, 2021

Violence & Injury Prevention

CRIME STATISTICS

Table 20. Crime Statistics

Indicator	Benton County	Franklin County	Washington State
Violent Crime Rate per 1,000 Residents*			3.4
Rate of Reported Domestic Violence Offenses per 100,000 Residents**	875.55	635.59	774.39
Total youth (12-17) Arrest Rate per 10,000 Youth***	336.20	202.36	121.24

**Source: Washington Association of Sheriffs and Police Chiefs (WASPC), 2020*

***Source: WASPC, 2020*

**** Source: Washington Statistical Analysis Center (WA SAC), 2020*

INJURIES

Table 21. Injuries

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Hospitalization Rate per 100,000 Population Due to Falls for People Aged <65	129.74	60.31	106.57	118.65
Hospitalization Rate per 100,000 Population Due to Falls for People Aged 65+	2222.45	1627.43	2088.72	1789.26
Age-Adjusted Hospitalization Rate per 100,000 Population for Unintentional Injuries	654.4	536.53	624.41	574.36
Age-Adjusted Non-Fatal Intentional Self-Harm/Suicide Rate per 100,000 Population	53.59	23.26	43.85	49.83

Source: CHAT, 2019

YOUTH SEXUAL ASSAULT

Table 22. Youth Experiencing Sexual Assault

Indicator	Benton & Franklin Counties Combined	Washington State
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 8th Grade	18.40%	20%
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 10th Grade	27.90%	24.80%
Youth Surveyed Report Having Ever Seen Someone Else Forced into a Sexual Situation – 12th Grade	31.40%	27.20%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 8th Grade	9.30%	9.90%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 10th Grade	18.80%	13.80%
Youth Surveyed Report Having Ever Been Forced into a Sexual Situation – 12th Grade	19.50%	22%

Source: HYS, 2021

Chronic Illness

Table 23. Chronic Illness

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Age-Adjusted All Cancer Incidence Rate per 100,000 Population	343.95	321.14	336.23	474.59
Adults Reporting Having Ever Been Told They Had Coronary Heart Disease and/or a Heart Attack**	6.32%	4.84%	5.70%	4.61%
Adults Reporting Having Ever Been Told They Had Diabetes (Excludes Gestational and Pre-Diabetes)**	8.35%	8.72%	8%	8.02%
Age-Adjusted Hospitalization Rate per 100,000 Population Due to Chronic Obstructive Pulmonary Disease (COPD) and Bronchiectasis*	112.23	94.64	107.26	60.66

** Source: CHAT, 2019*
*** Source: BRFSS, 2020*

Life Expectancy, Leading Causes of Death & Quality of Life

LIFE EXPECTANCY & YEARS OF POTENTIAL LIFE LOST

Table 24. Life Expectancy and Years of Potential Life Lost

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Life Expectancy	78.70	79.80	79.08	79.85
Years of Potential Life Lost**	4,402 Years	3,520 Years	4,106 Years	3,860 Years

Source: CHAT, 2020
***A cumulative estimation of the average time a person would have lived had they not died prematurely (before the age of 65)*

Table 25. Life Expectancy and Years of Potential Life Lost by County

County	Population	Years of Potential Life Lost (YPLL) Rate	Estimated Years Lost
Benton County	205,700	4,402 Years per 100,000 Population	9,055 Years
Franklin County	96,760	3,520 Years per 100,000 Population	3,406 Years

Table 26. Life Expectancy by Zip Code

Indicator	Life Expectancy Years
Benton City (99320)	78.41
Kennewick (99336)	74.59
Kennewick (99337)	79.75
Kennewick (99338)	85.77
Plymouth (99346)	67.68
Prosser (99350)	79.06

Richland (99352)	79.38
West Richland (99320)	80.30
Richland (99354)	80.14
Pasco (99301)	78.86
Connell (99326)	85.88
Eltopia (99330)	78.96
Mesa (99343)	89.91

Source: CHAT, 2020

LEADING CAUSES OF DEATH

Table 27. Leading Causes of Death

Indicator	Benton County	Franklin County	Benton & Franklin Counties Combined	Washington State
Major Cardiovascular Diseases Mortality Rate per 100,000 Population	187.51	186.44	186.31	180.27
Malignant Neoplasms Mortality Rate per 100,000 Population	137.37	122.69	133.24	135.74
COVID-19 Mortality Rate per 100,000 Population	60.42	89.02	67.33	35.82
Alzheimer's Disease per 100,000 Population	67.56	42.42	62.26	41.71
Unintentional Injuries per 100,000 Population	52.40	42.22	49.50	51.42
Chronic Lower Respiratory Disease per 100,000 Population	32.05	37.57	33.40	28.89
Diabetes Mellitus per 100,000 Population	16.93	26.94	19.07	22.23
Chronic Liver Disease and Cirrhosis per 100,000 Population	14.30	15.26	13.90	14.12
Intentional Self-Harm (Suicide) per 100,000 Population*	18.22			15.39
Parkinson's Disease per 100,000 Population*	9.04			9.25

Source: CHAT, 2020

**To protect personal health information, rates from counts <10 will be suppressed. If counts are zero, "0" will be recorded.*

SUICIDE MORTALITY

Table 28. Age-Specific Suicide Mortality Rates by Age

Indicator	Benton & Franklin Counties Combined	Washington State
Population Aged 0-17	2.71	2.68
Population Aged 18-34	15.39	19.31
Population Aged 35-64	19.65	21.42
Population Aged 65+	25.27	20.25

Source: CHAT, 2016-2020
To protect personal health information, multiple years and large groups were combined.

See Appendix 1: Quantitative Data

COMMUNITY INPUT

Interviews and Listening Sessions

To better understand the unique perspectives, opinions, experiences, and knowledge of community members, Benton-Franklin CHNA steering committee members conducted 21 interviews with working partners and community collaborators (partners) including 33 participants. They also conducted 10 listening sessions with a total of 67 community members. Interviews and listening sessions were conducted between March and May 2022. Below is a high-level summary of the findings of these sessions; **full details on the protocols, findings, and attendees are available in Appendix 2.**

VISION FOR A HEALTHY COMMUNITY

Listening session participants were asked to describe their vision of a healthy community. This question is important for understanding what matters to community members and how they define health and wellness for themselves, their families, and their communities. The primary theme shared was "community engagement and connection" and participants noted the importance of people working together towards common goals, having meaningful conversations, and volunteering. The following is a list of all the themes that emerged:

- Community engagement and connection
- Easy access to health care, including mental health services, for everyone
- Safety
- Diversity, inclusion, and respect
- Opportunities for recreation and a healthy lifestyle
- Economic security, including affordable housing and employment

COMMUNITY STRENGTHS

While a CHNA is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist, including the following identified by partners:

Community engagement and willingness to help

Partners identified the greatest strength of Benton and Franklin Counties as the community engagement and people's willingness to show up to help one another. They shared that people care for one another, support one another, welcome new folks to the community, and volunteer to meet the needs of others. People care deeply about the community and many people have remained in the community for many years and are giving back.

A spirit of collaboration and partnership

Partners spoke to a strong spirit of collaboration and partnership in Benton and Franklin Counties. There is a lot of commitment to working together to make meaningful change towards shared goals. They shared examples of collaborations between law enforcement agencies, nonprofits, faith-based organizations, health care, government, emergency response teams, and community members.

Strong network of community organizations to meet needs

Partners shared there are many local organizations to meet people's health and Social Determinant of Health needs. There are multiple hospitals, clinics, urgent care centers, and specialists in the community to give patients options. There are strong school districts which are connected to many of the families and serve as a trusted partner. The Hanford site employs many people.

Diversity of cultures and community knowledge

Partners shared the people of Benton and Franklin Counties are a strength. There are many cultures represented in the communities and opportunities to build relationships with people of different backgrounds.

COMMUNITY NEEDS

Listening session participants discussed a variety of needs, but the four most common were **mental health, homelessness and housing instability, access to health care services, and substance use/misuse.** Mental health was the most frequently discussed need. Long wait times for appointments, provider turnover, and insurance barriers prevent people from accessing timely, high-quality mental health, primary care, and specialty care. Groups that may experience additional barriers to responsive care include young people, older adults, Spanish-speaking people, veterans, and people with developmental disabilities. Participants discussed the importance of more culturally responsive health care services, and providers with empathy for patients' situations. Participants were concerned about the high cost of housing and lack of affordable housing in the area. Substance use/misuse was also identified as a community challenge and the lack of detox services was frequently identified as a gap.

Other needs discussed in detail by listening session participants include **community resources, safety, transportation, and family support and resources.**

Mental health	Mental health was overwhelmingly identified as the most pressing community need. Most partners spoke to needing more mental health treatment services, including mental health counselors and facilities at all clinical levels. Specifically, they noted a need for improved crisis services and pediatric inpatient services. Contributing to the community needs are workforce challenges, noting high burnout, testing and supervision barriers, and low wages for entry level roles as contributors. Transportation can be especially challenging for people living in more rural parts of the counties when accessing mental health supports. Language is also a barrier for people whose primary language is not English. Partners were particularly concerned about young people, including youth in foster care, noting that mental health needs have only increased during the COVID-19 pandemic. They noted seeing an increase in anxiety, depression, and social isolation, as well as an increase in behavioral issues with students, potentially connected to a lack of stability during the pandemic. People with developmental disabilities have few options for accessing behavior support specific to their needs locally, noting a need to provide more intentional support for this group and their caregivers. Partners spoke to the COVID-19 pandemic as exacerbating mental health needs for everyone and contributing to a lot of stress for families, and a lack of connection for many people, including older adults. Health care providers also experienced increased stress and mental health needs during the pandemic. Telehealth services improved access for some people but created challenges for others, particularly people with a developmental disability or people lacking access to or comfort with technology.
Substance use/misuse	Partners highly prioritized substance use/misuse because of how it affects whole families and communities. They shared there are not enough substance use disorder (SUD) treatment services in the community, although there are many great efforts underway, including the Recovery Center, to meet the need. There is specifically a need for inpatient SUD treatment services and a detox center for withdrawal management. Partners emphasized how critical it is to have a detox center within the community. There is insufficient behavioral health workforce to meet the need, potentially due to low wages for people without advanced degrees and burnout in the field. Partners identified young people, older adults, and people experiencing homelessness as groups that may not receive the support needed in accessing support for substance use/misuse issues. During the COVID-19 pandemic, partners have seen substance use/misuse increase for both adults and young people.

Access to health care services	Partners shared that while there are many health care services in the two counties, there is still a need for more primary care providers and specialists to reduce wait times. Access to preventive care is especially important for ensuring people receive timely and appropriate care, avoiding unnecessary calls to EMS or avoidable ED visits. In addition to preventive care, partners spoke to a need for improved discharge planning, including medication management, particularly for people experiencing homelessness. For people needing a skilled nursing facility or hospice, there are also limited options in the community. Partners shared it can be challenging to recruit health care professionals from outside of the area, particularly with the high cost of housing. The health care system can be challenging for people to navigate, particularly for older adults, people whose primary language is not English, and people with a disability. Transportation was highlighted as a primary barrier for people, particularly if they live in a rural area or have mobility issues. Other barriers include cost of care, language, childcare, and appointment times during work hours. Partners highlighted the following populations as experiencing additional barriers to care: people with developmental disabilities, older adults, young people, the Latino/a community, and people experiencing homelessness. Due to the COVID-19 pandemic, some people delayed preventive health care services or were not able to access the health care services they needed. Telehealth improved access for some patients but is challenging for those without access to or comfort with technology. COVID-19 vaccine disinformation and the politicization of public health practices put additional strain on the health care system and providers. Positively, the pandemic created more opportunities for education and outreach with communities, and increased awareness of the role of health care and public health in the community.

Homelessness and housing instability	Partners prioritized homelessness and housing instability because of its connection to so many other needs and because of the importance of people first being stably housed before addressing their other needs. They described homelessness as a symptom of other issues and noted concern for folks not just living unsheltered, but also those living in their cars or RVs, couch surfing, and moving frequently. They spoke to needing more homelessness services in the community to address hygiene issues and care coordination needs. They emphasized a need for more housing in general, but in particular low-barrier permanent supportive housing, transitional housing, and workforce housing. Partners emphasized the importance of taking a Housing First approach. The high cost of housing and low housing stock have made finding affordable housing a challenge for many people in the community, both wanting to buy and rent homes. They spoke to very low vacancy rates, leading to competition for rentals, increases in rent, and overcrowding. For people with low incomes, a behavioral health condition, or any negative rental history, finding affordable, stable housing can be more challenging. Older adults and families with children with special needs also lack housing that meets their needs, including skilled nursing facilities.

The following needs were frequently prioritized, but with lower priority by partners. They represent the **medium-priority health-related needs,** based on community input:

Economic insecurity, education, and job skills	Partners discussed the need for more financial stability for many families, ensuring there are living wage jobs, job skill trainings, and investments in education. With high cost of housing, families may spend a substantial portion of their income on rent, especially for seasonal and agricultural workers. To address these needs, partners advocated for more equitable funding of public education and support for higher education, increased job skill training particularly for students in more rural districts, and support for skilled work training. Partners identified single parents with a special needs child, seasonal workers, and the Latino/a community as being disproportionately affected by economic insecurity. The pandemic affected businesses and workers, particularly in the service and hospitality industries.
Affordable childcare and preschools	Partners emphasized affordable and flexible childcare as crucial for stable families and a strong workforce. Without addressing this need, people will not be able to participate fully in the workforce and there will continue to be staffing challenges. There is very little affordable childcare in the community and limited free preschool spots. For families working non-traditional hours, finding flexible childcare can be very difficult. For families with a child with a disability, there is very little childcare that can meet the child's needs. This prevents parents from working. The pandemic highlighted how important childcare is for keeping people staffed and for businesses being able to recruit and retain employees.
Food insecurity	Many partners shared that the community is working to ensure people have access to food, although the food options may not always be the healthiest and programs may not address what is causing food insecurity. They shared that food pantries often provide non-perishable foods, which are often not as nutritional as fresh foods. Fresh and healthy foods can be challenging for families with low incomes to afford. Families new to the United States may not be familiar with reading the food labels and identifying healthy foods for their children. Workers on the Hanford site have little access to food on-site besides what they bring. The pandemic exacerbated food insecurity more many people. While there have been additional supports to provide food to families, partners noted there are often a lot of cars lined up waiting to receive food assistance at events, underscoring the need.
Community safety	Partners shared that while they do not think Benton and Franklin Counties overall are unsafe, they are concerned about increased community violence and neighborhoods where residents do not feel safe. This might contribute to people not feeling comfortable accessing parks or recreation. Partners spoke to seeing a large increase in gun violence in 2021, as well as people manifesting anger and stress into violence. They emphasized that addressing community safety needs to be a collaboration between law enforcement and the community.

Community Survey

Benton-Franklin Health District contracted with Zencity, a well-respected community input and insights platform, to conduct a community health survey. The survey was conducted in English and Spanish, respondents were recruited via the internet, and was fielded from March 17-April 11, 2022. The sample survey of Benton and Franklin Counties adults, 18+ was 657. The data was weighted to represent the population in Benton and Franklin Counties. Key findings:

- Just over half the respondents (54%) are satisfied with the quality of life.
- Around half the respondents rate their physical, mental, and dental health as good.
- Fifty-seven percent of respondents reported getting all the health care they needed with no delay, 73% reported getting all the mental health care they need, and 67% responded that they got all the dental health care they needed. Cost and not having a regular provider were leading reasons for not getting enough care.
- Respondents feel that a healthy community is one in which health care and services are accessible to all. They think mental health services are the most important thing the community needs.
- Four groups consistently reported lower quality of life, lower overall health, and less access to health care than other groups: respondents aged 18-34, Hispanic/Latino/a respondents living in Franklin County, and respondents with low incomes.

See Appendix 1: Community Survey

Trends in Behavioral Health

The Institute for Public Policy & Economic Analysis completed "An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties." A survey of mental health providers was conducted and two behavioral health forums were held in person in May of 2022. Forum participants included representatives from community service and non-profit organizations, health care, businesses, government agencies, community members. Relevant data was shared and participant input sought to help identify current needs and gaps in community behavioral health.

KEY FINDINGS FROM THE BEHAVIORAL HEALTH FORUMS

- Significant workforce shortages, more services, more providers, more coordination across organizations and broader social supports are important behavioral health needs in the community today.

KEY FINDINGS FROM THE DATA PRESENTATION

- In adults and youth data alike, rates of mental health issues, substance use/misuse, and the need for treatment is undeniable. If left untreated, many of these issues can lead to higher rates of thoughts of suicide and reliance on substances.
- Suicide rates for the total population have increased slightly over past 25 years while youth suicides and attempts have likely grown over past 20 years. Depression in adults and youth alike

are rising, and the rate of prescribing depression medication is growing, at least among the Medicaid population.

- On a positive note, there has been a steep drop in alcohol and marijuana usage in 10th graders, and rates of binge drinking in adults have slightly decreased.
- Opioid prescribing has declined steeply over past few years, although the lethality of the drugs appears to have climbed.
- Community protective factors declined to 50% in Benton County in 2021, which is 10% lower than WA benchmark. These are conditions or attributes in communities that promote the health and well-being of children, ultimately leading to the development of healthy young adults in the community. These factors include access to economic and financial resources, safe and stable housing, safe childcare, along with medical care and mental health services. On the other hand, school and family protective factors have shown overall increases through 2010-2021 in Benton County and WA.

KEY FINDINGS FROM THE SURVEY OF MENTAL HEALTH PROVIDERS

- Issues with insurance companies significantly impair the ability of providers to care for their patients. For example, having access to other Medicaid insurance carriers like Amerigroup and Molina, along with greater accessibility to medications from insurance companies, were mentioned. Additionally, some providers had specific concerns that some mental health issues are not being recognized by insurance companies for treatment. When insurance companies are willing to work with providers, there are delays in reimbursements and complications with filing paperwork.
- Survey respondents expressed a strong desire for more coordination across organizations to help reduce significant wait times they are currently experiencing.

Click here for “An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties.”

Trends in the Continuum of Housing

The Institute for Public Policy & Economic Analysis completed “An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties.”

A survey of housing providers was conducted and two housing and homelessness forums were held in person in May of 2022. Forum participants included representatives from community service and non-profit organizations, health care, businesses, government agencies, community members. Relevant data was shared, and participant input sought to help identify current needs and gaps in the continuum of housing availability for residents with low incomes and experiencing homelessness.

KEY FINDINGS FROM THE HOUSING AND HOMELESSNESS FORUMS

According to the participants at the forums, the four greatest needs in helping to reduce challenges for residents with low incomes and experiencing homelessness to secure housing include:

(1) Removing barriers,
(2) Greater availability of housing options,
(3) Need for more coordination, and
(4) Need for stronger social supports.

