The McDowell Hospital
CHNA Summary

7/26/2016
This document is a hospital facility-specific summary of Community Health Needs Assessment (CHNA) process and findings. For more process and data details on counties within our defined community, specific health data, and the collaborative community health assessments for each county, see:


Our Community Health Needs Assessment process and product were also supported by technical assistance, financial support, and collaboration as part of WNC Healthy Impact, a partnership and coordinated process between hospitals, health departments, and their partners in western North Carolina to improve community health.
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1 – Evaluation of Actions Taken Since Previous (2012) CHNA

Moving the needle on population level health priorities requires an array of initiatives across the community and is the collective accountability of the programs, agencies, and service systems striving to address these priority health issues. As part of a collaborative response to addressing health needs in our community, McDowell Hospital is an important contributor to meaningful progress on these health priorities. The brief summary below provides an overview of the progress and impact of actions taken since our last CHNA that was conducted in 2012.

### 2012 Priority Area 1 Teen Pregnancy Prevention

**Population Level Data:**
In 2010, there were 77 babies born to teen mothers in McDowell County (up from 67 in 2009). Since 2010, the McDowell Teen Pregnancy Rate has declined. It is encouraging that the number of teen pregnancies are decreasing.

![Pregnancy Rate](image)

**Collaborative Efforts:**
Established in 2012, McDowell Hospital has supported the RPM Health Department with both financial and human resources in reestablishing access to maternity services and family planning in the health departments located in Rutherford, Polk and McDowell counties.

**Implementation Strategy Update**

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<th>Hospital Strategy</th>
<th>Evaluation/Note</th>
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<tr>
<td>Support the RPM Health District through the establishment of Family Planning Services and support with qualified providers</td>
<td>The contract with RPM Health District was established in July 2013 and has been renewed annually. This collaborative effort has ensured patient access to family planning services in all three counties.</td>
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<tr>
<td>Support the RPM Health District through the establishment of maternity services at each location throughout the district</td>
<td>McDowell Hospital entered into a contract in July 2014 to provide financial and human resources for restoring access to maternity care throughout the RPM Health District. The RPM District continues to show growth in maternity visits at each location and we anticipate that in 2017, we will be able to reduce our financial support for the program. Without this access point for pregnant women in our community, a need would be unmet.</td>
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2012 Priority Area 2 Tobacco Use

Population Level Data:
Data supporting a focus on decreasing tobacco use included evidence that McDowell County residents had a higher incidence of lung cancer than both WNC and NC (92.9 new cases of lung cancer per 100,000 population- a 21.9% increase from 2003). Additionally, the percentage of residents who smoke was 21.6% (higher than WNC, the State and the Nation).

Collaborative Efforts:
McDowell Hospital collaborated with the RPM Health District, the McDowell County School System, and the McDowell Health Coalition as we focus on reducing tobacco use. McDowell Hospital, supported by Mission Health System, served as a lead in providing smoking cessation classes accessible to industry, teens and young adults, and patients.

Implementation Strategy Update

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<td>Offer smoking cessation classes to the community including industry and schools</td>
<td>Smoking cessation: “Freedom From Smoking classes, a 7 week course with 2 to 3 individuals per class. While this class format has had low volume, our Smoking Cessation educator currently goes to two of our primary care practices, Old Fort and Glenwood, monthly to meet with patients. Community efforts to provide the community smoking cessation information access have continued through health events, presentations in the school system, highlighting the use of the NC Quitline, and providing smoking cessation presentations at Job Link for each new manufacturing class. The Job Link presentation has proved to be a great outreach effort. With two sessions performed to date, each class has 25 to 30 participants.</td>
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2012 Priority Area 3  Healthy Eating and Active Living – Diabetes Reduction

Population Level Data:
The average self-reported prevalence of McDowell County adults with diabetes was 10.6% in the period from 2005 - 2011. Over the same period the WNC average was 9.0%. Prevalence of self-reported adult diabetes has been rising over time in both WNC and McDowell County as demonstrated in the following graphic:

![Image of Estimated Adult Diabetes Prevalence]

Despite the successful strategies implemented below, the prevalence of Diabetes continues to rise in McDowell County resulting in a shift of focus to healthy eating and activity as a strategy while continuing to maintain the strategies below to assist the community in managing their diabetes.

