GARRETT COUNTY
HEALTH DEPARTMENT

COMMUNITY HEALTH ASSESSMENT

2016

Garrett County, a healthier place to live, work, and play!

WELCOME!

Garrett County, a healthier place to live, work, and play!

We each have our own ideas about what it means to be healthy, what we feel the biggest issues are for ourselves, and the community we live in. Unfortunately, the issues we face depend dramatically on what we're able to afford. Fresh fruits and organic cuts of meat are inconceivable for many, but a staple on others' grocery list. When we think about health, it cannot be adequately discussed without acknowledging that our health is fundamentally affected by our community. Concerns like: Can we afford health insurance? Is our well water contaminated? Can I pay for the cancer treatment if they find something on my mammogram? Is the air clean? How many people rely on the emergency room as their main health care provider? Is the person living next door selling drugs? These are some of the questions that impact all of us every day. Every community chooses to confront these challenges in different ways that reflect the varying sensibilities and priorities of the people who live within it. What is consistent; however, is that a community is better equipped to make choices and set priorities when its residents are well-informed about the health status of the community and are willing to come together with agencies to discuss those realities and make sustainable changes together.

The Community Health Assessment contained on the following pages provides some of the information necessary to make informed choices and set priorities so that we can take action. This document is a summary of work that began more than one year ago to gather data by consulting with county residents and community leaders. It was our goal to learn more about the health of our community by hearing directly from its members.

The pages that follow contain information that will be relevant to different people and organizations in different ways. Though we could not include every opinion we were able to identify trends and report on the issues important to residents. The organizations that sponsored this assessment intend to share its contents widely so that Garrett County residents and organizations can use it in ways that make sense for them. We have begun an effort to facilitate a community health improvement plan to identify high-priority issues and build awareness to craft viable solutions. Please join us as we endeavor to make a difference in our community!

CONTRIBUTORS

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PROJECT TIMELINE

May '15	Stakeholder Engagement
June '15	CHANGE Tool Adoption for the Community Assessment
Sept. '15	Workgroups Established
Oct. '15	Collaboration with an Expert from the University of Maryland Extension Office
Nov. '15	Established Healthy Mountain Maryland as the Planning Brand and Developed Community Survey Instrument and Website
Dec. '15	Laid Groundwork for Community Engagement
Jan. '16	Launched Survey & Conducted 16 Focus Groups
March '16	Study Concluded

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EXECUTIVE SUMMARY

The 2016 Garrett County Community Health Assessment

This Community Health Assessment is simply a slice in time of a dynamic process contiguous with our efforts to make a difference in the lives of those we serve. Great care and attention was placed on collecting as much data as possible from the many subsections within our community. Expertise was garnered from the University of Maryland Extension to ensure rigorous standards during our needs assessment process.

"We are confident that by defining our community's needs, it will result in better service to our citizens, better outcomes, and a clearer path for all of us to follow together." *- Rodney Glotfelty R.S. M.P.H., GC Health Officer*

Extensive research was conducted from January 1st through March 15th, 2016. We conducted 16 focus groups and analyzed responses from 897 web based surveys completed by staff, community organizations, and adult constituents. We also evaluated secondary sources of information about our community. The Health Planning Council, the Health Officer, the President and CEO of Garrett Regional Medical Center, the Data Committee, and many community members all played key roles in pulling this information together for this report. We are pleased to publish this document and wish to convey gratitude for all those who took an interest and spent valuable time making this possible.

With just shy of 1,000 people participating in the focus groups and community survey, our sample size for a county with 30,000 people was a bit small. However, we were able to identify trends and learn about the perception of those who participated. The perceptions of people may be and are at times in direct conflict with the secondary data sources. That's why the data team and others have looked at all the data to set priorities and have attempted to find an appropriate balance between the two.

COMMUNITY PROFILE

A Glance into Rural Appalachia

Garrett County is a unique place situated in the westernmost corner of Maryland. According to the census, it is a large county with a geographic base of 656 square miles, and 46.5 persons per square mile. Our low population density ranks Garrett County as the third least populous county in Maryland. Natural beauty abounds with plenty of open space to enjoy. The county is bordered by West Virginia and Pennsylvania and is considered a tri-state area. The unique assets of the County provide an excellent quality of life for some in a rural environment. Diverse outdoor recreational opportunities abound with over 76,000 acres of parks, lakes and publicly accessible forestland. Protective factors include a sense of belonging in the small communities that exist in the county.