KEY FINDINGS FROM THE REVIEW OF THE DATA

- A review of the housing data indicates that total housing units have not been meeting population demand, but there are efforts to build up units, specifically multi-family units.
- Increasing rental rates are a challenge for renters because the growth rate of household income is about one-third of the growth rate of rent.
- The greater Tri-Cities (Kennewick, Pasco, Richland, West Richland, and surrounding towns) has consistently been in a very tight market for rental housing, as the vacancy rate is below 2% for most years from 2016 to 2021.
- Persons experiencing homelessness and unstable housing are growing in Tri-Cities, whereas the WA number is decreasing. There are currently almost 4,000 people in the Homeless Management Information System (HMIS) system in the greater Tri-Cities. The length of days someone is homeless in the greater Tri-Cities has nearly doubled and the rate of those returning to homelessness is still increasing.

KEY FINDINGS FROM THE SURVEY OF HOUSING OPTIONS

- The most significant obstacles facing housing facilities that serve residents with low incomes and experiencing homelessness are lack of financial resources, drug use, and workforce challenges. Relations with neighbors and ability to attract potential clients are ranked lower.

Click here for "An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties."

Community Forums

Two general forums were convened in July to share qualitative and quantitative data with community members and to ask them to identify additional community health needs that may be present in Benton and Franklin Counties. The first general forum was held in person on July 12, 2022, with 41 participants, and the second was held virtually on July 14, 2022, with 35 participants. They were asked to consider the following:

- What is going well?
- What are the most significant community health issues?

- What is most concerning to you?
- What do you think this community is ready, able, willing to work on?
- What else would you like to know?

Forum participants believe that there is a willingness to collaborate and find solutions as a community, that people care and are willing and invested in creating a better community. An increase in the number of Community Health Workers and the impact they are making was noted. Participants want to know the results of the current CHIP, how programs are funded, and who the champions are for each major challenge. The one-tenth of one percent local sales tax that went into effect in April of 2022 for chemical dependency or mental health purposes was noted as a positive development for future program funding. The need for increased awareness of community resources was noted especially for youth. There is an interest in improving transportation as it can be a barrier to accessing healthcare. Childcare costs and the nursing shortage were identified as priorities. Top priorities identified include behavioral health, access to care, workforce, and housing. Participants believe that the community is ready, willing, and able to work on mental health, substance use and abuse, access to healthcare, and housing and homelessness.

Challenges in Obtaining Community Input

The COVID-19 pandemic continues to present barriers and challenges to collecting community input. Rather than being held in person, partner interviews were held virtually presenting technological challenges for some participants and decreasing the opportunities for in person, interpersonal communication. Technology presented challenges in one listening session and participation was limited for the in person older adult listening session, likely due to the pandemic. While video conferencing does facilitate information sharing, there are challenges creating the level of dialogue that would take place in person.

SIGNIFICANT HEALTH NEEDS

Prioritization Process and Criteria

CHNA steering committee members reviewed the qualitative and quantitative data independently, in steering committee meetings, and by participating in the three community forums. Committee members met weekly in July and August 2022 to apply the prioritization criteria to the identified needs and reached consensus through discussion and debate. Prioritization criteria included worsening trend over time, disproportionate impact on low income and/or Black, Brown, Indigenous, and People of Color (BBIPOC) communities, community rates worse than state average, the opportunity to impact based on community partnerships, severity of the need and/or scale of need. The following Community Health Improvement Plan Guiding Concepts also informed the prioritization process: Equity, Life-course wellness, Health in All Policies (HiAP), Evidenced-based, and Collective Impact.

See Appendix 3: Community Health Improvement Plan Guiding Concepts

2022 Priority Needs

The list below summarizes the significant health needs identified through the 2022 Community Health Needs Assessment process in no particular order:

BEHAVIORAL HEALTH

The 2019 Benton & Franklin Counties Community Health Needs Assessment (CHNA) identified that our community needed to better understand the behavioral health gaps and needs within the community. The 2020 Benton & Franklin Counties Community Health Improvement Plan (CHIP) included an objective (BH 2.1.1) to complete a comprehensive behavioral health needs assessment. The assessment was completed in the spring of 2022 through a partnership with Eastern Washington University (EWU). The assessment identified significant needs for behavioral health response and prevention. In fact, in all areas of the CHNA, behavioral health was identified as a need. Behavioral health includes mental health and substance use/misuse. With the serious behavioral health workforce shortage, increase in need, and existing coalitions working towards solutions, our steering committee identified behavioral health as a priority area.

HOUSING AND HOMELESSNESS

The 2019 CHNA identified that our community needed to better understand the housing and homelessness gaps and needs within the community. The 2020 Benton & Franklin Counties Community Health Improvement Plan (CHIP) included an objective (SDOH 2.1.1) to complete a comprehensive housing and homelessness needs assessment. The assessment was completed in the spring of 2022 through a partnership with EWU. On housing, the assessment identified a low supply of affordable housing, low supply of multi-family units, low vacancy rates for rentals, and increased rental costs. Housing increases in Benton and Franklin Counties are not keeping up with population growth and

demand. Regarding homelessness, the assessment identified a shortage of low-barrier housing options for residents experiencing homelessness. Additionally, there has been a greater than two-fold increase in the average number of days a person experiences homelessness in Benton and Franklin Counties. Stable housing has consistently been shown to improve both physical and mental health outcomes. For this reason and because the Benton and Franklin regions are experiencing rapid growth, a lack of affordable housing, a lack of low-barrier solutions to homelessness, and the complexity of solving these issues through effective community partnerships, our steering committee identified these issues as priorities for the upcoming CHIP.

ACCESS TO HEALTH

The 2019 CHNA identified a need for access to not only healthcare, but also access to community supports that enable health. It is understood that optimal health is influenced by access and quality of healthcare, health promoting behaviors, the physical environment, and socioeconomic factors. Access to Health will include a focus on addressing barriers to medical care, including healthcare provider to patient ratios and linguistically appropriate, culturally responsive, and accessible care. In addition, the steering committee broadened this priority to include needs identified in the CHNA, such as access to safe and nutritious food; transportation; safe, licensed, and affordable childcare; health education; chronic disease prevention; and resource awareness.

COMMUNITY PARTNERSHIP DEVELOPMENT

Benton and Franklin Counties are fortunate to have numerous community coalitions and committees aimed at improving and supporting community health. This region also has a business community which is quite supportive of promoting local health and social initiatives. However, the CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources. This priority area will impact the other three priority areas by improving communications, clarifying coalition functions, and expanding the work of community health improvement to non-traditional partnerships.

Potential Resources Available to Address Significant Health Needs

Understanding the potential resources to address significant health needs is fundamental to determining current state capacity and gaps. The organized health care delivery systems include the Benton-Franklin Health District, Trios Health, Lourdes Health, Prosser Memorial Health, Miramar Health Center, and Tri-Cities Community Health. In addition, there are numerous social service non-profit agencies, faith-based organizations, and private and public-school systems that contribute resources to address these identified needs. As noted in the Community Partnership Development priority section above, the CHNA identified that strengthening partnerships and coordinating efforts has the potential to improve outcomes through shared goals and resources and expanding the work of community health improvement to non-traditional partnerships to address the needs identified in this CHNA.

See table on page 101 in Appendix 2, "Organizations and Initiatives Addressing Community Needs in Benton and Franklin Counties."

EVALUATION OF 2020 BENTON & FRANKLIN COUNTIES CHIP IMPACT

Table 29. Outcomes from BFHD 2020 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Social Determinants of Health	Housing and Homelessness Community Health Needs Assessment	Complete a comprehensive housing and homelessness assessment.	BFHD contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a comprehensive housing and homelessness needs assessment. The assessment included analysis of data, a survey of housing providers, and two community forums attended by over 60 participants. The assessment meets a 2020 CHIP objective, and the results are incorporated in this 2022 CHNA.
Social Determinants of Health	Built for Zero (BFZ) Model	BFZ is an initiative that utilizes real-time, by-name data to secure housing resources and target them for the greatest possible reduction in homelessness.	Built for Zero presentation was made at the Housing Continuum of Care Task Force meeting in April of 2022 to introduce the model to community partners.
Social Determinants of Health	People have access to nutritious foods	Establish a Food Access Coalition.	BFHD and BFCHA formed an Access and Security Coalition (FASC) that started meeting in March of 2022.
Social Determinants of Health	Health and social determinants of health are considered and evaluated in community-level initiatives and agency-wide policies.	Apply for and attend the Washington Walkability/Movability Action Institute with interdisciplinary team.	BFHD partnered with BFCOG and Benton-Franklin Transit (BFT) to submit a proposal to attend the Washington Walkability/Movability Action Institute (WA WAI). The WA WAI is a multi-day, multi-disciplinary course focused on equitable policies, systems, and environmental interventions to enhance active transportation opportunities. The team from BFHD, BFCOG, and BFT were joined by representatives from the City of Pasco and Southeast Washington Aging & Long-Term Care (SEWALTC). The team will continue to meet, expand, and receive support from the faculty at the

			National Association of Chronic Disease Directors and the Centers for Disease Control and Prevention (CDC).
Access and Cost of All Healthcare	Health Equity and Access Team (HEAT)	HEAT serves to innovate on ways to increase the provider/population ratio and expand resources to the community.	HEAT has connected with TRIDEC, the Chamber of Commerce and Hispanic Chamber of Commerce, and Visit Tri-Cities on recruitment and retention of providers in primary care.
Access and Cost of All Healthcare	COVID-19 Response	Coordinated and comprehensive infectious disease management	BFHD, Kadlec, PMH, the Hispanic Chamber of Commerce, and many other community partners came together to expand COVID-19 testing and vaccination sites. In addition, BFHD provided community COVID-19 surveillance, served to educate the public about COVID-19 risks and precautions, provided recommendations to businesses, schools, and healthcare organizations, and worked with Washington State Department of Health for a state-wide, coordinated response.
Access and Cost of All Healthcare	Clinical expansion	Expansion of access through increased regional clinical capacity	To expand into rural communities, Columbia Basin Health Associates established primary care facilities in rural areas of north Franklin County. PMH hired multiple new providers in urgent/after-hours care, pediatrics, family practice, obstetrics and women's health, emergency medicine, and behavioral health. PMH also expanded clinic hours where appropriate. Kadlec Clinic hired numerous specialty providers, family medicine physicians, and primary care Nurse Practitioners (NP).
Access and Cost of All Healthcare	Data sharing	Coordinated sharing of community health data	Kadlec and PMH are engaged in data sharing with the coordinated use of MyChart, by Epic.
Access and Cost of All Healthcare	Resource connection	Community Resource Desk (CRD)	Kadlec established the CRD in October of 2020. It is a free service that connects people with community resources including establishing a primary care provider, dental care,

			medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and basic needs such as food, transportation, clothing, work, or housing aid. By connecting people with resources, a barrier to access is removed.
Behavioral Health Challenges	Tax policy	Sales tax revenue for behavioral health	In the spring of 2022, a sales tax in Benton and Franklin Counties went into effect, providing one penny per every $10 to go towards behavioral healthcare and access in the two counties. This is sustainable funding that will result in about $1.4 million annually to address the needs identified. Work is being done to establish the plan for prioritizing the spending towards the greatest need.
Behavioral Health Challenges	Washington Youth Safety and Wellbeing Taskforce	Advocacy, testimony, and representation	Another policy-level activity related to behavioral health support was BFCHA's involvement in advocating and testifying on the Washington Youth Safety and Wellbeing Taskforce, which recommended a statewide Tip Line. The Tip Line, which is expected to come online in the 2022-23 school year, will be a resource for anyone to call with a tip related to a risk of harm to self or others, including suicide, domestic violence, or other risks. BFCHA has printed and distributed more than 50,000 credit-card size Mental Health Resource handouts in English and Spanish. These are distributed through schools, health fairs, and other venues.
Behavioral Health Challenges	Positive Messaging	Messages to reinforce resilience and positive thinking	Key Connection, the Behavioral Health Committee of BFCHA, BFHD, Educational Service District (ESD) 123, Kadlec, and school districts partnered to develop positive messaging signs to support youth mental health and resilience. BFHD supported a Mental Health Mondays campaign and hosted Trauma Informed Training for school staff to increase awareness of behavioral health issues and provide tools for educators. Greater Columbia

			Accountable Community of Health (GCACH) established "Practice the Pause" campaign, which has run several times during the COVID-19 pandemic and is undergoing a refresh to branding and content for continued use. Partners who provide community education on behavioral health issues and/or suicide prevention include Catholic Charities, Lutheran Social, ESD123, the National Alliance on Mental Illness (NAMI), and Kadlec.
Behavioral Health Challenges	Means Restrictions	Firearm lock boxes and education	Kadlec partnered with Ranch & Home retailer to provide 500 free firearm lock boxes and safe storage education as a means of preventing suicide. The project was funded by Kadlec Foundation.
Behavioral Health Challenges	Behavioral Health Needs Assessment	Comprehensive community-wide assessment of behavioral health needs	BFHD contracted with the Institute of Public Policy and Economic Analysis at Eastern Washington University to conduct a comprehensive behavioral health needs assessment. The assessment included analysis of data, a survey of behavioral health providers, and two community forums attended by over 35 participants. The assessment meets a 2020 CHIP objective and the results are incorporated in this 2022 CHNA.

EVALUATION OF 2020-2022 KADLEC REGIONAL MEDICAL CENTER CHIP IMPACT

This report evaluates the impact of the 2020-2022 Kadlec Community Health Improvement Plan (CHIP). Kadlec responded to community needs by making investments of direct funding, time, and resources to internal and external programs dedicated to addressing the previously prioritized needs using evidence-based and leading practices.

Table 30. Outcomes from Kadlec 2020-2022 CHIP

Priority Need	Program or Service Name	Program or Service Description	Results/Outcomes
Behavioral Health Challenges	Integrated Behavioral Health	Behavioral health integrated in primary care clinics	Three social workers are embedded in three Kadlec Clinics.
Behavioral Health Challenges	Mental Health First Aid	Community education programs	Between January 2020 and September 2022, 669 people were trained in Mental Health First Aid and other mental health and suicide prevention programs.
Behavioral Health Challenges	Positive Messaging Campaign	Messages to reinforce resilience and positive thinking	Kadlec, Key Connection, the Behavioral Health Committee of BFCHA, BFHD, ESD 123, and school districts partnered to develop positive messaging signs to support youth mental health and resilience. Kadlec housed, coordinated, and distributed signs throughout the community.
Behavioral Health Challenges	Means Restrictions	Firearm lock boxes and education	Kadlec partnered with Ranch & Home retailer to provide 500 free firearm lock boxes and safe storage education as a means of preventing suicide. The project was funded by Kadlec Foundation.
Access and Cost of Health Care	Telemedicine Services	Expand telemedicine services	Expanded telemedicine services completed 48,291 telemedicine visits in 2020 and 37,260 telemedicine visits in 2021.
Access and Cost of Health Care	Family Medicine Residency program		Kadlec's Family Medicine Residency program residents graduated in 2022 with four of the eight staying within Kadlec.
Access and Cost of Health Care	Healthy Ages	Provide Medicare education and consultations	Between January 2020 and August 2022, 1079 people participated in Medicare education programs and/or consultations.

Access and Cost of Health Care	Community Outreach	Community Health Workers (CHW)	As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking CHWs joined the Population Health team in 2021.
Access and Cost of Health Care	Medication Assistance Program (MAP)	Medication assistance to Kadlec patients who qualify	MAP started in March of 2020. In 2021, 161 patients were served.
Access and Cost of Health Care	Community Resource Desk (CRD)	Awareness of, and access to, community resources	Kadlec established the CRD in October of 2020. It is a free service that connects people with community resources including establishing a primary care provider, dental care, medical equipment, eye care, alcohol or drug recovery, health insurance, mental health counseling, and transportation.
Social Determinants of Health (SDOH)	Community Resource Desk (CRD)	Awareness of, and access to, community resources	The CRD connects people with community resources to meet basic needs such as food, transportation, clothing, work, or housing aid.
Social Determinants of Health	Community Outreach	Community Health Workers	As part of Kadlec's commitment to addressing health equity, three bilingual/bicultural Spanish-speaking CHWs joined the Population Health team in 2021.
Social Determinants of Health	Built for Zero (BFZ) Model	BFZ is an initiative that utilizes real-time, by-name data to secure housing resources and target them for the greatest possible reduction in homelessness.	BFZ presentation was made at the Housing Continuum of Care Task Force meeting in April of 2022 to introduce the model to community partners.

Addressing Identified Needs

The Community Health Improvement Plan developed for Benton and Franklin Counties will consider the prioritized health needs identified in this CHNA and develop strategies to address needs considering resources, community capacity, and core competencies. Those strategies will be documented in the CHIP, describing plans to address the health needs. If the need will not be addressed or have limited response to the identified need, the CHIP will explain why. The CHIP will not only describe the actions that will be taken, but also the anticipated impact of these actions and the resources needed to address the need.

Because partnership is important when addressing health needs, the Benton and Franklin Counties CHIP will describe any planned collaborations between BFHD, BFCHA, Kadlec and community-based organizations in addressing the health need.

In addition to the Benton and Franklin Counties CHIP that will be developed, Kadlec will develop a Kadlec CHIP that will be approved and made publicly available no later than May 15, 2023.

2022 CHNA GOVERNANCE APPROVAL

Kadlec Regional Medical Center

10/19/22

Reza Kaleel — Date
Chief Executive, Providence Southeast Washington

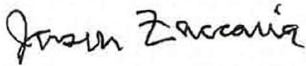
10/19/22

Ted Samsell, MD — Date
Community Board Chair

11/15/22

Joel S. Gilbertson — Date
Divisional Chief Executive — Central, Providence

Benton-Franklin Health District



10/20/22

Jason Zacarria — Date
District Administrator

Benton-Franklin Community Health Alliance

10/21/22

Kirk Williamson — Date
Program Manager

Prosser Memorial Health

10/28/22

Craig J. Marks — Date
Chief Executive Officer

To request a printed paper copy free of charge, provide comments, or view electronic copies of current and previous Community Health Needs Assessments, please email info@BFCHA.org or CHI@providence.org

APPENDICES

Appendix 1: Quantitative Data

Appendix 2: Community Input

Appendix 3: Community Health Improvement Plan Guiding Concepts

Appendix 4: Community Health Needs Assessment Steering Committee

Appendix 1: Quantitative Data

PRIMARY DATA COLLECTION SURVEY RESULTS

1

Executive Summary

- Just over half the respondents (54%) are satisfied with the quality of life in the county.
- Around half the respondents rate their physical, mental, and dental health as good.
- 57% of respondents got all the health care they needed with no delay, 73% got all the mental health care they needed, and 67% got all the dental health care they needed. Cost and not having a regular provider were leading reasons for not getting enough care.
- Respondents feel that a healthy community is one in which health care and services are accessible to all. They think mental health services are the most important thing the community needs.
- Four groups consistently reporter lower quality of life, lower overall health, and less access to health care than other groups: respondents aged 18-34, Hispanic respondents, respondents living in Franklin County, and low-income respondents.