Collaborative Efforts:
McDowell Hospital collaborates with the Corpening YMCA in providing a diabetes education program to the community.

Implementation Strategy Update: Diabetes Reduction

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<td>Implement “Taking Control of Type 2” (TCT2) Diabetes Management Program</td>
<td>Implemented in 2013, the “Taking Control of Type 2” Diabetes program continues to grow and have positive patient outcomes for the participants. The program since its inception has been recognized at the State and National level for the outcomes achieved.</td>
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<tr>
<td>Enroll clients in program to stabilize or reduce glucose levels in participants</td>
<td>Taking Control of Type 2 Diabetes (TCT2) was initiated in 2013. Starting with 26 individuals, the program touched 106 lives in 2015. This program, with participation growing, has resulted in Diabetic participants changing their health.</td>
</tr>
<tr>
<td>Enrollment and participation in YMCA’s Diabetes Prevention Program</td>
<td>Kimberly Freeman, Diabetes Educator, began her collaboration with the Corpening YMCA in 2012. Starting with 83 individuals, the program has grown with 311 individuals participating in the program in 2015. This collaboration has been highly effective on changing the health of the participating individuals participating.</td>
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As we move forward with partners in implementing strategies in response to the 2015 CHNA presented in this document, we will continue to build our capacity around evaluation through using Results-Based Accountability™ as a framework for understanding the results we are achieving.
2 – COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS

Community Served

McDowell County has a population of 45,231 people and geographically consists of 442 square miles located in the Appalachian Mountains. McDowell County residents are 90.6% white and 9.4% non-white, compared to a North Carolina average of 68.5% white and 31.5% nonwhite. Five (5%) percent of the population identifies as Hispanic or Latino. Approximately 70.3% of the population in this county live in a rural area. Some may experience transportation barriers. Unemployment is slightly higher in McDowell than in the rest of North Carolina, at 5.8% in the county as compared to 5.4% in the rest of the state. McDowell County also has a relatively large elderly population. McDowell is consistently ranked in the lower half of counties in North Carolina for health outcomes: 22% of McDowell adults (vs.18% of NC residents and 16.9% of US residents overall) report they are in poor or fair health; 23% are current smokers (vs. 22% of NC residents and 19.6% of US residents overall); 33% of adults are obese (vs. 29% of NC residents and 27.6% of US residents overall); 31% of adults in McDowell County report no leisure time physical activity (vs. 25% of NC residents and 22.9% of US residents overall).

Many health indicators in McDowell County have shown little improvement in the last three years since the 2012 Community Health Needs Assessment. Notable unfavorable changes in social determinants of health that have occurred over the past three years include: a reduction in the median family income, an increase in residents living below the poverty level and childhood poverty along with increases in crime and domestic violence. From a health outcomes standpoint, McDowell County has demonstrated increases in cancer (lung, prostate, breast and colorectal) along with rates of Chronic Obstructive Pulmonary Disease (COPD) that are more than double state rates. Further, there are continued high rates of poisoning deaths due to medication or drug overdoses and continued high rates of adult obesity. In the past three years, an alarming hike in the rates of current smoking, smoking during pregnancy and use of e-cigarettes is of concern.

Data Collection Process

The following section describes how data was obtained, compiled and analyzed in our assessment process.

WNC Healthy Impact

WNC Healthy Impact is a partnership which provides a coordinated process between hospitals and health departments in western North Carolina to improve community health. As part of a larger, and continuous, community health improvement process, these partners are collaborating to conduct community health (needs) assessments across western North Carolina www.WNCHealthyImpact.com. McDowell Hospital is also involved in this regional/local vision and collaboration. Participating counties include: Buncombe, Cherokee, Clay, Graham, Haywood,
Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania and Yancey.