As of July 1, 2014, the population of Garrett County was 29,460, a slight decrease over the 30,097 population in 2010. Garrett County is a place of limited racial diversity, with 97.5 % of the population reporting as White. Similar to other parts of the nation, Garrett County's population is aging. Only 4.9 percent is under 5 years old while 20.0 percent of the population is 65 years old and over. Those under 18 years represent 19.8 percent of the County's population (US Census, 2014).

Though Garrett County is a wonderful place to live, it is not without its challenges. Newly released data from the U.S. Census Bureau's 2014 American Community Survey details the country's richest and poorest states. While Maryland was ranked among the wealthiest three states, with an average household income of $73,971, Garrett County is well below that at $46,096. This more closely aligns Garrett County with our neighboring state of West Virginia, which is ranked 49th with a median income of $41,059 (US Census, 2014).

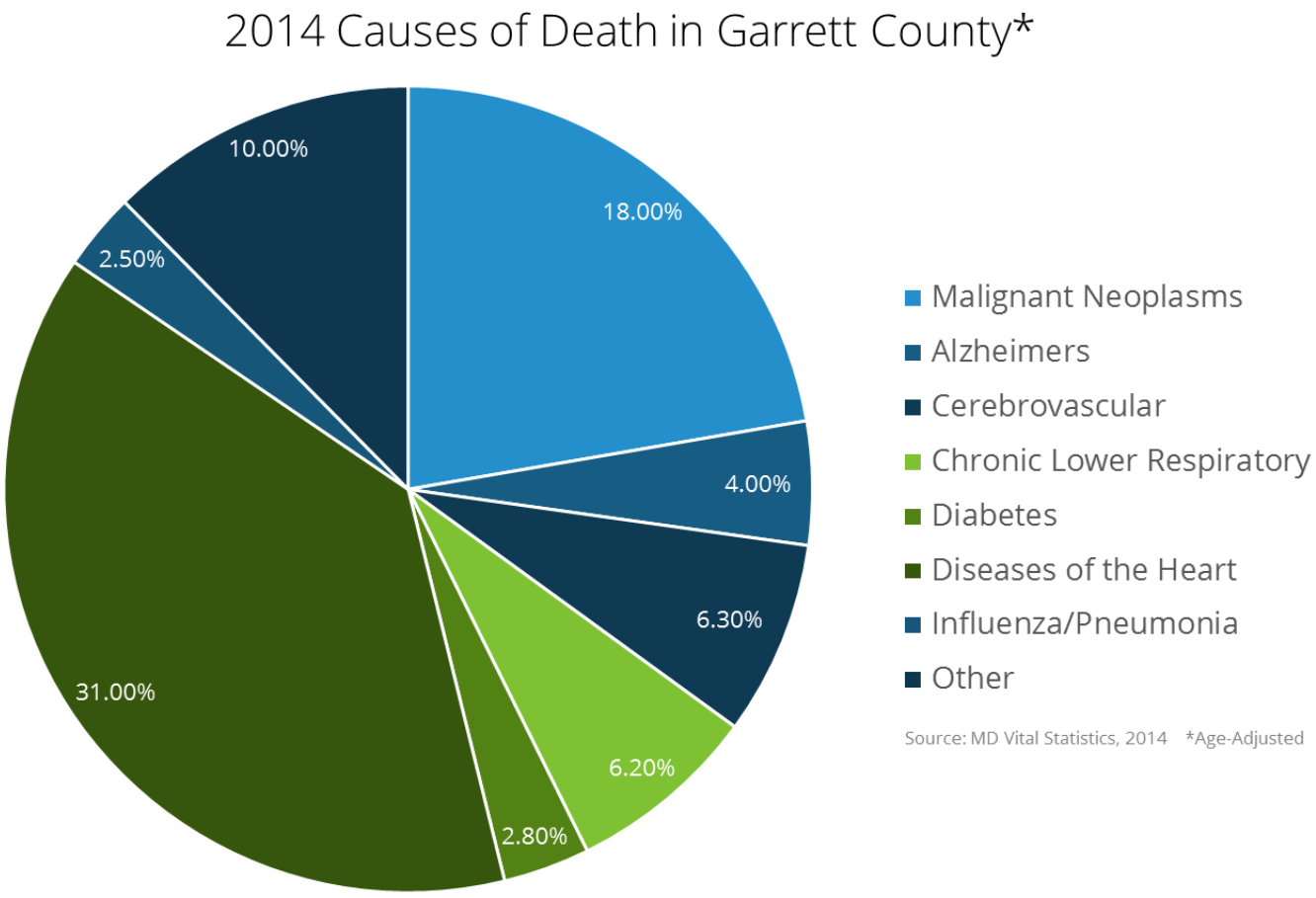
Poverty in Rural Appalachia

The economic disparity between Garrett County, the rest of Maryland, and the United States is striking. The US Census states that 12.4% of people live in poverty, and 19.7% of Garrett County children under 18 years old are in poverty, compared to the average rate of 10.7% throughout Maryland. The continued disparity between the overall health of Marylanders and Garrett County is reflected in certain areas of the State Health Improvement Process or the SHIP data.

Measures for improvement are aligned with the Healthy People 2020 objectives established by the Department of Health and Human Service. To see a detailed breakdown, visit garretthealth.org for the latest status of health report given by Health Officer, Rodney Glotfelty.

"Despite some of the indicators, Garrett County does surprisingly well."

- Rodney Glotfelty R.S. M.P.H., GC Health Officer



U.S. Census Bureau: http://www.census.gov/quickfacts/table/HSG495214/24023 April 6, 2016
U.S. Census Bureau, American Community Survey:
https://www.census.gov/search-results.html?q=Maryland+poverty&page=1&stateGeo=none&searchtype=web April 6, 2016
Vital Statistics Administration, MD DHMH: http://dhmh.maryland.gov/vsa/Documents/14annual_revised.pdf May 15, 2016
SHIP: http://dhmh.maryland.gov/ship/Pages/home.aspx March 2, 2016

HEALTHCARE INFRASTRUCTURE

Garrett Regional Medical Center

According to the Office of Primary Care, “There is a positive correlation between health care access and health status emphasizing the need for an increased number of providers in areas where health care access is limited to improve health outcomes” (Appendix A).