2

The structure of the report

01. Methodology	The sample, distribution method, and research tools
02. Overall Health	How to respondents rate their overall quality of life and their health?
03. Individual Health	Do respondents receive all the care they need? What are they missing and why?
04. Community Health	What do respondents think makes a healthy community? What do they think their community is missing?
Summary	

3

4

Methodology

5

Methodology – how we ensure the sample is statistically valid

- 657 respondents were recruited online between March 17th and April 11th, 2022, using targeted ads on various platforms (e.g., social media, apps for Android and IOS) as well as online survey panels.
- Using data from the Census Bureau, this survey employed quotas to match the distribution of race, ethnicity, age, and gender in Benton and Franklin, ensuring that the sample represents residents of both counties.
- To make sure our sample is representative, a technique called rake-weighting was used to balance out any remaining differences between the makeup of the survey respondents and the community. This process serves as a statistical safeguard against any demographic group being overrepresented or underrepresented in the final score calculations by giving overrepresented groups a lower weight and underrepresented groups a higher weight in the analysis.

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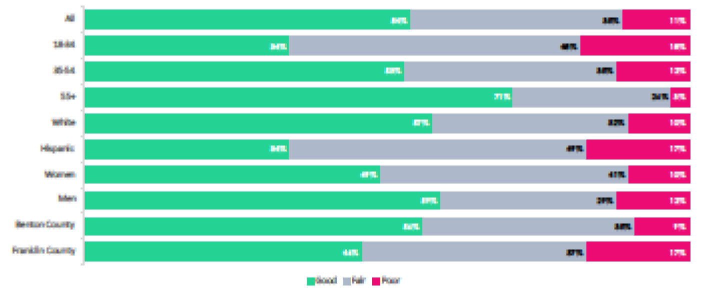
7

Overall Quality of Life: Just over half the respondents (54%) reported good overall quality of life in their community, and very few reported poor quality of life (11%). Respondents aged 18-34, Hispanic respondents and Franklin County residents reported less satisfaction with the quality of life in their communities than other groups.

Question: How would you rate the overall quality of life in your community?



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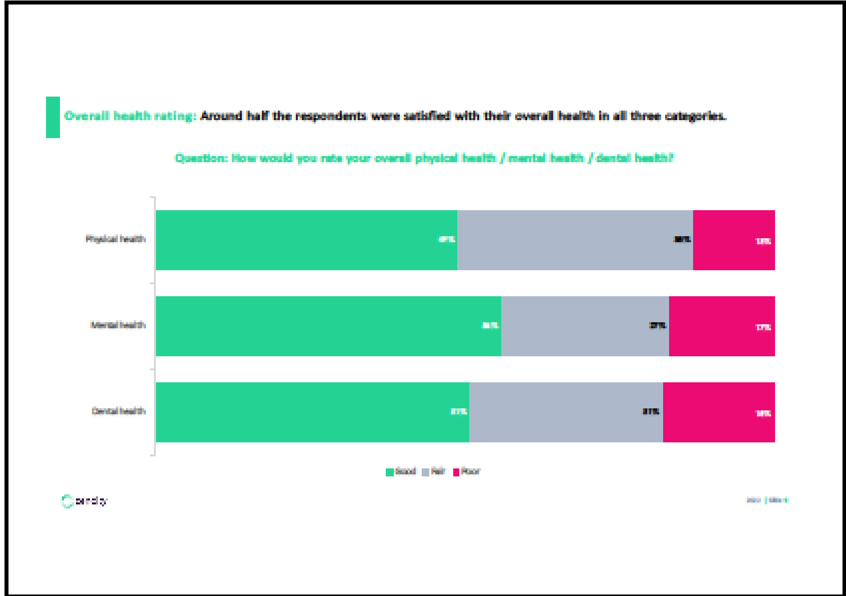

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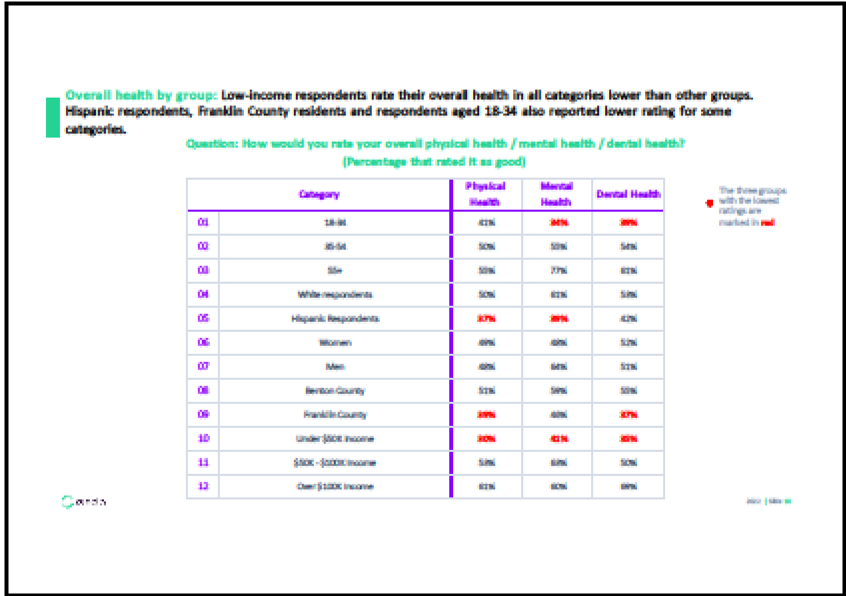

Overall health by group: Low-income respondents rate their overall health in all categories lower than other groups. Hispanic respondents, Franklin County residents and respondents aged 18-34 also reported lower rating for some categories.

Question: How would you rate your overall physical health / mental health / dental health? (Percentage that rated it as good)

	Category	Physical Health	Mental Health	Dental Health
01	18-34	41%	34%	39%
02	35-54	50%	55%	54%
03	55+	55%	77%	61%
04	White respondents	50%	61%	58%
05	Hispanic Respondents	37%	39%	42%
06	Women	49%	48%	52%
07	Men	48%	64%	51%
08	Benton County	51%	59%	55%
09	Franklin County	39%	48%	37%
10	Under $50K Income	30%	41%	30%
11	$50K - $100K Income	58%	69%	50%
12	Over $100K Income	61%	60%	69%

The three groups with the lowest ratings are marked in red

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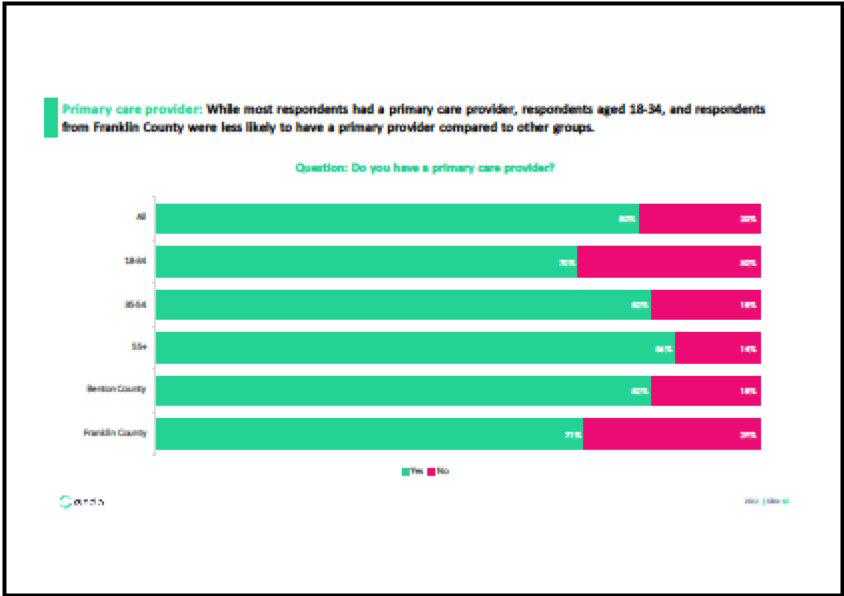

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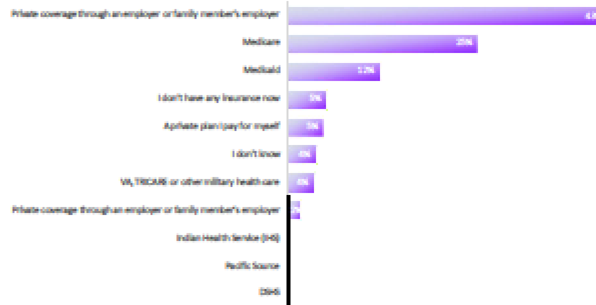
Health coverage: Almost half the respondents (43%) have private coverage through an employer, and many had insurance through Medicare or Medicaid. 5% of respondents reported not having any insurance.

Question: What kind of health coverage or insurance do you have?



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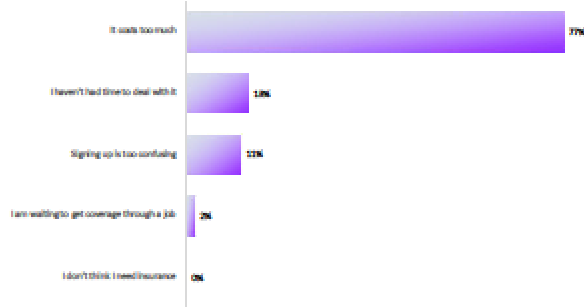
Reasons for not having health coverage: The main reason respondents gave for not having health coverage was that it cost too much.

Question: What are the main reasons why you don't have health coverage or insurance? (only those who don't have coverage, n= 24)



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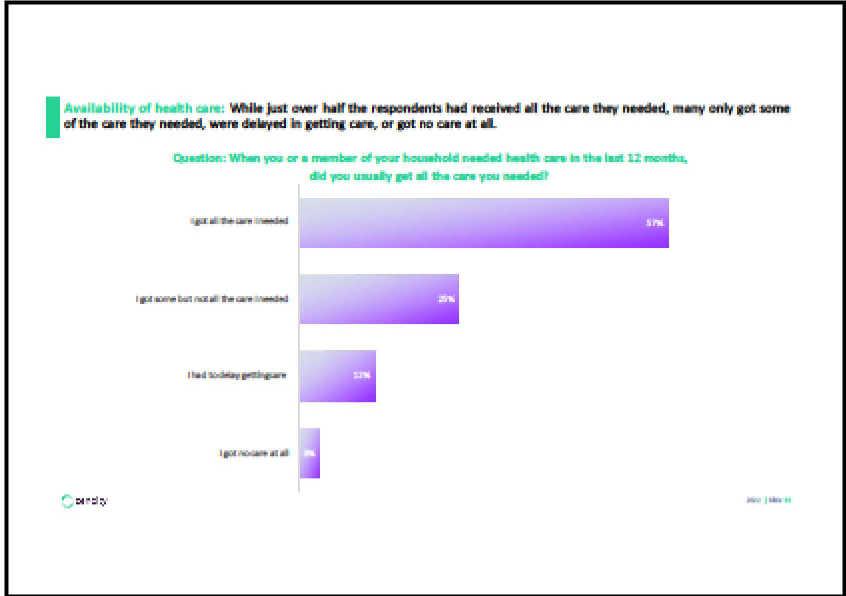

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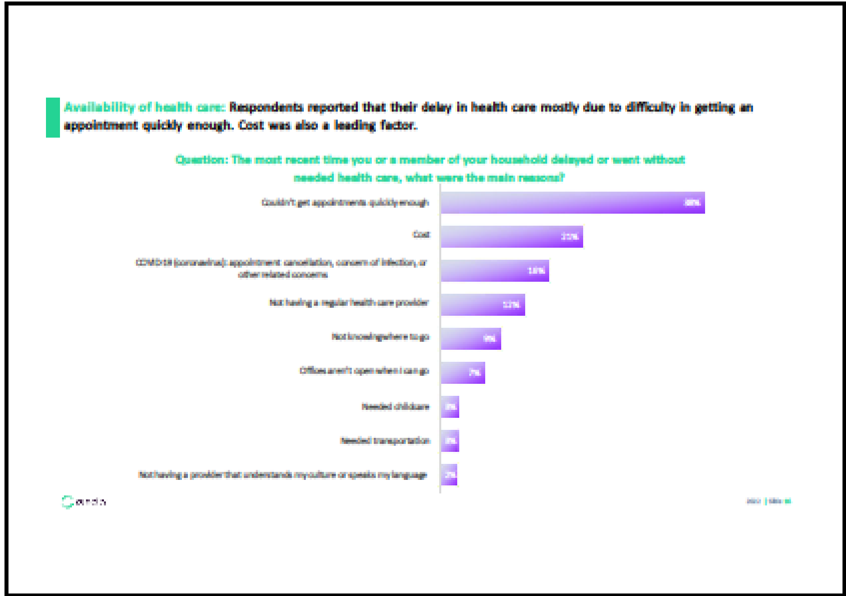

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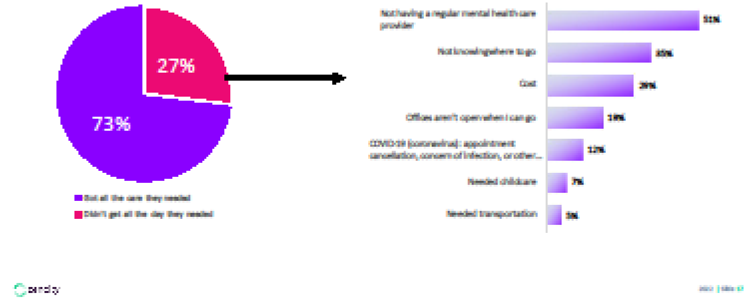
Availability of mental health care: Almost a third of respondents didn't get the mental health care they needed. For half of them, the main reason for this was that they didn't have a regular provider, and another third didn't know where to go. Cost was a factor for about a third.

Question: Was there a time in the last 12 months when you or a member of your household needed mental health care or substance use treatment but did NOT get the care you needed? What were the main reasons you didn't get the mental health care or substance use treatment you needed?



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Availability of dental care: A third of respondents didn't get the dental care they needed in the past 12 months. For over half of them, cost was a major factor.

Question: Was there a time in the last 12 months when you or a member of your household needed dental care but did NOT get the care you needed? What were the main reasons you didn't get the dental care you needed?

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Availability of dental care and mental health care by group: Many low-income residents reported not getting the care they needed in all three categories.

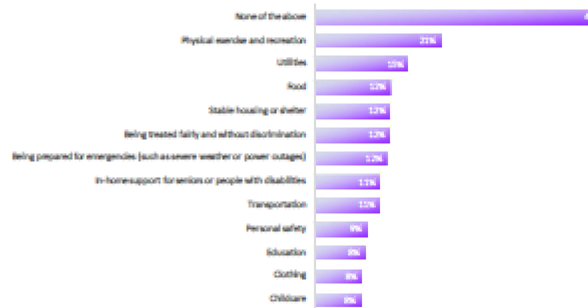
	Category	% who didn't get the physical care they need	% who didn't get the mental care they need	% who didn't get the dental care they need
01	18-34	27%	33%	40%
02	35-54	33%	30%	35%
03	55+	24%	15%	24%
04	White respondents	29%	28%	32%
05	Hispanic Respondents	23%	32%	41%
06	Women	32%	30%	38%
07	Men	24%	19%	38%
08	Benton County	30%	28%	32%
09	Franklin County	22%	30%	38%
10	Under $50K Income	31%	34%	48%
11	$50K - $100K Income	30%	27%	32%
12	Over $100K Income	24%	27%	20%

The three groups that got the least amount of care are marked in red

19

What challenges are residents facing? Almost half the respondents didn't have challenges meeting any of the mentioned needs in the past 12 months. The top needs residents had challenges meeting exercise and recreation needs and utility needs.

Question: In the past 12 months, have you or someone in your household had challenges meeting your needs in any of the following areas?



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Main challenges for each group

	Category	18-34	35-54	55+	White	Hispanic	Benton County	Franklin County	Under $50K	$50K - $100K	Over $100K
01	Physical exercise and recreation	21%	24%	17%	18%	25%	20%	23%	28%	19%	14%
02	Utilities	19%	18%	8%	13%	20%	16%	12%	32%	11%	2%
03	Food	14%	16%	7%	13%	18%	13%	10%	27%	8%	4%
04	Stable housing or shelter	13%	10%	7%	12%	15%	11%	17%	20%	9%	4%
05	Being treated fairly and without discrimination	12%	15%	10%	11%	15%	13%	11%	17%	12%	8%
06	Being prepared for emergencies	13%	14%	8%	10%	15%	12%	10%	19%	11%	5%
07	In-home support for seniors or people with disabilities	6%	10%	16%	11%	9%	11%	10%	16%	12%	5%
08	Transportation	16%	10%	7%	10%	12%	11%	8%	21%	8%	5%
09	Personal safety	7%	10%	8%	9%	10%	9%	7%	12%	9%	4%
10	Education	15%	8%	2%	5%	15%	6%	17%	14%	5%	1%
11	Clothing	11%	8%	4%	6%	13%	6%	13%	19%	4%	1%
12	Childcare	12%	9%	3%	7%	12%	6%	12%	9%	9%	8%

The top three challenges for each group are marked in green

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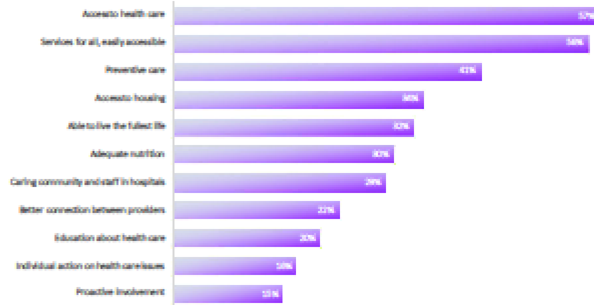
Meaning of a healthy community: Over half the respondents felt that a healthy community meant access to health care and accessible services for all.

Question: What does a healthy community mean to you?



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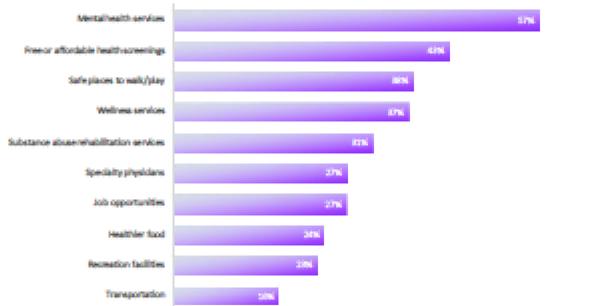
Most important thing for a healthy community: Over half the respondents felt that their community was most in need of mental health services.

Question: Which of the following are most important in improving the health of your community?