**Core Dataset Collection**

The data reviewed as part of our community’s health needs assessment came from the WNC Healthy Impact regional core set of data. WNC Healthy Impact’s core regional dataset includes secondary (existing) and primary (newly collected) data compiled to reflect a comprehensive look at health. The following data set elements and collection are supported by WNC Healthy Impact data consulting team, a survey vendor, and partner data needs and input:

- A comprehensive set of publically available secondary data metrics with our target population compared to the other WNC regions as “peer”
- Set of maps accessed from Community Commons and NC Center for Health Statistics
- Telephone survey of a random sample of adults in the county
- Email key-informant survey


**Additional Community-Level Data**

During the data collection process, the team locally reviewed NC DETECT data and Highway Safety data as well as PRIDE survey data for 8th graders in McDowell to learn more about specific health concerns. In 2015, a collaboration between McDowell County, UNC–Chapel Hill Gillings School of Global Public Health and the Carolina Collaborative for Research on Work & Health produced the McDowell County Worksite Wellness Project Report. This Report provides a great deal of information about current practices at Worksites in McDowell as well as recommendations to improve employee health and wellness. The full report can be found in the Appendix A of the McDowell County Community Needs Assessment located at [http://www.rpmhd.org/index.php/health-promotion/community-health-assessment](http://www.rpmhd.org/index.php/health-promotion/community-health-assessment).

**Gaps in Available Information**

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community’s health needs. For example, certain population groups (such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish) are not represented in the survey data. Other population groups (for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups) might not be identifiable or might not be represented in numbers sufficient for independent analyses. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community.
Community Input

Throughout the collaborative health needs assessment process in our community, input was obtained in a number of ways. See below for a list of the organizations that provided input into this process, the period of time they were involved, how their input was obtained, and the nature and extent of their input.

Our collaborative health needs assessment process solicited and took into account input from the following:

Public Health Department

In the collaborative assessment process for our community, the Rutherford Polk McDowell (RPM) Health District is a key partner. They provided coordination for the local process that we help support and partner to implement. Our collaborative relationship with RPM Health District is highly valued and productive as we work together to improve the health outcomes for McDowell County.

Medically underserved, low-income, and minority populations

Throughout our community health assessment process and product, our team was focused on understanding general health status and related factors for the entire population of our county as well as the groups particularly at risk for health disparities or adverse health outcomes. In particular, for the purposes of the overall community health assessment, we aimed to understand variability in health outcomes and access of medically underserved, low-income, minority, and others experiencing health disparities.

Through this process, input was gathered from several individuals whose organizations work with low-income, minority populations, or other medically underserved populations. Specific vulnerable populations that we focused on include: African America, Children, Disabled, Elderly, Hispanic/Latino, Low Income, Non-English Speaking, Single Parents, and Teen Mothers.

Our process included input regarding the needs of medically underserved, low-income, and minority populations in two ways. (1) As part of our collaborative data collection effort, a community-wide telephone survey was conducted to better understand the specific health needs and status of all of the community, which includes these special populations. (2) In addition, a survey of key informants was conducted to gain input from the individuals and organizations in our community representing the interests of these populations in their local efforts. Throughout the community health assessment process and product, the team was focused on understanding general health status and related factors for the entire population of our county as well as the groups particularly at risk for health disparities or adverse health outcomes. In particular, for the purposes of the overall community health assessment, we aimed to understand variability in health outcomes and access of medically underserved, low-income, minority, and others experiencing health disparities.
Written Comments
Our facility also considers any written comments received since the last CHNA and implementation strategy. Beyond the Key Informant process initiated this cycle, McDowell Hospital has not received any additional written comments regarding the Community Health Needs Assessment.

Additional Input
In addition to the input described above, our facility, as part of our collaborative community health needs assessment process, took community input, including our medical providers and community leadership, into account in the process of identifying health issues and priorities and identifying health resources available to address these needs.

Nearly 90% of key informants characterized Social Determinants of Health as a “major contributor” to local health issues. Those who rated this as a “major contributor” feel that the following contribute the most to health problems in McDowell County: Access to High Quality, Affordable Child Care, Alcohol/Drug Abuse, Dysfunctional Families, Economy, Education, Employment, Employment That Pays a Living Wage, Income/Financial Ability, Institutionalized Racism, Lack of Motivation to Change, Lack of Transportation, Learned Behaviors, Politics, Poverty, Welfare Systems.