Until recently, those who could afford it, drove a minimum of 60 miles for cancer care. In response to this, our local hospital, Garrett Regional Medical Center became a clinical affiliate of West Virginia University Healthcare in Morgantown, WV, and opened the doors of an infusion center January 1, 2016. **“It has brought welcome relief to so many families who no longer have to drive 60 miles for chemo treatments,”** said President and CEO Mark Boucot, FACHE.

GRMC has been serving the health needs of regional residents and visitors for over 60 years and today is a 55 bed general medical and surgical hospital that sees about 21,000 patients annually. It continues to make progress in bridging the healthcare access gap by providing more specialty services to our rural community.

"The Office of Primary Care (OPC), a unit under Maryland Department of Health and Mental Hygiene is charged with improving access to health services and reducing health disparities among state residents. The OPC prepares all federal shortage designation applications for the State in an effort to garner additional provider resources for underserved communities and populations. The Health Services Cost Review Commission (HSCRC) was established by an act of the Maryland legislature in 1971. Acting as an independent state agency that has broad responsibility regarding the public disclosure of hospital data and operation performance. The commission is authorized to establish hospital rates that promote cost containment, access to care, equity, financial stability and hospital accountability".

The infusion center and major improvements to the hospital over the last several months have been beneficial for our community, allowing more people to choose local healthcare. However, GRMC continues to work with HSCRC to adjust rates to meet community needs and provide increased care options in our community.

Garrett Regional Medical Center: https://www.gcmh.com/ April 6, 2016

PREVIOUS HEALTH IMPROVEMENT PLAN

Background

Maryland is one of the richest states in the nation and has one of the top-rated educational systems in the country, yet Maryland came in 18th by a national organization (America's Health Rankings 2015) that ranks the states on the health of their people. We want to change that. The Department of Health and Mental Hygiene mission is: To protect, promote, and improve the health and well-being of all Maryland citizens in a way that is fiscally and ethically responsible. To that end, the State Health Improvement Process (SHIP) was developed to provide a framework for accountability, local action, and public engagement to improve the health of Marylanders by setting measurable targets based on data. The SHIP includes 39 measures in 6 vision areas. Our Health Planning Council utilized these targets to help develop a Community Health Improvement Plan dated 2012 to December of 2015.