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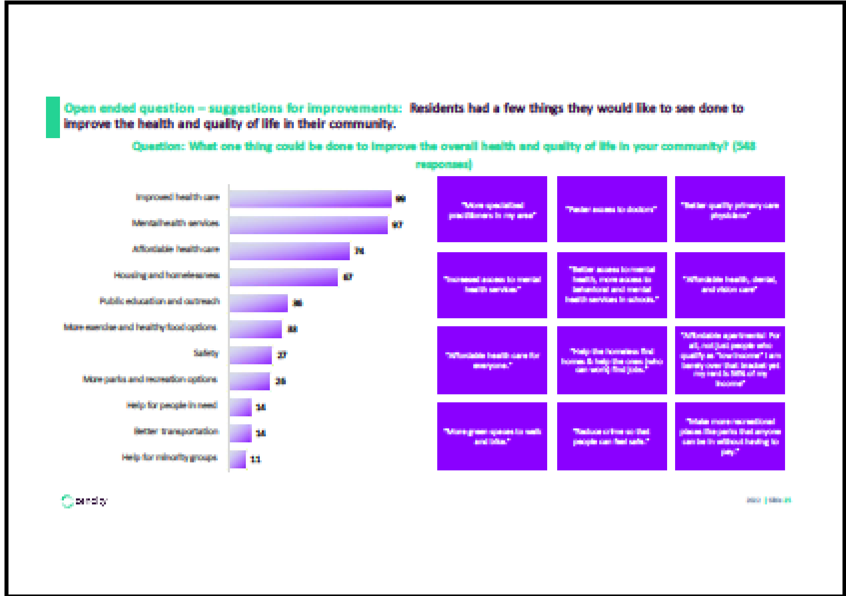

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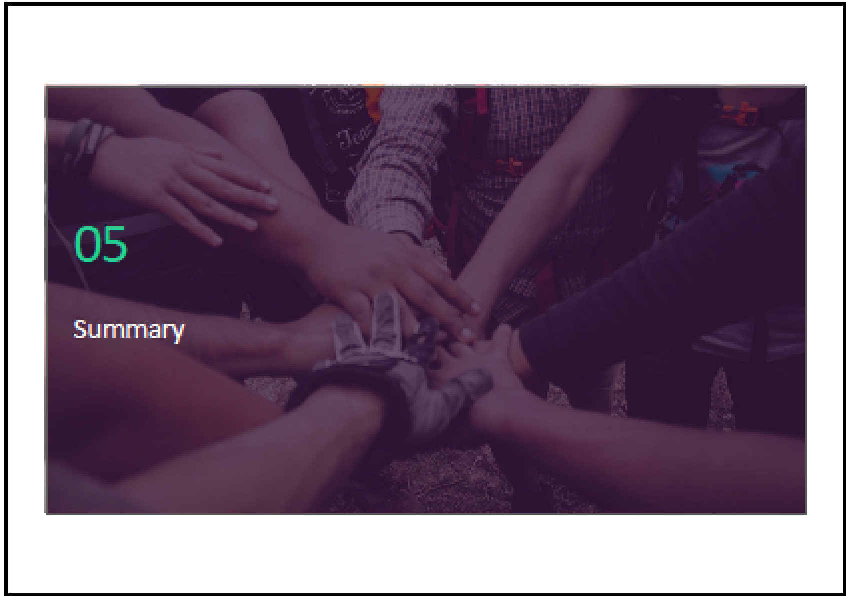

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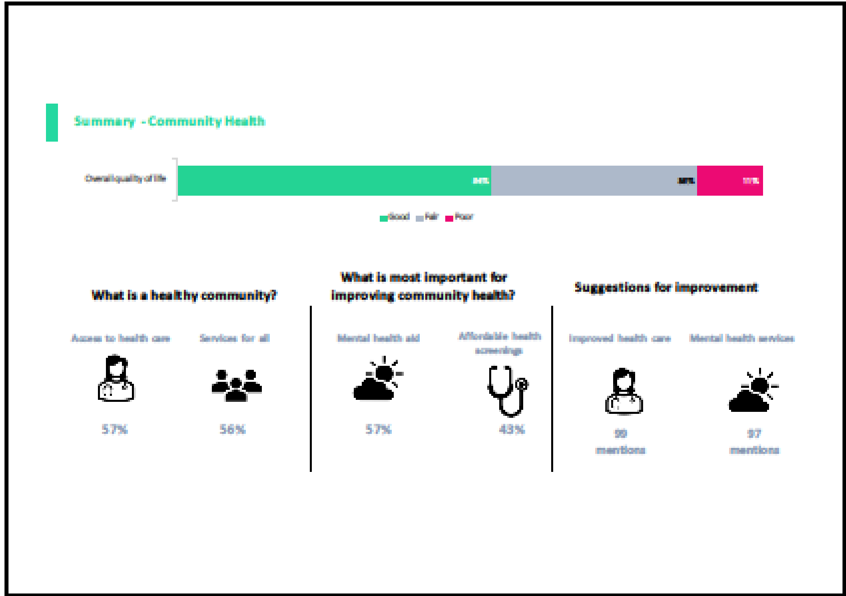

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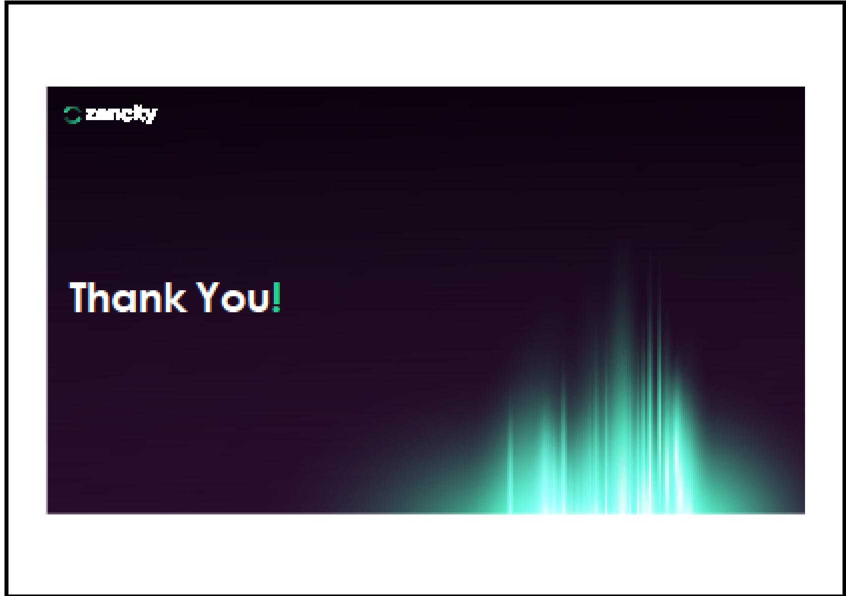

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Links

Link to survey

Link to open-ended responses

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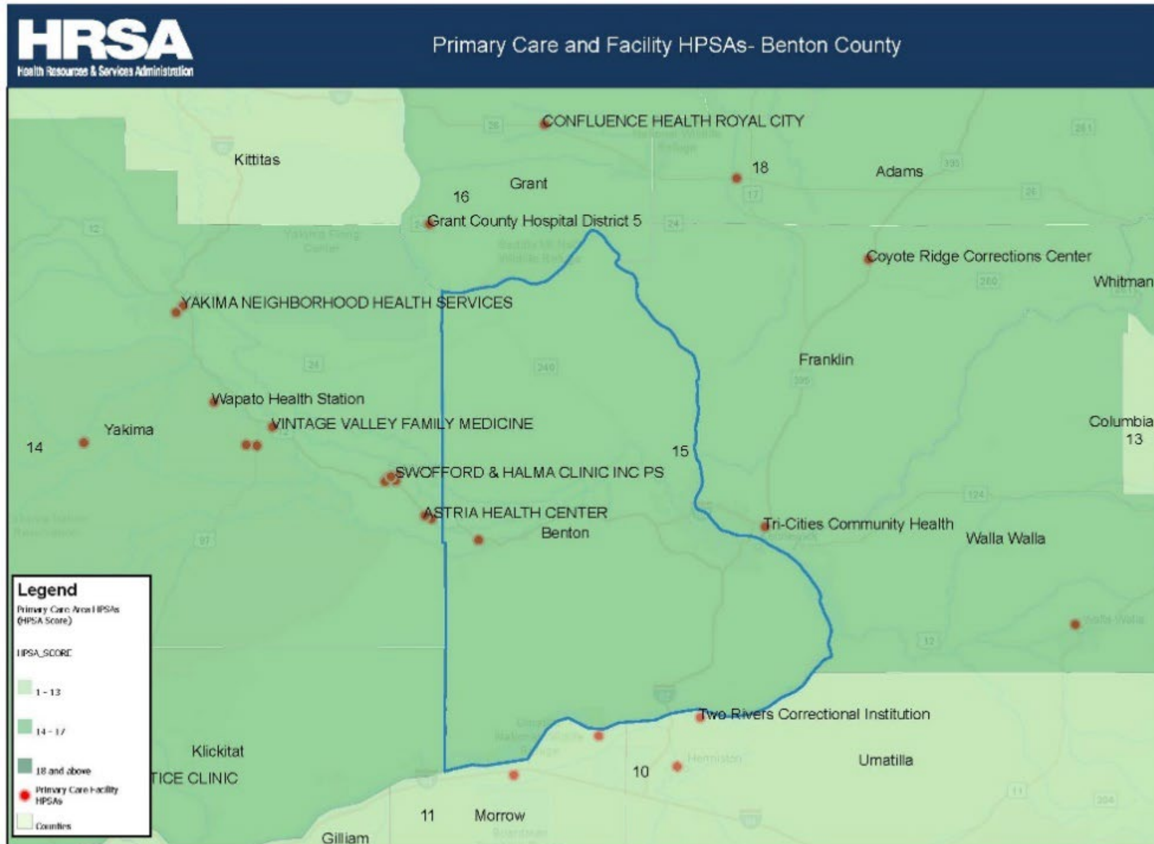
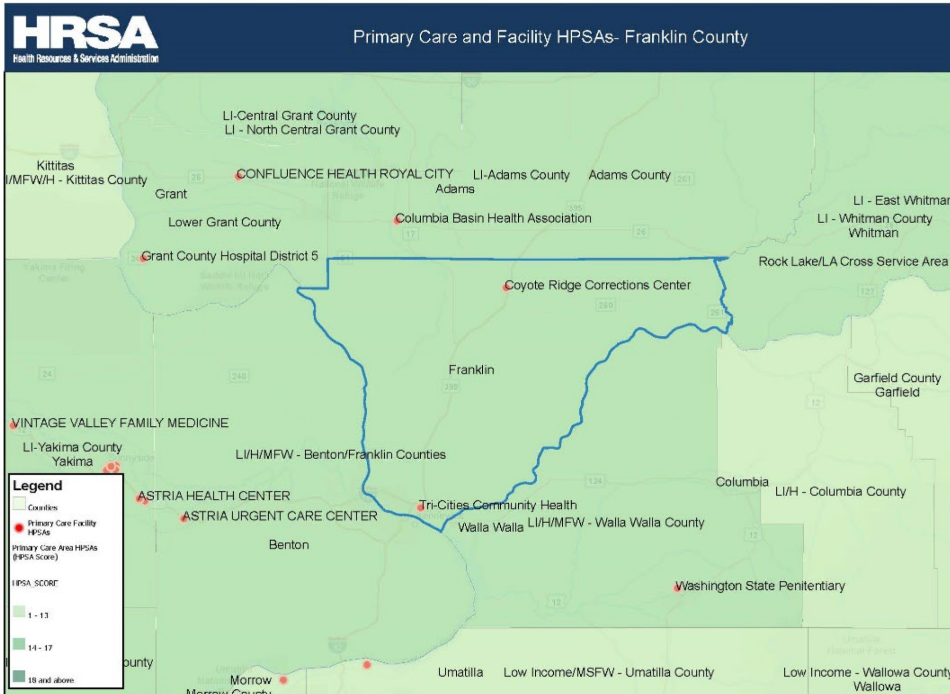
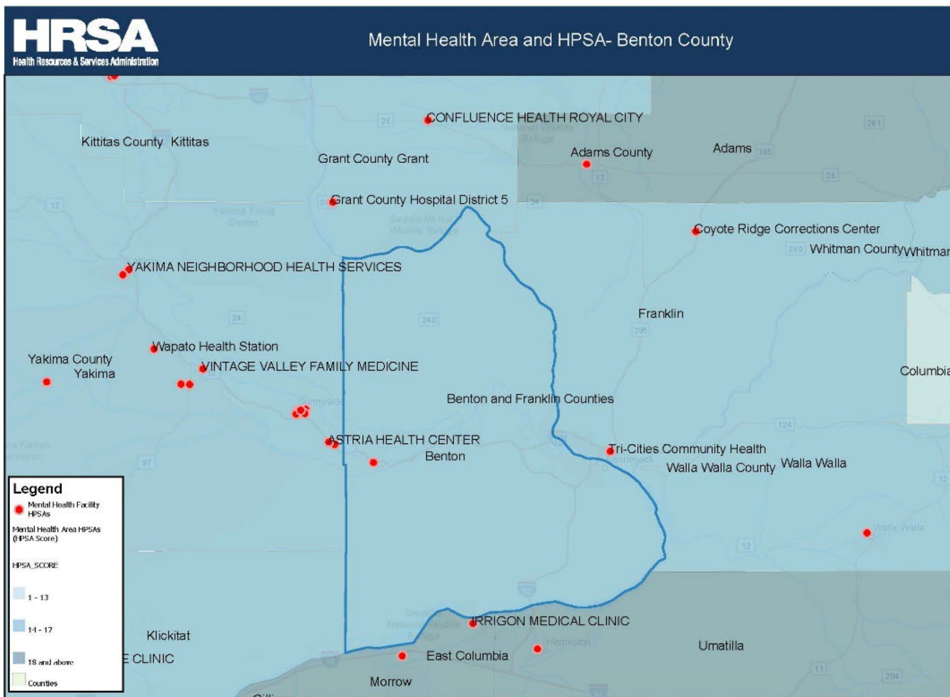
HEALTH PROFESSIONAL SHORTAGE AREA

The Federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas HPSAs) as areas with a shortage of primary medical care, dental care, or mental health providers. They are designated according to geography (i.e., service area), demographics (i.e., low-income population), or institutions (i.e., comprehensive health centers). Benton and Franklin Counties are HPSAs as depicted on the maps below.




HRSA
Health Resources & Services Administration
Primary Care and Facility HPSAs- Franklin County
LI-Central Grant County
LI - North Central Grant County
Kittitas
I/MFW/H - Kittitas County
Grant
CONFLUENCE HEALTH ROYAL CITY
LI-Adams County
Adams County
Adams
Lower Grant County
Columbia Basin Health Association
LI - East Whitman
LI - Whitman County
Whitman
Grant County Hospital District 5
Rock Lake/LA Cross Service Area
Coyote Ridge Corrections Center
Franklin
Garfield County
Garfield
VINTAGE VALLEY FAMILY MEDICINE
LI-Yakima County
Yakima
LI/H/MFW - Benton/Franklin Counties
Columbia
LI/H - Columbia County
ASTRIA HEALTH CENTER
ASTRIA URGENT CARE CENTER
Tri-Cities Community Health
Walla Walla
LI/H/MFW - Walla Walla County
Benton
Washington State Penitentiary
Legend
Counties
Primary Care Facility HPSAs
Primary Care Area HPSAs (HPSA Score)
HPSA_SCORE
1 - 13
14 - 17
18 and above
Morrow
Morrow County
Umatilla
Low Income/MSFW - Umatilla County
Low Income - Wallowa County
Wallowa
data.HRSA.gov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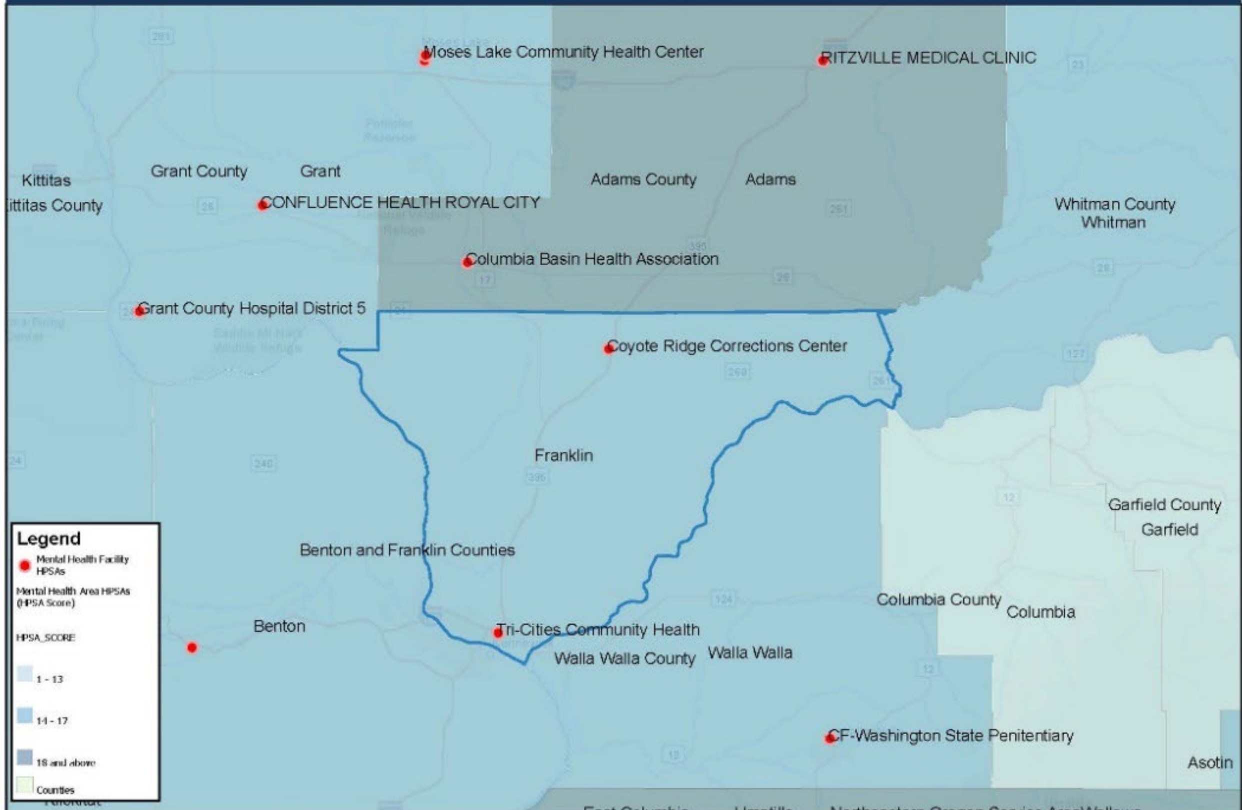
Health Resources & Services Administration
Mental Health Area and HPSA- Benton County
CONFLUENCE HEALTH ROYAL CITY
Kittitas County Kittitas
Grant County Grant
Adams County
Adams
Grant County Hospital District 5
Coyote Ridge Corrections Center
Whitman County
Whitman
YAKIMA NEIGHBORHOOD HEALTH SERVICES
Franklin
Wapato Health Station
Yakima County
Yakima
VINTAGE VALLEY FAMILY MEDICINE
Columbia
Benton and Franklin Counties
ASTRIA HEALTH CENTER
Benton
Tri-Cities Community Health
Walla Walla County
Walla Walla
Legend
Mental Health Facility HPSAs
Mental Health Area HPSAs (HPSA Score)
HPSA_SCORE
1 - 13
14 - 17
18 and above
Counties
Klickitat
IRRIGON MEDICAL CLINIC
Umatilla
East Columbia
Morrow
data.HRSA.gov