3 – Health Needs in Our Community

Health Status
Data on the health status of McDowell County and health factors that influence health are included in the full community health assessments for each county in our community. See McDowell County assessments for these details. http://www.rpmhd.org/index.php/health-promotion/community-health-assessment

The collaborative local assessments include a basic review of trends and progress and changes in health status for the broad community. These assessments also include details on populations at risk or facing health disparities in our community.

Health Issues

Process
To identify the significant health issues in our community, our key partners reviewed data and discussed the facts and circumstances of our community. We used the following criteria to identify significant health issues:

• County data deviates notably from the region, state or benchmark
• Significant disparities exist
• Data reflects a concerning burden, scope or severity
• Surfaced as a priority community concern

The Rutherford Polk McDowell District Health Department shared the CHA findings with the McDowell Health Coalition members and other interested community leaders on five occasions in the fall of 2015: October 9, 12, 28, November 9 and December 1, 2015. A Community Forum was held on January 14, 2016 at McDowell Technical Community College. CHA data was reviewed and evidence based strategies were explored to address the three chosen health priority areas. There were 39 people in attendance.

**Identified Issues**

The following health issues were surfaced through the above process:

**McDowell County**

- **Issue 1: Tobacco Use:** McDowell County has a high rate of current smokers (29%) which increased from 2012.

- **Issue 2: Smoking During Pregnancy:** 23.6% of pregnant women in McDowell County smoke.

- **Issue 3 Secondhand Smoke:** 36% of employed respondents say that they have breathed someone else’s smoke at work during the past week

- **Issue 4 Diabetes:** The incidence of diabetes in McDowell County is rising.

- **Issue 5 Overweight & Obese:** The prevalence of adult overweight and obesity in McDowell County is among the highest in the WNC region at 72%.

- **Issue 6 Substance Abuse:** Substances with the highest incidence in McDowell County are opioids, methadone, and cocaine and abuse continues to be a major contributor to death and disability.

- **Issue 7 Injury Mortality:** The rate of death due to unintentional poisoning is 24.1% with 96% of those deaths due to medication or drug overdoses.

- **Issue 8 Healthy Eating:** 35% of respondents said that accessing fresh produce at an affordable prices was difficult or very difficult.

- **Issue 9 Poverty:** The median household income is $35,297 - $11,037 below the state income average.

- **Issue 10 Childhood Poverty:** Children suffer significantly and disproportionately from poverty with a rate of 35.1% in McDowell.
Priority Health Issues

Process & Criteria

A data presentation was given to the McDowell Health Coalition Board of Directors on October 12, 2015. The Chief Nursing Officer for McDowell Hospital serves on the McDowell Health Coalition Board. Board members were given an opportunity to give feedback about key issues. Three Action Teams were given data presentations and asked to comment on their perceptions of health priorities.

On December 1, 2015, a three-county Health Prioritization Advisory Team met to determine health priorities for each county: Rutherford, Polk and McDowell. During our group process, the following criteria were used to select priority health issues of focus for our community over the next three years:

- Relevance – How important is this issue? We looked at the size and severity of the problem with a focus on equity. We considered the urgency and the level of community concern. Is this linked to other important issues?
- Impactful – What will we get out of addressing this issue? Are there available and proven strategies to improve this? Does this build on current work? Are there significant consequences of not addressing this issue now?
- Feasible – Can we adequately address this issue? We considered the availability of resources including staff, partners, time, and money. Can we identify easy short term wins? Do we have political capacity and will and is it ethical to address this priority? Will it be acceptable to our community?

Identified Health Priorities

The following health issues are the final community-wide priorities:

McDowell County:

- **Priority 1: Tobacco Free Lifestyles**
  Tobacco Use was selected because of high rates of lung cancer incidence and prevalence, a COPD rate of 18.8% and a current smoking rate of 29%. Additionally, the first three issues identified during the CHNA involved tobacco.

- **Priority 2: Easy Access to Healthy Food and Activity**
  Built Environment & Active Living was selected because there is a strong desire among local partners to build upon the work already underway in this area. The data clearly indicates a need for a cultural shift toward becoming more physically active throughout the McDowell population. With over 70% of McDowell County residents not at a healthy weight, increasing opportunities for physical activity is a winning strategy for working on the community level to increase rates of residents at a healthy weight. Addressing
healthy food access and activity, focuses us on creating healthy lifestyles that prevent chronic disease such as Diabetes.