Community Health Improvement Plan Evaluation

Of the objectives defined by SHIP in 2012, Garrett County was comparable to, or better than, the State average in 31 of the 39 objectives. The following were ranked worse than the State:

- Adult Obesity
- Child/Adolescent Obesity
- Adult Tobacco Use
- Youth Tobacco Use
- Adult Seasonal Influenza Vaccine Rate
- Heart Disease Mortality
- Adults Without Health Insurance
- Life Expectancy

Targeted objectives were created to guide our health improvement goals and track progress via SHIP data. The following table shows the objective, baseline, result, intended result and outcome for evaluation of the plan.

SHIP: http://dhmh.maryland.gov/ship/Pages/home.aspx March 2, 2016
America's Health Rankings, United Health Foundations 2015 Annual Report: http://www.americashealthrankings.org/ May 2, 2016
Maryland Department of Health and Mental Hygiene, A public Health Needs Assessment:
http://pophealth.dhmh.maryland.gov/Documents/Maryland%20Public%20Health%20Needs%20Assessment%202014.pdf September 1,2014
Garrett County Community Health Improvement Plan 2012-2015

Community Health Improvement Plan Evaluation (Cont.)

2012-2015 Community Health Improvement Plan Evaluation

Objective:	Baseline Stat:	Result:	Intended Result:	Outcome:
By 2014, reduce death rate from heart disease by 10% to 203.3 per 100,000 [2007-2009]; MD SHIP target 173.4	225.9 deaths per 100,000 population	222.5 deaths per 100,000 population	Reduced mortality rate	Goal not met, but progress was made
By 2014, reduce overall cancer rate to MD SHIP target of 169.2 per 100,000 [2007-2009]	176 age adjusted mortality rate from cancer per 100,000 population	131.8 age adjusted mortality rate from cancer per 100,000 population	Reduced cancer death rate	Goal was exceeded
By 2014, increase the proportion of adults who are at a healthy weight by 10% to 37% [2011]	33.7%; percentage of adults who are at a healthy weight	27.3%; percentage of adults who are at a healthy weight	Increase in adults who are a healthy weight	Goal was not met
By 2014, reduce the proportion of high school students who are obese by 10% to 12.8% [2010]	15.5%; percentage of adolescents ages 12-19 attending public school who are obese	15.6%; [2013] percentage of adolescents ages 12-19 attending public school who are obese	Reduce the proportion of high school students who are obese	Goal was not met
By 2014, reduce diabetes-related emergency department visits to MD SHIP target of 330 [2010]	238.3 emergency department visit rate due to diabetes (per 100,00 population)	352.1 emergency department visit rate due to diabetes (per 100,000 population)	Reduce diabetes-related emergency visits	Goal was not met

Community Health Improvement Plan Evaluation (Cont.)

2012-2015 Community Health Improvement Plan Evaluation (Cont.)

Objective:	Baseline Stat:	Result:	Intended Result:	Outcome:
By 2014, reduce the percentage of high school students that use tobacco by 10% to 36% [2010]	40% percentage of high school students who use tobacco	34.3% percentage of high school students who use tobacco	Reduce the percentage of high school students who use tobacco	Goal was met, but we still have the highest percentage of use in the state
By 2014, reduce the percentage of adults who currently smoke by 10% to 15.5% [2011]	25.3% percentage of adults who currently smoke	15.1% percentage of adults who currently smoke	Reduce the percentage of adults who currently smoke	Goal was met
By 2014, increase the life expectancy in Garrett County to the MD SHIP target of 82.5 yrs [2009-2011]	78.2 shows life expectancy from birth in years	79.5 shows life expectancy from birth in years	Increase the life expectancy in Garrett County	Goal was not met
By 2014, increase the percentage of adults who have had a flu shot by 10% to 40.7% [2011]	31.6% percentage of adults who have had a flu shot	36.7% percentage of adults who have had a flu shot	Increase the percentage of adults who have had a flu shot	Goal not met, but progress was made
By 2015, maintain or reduce child maltreatment [2015]	4.9% rate of children who are maltreated per 1,000 population under the age of 18	9.2% [2014] rate of children who are maltreated per 1,000 population under the age of 18	Maintain or reduce child maltreatment rate	Goal was not met

Community Health Improvement Plan Evaluation (Cont.)

2012-2015 Community Health Improvement Plan Evaluation (Cont.)