HRSA
Health Resources & Services Administration
Mental Health Area HPSA and Facility- Franklin County
Moses Lake Community Health Center
RITZVILLE MEDICAL CLINIC
Kittitas
ittitas County
Grant County
Grant
CONFLUENCE HEALTH ROYAL CITY
Adams County
Adams
Whitman County
Whitman
Columbia Basin Health Association
Grant County Hospital District 5
Coyote Ridge Corrections Center
Franklin
Garfield County
Garfield
Legend
Mental Health Facility HPSAs
Mental Health Area HPSAs (HPSA Score)
HPSA_SCORE
1 - 13
14 - 17
18 and above
Counties
Benton and Franklin Counties
Columbia County
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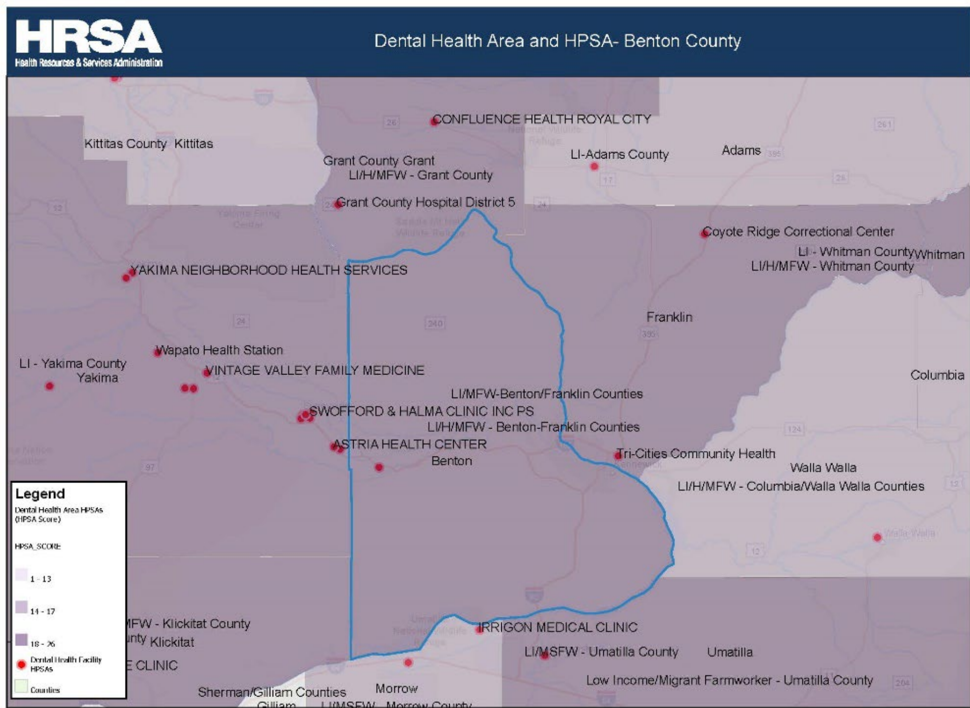
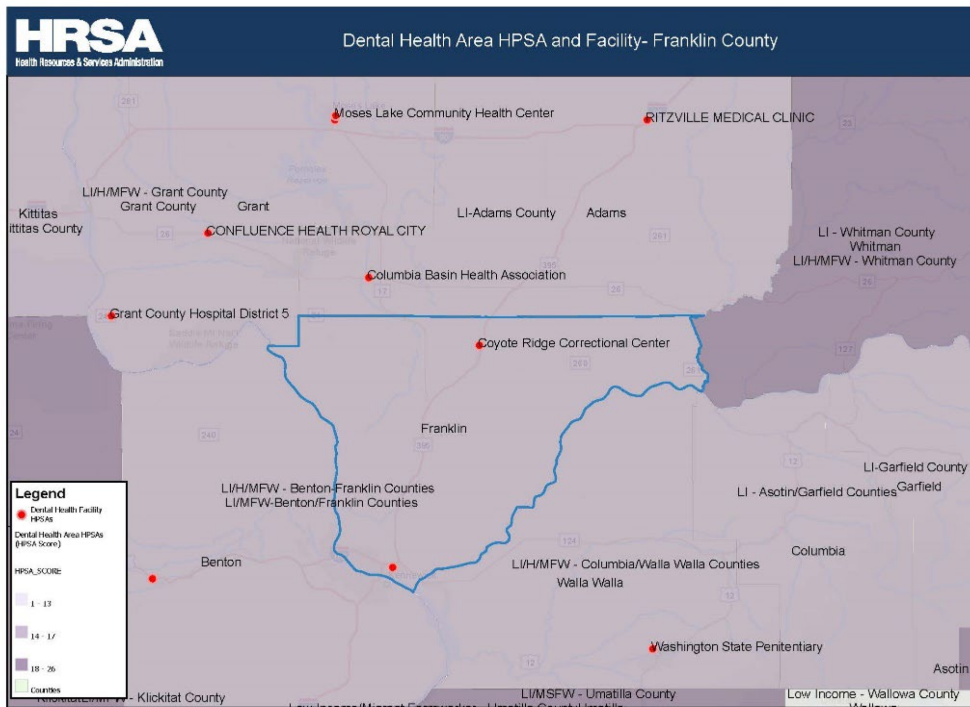
Benton
Tri-Cities Community Health
Walla Walla County
Walla Walla
CF-Washington State Penitentiary
Asotin
data.HRSA.gov


HRSA
Health Resources & Services Administration
Dental Health Area and HPSA- Benton County
CONFLUENCE HEALTH ROYAL CITY
Kittitas County Kittitas
Grant County Grant
LI/H/MFW - Grant County
LI-Adams County
Adams
Grant County Hospital District 5
Coyote Ridge Correctional Center
LI - Whitman County
Whitman
LI/H/MFW - Whitman County
YAKIMA NEIGHBORHOOD HEALTH SERVICES
Franklin
Wapato Health Station
LI - Yakima County
Yakima
VINTAGE VALLEY FAMILY MEDICINE
Columbia
LI/MFW-Benton/Franklin Counties
SWOFFORD & HALMA CLINIC INC PS
LI/H/MFW - Benton-Franklin Counties
ASTRIA HEALTH CENTER
Benton
Tri-Cities Community Health
Walla Walla
LI/H/MFW - Columbia/Walla Walla Counties
Legend
FW - Klickitat County
Klickitat
IRRIGON MEDICAL CLINIC
LI/MSFW - Umatilla County
Umatilla
E CLINIC
Sherman/Gilliam Counties
Morrow
Low Income/Migrant Farmworker - Umatilla County
data.HRSA.gov


HRSA
Health Resources & Services Administration
Dental Health Area HPSA and Facility- Franklin County
Moses Lake Community Health Center
RITZVILLE MEDICAL CLINIC
LI/H/MFW - Grant County
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LI-Adams County
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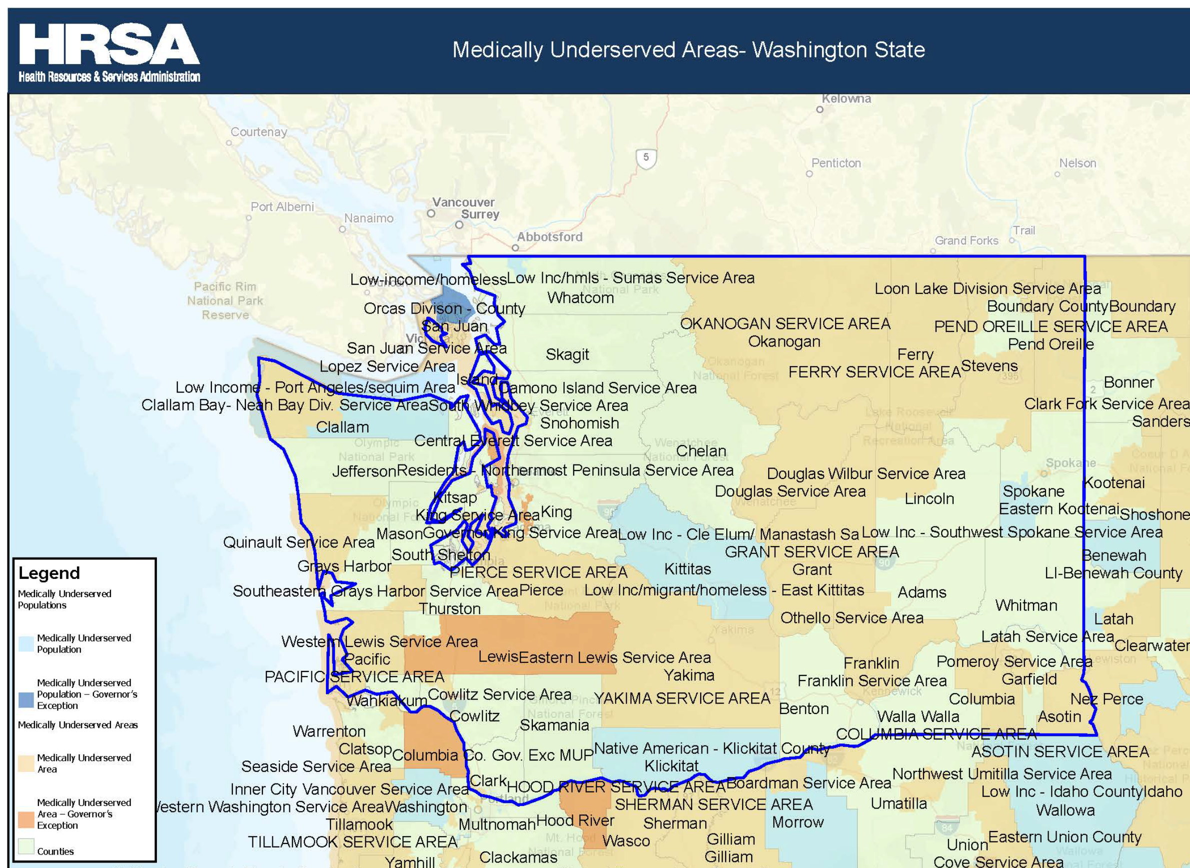
CONFLUENCE HEALTH ROYAL CITY
LI - Whitman County
Whitman
LI/H/MFW - Whitman County
Columbia Basin Health Association
Grant County Hospital District 5
Coyote Ridge Correctional Center
Franklin
LI-Garfield County
Garfield
LI - Asotin/Garfield Counties
Legend
LI/H/MFW - Benton-Franklin Counties
LI/MFW-Benton/Franklin Counties
Columbia
Benton
LI/H/MFW - Columbia/Walla Walla Counties
Walla Walla
Washington State Penitentiary
Asotin
- Klickitat County
LI/MSFW - Umatilla County
Low Income - Wallowa County
data.HRSA.gov

MEDICALLY UNDERSERVED AREA/ MEDICAL PROFESSIONAL SHORTAGE AREA

Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs) are defined by the Federal Government to include areas or populations that demonstrate a shortage of health care services. This designation process was originally established to assist the government in allocating the Community Health Center Fund to the areas of greatest need. MUAs are identified by calculating a composite index of need indicators compiled and with national averages to determine an area's level of medical "under service." MUPs are identified based on documentation of unusual local conditions that result in access barriers to medical services. MUAs and MUPs are permanently set and no renewal process is necessary. The following map depicts Franklin County as a MUA. Benton County and Franklin County are not identified as having MUPs.



Appendix 2: Community Input

INTRODUCTION

Listening to and engaging with the people who live and work in the community is a crucial component of the CHNA, as these individuals have firsthand knowledge of the needs and strengths of the community. The Benton-Franklin CHNA Collaborative conducted 21 interviews with working partners and community collaborators (partners), including 33 participants. Partners are defined as people who are invested in the well-being of the community and have first-hand knowledge of community needs and strengths. They also conducted 10 listening sessions with 67 community members. The goal of the interviews and listening sessions was to identify what needs are currently not being met in the community and what assets could be leveraged to address these needs.

METHODOLOGY

Selection

The Benton-Franklin CHNA Collaborative completed 10 listening sessions that included a total of 67 participants. The sessions took place between March 30 and May 26, 2022.

Table_Apx 1: Community Input

Community Input Type and Population	Location of Session	Date	Language
Listening session with older adults	Senior Life Resources/ Meal on Wheels	5/11/2022	English
Listening session with college students	Virtual	5/4/2022	English
Listening session with youth experiencing homelessness	Virtual with My Friends' Place	4/6/2022	English
Listening session with men experiencing homelessness	Tri-City Union Gospel Mission	3/30/2022	English
Listening session with Spanish-speaking men experiencing homelessness	Tri-City Union Gospel Mission	3/30/2022	Spanish
Listening session with women experiencing homelessness	Women's Shelter of the Tri-City Union Gospel Mission	3/30/2022	English
Listening session with veterans	Virtual	5/5/2022	English
Listening session with people whose family members are or were living with mental illness and SUD as well as people living with mental illness	Virtual with NAMI	5/26/2022	English
Listening session with parents of students in the Migrant Program	Kennewick School District Admin Building	5/12/2022	Spanish
Listening session with parents of children and adults with developmental disabilities	The Arc of Tri-Cities	5/19/2022	English

The collaborative conducted 21 partner interviews including 33 participants overall between March and April 2022. Partners were selected based on their knowledge of the community and engagement in work that directly serves people experiencing health disparities and social inequities. The Benton-Franklin CHNA Collaborative aimed to engage partners from social service agencies, health care, education, housing, and government, among others, to ensure a wide range of perspectives.

Table_Apx 2. Key Community Partner Participants

#	Organization	Name	Title	Sector
1	Arc of Tri-Cities	Donna Tracy	Program Manager	Intellectual and developmental disabilities
	Arc of Tri-Cities	Melissa Brooks, RN	Parent to Parent Coordinator	
2	Benton County Department of Human Services	Kyle Sullivan	Manager	Developmental disabilities, community resources, emergency services, housing, veteran's resources
3	Boys and Girls Clubs of Benton and Franklin Counties	Brian Ace	Executive Director	Education, preschool, childcare
4	Columbia Basin College	Dr. Rebekah Woods, JD, PhD	President	Education, college, health care workforce development
	Columbia Basin College	Douglas Hughes, MAE-CI, CSFA, CST, CRCST	Dean: School of Health Sciences	
5	Community Health Plan of Washington City of Pasco	Blanche Barajas	Outreach Specialist Mayor	Health insurance City government
	Pasco Fire Department/ EMS	Ben Shearer	Community Risk Reduction Specialist	Emergency services
6	Family Learning Center	Teresa Roosendaal	Executive Director	Education, ESL, refugee services
7	Greater Columbia Behavioral Health Youth Suicide Prevention Coalition	Cameron Fordmeir	Regional Administrator for the Substance Use Disorder Recovery Navigator Program Chair	Mental health, substance use/misuse
8	HPMC Occupational Medical Services	Karen Phillips, MD	Site Occupational Medical Director	Occupational medicine, environmental safety, Hanford workers
	HPMC Occupational Medical Services	Audrey Wright	Health Education Specialist	

9	Kennewick Police Department	Chris Guerrero	Kennewick Police Chief	Law enforcement, emergency services
	Kennewick School District	Brian Leavitt	K-12 Student Services Director	
	Kennewick School District	Alyssa St. Hilaire	Director of Federal Programs	
	Kennewick School District	Traci Pierce	Superintendent	
10	Kennewick School District	Robyn Chastain	Executive Director, Communications and Public Relations	Education
11	Kiona-Benton City School District	Pete Peterson	Superintendent	Education
	Lourdes Health	Joan White-Wagoner	CEO	
12	Trios Health	John Solheim	CEO	Health care
13	North Franklin School District	Jim Jacobs	Superintendent	Education
	Prosser Memorial Health	Craig Marks	CEO	
14	Prosser Memorial Health	Kristi Mellema	Chief Safety Officer	Health care
15	Senior Life Resources Northwest	Grant Baynes	Executive Director	Senior supportive care services, older adults
16	Tri-Cities Hispanic Chamber of Commerce Heritage University	Martin Valadez	Executive Director Regional Director Tri-Cities Campus	Commerce, Latino/a community Education, university
	Tri-City Development Council (TRIDEC)	Karl Dye	CEO	
17	Visit Tri-Cities	Michael Novakovich	CEO	Economic development, business, tourism
18	Tri-City Union Gospel Mission	Susan Campbell, RN	Tri-City Union Gospel Mission Volunteer	Homelessness
	Two Rivers Health District, Kennewick Public Hospital District	Gary Long	President	
19	Two Rivers Health District, Kennewick Public Hospital District	Wanda Briggs	Commissioner	Health care
	United Way of Benton and Franklin Counties	Dr. LoAnn Ayers	President and CEO	
20	United Way of Benton and Franklin Counties	Paul Klein	Director of Community Impact	Community resources, food security, education
21	Yakima Valley Farm Workers Clinics (locally known as Miramar)	Micheal Young	Vice President of Operations East	Community health center, health care

Facilitation Guides

For the listening sessions, participants were asked an icebreaker and three questions (see Listening Session Questions for the full list of questions):

- Community members' definitions of health and well-being
- The community needs
- The community strengths

For the partner interviews, Providence developed a facilitation guide that was used across all hospitals completing their 2022 CHNAs (see Partner Interview Questions for the full list of questions):

- The community served by the partner's organization
- The community strengths
- Prioritization of unmet health related needs in the community, including social determinants of health
- The COVID-19 pandemic's effects on community needs
- Suggestions for how to leverage community strengths to address community needs
- Successful community health initiatives and programs
- Opportunities for collaboration between organizations

Training

The facilitation guides provided instructions on how to conduct a partner interview and listening session, including basic language on framing the purpose of the sessions. Facilitators participated in trainings on how to successfully facilitate a partner interview and listening session and were provided question guides.

Data Collection

Partner interviews were conducted virtually and recorded with the participant's permission. Two note takers documented the listening session conversations.

Analysis

Qualitative data analysis was conducted by Providence using Atlas.ti, a qualitative data analysis software. The data were coded into themes, which allows the grouping of similar ideas across the interviews, while preserving the individual voice.

The recorded interviews were sent to a third party for transcription. The analyst listened to all audio files to ensure accurate transcription. The partner names were removed from the files and assigned a number to reduce the potential for coding bias. The files were imported into Atlas.ti. The analyst read through the notes and developed a preliminary list of codes, or common topics that were mentioned multiple times. These codes represent themes from the dataset and help organize the notes into smaller pieces of information that can be rearranged to tell a story. The analyst developed a definition for each code which explained what information would be included in that code. The analyst coded eight domains relating to the topics of the questions: 1) name, title, and organization of partner, 2) population served by organization, 3) greatest community strength and opportunities to leverage these strengths 4)

unmet health-related needs, 5) disproportionately affected population, 6) effects of COVID-19, 7) successful programs and initiatives, and 8) opportunities to work together.