- **Priority 3: Addiction Free Lifestyles**
  Substance Abuse was selected because of the devastating impact addiction has on the health and wellbeing of the community. Additionally, there are two active Work Groups that have been diligently working on strategies to address substance abuse – one among adults and the other among youth. These Work Groups would like to build upon their existing interventions and expand into more work on the community level. In McDowell County, the poor economy, lack of job opportunities, poverty, household disruption, all contribute to the problem of substance abuse. Children who are raised in homes that have been affected by drug abuse are more likely themselves to be victims of the substance abuse epidemic as well. McDowell County Physician Data shows that binge drinking and illicit drug use are health risks in McDowell that need to be addressed. The rate of unintentional injury deaths due to drug overdose are very high in comparison to regional and state rates.

As these priorities are approved by the McDowell Board of Directors, McDowell Hospital will create a specific Implementation Strategy in collaboration with the RPM Health District, the McDowell Health Coalition and other key stakeholders in the community, presented at a later date, which will discuss what role our facility will have in leading, collaborating on, or supporting others in responding to these health issues.
4 – AVAILABLE RESOURCES

Health Resources Inventory
An inventory of available resources of our community was conducted through reviewing a subset of existing resources currently listed in the 2-1-1 database for our community as well as working with partners to fill in additional information. The McDowell County 2-1-1 Health Listing is located in the Appendix of the McDowell County Community Health Needs Assessment beginning on Page 264 of the document. Where gaps were identified, we partnered with 2-1-1 to fill in or update this information when applicable. The following outlines resources specific to Tobacco Use efforts in McDowell County:

- McDowell Hospital offers smoking cessation classes.
- The Rutherford Polk McDowell District Health Department offers 5As Brief Cessation Counseling Training to Health Care and Human Service Providers through the Healthy Communities Program.
- To establish policy changes aimed at supporting tobacco free spaces, McDowell County works closely with Karen Caldwell, MS, Regional Tobacco Control Manager, Tobacco-Free WNC Coalition, Division of Public Health, Tobacco Prevention and Control Branch, North Carolina Department of Health and Human Services.
- NC Quitline Referral Program is used by the McDowell Health Department, McDowell Hospital and community partners working in substance abuse treatment and mental health treatment and counseling.
- A media campaign was launched by RPMHD in 2015 to promote NC Quitline use. As funds allow, radio and television Public Service Announcements are purchased to promote smoking cessation in general and to promote use of the NC Quitline.
- More Tobacco Prevention Education in schools is needed. While some Tobacco Prevention Education is covered in ninth grade through the Healthful Living Curriculum, the community has expressed a need for more education throughout all grade levels.

Findings
During the review of resources, updates were made to the 2-1-1 database to ensure that this valuable resource accurately reflects the vast amount of resources available. The greatest finding is the establishment of excellent collaboration and effort among agencies and community entities to move the needle on health outcomes.

Resource Gaps
There is very limited public transportation in McDowell County. This poses a gap for those needing transportation to access care and childcare for themselves and their families. Key Informants frequently mentioned limited access to mental health care providers and resources to serve the behavioral health needs of our community.
5 - Next Steps

Sharing Findings
Our facility will post its CHNA report on the Mission Health System website https://www.mission-health.org/community-health-needs-assessment.php. The paper copy of our CHNA will be made available, upon request, at our hospital free of charge. Comments and suggestions will be accepted from the public by e-mail.

Collaborative Action Planning
McDowell Hospital will participate in a collaborative action planning process with our community partners which results in the creation of a community-wide plan at the county level. Our hospital will then develop a facility specific implementation strategy that speaks to our specific contributions to the identified priority health issue. We aim to leverage existing assets, avoid duplication, and implement evidence-based and innovative efforts, while working towards a vision of collective impact.

This Community Health Needs Assessment completed by McDowell Hospital was presented and adopted at the McDowell Board of Directors meeting on: 7/26/2016
WORKS CITED