Objective:	Baseline Stat:	Result:	Intended Result:	Outcome:
Through 2015, maintain or reduce hypertension-related emergency department visits [2012]	129.3 rate of emergency department visits due to hypertension (per 100,000 population)	148.9 [2014] rate of emergency department visits due to hypertension (per 100,000 population)	Maintain or reduce hypertension-related emergency department visits	Goal was not met

Evaluation of the previous CHIP was not completed in a comprehensive manner, due to the State of Maryland's mandate that the local plan address the 39 Maryland objectives set forth by DHMH. We were well into a Mobilizing for Action through Planning an Partnerships (MAPP) process that was reflective of the Community Health Assessment. However, the CHIP was heavily influenced by the state mandate and much less by the actual Community Health Assessment. Therefore, tracking progress was very difficult because of the lack of community buy-in. In moving forward, the increased community buy-in, along with investing significant resources in a digital planning tool with transparency and ease of data collections and reporting will equip each partner to report and access data at any point. Taking into consideration the evaluation of the previous CHIP and our current status of health, new planning efforts and innovation are underway. We're hopeful these efforts, along with this Community Health Assessment will make the CHIP more useful.

JOIN US!

PARTICIPATE IN THE DISCUSSION ONLINE AT

GARRETTPLAN.ORG

ENGAGING MULTIPLE STAKEHOLDERS

Overview of the Health Planning Council

For decades, the Garrett County Health Department has led the way in addressing issues concerning public health. At the Garrett County Health Department, we not only provide traditional population-based public health programs, like environmental health services, but are an essential community provider for many direct specialty services, like the behavioral health center. By doing so, we provide assurance that these services are available for our residents. We strive to provide the 10 essential public health services important to any community. We continually work to respond rapidly to changing conditions or to take new approaches to solving long standing problems like our changing tobacco cessation efforts. We realize it takes more than a single agency to improve population health. A formalized collaborative group formed in 1997, brings agencies and community members together. The mission of the Health Planning Council (HPC). is to ensure a high quality effective integrated community care system that is responsive to the needs of the Garrett County people. The Council strives to accomplish this mission through an open public process that encourages and enables the community to work together to adopt goals and achieve objectives. This Council also serves as an advisory council to the Garrett County Board of Health.

In 2012, the Maryland Department of Health and Mental Hygiene (DHMH) mandated that every county have a Local Health Improvement Coalition to use local health data to set priorities and work toward population health improvement. The Health Planning Council serves in this role by providing leadership for the Community Health Assessment (CHA) and the Community Health Improvement Process (CHIP).

A dedicated health planner was hired by the Garrett County Health Department in April of 2015 to champion the planning efforts of the community. The first order of business was to expand the HPC to include permanent members from non-traditional sectors in the community making it easier to address the social determinants of health. This enabled the Council to have greater collaboration across sectors and included representation from various community organizations, local businesses, non-profits, government agencies, health care systems, economic development, and the local chamber of commerce to advance public health practice with the goal of improving population health.

SHIP: http://dhmh.maryland.gov/ship/Pages/home.aspx March 2, 2016

Groups and Organizations Involved in this Study

The Community Health Assessment was championed by the Garrett County Health Department, supported by the Garrett Regional Medical Center, led by the Health Planning Council with collaboration from the University of Maryland Extension Office. This effort wouldn't have been as successful without the partners listed below. Due to the confidential nature of the study the need to protect those individuals who spoke freely in the focus groups will not be disclosed. Special thanks goes out to everyone for their sincere sharing and hope demonstrated by participation. It was a true grass roots initiative holding true to Garrett County's reputation of working together.

- AHEC-West
- Area on Aging
- Core Service Agency
- Department of Juvenile Services
- Department of Planning, Land Management
- Dove Center
- Drug Free Communities Coalition Action Teams
- Garrett College
- Garrett County Chamber of Commerce
- Garrett County Commissioners
- Garrett County Community Action
- Garrett County Department of Social Services
- Garrett County Emergency Management
- Garrett County Health Department
- Garrett County Public Safety
- Garrett County Public Schools
- Garrett County Sheriff's Office
- Garrett County State's Attorney
- Garrett Regional Medical Center
- Garrett Trails
- Hospice of Garrett County
- Oakland Nursing and Rehab Center
- Office of Economic Development
- Office of Public Safety
- Mountain Laurel Medical Center
- My Bank First United Bank & Trust
- Ruth Enlow Libraries of Garrett County
- The Republican
- The University of Maryland Extension Office
- Wildwood Athletic Club

METHODS

Implementing the CHANGE Tool

In June of 2015, the Health Planning Council (HPC) began the work of identifying and choosing a framework on which to build the Community Health Assessment. The CHANGE (Community Health Assessment and Group Evaluation) tool, a gold standard for community planning from the Centers for Disease Control and Prevention was voted upon and chosen unanimously. The CHANGE tool is designed to help communities evaluate how its community makeup and structure are influencing community health and the indenification of improvement improvement areas.