The analyst then coded the information line by line. All information was coded, and new codes were created as necessary. All quotations, or other discrete information from the notes, were coded with a domain and a theme. Codes were then refined to better represent the information. Codes with only one or two quotations were coded as "other," and similar codes were groups together into the same category. The analyst reviewed the code definitions and revised as necessary to best represent the information included in the code.

The analyst determined the frequency each code was applied to the dataset, highlighting which codes were mentioned most frequently. The analyst used the query tool and the co-occurrence table to better understand which codes were used frequently together. For example, the code "food insecurity" can occur often with the code "obesity." Codes for unmet health-related needs were cross-referenced with the domains to better understand the populations most affected by a certain unmet health-related need. The analyst documented patterns from the dataset related to the frequency of codes and codes that were typically used together.

This process was repeated for the listening sessions, although rather than recordings, notes were used. The analyst coded three domains related to the topics of the questions: 1) vision, 2) needs, and 3) strengths.

FINDINGS FROM COMMUNITY LISTENING SESSIONS

Vision of a Health Community

Listening session participants were asked to share their vision of a health community. The following themes emerged:

- **Community engagement and connection:** In a healthy community there is a sense of engagement and willingness to work together to help one another. People are working together towards common goals, having meaningful conversations, and volunteering. They work to build community and put in the effort to care for one another, including keeping one another safe from COVID-19.
- **Easy access to health care, including mental health services, for everyone**: Community members shared that in a healthy community everyone has access to health care services, including mental health care. No one is turned away and people are treated with compassion. They shared people should be able to get the care they need in a timely manner and care should be patient centered.
- **Safety**: Many community members spoke to the importance of feeling safe in their community. Part of feeling safe is addressing crime and substance use on the streets. Some members also thought having a good police presence indicates a healthy community.
- **Diversity, inclusion, and respect**: Community members spoke to the importance of all people being accepted and having a united community. They shared that a healthy community is diverse and welcoming of people. Specifically people with disabilities are able to engage meaningfully and safely in the community.

- **Opportunities for recreation and a healthy lifestyle**: Community members shared people should have opportunities for recreation and a physically, spiritually, and emotionally healthy lifestyle. They can exercise and eat healthy food, as well as care for their spirituality. Their physical environment, including the water and air, also promotes health.
- **Economic security, including affordable housing and employment:** In a healthy community everyone has access to affordable housing, employment opportunities, and education.

Community Needs

High priority community needs identified from listening sessions

- **Mental health:** Mental health was the most frequently discussed need by community members. Their primary concern was how challenging it can be to find a mental health provider accepting new patients and covered by one's insurance. Long wait times, potentially caused by staffing shortages, means many people have unmet mental health needs. There is also a need for improved services for people in crisis, such as mobile outreach—a service which has been discontinued. The following populations were identified as having unmet needs:
    - Veterans: There are a lack of local providers who take VA patients. It can be challenging for veterans to get mental health services until in crisis.
    - Spanish-speaking people: There is a need for more mental health services in Spanish, including group therapy in Spanish.
    - Young people: It can be very challenging for young people to access mental health appointments. There is a lack of inpatient facilities for young people, meaning they often have to travel to other parts of the state far from their families. Participants spoke to the importance of more screening for mental health needs and teaching coping skills in schools.
    - Older adults: To address social isolation, there is a need for more prosocial activities for older adults. It is also important the community foster opportunities to demonstrate that older adults matter and belong.
- **Homelessness and housing instability:** Participants shared housing is expensive and there is a lack of affordable and low-income housing. Applying to rent an apartment is time intensive and requires resources. Participants noted additional challenges for the following populations:
    - Young people: Young people often need a cosigner to rent an apartment, which is challenging for those without support. There is a need for more resources for young people looking for housing.
    - People with developmental disabilities: There is a need for more independent housing for people with developmental disabilities. It is currently a crisis-driven housing system.
    - Older adults: To remain in their homes, older adults often need support, including help with upkeep and safety checks. The rising cost of housing can be challenging for older adults, noting a need for discounts.
- **Access to health care services:** Participants were particularly concerned about challenges accessing timely and affordable primary and specialty care because of long wait times and

provider turnover. Patients with Medicaid or those uninsured have fewer options for care. Everyone should have access to health care insurance. They discussed the need for more culturally responsive health care services, and providers with empathy for patients' situations. They shared there are specific challenges in accessing responsive and timely care for the following groups:

  - Young people, including those estranged from guardians, experiencing houselessness, and/or identifying as LGBTQIA+: Young people estranged from a guardian cannot access crucial health care services due to lack of parental consent. There is a need for providers to be more aware of the "Mature Minor" law. Young people, particularly those experiencing homelessness or identifying as LGBTQIA+, spoke to not always receiving respectful care and feeling judged by providers. There is a need for LGBTQIA+ specific health resources, including Hormone Replacement Therapy, and for providers to be better educated on how to provide respectful and competent care to this group.
  - People with developmental disabilities: Participants spoke to the need for more local providers with training in treating people with developmental disabilities. There is a need for more accommodations at hospitals and healthcare facilities to support these families.
  - Veterans: There is a need for improved continuity of care for veterans being discharged from the VA. The nearest permanent VA medical facilities are in Walla Walla, Yakima, and Spokane.
- **Substance use/misuse:** Participants were particularly concerned about the lack of detox services in the community, noting the need for a detox center locally. They were also concerned about their perception of increased substance use/misuse by people on the street and living unhoused.

Medium priority community needs identified from listening sessions

- **Community resources:** Participants shared there needs to be more communication about available programs and resources in the community, through a variety of channels. They mentioned the importance of not only sharing information online but through additional methods. This may require more intentional outreach.
- **Safety:** Community members spoke to concerns about an increase in crime and concerns about safety. In particular, they were worried about theft, people carrying weapons close to schools, substance use in public, and gangs. They noted wanting to see faster response times from first responders and some participants shared wanting to see better police engagement in the community.
- **Transportation:** Participants shared transportation can be especially challenging for older adults and people with disabilities. They shared the current process for accessing transportation services is invasive and time intensive, with long wait times. They noted transportation is a barrier to getting to health care appointments and other resources. They shared wanting to see free bus passes and transportation services that do not require long applications.

- **Economic security, including job training and educational opportunities:** Participants discussed wanting more investment in educational opportunities for adults, as well as college resources for high school students. They noted a need for job training, particularly for Spanish-speaking adults, and more temporary job placement for veterans being discharged.

While less frequently discussed, participants also talked about needs related to **parenting and family support**, including affordable childcare and before/after school care, as well as help purchasing necessities for children, like diapers. Participants also discussed **racism, discrimination, and lack of inclusion.** Participants shared they experience racism when seeking job opportunities and discrimination contributed to people being turned away from care. They want to see more inclusion for people with developmental disabilities and marginalized groups, including people experiencing homelessness.

Community Assets

The following table includes programs, initiatives, or other resources that participants noted are working well for them.

Area of Need	**Program, Initiative, or Other Resource**
Access to health care	Grace Clinic
Community resources and information	2-1-1 Department of Social & Health Services iMPACT! Compassion Center JustServe Local churches providing food, clothing, and other resources
Disability services and inclusion	Benton Franklin Parent Coalition Children's Developmental Center Down Syndrome Association of the Mid-Columbia, particularly playdates for all ages The Arc of Tri-Cities, particularly the Spanish program for parents and resource list on website Special Olympics
Domestic violence, assault, and trafficking	Mirror Ministries Support, Advocacy & Resource Center (SARC)
Education	Migrant Education Program
Economic	Goodwill Industries employment services Grace Kitchen WorkSource
Food security	Food banks Meals on Wheels

Housing and homelessness	Housing Resource Center Safe Harbor's My Friends' Place Tri-City Union Gospel Mission
LGBTQIA+ resources	The Q Card Project
Mental health	Clubhouse International Mental Health Court Parents and Children Together (PACT) Practice the Pause program
Recreation	Fitness center and walking paths at the Columbia Basin College Parks and green spaces
Substance use/misuse	Oxford House Tri-Cities—Transitional Housing
Transportation	Dial-a-Ride Free public transportation and bus passes
Veterans	Columbia Basin Veterans Center Benton County Veterans Therapeutic Court Sport therapy programs and recreational therapy programs for veterans (social situation with free activities)

FINDINGS FROM PARTNER INTERVIEWS

Community Strengths

The interviewer asked partners to share one of the strengths they see in the community and discuss how we can leverage these community strengths to address community needs. This is an important question because all communities have strengths. While a CHNA is primarily used to identify gaps in services and challenges, we also want to ensure that we highlight and leverage the community strengths that already exist. The following strengths emerged as themes:

Community engagement and willingness to help

Partners identified the greatest strength of Benton and Franklin Counties as the community engagement and people's willingness to show up to help one another. They shared that people care for one another, support one another, welcome new folks to the community, and volunteer to meet the needs of others. People care deeply about the community and many people have remained in the community for many years and are giving back. For example, at the start of COVID-19, community members donated soap and cleaning supplies to health care facilities. Another example is the active, grassroots network of parents coming together to help children with developmental disabilities. The passage of the one-tenth of 1% sales tax for behavioral health needs demonstrates the community's commitment to ensuring people can access the services needed.

> *"We have a community that cares and wants to improve the conditions and the lives of the children, youth, and their families in our community. I see a lot of things, a lot of great things going on. This is not a community that stands by and watches passively, this is a community that rolls up its sleeves and gets to work."—Community Partner*
>
> *"It's a community that rises up to help one another."—Community Partner*

To leverage this strength, partners recommended reaching out to community members to share what the community needs are and how they can get involved in solutions. Another example is to create a model that ensures volunteers provide support where it is needed most to create collective impact. This would involve community agencies working together to identify how to leverage volunteers to make the greatest impact.

> *"The biggest asset anybody have (sic) isn't money, it's their time. How they could get engaged with different things would be huge, because that's why it's called a community and people getting involved in things."—Community Partner*

A spirit of collaboration and partnership

Partners spoke to a strong spirit of collaboration and partnership in Benton and Franklin Counties. There is a lot of commitment to working together to make meaningful change and working towards shared goals. They shared examples of collaborations between law enforcement agencies, nonprofits, faith-based organizations, health care, government, emergency response teams, and community members. The COVID-19 pandemic has been an example of organizations coming together to respond to a crisis.

> *"I think the willingness to collaborate and to really talk about what's going on in the community, that is a strength of this community, but I see it in the nature of my job in talking to a lot of people. I see it over and over again that the will is there, but there are often gaps in communication. Even though people are really trying, it's not for lack of trying or for a lack of goodwill, but people don't know what other people are doing or other organizations are doing."—Community Partner*

Partners emphasized this strength can be leveraged to align priorities and goals between organizations, creating shared efforts and avoiding territorialism. Partners recommended leveraging this strength by focusing on local organizations to meet community needs, rather than outside sources. They also recommended bringing in community members to participate in collaboratives and continuing to create opportunities for more communication. This communication can help identify available capacity to address challenges and services that can meet needs.

> *"I'll start by saying I think the greatest strength in the Tri-Cities is the collaborative nature of all the different entities that put their specific agendas aside and they absolutely want to work together with partners to do what's best for the community as a whole."—Community Partner*

Strong network of community organizations to meet needs

Partners shared there are many local organizations to meet people's health and social determinant of health needs. There are multiple hospitals, clinics, urgent care centers, and specialists in the community to give patients options. There are strong school districts which are connected to many of the families and serve as a trusted partner. The Hanford site employs many people.

To leverage this network of organizations partners suggest facilitating more coordinated responses to ensure they are not operating in silos. They also suggested more communication between health care systems and collaborating on creative ways to recruit health care professionals to the community. The schools and many community-based organizations have trust built with community members and can

help share information, particularly during challenging times like the COVID-19 pandemic. Services can also be co-located at schools which can serve as a trusted site for families.

Diversity of cultures and community knowledge

Partners shared the people of Benton and Franklin Counties are a strength. There are many cultures represented in the communities and opportunities to build relationships with people of different backgrounds. This strength can be leveraged by ensuring community-building events celebrate the diversity in the community. In conversations about how to address needs, community members affected by those needs should be included in the decision making.

> *"Are we paying attention to those community events that can highlight some of the diversity in our community? Are there such things? Very few. Celebrate the different cultures."—Community Partner*

High Priority Unmet Health-Related Needs

Partners were asked to identify their top five health-related needs in the community. Four needs were prioritized by most partners and with high priority. Four additional needs were categorized as medium priority. The effects of the COVID-19 pandemic will be woven throughout the following sections on health-related needs.

Partners were most concerned about the following health-related needs:

1. Mental health
2. Substance use/misuse
3. Access to health care services
4. Homelessness and housing instability

Mental health

Mental health was overwhelmingly identified as the most pressing community need. Partners frequently spoke to mental health as a foundational need connected to many other needs and important for well-being. They noted mental health needs to be addressed in conjunction with substance use/misuse challenges. They also see mental health challenges as connected to community violence, with anger and stress manifesting in the form of violence. Racism and discrimination also affect people's mental health and feeling of belonging.

> *"How are we making people know and understand that they are welcome here that this is a place that wants them to be part of the community and that cares about them?"—Community Stakeholder*

Community partners spoke to the following needs related to mental health services:

- **More mental health treatment services:** This includes mental health counselors and facilities at all clinical levels. They noted it can be challenging to find providers locally.

“Of course, mental health is on everybody's mind. Just isn't enough [services] available.”—Community Stakeholder

- **Improved crisis services:** Partners shared crisis response is often overwhelmed. They would like more crisis response professionals who can go to schools or other locations in the community when there is a crisis.
- **Pediatric inpatient services:** There is a need for more pediatric psychiatry facilities and inpatient services.
- **A focus on early identification and early intervention**: Partners shared they want to see a new model of responding to mental health challenges that focuses on early identification and intervention of needs in response to early signs of emotional and mental health challenges.

“We just don't seem to have the resources as a nation and as a community to address mental health, both in its most tragic outcomes, meaning those that really need to find some sort of residency to help deal with that, but I think, also, in trying to understand the mental health precursors. How someone may start on this end of the spectrum.”—Community Stakeholder

Contributing to the community needs are system challenges and access barriers including the following:

- **Workforce challenges:** Recruiting and retaining qualified mental health professionals is difficult. The challenging nature of the work and low wages for entry level roles contribute to burnout. This work can be draining, particularly without good support and supervision. The testing and supervision requirements for licensure can also be a barrier for professionals. There is a need to build up the workforce by opening up pathways for existing health care professionals to become mental health professionals. Partners also suggested mental health organizations work together to meet community needs by each providing one piece of the needed services, rather than competing to provide the same services and recruit the same people.

“You're working with the most vulnerable people, situations, and scenarios, and when you help somebody they go off living productive lives and you don't hear from them. Individuals that don't have a good outcome, whether it's perceived or actual, you'll hear a lot about it. When you do good it's not really emphasized unless you have good leadership who reminds you and does those supervisions and debriefings and remind you of the purpose and why you're there. Otherwise, you're just hearing the bad all day long and you're seeing the bad and it's reinforced. It can be draining and there can be high burnout in that field.” – Community stakeholder

- **Transportation**: Transportation to services can be especially difficult for people living in more rural areas, including North Franklin County. Other areas, such as Benton City have no mental health services locally. Within the Tri-Cities, people may have to travel quite a distance between different services and appointments, meaning people may have to prioritize some services over others.

- **Language and culture:** There are limited mental health services in Spanish, Russian, and other primary languages spoken in the area.

Partners names the following populations as having additional mental health needs:

- **Young people**: Mental health needs for young people have only increased due to the COVID-19 pandemic. Partners noted seeing an increase in anxiety, depression, and social isolation. They were also concerned about youth suicide. They were concerned about bullying and social media negatively affecting youth mental health. They noted seeing an increase in behavioral issues with students, potentially connected to a lack of stability during the pandemic.
- **Young people in foster care**: Accessing quality mental health treatment and having treatment options can be more challenging for young people in foster care.
- **People with developmental disabilities:** Partners shared people with developmental disabilities have few options for accessing behavior support specific to their needs locally, noting a need to provide more intentional support for this group and their caregivers. Some of these support needs include building social skills, support for families in crisis, and providers with knowledge and training to support people with developmental disabilities. Washington State mandates insurance cover behavioral services for individuals with autism, but it is challenging to find providers. There is a need for more provider education and improved disability inclusion.

  "[People with developmental disabilities] require more of a behavior mechanisms and new structure, we just don't have the services here in the Tri-Cities."—Community Partner

- **Older adults:** Ensuring older adults feel cared for and valued in the community is important. There is a need for improved social connections for older adults experiencing social isolation.
- **Hanford workforce:** Accessing mental health services may be challenging for some of the workforce at Hanford.

Partners spoke to the COVID-19 pandemic as exacerbating mental health needs for everyone and contributing to a lot of stress for families, and a lack of connection for many people, including older adults. While there has been more stress for people, it has been more socially acceptable to talk about that stress.

> *"People talking more about their stress because it was something that more people felt comfortable because more people were openly discussing it. It might have always been something but now, it was in your face and okay to talk about. The mental health really took an upswing in need and verbalized need during the pandemic."—Community Partner*

The pandemic has contributed to a lack of connection for many people, including older adults, making it more difficult for people to feel connected and build relationships.

> *"If I was looking for a glaring gap, mental health services for students, parents, families, the community as a whole, that's probably our number one issue right now and along with that, almost those clinical-level mental health services but also just counseling in general."—Community Partner*

The pandemic has negatively affected the mental health of young people. A lack of stability and access to caring adults for some children during the pandemic contributed to increased behavioral needs. Partners spoke to schools experiencing challenges with students re-adjusting to being in person and dealing with the resulting mental health and behavioral needs.

> *"The youth that most needed stability during the last two years and access to caring adults to advocate for them, probably had the least access as we dealt with isolation in school shutdown. I think that's been for sure negatively impact due to COVID."—Community Partner*

Partners have seen increased anxiety in young people and exacerbated mental health needs for school-age children, particularly in areas where there may not be the resources in schools to address the needs.

> *"I honestly believe in and can attest with my job and the kids we serve and staff we serve, because of COVID, there's been an increase in anxiety. There's been a clear shift in need from physical to mental health and maybe seeking some stability around that becomes quite a priority."—Community Partner*

> *"I think what it has done is it's exacerbated the need for mental health, especially among our school-aged kids, and we do not have the same level of resources given our rural atmosphere that some of the other school districts may have access to. There's no doubt that the pandemic has exacerbated that, though, in a big way."—Community Partner*

Health care providers also experienced increased stress and mental health needs during the pandemic. Some of the mental health workforce moved to telehealth positions where they can be compensated at a higher rate.

Telehealth services improved access for some people but created challenges for others, particularly people with a developmental disability or people lacking access to or comfort with technology.

Substance use/misuse

Partners highly prioritized substance use/misuse because of how it affects whole families and communities. They shared substance use/misuse is a huge issue in the community. They emphasized the importance of addressing mental health and substance use/misuse together, as these issues can be co-occurring.

> *"[A] substance use disorder always affects the children. It creates a feeling of uncertainty and unsafety in the home, there's a desire to find stability elsewhere. There also comes with that a sense of dependence and being able to take care of the parents and others in the home."—Community Partner*

They shared there are not enough substance use disorder (SUD) treatment services in the community, although there are many great efforts underway, including the Recovery Center, to meet the need. Partners were especially excited about these efforts although shared the following needs:

- **A detox center for withdrawal management:** Partners emphasized how critical it is to have a detox center within the community. Without these services, people who need medically

supervised detox either end up in jail or have to seek services in Yakima or Spokane. Traveling outside the area is challenging for the individual and their support system. Patients ready for treatment need to have immediate access to an assessment to ensure they have timely access to treatment when they are engaged.

- **Inpatient SUD treatment services**: The Recovery Center should help address this need.

> *"It's I think a shame, a crime and shame that you have somebody in the community as big as ours, that if they need inpatient drug or alcohol treatment, that they can't have access to that locally, that they have to go out of the community for that. That will be something that we address with [the recovery center]."—Community Partner*

Addressing the substance use/misuse needs in the community is a huge challenge without the appropriate treatment options locally. They shared there needs to be a unified approach with warm handoffs between services.

> *"The mental health and substance use disorders issues that we're dealing with right now are huge and I strongly believe we're not going to rest our way out of this problem."—Community Partner*

There is insufficient behavioral health workforce to meet the need, potentially due to low wages for people without advanced degrees and burnout in the field. There can also be high burnout in the field considering negative outcomes are often most emphasized. Good support and quality supervision are crucial to supporting this workforce.

> *"You're working with the most vulnerable people, situations, and scenarios, and when you help somebody they go off living productive lives and you don't hear from them. Individuals that don't have a good outcome, whether it's perceived or actual, you'll hear a lot about it. When you do good it's not really emphasized unless you have good leadership who reminds you and does those supervisions and debriefings and remind you of the purpose and why you're there. Otherwise, you're just hearing the bad all day long and you're seeing the bad and it's reinforced. It can be draining and there can be high burnout in that field." – Community Partner*

Partners identified the following groups that may not receive the support needed in accessing support for substance use/misuse issues:

- **Young people:** Partners were concerned about substance use/misuse starting in middle and high school.
- **Older adults:** Their needs may be overlooked or ignored because of their age.
- **People experiencing homelessness:** Partners were concerned about substance use/misuse on the streets, potentially affecting community safety.

During the COVID-19 pandemic, partners have seen substance use/misuse increase for both adults and young people.

Access to health care services

Partners shared that while there are many health care services in the two counties, there is still a need for more primary care providers and specialists to reduce wait times. Partners report patients can wait months to see a primary care provider. People without one may be forced to use their ED for health care needs. Partners also reports it can be challenging finding enough primary care physicians for all the Hanford staff.

> *"Not having enough primary care providers in the area or having long waits for individuals who need basic healthcare needs. Then it would be also the transportation to where unfortunately there's some communities that wait to see a doctor until are actually in pain or they wait it out. Usually at that point, you may need to call an ambulance, the ER. — Community Partner*

There are also long wait times to see specialists, including for endocrinology, gastroenterology, oncology, etc. People travel from other areas to receive specialty care locally, which can increase demand. Partners report a desperate shortage of specialists, meaning patients wait three or four months to get an appointment and many specialists are overwhelmed with demand.

> *"Most specialty care just cannot wait three, four, or five months to get in, and that's where we end up a lot. We have patients who are able, that often go outside the community to larger markets like Seattle or Portland or Spokane, but it's often problematic there as well."—Community Partner*

In addition to more primary care providers and specialty providers, partners spoke to the following needs to improve access to care:

- **Improved training and recruitment:** Partners shared it can be challenging to recruit health care professionals from outside of the area, particularly with the high cost of housing. It is also important to ensure people within the community stay and provide services. Local training programs, like Columbia Basin College, are limited by a finite number of clinical placements. Training programs cannot grow without new practices or expanded hospitals. The COVID-19 vaccine mandate has also meant some providers have left.
- **Discharge planning and medication management:** Improved discharge planning to ensure patients can fill their prescriptions is important for all patients, but especially people experiencing homelessness.
- **Post-acute care:** For people needing a skilled nursing facility or hospice, there are also limited options in the community.
- **Health education, including family planning support:** Health education should be provided in a culturally sensitive way.

Access to preventive care is especially important for ensuring people receive timely and appropriate care, avoiding unnecessary calls to EMS or avoidable ED visits. Because of policies, EMS and the Fire Department are only reimbursed if they transport a patient to the hospital, but sometimes treating and not transporting is the best option. Another challenge is that EMS and the Fire Department have to bring

patients to the Emergency Department for jail booking clearance. This can be unnecessary from a medical perspective and potentially not the best use of resources. There is opportunity for better collaboration and policy change to address some of these systems.

> *"Trying to encourage our lawmakers, Congress, and legislation to think about those things that we need to redesign those systems to take care of people."—Community Partner*

The health care system can be challenging for people to navigate due to the following barriers:

- **Technology and health literacy:** Technology and online forms may be difficult for people to navigate if they lack a computer or comfort with technology. Technology can create additional barriers for older adults, people whose primary language is not English, and people with a disability. There is a need for more support for people experiencing barriers to care, rather than leaving people to figure it out on their own.

> *"I think the world of electronics is alienating a lot of people… I personally love it, but if you have a language barrier, a disability, your hearing, your vision, bottom line, it's not accessible to you."—Community Partner*

- **Transportation**: This was highlighted as a primary barrier for people, particularly if they live in a rural area or have mobility issues. Public transportation can be difficult for people needing to take multiple buses to get to appointments. Tri-Cities is very spread out, meaning patients may have to travel between different providers and appointments. Reliable transportation can be crucial for ensuring people with chronic conditions and people experiencing homelessness receive preventive and timely care.

> *"We're so spread out, nobody can just go one place and be served. You have to bounce all over the different appointments in three cities, and we don't have the transportation structure that I think other cities may have."—Community Partner*

- **Cost of care**: People with low incomes or lacking insurance may not be able to afford the cost of care.

> *"There's a broad population of people who, for whatever reason, don't have the ability to pay for their medical care and are not on some sort of state supplemental plan."—Community Partner*

- **Language**: Ensuring all materials are translated into Spanish, Russian, and other primary languages of patients is important for improving access.
- **Childcare**: A lack of childcare can make it more difficult for parents to go to their appointments.
- **Appointment times during work hours: T**here is a need for extended clinic hours and weekend hours to ensure people can see their provider without missing work. This is also relevant for Hanford site workers.

Partners highlighted the following populations as experiencing additional barriers to care:

- **People with developmental disabilities:** Care needs to be adapted to meet the needs of people with developmental disabilities. Partners suggested finding creative solutions to working with patients is important.

  "I think that's one thing too is our providers are pretty stretched in our community and so the ability to be creative tends to get diminished. I don't know if we just don't have enough providers."—Community Partner

- **Older adults:** Technology and transportation can be barriers to care for older adults and they may need support in navigating the health care system. Health care workers that provide home visits may be able to support discharge planning and ensure older adults are safe in their home.

  "[Older adults] either don't get on, or if they're able to get on Zoom somehow, they don't interact to the same degree with that. I think we've just got to broaden out our communication styles and simplify them for those groups that need that done for them."—Community Partner

- **Young people**: School have identified a need for improved home hygiene related to things like lice, bed bugs, etc. Accessing appointments with pediatricians is difficult.

  "As a parent, it's been really difficult even in my own personal life and then also having and seeing this echoed broadly in the community and hearing stories from our students, how difficult it is to get kids into the doctor, or to do so in a way that's timely or to get feedback about just the care that they're receiving because the clinics are so inundated."—Community Partner

- **The Latino/a community:** Partners were concerned about the Latino/a community having access to preventive care if patients lack a primary care provider and insurance. Due to social inequities and disinformation about the COVID-19 vaccine, the Latino/a community was disproportionately affected by COVID-19. This underscores the importance of building trust with this community.
- **People experiencing homelessness:** This population may need additional resources to support accessing care, including transportation resources.

Due to the COVID-19 pandemic, some people delayed preventive health care services or were not able to access the health care services they needed. As people return to care, there are long-wait times for appointments and delays, leading to unmet health needs. Some patients had surgeries delayed or canceled and others had medications lapse.

> *"I think this last year and particularly this year since January, we've seen a lot of unmet health things where, what, maybe a diabetic hadn't come in as regularly as they were because we couldn't get them in or they were scared to come out or they had just declined to get service during that time. The amount of unmet needs went up during COVID because*

so much of our healthcare capacity was directed and siloed toward COVID care."—Community Partner

Partners agreed telehealth improved access for some patients but is challenging for those without access to or comfort with technology. They shared it should not fully replace in-person care considering the importance of those face-to-face interactions. Families without internet access or technology were isolated at the start of the pandemic.

COVID-19 vaccine disinformation and the politicization of public health practices put additional strain on the health care system and providers. Partners emphasized the lessons learned about the importance of building trust with the community, particularly specific populations that have been historically marginalized. While health care providers are generally seen as experts, some experienced distrust by patients related to COVID-19 vaccine information.

"As a general rule, patients have a high respect for providers and nurses and medical staff and tend to look for them for expertise and direction, and I think that the pandemic, because of [vaccine disinformation and the politicizing of COVID], has really influenced patients into rejecting or questioning things that they would have typically just naturally accepted."—Community Partner

Positively, the pandemic created more opportunities for education and outreach with communities, and increased awareness of the role of health care and public health in the community.

"I guess it just goes back to my previous statement about awareness and let's say education. Because it's really more awareness and to get people to buy in and understand why public health and its role within healthcare, in general, is important to us."—Community Partner

Through vaccine outreach and engagement with Community Health Workers, partners learned the importance of providing vaccine clinics outside of work hours and ensuring they are offered at places where people already go, like grocery stores. Having bilingual folks working and being very consistent with timing helps build trust.

"Consistency, finding out what works for them, making it easy. How do you lower the barriers [to the COVID-19 vaccine]? How do you make it easier for them and comfortable for them?"—Community Partner

Partners also saw that providing isolation and quarantine space at local motels for people living unsheltered worked well.

Homelessness and housing instability

Partners prioritized homelessness and housing instability because of its connection to so many other needs and because of the importance of people first being stably housed before addressing their other needs.

"Yes, food in their stomach, those essential needs truly are essential because it starts there. It starts with a good night's sleep, it starts with being warm in the winter, it starts with having access to appropriate meals, and then the rest of that stuff can work itself out."—Community Partner

They described homelessness as a symptom of other issues, including mental health, substance use/misuse, access to health care, economic security, and more.

"I guess, circling back around to my main theme is that homelessness is a symptom. It's a symptom of issues that have occurred probably over time that we really need to keep focusing in my view on the upstream, which is mental health, substance use disorder, healthcare. Even financial planning when it comes to major medical needs because that's, healthcare is one of the big issues in bankruptcy, and bankruptcy then leading to loss of a home." – Community Partner

Partners shared homelessness and housing instability is growing and it includes people in a variety of living situations, including folks not just living unsheltered, but also those living in their cars or RVs, couch surfing, and moving frequently.

"We're seeing folks who are living out of their cars and not just the typical, what people associate homelessness with, someone living in a tent or living under an overpass type of scenario. We have people living in their cars, living in motor homes, moving from spot to spot."—Community Partner

This means people in different situations may need different levels of support and different types of services.

"When I looked at the homeless as a population, it truly is not a homogenous group, there are many reasons why people become homeless and the needs of the homeless as we addressed them, really we need strategies that meet their specific needs."—Community Partner

They spoke to needing more housing in general and more services including the following:

- **Homelessness services:** More hygiene services for students, care coordination and navigation for folks experiencing chronic homelessness, and more street-based care to meet folks where they are needed to improve the health and well-being of folks experiencing homelessness.
- **Low-barrier permanent supportive housing:** This type of housing with on-site services is particularly important for ensuring folks in recovery or with a substance use disorder remain stably housed. Partners emphasized the importance of taking a Housing First approach.

  "In Benton County, we need to develop permanent supportive housing options. It works. Again, it's an initial investment, but in the long run from a quality of life, from a humanistic standpoint, and from the people that don't care about that, they just care about where their taxpayer dollars goes, it saves taxpayer dollars in the end too, with these ancillary services."—Community Partner

- **Transitional housing:** Providing housing for 6-12 months with supportive staff will help people re-engage in the community and build skills to live independently.
- **Workforce housing**: There needs to be housing available for folks who are recruited for jobs in the community. A lack of affordable housing units in the community makes it challenging to attract workforce to the area and some workers find themselves living in RVs because they cannot find housing.

The high cost of housing and low housing stock have made finding affordable housing a challenge for many people in the community, both wanting to buy and rent homes. Partners were concerned about young people and young families being able to find an affordable home. The market is competitive and expensive, meaning young people are priced out of buying their first home and building equity.

> *"I sit there and I think when a young family, they're both working but not making a huge salary and they maybe have a kid or two, I don't know how they're going to be able to purchase a home or even in a lot of situations, rent. When we start talking about affordable housing, affordable for young families, but then again, we just simply don't have enough units for people that are at the poverty level too."—Community Partner*

People are willing to pay above fair market rent, meaning landlords are able to charge high prices for apartments. Partners are seeing landlords increase rent by $400 or $600 a month, burdening people and leading to spending tradeoffs. This high cost of rent also contributes to overcrowding as families double up in apartments.

> *"They have to spend too much money on their housing to be able to afford some of the other things that they need in life."—Community Partner*

They spoke to very low vacancy rates, leading to competition for rentals and increases in rental prices. This can make it more challenging for people with any criminal history or a poor credit score to find housing. While there are efforts to develop new housing locally, it tends to be for people with higher incomes and therefore, is not meeting the unmet need.

> *"Our vacancy rate in Benton and Franklin Counties is below 1%. There just aren't units to put [people] in."—Community Partner*

> *"I never thought that we'd be in this situation where our housing stock, availability, whatever you want to call it is in such bad shape."—Community Partner*

For people with low incomes, a behavioral health condition, or any negative rental history, finding affordable, stable housing can be more challenging. People's incomes have not increased at the same rate as the cost of housing, meaning those who work in seasonal roles may have more difficulty finding affordable, stable housing.

> *"I think the overarching concern we hear from people is affordable housing. If we're trying to attract the young workforce to our community, there's certainly challenges related to that. When we look at a lot of the hospitality workers, particularly the people that haven't worked their way into managerial roles, the incomes that they make, housing becomes a challenge."—Community Partner*

There are no skilled nursing facilities locally and older adults living on a fixed income may be more likely to be unstably housed. Families with children with special needs may also have difficulty finding housing that accommodates and meets their needs.

The COVID-19 eviction moratoriums benefited some renters, but also created frustration for landlords falling behind on their mortgage. There is a strong need for rental assistance for people unable to pay back the rent they owe.

Medium Priority Unmet Health-Related Needs

Four additional needs were often prioritized by partners:

5. Economic insecurity, education, and job skills
6. Affordable childcare and preschools
7. Food insecurity
8. Community safety

Economic insecurity, education, and job skills

Partners discussed the need for more financial stability for many families, ensuring there are living wage jobs, job skill trainings, and investments in education. Economic security is connected to a lot of other needs, including housing and access to other resources.

With the high cost of housing, families may spend a substantial portion of their income on rent, especially for seasonal and agricultural workers. To address these needs, partners advocated for the following:

- **More equitable funding of public education and support for higher education:** The way public education is currently funded contributes to the opportunity gap. Higher-income schools receive more funding than lower-incomes schools, which creates economic inequities later.
- **Increased job skill training, particularly for students in more rural districts:** There are fewer opportunities for high school students to access business internships, apprenticeships, etc. than there used to be. Transportation can be a barrier for some students.
- **Support for skilled work training**: Some high schools are cutting classes related to skilled work, such as metalworking and mechanics. Partners noted the importance of having programs to train plumbers, electricians, construction workers, etc. which are in demand.

> *"We need skilled workers. We don't need everyone to go to a four-year college, I'm sorry. We need plumbers, we need electricians, we need construction people and those are all really good-paying jobs."—Community Partner*

They emphasized the importance of supporting educational opportunities so that people can do work that is meaningful to them and something they feel good about accomplishing.

> *"I think it would be nice if we look at how do we help people evolve or improve the stability of that socio-economic situation over the course of their lives and, at a minimum, generationally."—Community Partner*

High inflation and challenges with workforce employment were identified as challenges for the local economy. Business owners are having difficulty filling positions, affecting their ability to meet demands and stay open.

Partners identified the following populations as being disproportionately affected by economic insecurity:

- **People with developmental disabilities and their caregivers:** Finding childcare for children with special needs is very challenging, meaning these parents are often unable to work full time jobs. This is especially difficult for single parents of a child with a developmental disability or other special need. There are also limited opportunities for people with developmental disabilities to develop job-related skills.

"Most kids with developmental disabilities are staying [in school] until 21 because the world looks pretty bleak for them in a lot of opportunities."—Community Partner

- **Seasonal workers:** Due to the nature of the work, seasonal workers may receive variable income throughout the year.
- **The Latino/a community:** Partners spoke to the importance of supporting the Latino/a community in accessing educational opportunities and addressing inequities in access to education. For some, there may be a lack of understanding about the return on investment for higher education.

"I don't think there's enough individuals from the Latino community that are going on to higher education. There's more and more… There's still so many people that don't go on and really educating them and their parents about the importance of higher education."—Community Partner

The COVID-19 pandemic affected businesses and workers, particularly in the service and hospitality industries. Some small businesses and restaurants closed when people were staying home, leading to workers in the service sector losing their jobs. Schools are also facing many challenges meeting the needs of their students and can benefit from additional resources.

Affordable childcare and preschools

Partners emphasized affordable and flexible childcare as crucial for stable families and a strong workforce. Without addressing this need, people will not be able to participate fully in the workforce and there will continue to be staffing challenges. Many employers are reporting that childcare is a factor in their difficulty recruiting workers.

"That's affordable childcare and preschools. It's having a dramatic effect on our workforce and our ability for meeting the needs of our clients because we just can't, we could hire 100 people today and still be short. It's that bad. I think a lot of it is because of that inability to have their kids look after in an affordable place. We don't get to use their talent."—Community Partner

Childcare is also crucial for allowing caregivers to access other services, including health care.

There is very little affordable childcare in the community and limited free preschool spots, meaning the cost is a barrier for many families. The Early Childhood Education and Assistance Program (ECEAP), or Washington's free pre-kindergarten program, gets full quickly.

> *"I've heard multiple times that it's almost impossible to find affordable childcare in this community."—Community Partner*

For families working non-traditional hours, finding flexible childcare can be very difficult. Some parents may only need childcare on certain days or specific hours, particularly if they work an early or late shift. It also needs to be easily accessible for people living in rural areas.