One of the key recommendations of CHANGE is to collect data simultaneously through multiple methods with various sectors of the community. This is done to ensure data is current and represents the whole community. These sectors are:

- Community at Large
- Community Organizations
- Schools
- Healthcare
- Worksites

Workgroups were formed for each of these sectors, the groups discussed in depth what information we needed to gather and who we should gather it from. The HPC decided to collect both primary and secondary data to create a holistic picture of Garrett County's health. Primary data consisted of focus groups and a community needs survey. Secondary data included SHIP (State Health Improvement Process), Census, Vital Stats, BRFSS (Behavioral Risk Factors Surveillance System), YRBS (Youth Risk Behavior Survey), Robert Wood Johnson Foundation County Rankings and Roadmaps, Office of Primary Care Needs Assessment, and a walkability audit.

Community Health Assessment and Group Evaluation (CHANGE): Building a Foundation of Knowledge to Prioritize Community Health Needs—An Action Guide: http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/change/downloads.htm June 6, 2015

Implementing the CHANGE Tool (Cont.)

Two methods outlined by CHANGE allowed the HPC to understand both what was going on in the community and how it impacted their lives. Further refinements and adaptations of the CHANGE tool were made to fit the needs of Garrett County. First, the committee voted on and agreed to capture data on behavioral health. Second, the committee decided that they wanted to collect both community level data and individual data, which is not part of the original CHANGE tool. Finally, the committee agreed to include a participatory approach to data collection by seeking the voices of clients, fellow service providers, partners, and funders.

In order to accomplish this, an expert was sought to conduct the research and a significant donation was made by Garrett Regional Medical Center to aid the study which began January 1, 2016, and concluded March 15, 2016. Healthy Mountain Maryland hosted the community needs survey, capturing two perspectives: (1) Answering questions related to the individual's main concerns and (2) Answering questions from what those individuals feel their top concern was for their community. The Survey was designed to examine many issues: 1) How well specific programs serve the participants according to their own assessment. 2) Current services offered by community providers to gain insight into the opportunities and the gaps providers experience in the offering of services in the community. In addition, sixteen community focus groups were held targeting each sector of the CHANGE tool.

Both quantitative and qualitative information is needed to develop a shared understanding of how people are affected in communities. Simplistically, quantitative data provides a numerical picture of "How many?" and qualitative data focuses on determining the nature of the impact by answering the "How?" and "Why?" questions. In any assessment there are challenges in finding the right balance of both types of data to identify trends and overarching issues.

The results of our process yielded a tremendous amount of data. What we can hope is that despite relatively small sample sizes of data sources like the YRBS and others, the analysis will help us recognize trends over time. Generally, qualitative data provides textual observations that portray attitudes and perceptions of the sub groups that participate. Though we held focus groups for diverse sub groups, assertions of certain experiences may be held only by those sub groups and not representative of the general population.

For the purposes of this document, the input gathered from this process provides a descriptive picture of needs in our community. The survey and template focus group script can be found in Appendices B and C respectively.

RESULTS

Primary Data Reporting

Outreach and General Demographics
For the survey, we used our partner network as a main source of outreach beginning with employee emails, meetings, and public events to encourage people to participate. We offered a $100.00 incentive to one person at the end of the survey. All branches of the library provided internet access to the community as well as a Kiosk in the Hospital Lobby managed by dedicated hospital volunteers.

People Reached: Just shy of 1,000
Those ages 45 to 54 made up the majority at 173. Those ages 55-64 were the second most represented at 167. Those ages 35 to 44 made up 140, while 25 to 34 year olds had 103 of the total responses. Our youngest segment, ages 18 to 24 had 89 people represented, and our eldest 75+ were represented by 10 people.

The following 8 towns were represented in the county with more than 10 responses each:
Oakland (313), *Accident* (43), *Grantsville* (67), *Swanton* (43), *McHenry* (46), *Friendsville* (29), *Mountain Lake Park* (29), and *Deer Park* (11).

Those with an income between $50,000 and $74,999 were most represented. However the focus group participants had the majority of income between $35,000 and $49,999. 17% of the population surveyed had an education level of high school diploma or GED, 40% had some college, 22% had advanced degrees, and 21% had a Bachelor's degree.