> *"Is childcare available for nontraditional work shifts? What does it look like if you work Tuesday, Wednesdays, and Thursdays, but not any other days? The way the model is structured, you have to pay for your slot. That becomes really problematic."—Community Partner*

For families with a child with a disability, there is very little childcare that can meet the child's needs. Even children eligible for benefits through the Developmental Disability Administration (DDA) experience challenge finding childcare providers with the capacity and knowledge to support the child. Children with a disability but who are unable to qualify for the DDA will have even more difficulty. This prevents parents from working and can be especially challenging for single parents who may have no choice but to care for their child instead of working. This puts families in very challenging positions where they are not able to meet their basic needs because the parent(s) cannot work without safe childcare.

The pandemic highlighted how important childcare is for keeping people staffed and for businesses being able to recruit and retain employees.

> *"Affordable childcare and preschools, just from a workforce development standpoint, this pandemic brought a lot of interesting things to the forefront and the care of children and the flexibility that we have to provide to our teams so that we can continue to keep them employed and doing the great work that they do, but also taking care of their families. This has really found itself on the map in a pretty significant way."—Community Partner*

While challenging before the COVID-19 pandemic, staffing for childcare centers only became more difficult. Some staff had to resign to care for their own children and there is generally high turnover.

> *"Oh, and whether it's pandemic-related or not, I couldn't tell you, but staffing for us has been a challenge, just like everybody. I haven't been able to find qualified [childcare] staff that'll stay the course and be there long enough to make a meaningful difference. It's a challenge."—Community Partner*

Childcare centers had to drastically reduce enrollment based on COVID-19 guidelines, meaning they could serve fewer children. Some centers changed how they provide services and are not returning to their pre-pandemic enrollment numbers.

Food insecurity

Many partners shared that the community is working to ensure people have access to food, although the food options may not always be the healthiest and programs may not address what is causing food insecurity. People may not be able to access these food resources if they lack transportation.

They shared that food pantries often provide non-perishable foods, which are often not as nutritional as fresh foods. School lunches provided by the districts may not always be the healthiest either. Cost may be a factor.

> *"Once again, because you're dealing with a lot of donated food especially non-perishables, it's not necessarily going to be the healthiest choice, and so I think there's real disconnect between healthy options for families and what is easily and readily available. I think that's problematic in the long run."—Community Partner*

Fresh and healthy foods can be challenging for families with low incomes to afford. Families new to the United States may not be familiar with reading the food labels and identifying healthy foods for their children. For example, families may assume a lot of the foods like breakfast cereals are healthy options, but they can have a lot of sugar.

> *"At Christmas time, a lot of schools think it's a good thing to send kids home with a box or a number of boxes of cereal to eat over Christmas break. If those kids didn't have that cereal, they think that that's going to promote their health. You know what? They're used to eating rice and beans or something equivalent to that for breakfast or rice and vegetables. I think that's a healthier choice than sugar cereal."—Community Partner*

Workers on the Hanford site have little access to food on-site besides what they bring.

The pandemic exacerbated food insecurity for many people. While there have been additional supports to provide food to families, partners noted there are often a lot of cars lined up waiting to receive food assistance at events, underscoring the need. Partners emphasized the importance of ensuring all families that need help are receiving it, since the need only seems to have worsened in the past few years.

> *"It's a challenge we face in our nation, we subsidize the least healthy food. It makes it very difficult to be able to afford healthy fruits, vegetables, appropriate proteins, so on so forth."—Community partner*

Community safety

Partners shared that while they do not think Benton and Franklin Counties overall are unsafe, they are concerned about increased community violence and neighborhoods where residents do not feel safe. This might contribute to people not feeling comfortable accessing parks or recreation, which affects chronic conditions, mental health, and overall wellness.

"I think I will actually say community violence, lack of feeling of safety. I want to be clear to articulate that I don't think this is a broad community issue. I do think they're isolated neighborhoods within our community where this is a real challenge and does not get the focus that it should based on who does or does not live in those neighborhoods."—Community Partner

In neighborhoods with higher crime rates, residents feel more insecurity. Not all neighborhoods get the same level of attention to ensure safety.

Partners spoke to seeing a large increase in gun violence in 2021. The increase in gun violence is measured by an increase in shots fired for a variety of reasons.

"When I talk about gun violence, I'm talking shots-fired calls, whether it was directed at somebody or shots-fired in the air that we responded to, so that whole gamut. We saw a huge increase in that, and to pin it down to something specific, it's happening nationwide. There's huge increase across the nation."—Community Partner

Gun violence needs to be addressed locally as a community, as well as a country.

"I personally think that as a country, we need to do something about gun violence."—Community Partner

Partners are also seeing people manifesting anger and stress into violence, potentially due to the effects of the pandemic.

"There just seems to be, again, I don't know if it's COVID related, but anger and stress that's manifesting itself into ways that we're seeing in the community that are unusual."—Community Partner

They emphasized that addressing community safety needs to be a collaboration between law enforcement and the community. This requires building relationships between law enforcement and the community and also having the resources to move people into safe situations if they are affecting public safety.

"Public safety isn't about police or fire doing something specific. It is that collaboration when somebody feels safe to leave their doors unlocked like we used to. All of that. It can't be done alone. We tell our folks, every contact matters. Every single contact, when you're dealing with somebody, you can make a difference, because the majority of the time, you're dealing with really good people who are having a really bad day."—Community Partner

Community Partner Identified Assets

Partners were asked to identify one or two community initiatives or programs that they believe are currently meeting community needs.

Table_Apx 3. Organizations and Initiatives Addressing Community Needs in Benton and Franklin Counties

Community Need	Community Organization/Initiative
Access to Health Care	• Benton Franklin Community Health Alliance: Brings together representation from various groups in the health care community to promote conversation and collective problem-solving. • Camp Trios for children with Type 1 diabetes • Columbia Basin Health Association • Community Health Worker/ Promotores programs: They have the ability to go into people's homes to understand their specific needs and situation and provide more in-depth case management. • Free vaccinations for children in schools • Grace Clinic: Provides free medical, dental, and mental health services to people without insurance. Many partners emphasized how crucial this clinic is for ensuring everyone has access to health care services. • Nurse-Family Partnership at the Health Department: Brings health care services to people who need it most, rather than expecting people to seek out or travel to services. It is a good example of a community-based intervention. • Tri-Cities Community Health: In partnership with the National Alliance for Hispanic Health, provides the Diabetes Prevention Program for Latino/a individuals in Pasco. • Yakima Farmworkers Clinic: Provides health care services to communities with barriers accessing health care services.
Behavioral Health	• One-tenth of one percent sales tax for mental health that passed in Benton and Franklin Counties: Invests in an inpatient and outpatient treatment program. • Benton Franklin Behavioral Health Advisory Committee: This committee is currently in progress and will make recommendations on programs or services that will be funded by the one-tenth of one percent sales tax for mental health. • The Recovery Coalition: Brings a lot of awareness to behavioral health needs in the community and current gaps in services. • Wraparound with Intensive Services (WISe) Program: Wraparound services to help children, youth, and their families with intensive mental health care. • The Recovery Center: The current efforts underway to establish a drug and alcohol treatment center with mental health services is seen as great progress to meet a dire need. • Comprehensive Healthcare: Embedded therapists in Kennewick School District provides on-site mental health support in schools. This ensures there is no need to wait for outside referrals and minimizes a lot of barriers to care.
Education	• Communities in Schools: Provides resources to families and students, building trust and support to help students be successful.

Food Insecurity	• Churches providing food • Meals on Wheels: Partnering with Pasco Fire so that they can provide food baskets or frozen meals if a family has an urgent need for food. During the pandemic Meals on Wheels has adapted to meet people's needs, providing drive-through pick-up options and more flexibility with combinations of hot and frozen meals. • Salvation Army Food Bank: Provides food distribution twice a week. • Second Harvest: Works to ensure food is distributed at community events and is easily accessible. Food distributions at schools are also helpful.
Health and Social Services	• Coalition for a Healthy Benton City: Works with school districts to increase community connectedness and address substance use/misuse. • Mustangs for Mustangs: Provides emergency assistance for anyone in Prosser, along with their immediate families. Their services are related to personal safety, utility assistance, food security, transportation, housing, and medical needs. • Safe Kids Benton-Franklin: Evidence-based programs to help parents and caregivers prevent childhood injuries.
Housing and Homelessness	• Elijah Family Homes: Provides stable housing for families seeking recovery and safety from substance use/misuse, abuse, and poverty. The program invests in families long-term to help them gain self-sufficiency. • Pasco Haven: A 60-unit housing project in Pasco that provides mental health support and health care services.
Senior Services	• Prosser Senior Community Center
Services for People with Developmental Disabilities	• The Arc: Provides a space where children with developmental disabilities can feel included and part of a community through programs like the summer camp and Special Olympics. These programs create spaces for friendship and belonging. • Tri-Cities Community Health: Includes providers who have completed the Center of Excellence Training to be able to diagnose children with autism.

Community Partners: Opportunities to Work Together

Participants were asked, "What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?" Partners shared the following opportunities:

Engage in partnership opportunities based on shared community priorities

Community based organizations in Benton and Franklin Counties are working towards addressing similar needs. Partners emphasized rallying around these needs, acknowledging the primary issues in the community, and partnering to solve them. Partnering allows for more creative solutions to addressing challenging problems and opportunity for sharing resources. They described a need for strategic collaboration.

"Collaboration is wonderful. I think that strategic collaboration is even more useful. Collaboration can lead to outcomes or it can lead to conversations that don't lead to much else."—Community Partner

Partners recommended measuring progress towards goals and communicating frequently to keep everyone aligned.

"Those are the suggestions that I always have. Stay local, keep the facts in mind, get the emotions or all of your biases out of the way and let's speak to what needs to be done and how to do that appropriately."—Community Partner

Partners identified the following shared priorities where sectors could better align to address complex challenges:

- Addressing behavioral health staffing challenges: Partners shared organizations may compete to recruit the same people or provide the same services. They advocated for a system that works together to collectively meet the needs of the community, with different organizations each providing a sub-set of services. Together, multiple organizations will meet the full needs of the community, layering different services, rather than competing for the same services. This means all organizations do not need to try to do everything but can be strategic with how they leverage resources.

  "There are so many things that we could layer that don't have to be done by one agency or have to be done by all agencies. We can start layering the services that we don't have rather than competing for the same resources."—Community Partner

- Homelessness and health care: There is opportunity for more communication about post-discharge care and supporting the needs of patients experiencing homelessness. Finding solutions to barriers to care, including transportation, requires partnership. One opportunity is to create volunteer opportunities for nurses to work with people living unsheltered to give nurses a better understanding of community health work and the specific needs of this population.

De-siloed and whole person care

Patients have multiple needs and should have their needs addressed holistically. When people seek services in a health care setting, providers need to be considering what other services they need and how they can be connected. Unfortunately, patients can be passed between services without a lot of follow up or support. Warm hand offs may ensure people have support in those transitions. The COVID-19 pandemic made some communication and care coordination between organizations more difficult. Case conferencing on shared patients may help improve linkages.

"I just feel that in general, organizations just really need to collaborate to be more open and not so jealous of the services that they offer, but really look at it in the aspect of we're helping one person. What do they need? Do they need clothing? Do they need

transportation? Do they need health insurance? Just really be the connector of all the service."—Community Partner

Provide community-based services to ease access

Partners emphasized the benefits of bringing needed services to people. They shared home visits can be especially helpful for older adults who may have difficulty getting to care. Providing care in the home can be a preventive measure rather than waiting until people have emergent needs. Community Health Workers or Promotores can provide case management and personalized care in the community. Co-located services in schools or places where families already go can also reduce barriers. These services aim to reach out to people and meet them where they are, not expecting them to overcome barriers on their own.

> *"I think healthcare as a whole needs to be redesigned, if we're going to reach out to those disadvantaged people, we need to quit expecting them to overcome those barriers and do that."—Community Partner*

Leverage convenors to promote action

Partners would like to see more effective collaboration that moves beyond conversations and leads to community improvement. This requires dedicated funding and leadership to keep work moving. Neutral convenors can pull together competing systems to foster dialogue and promote community solutions. They can also support including community members and patients to gain insight. This can also reduce competition and help the community think strategically about how to leverage resources.

> *"Whatever the issue is, youth mental health or access to healthy food, or neighborhood safety, whatever the case is, you can pick the issue, but how do we find a way to convene people that care, but also to have action associated with it so you're not just spending time talking about the problem, but instead, you're trying to implement a solution. I think that would be the big suggestion I would have is to find conveners that are willing to bring together resources and people to try to solve bigger issues across boundaries and across scope."—Community Partner*

Build trust and relationships between organizations

Trust between organizations is the foundation for making progress towards community goals. Particularly in times of challenge and crisis, there has to be strong trust and communication. Opportunities for relationship building are between the police departments and the Emergency Departments at local hospitals. Additionally, the local health systems could continue to communicate to ensure they are collectively meeting the health needs of residents. Building relationships allows organizations to learn about others' strengths and opportunities to learn from one another.

LIMITATIONS

While partners and listening sessions participants were intentionally recruited from a variety of types of organizations, there may be some selection bias as to who was selected as a partner. Multiple interviewers conducted the session, which may affect the consistency in how the questions were asked. Multiple note-takers affected the consistency and quality of notes across the different listening sessions.

Some listening sessions were conducted virtually, which may have created barriers for some people to participate. Virtual sessions can also make facilitating conversation between participants more challenging.

The analysis was completed by only one analyst and is therefore subject to influence by the analyst's unique identities and experiences.

PARTNER INTERVIEW QUESTIONS

1. Please state your name, title, and organization as you would like them included in the report.
2. How would you define the community that your organization serves?
3. While a Community Health Needs Assessment is primarily used to identify gaps in services and challenges in the community, we want to ensure that we highlight and leverage the community strengths that already exist. Please briefly share the greatest strength you see in the community your organization serves.
4. Please identify and discuss specific unmet health-related needs in your community for the persons you serve. We are interested in hearing about needs related to not only health conditions, but also the social determinants of health.
5. Using the table, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). [see table below]
6. Has the COVID-19 pandemic influenced or changed the unmet health-related needs in your community? If yes, in what ways?
7. What suggestions do you have for how we can leverage community strengths to address these community needs?
8. Please identify one or two community health initiatives or programs that you see currently meeting the needs of the community.
9. What suggestions do you have for organizations to work together to provide better services and improve the overall health of your community?
10. Is there anything else you would like to share?

Question 5: Using the table below, please identify the five most important "issues" that need to be addressed to make your community healthy (1 being most important). Please note, these needs are listed in alphabetical order.			
	Access to health care services		Gun violence
	Access to dental care		HIV/AIDS

	Access to safe, reliable, affordable transportation		Homelessness/lack of safe, affordable housing
	Affordable childcare and preschools		Job skills training
	Aging problems		Lack of community involvement and engagement
	Bullying in schools		Mental health concerns and treatment access
	Community violence; lack of feeling of safety		Obesity and chronic conditions
	Disability inclusion		Opportunity gap in education (e.g. funding, staffing, support systems, etc. in schools)
	Domestic violence, child abuse/neglect		Racism and discrimination
	Economic insecurity (lack of living wage jobs and unemployment)		Safe and accessible parks/recreation
	Environmental concerns (e.g. climate change, fires/smoke, pollution)		Safe streets for all users (e.g. crosswalks, bike lanes, lighting, speed limits)
	Few community-building events (e.g. arts and cultural events)		Substance Use Disorders and treatment access
	Food insecurity		Other:

LISTENING SESSION QUESTIONS

1. What makes a health community? How can you tell when your community is healthy?
2. What's needed? What more could be done to help your community be healthy?
3. What's working? What are the resources that currently help your community be healthy?
4. Is there anything else related to the topics we discussed today that you think I should know that I haven't asked or that you haven't shared?

Click here for "An Analysis of Trends in Behavioral Health of Residents in Benton & Franklin Counties."

Click here for "An Analysis of Trends in the Continuum of Housing for Homeless & Low-Income Residents in Benton & Franklin Counties."

Appendix 3: Community Health Improvement Plan Guiding Concepts

Community Health Improvement Plan (CHIP) Guiding Concepts

Equity: As defined by the U.S. Department of Health and Human Services, health equity is the attainment of the highest level of health for all people. Population-level factors, such as the physical, built, social, and policy environments, can have a greater impact on health outcomes than individual-level factors. The root causes of health inequity can be directly linked to a failure to address these population-level factors. In addition, linkages between science, policy, and practice are critical to achieving health equity.
https://www.cdc.gov/minorityhealth/publications/health_equity/index.html#:~:text=As%20defined%20by%20the%20U.S.,outcomes%20than%20individual%2Dlevel%20factors.

Life-course wellness: Reducing health disparities requires an understanding of the mechanisms that generate disparities. Life course approaches to health disparities leverage theories that explain how socially patterned physical, environmental, and socioeconomic exposures at different stages of human development shape health within and across generations and can therefore offer substantial insight into the etiology of health disparities.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6356123/

Health in All Policies (HiAP): is a collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. https://www.cdc.gov/policy/hiap/index.html

Evidence-based: The interventions, policies, and community supports listed in the CHIP will be evidence-based. They will be disease prevention approaches that have the potential to impact public health. Resources from the National Institutes of Health list agencies and organizations with their own process to identify what is evidence-based but often a systematic review or a meta-analysis is used to evaluate the body of evidence in a given field.
https://prevention.nih.gov/research-priorities/dissemination-implementation/evidence-based-practices-programs

Collective Impact: Collective Impact is a framework to tackle deeply entrenched and complex social problems. It is an innovative and structured approach to making collaboration work across government, business, philanthropy, non-profit organizations and citizens to achieve significant and lasting social change. The Collective Impact approach is premised on the belief that no single policy, government department, organization or program can tackle or solve the increasingly complex social problems we face as a society. https://www.chathamcountync.gov/Home/ShowDocument?id=38860

Appendix 4: Community Health Needs Assessment Steering Committee

Table_Apx 4. Community Health Needs Assessment Committee Members

Name	Title	Organization	Sector
Sean Domagalski, RN, BSN, MHA	Performance Manager	Benton-Franklin Health District	Public Health
Kelly Harnish, MPH, MCHES	Public Health Educator, Community Health Improvement Plan Coordinator	Benton-Franklin Health District	Public Health
Karen Hayes, MA	Community Health Investment Manager	Kadlec Regional Medical Center/Providence	Hospital
Pernell Hodges	Epidemiologist	Benton-Franklin Health District	Public Health
Hazel Kwak, BHSC, NCMA	Community Health Investment Coordinator	Kadlec Regional Medical Center/Providence	Hospital
Kristi Mellema, BSN, RN	Chief Quality and Compliance Officer	Prosser Memorial Health	Hospital
Amy Person, MD	Health Officer	Benton-Franklin Health District	Public Health
Carla Prock, RN, BSN	Senior Manager, Healthy People & Communities	Benton-Franklin Health District	Public Health
Christy Wang, BSN, RN, MPH	Epidemiologist	Benton-Franklin Health District	Public Health
Kirk Williamson	Program Manager	Benton-Franklin Health Alliance	Public Health