Focus Groups consisted of 72 females and 41 males fora total of 155. The age ranges were closer in the focus groups, so we had about the same representation from the groups with the exception of the very old and very young. Those ages 35 to 44 made up the majority at 26%. Those ages 55-64 were the second most represented at 25%. Those ages 25 to 34 made up 17%, while 45 to 54 year olds had 16% of the total responses. 65-74 year olds made up 10.9%. Our youngest segment 18 to 24 year olds made up the smallest percent represented at 3.3%, and our eldest 75+ were represented by 5.4%. Education levels were also closer; 36% of the population held a graduate or professional degree, while 19% had a bachelor's degree. 28% had some college, and 16% just finished high school. 1% had less than a high school education.

Primary Data Reporting (Cont.)

After the participants read the explanation of the survey, they answered a series of general health questions with the final question of the first section asking them to choose their number one health concern. From here skip patterns were built into the survey and they were directed to answer only the questions that pertained to their top area of concern.

Finally, prior to starting both the focus groups and the survey, participants were informed of their rights as a participant. This included a review of confidentiality and privacy procedures, how their data would be used, and methods of reporting. These procedures were reviewed and approved by the University of Maryland Institutional Review Board.

Individual Health Findings

To start the survey, participants were asked a series of standardized health indicator questions. The majority of respondents indicated that their health was "very good" (45%), followed by "good" at 37%, 10.4% reporting "excellent" and the rest reporting "fair" or "poor". Participants were then asked to indicate their top health concern for them and/or their family. Table R-1 below shows the results:

Health	Number	Percent
Nutrition	224	36%
Physical Activity	203	33%
Chronic Disease	135	22%
Mental Health	25	4%
Tobacco	24	4%
Drugs and Alcohol	13	2%

Table R-1

The majority of participants were most concerned with nutrition, closely followed by physical activity and then chronic disease. For the categories mental health, tobacco, and drugs and alcohol, fewer than 30 people per category indicated it was their top concern. In fact, the reporting number was too low to draw any statistical meaning from the data.

Participants who indicated nutrition was their top concern were asked a series of questions about their eating habits. Over 50% of people indicated they cook and eat dinner with their family 5 or more times a week. However, this did not necessarily translate to healthier food options. Two thirds, or 67%, stated they met the federal nutrition guidelines 3 or fewer days a week.

Barriers to healthy eating were explored in both the survey and focus groups. Barriers differed by income, with those making $35,000 or more indicating the main barrier was time. For those making under $35,000 the main barrier was cost. The third most common response was lack of choice, which was consistent across all groups.

Nutrition

The reasons for unhealthy eating were reflected in the focus groups. Below are a few examples of the barriers to healthy eating:

"Local restaurants are not using the farm to table movement, who kind of have more creative menus, a little more adventurous, rather than normal bar foods."

"I think it is just the lifestyle for a lot of people, they get the bad stuff so often, that's what they know."

"I think a lot of it is conditioning. I mean you get a kid that's eight and you say do [you] want French fries or an apple….i don't know many kids who will choose the healthy one."

People were asked about awareness and use of community resources to assist in healthy eating. The majority of participants indicated they were not aware of the community resources. Of those who were aware, 30% accessed Hospital-based programs, followed by Extension services (24%) and WIC or the Mountain Laurel Food Bank (11%).

The survey also asked about healthy eating options in schools. Sixty-six percent of people stated that they believed that school cafeterias offered nutritious healthy eating options. However, 66% percent believed the vending machine food was not healthy and only 30% felt that nutrition education was adequate.

This tension or disagreement was also seen in the focus groups. Many participants, regardless of the community sector they represented, disagreed about how healthy food options actually were. One school sector group stated the options were healthy because they followed the federal guidelines, while another stated that they were not. Additionally, one noted that while school lunches might be governed by the federal guidelines, the free and reduced breakfasts offered in some schools were not healthy.

Finally, participants were asked about the assistance they received from health care providers and organizations. Thirty-six percent of participants stated that their physician spoke with them about nutrition at their most recent visit. Those who indicated they had gone to Garrett Regional Medical Center, Mountain Laurel and the Garrett County Health Department were less likely to indicate nutrition was discussed, at 21%, 12% and 27% respectively.

Physical Activity

Thirty-three percent indicated that physical activity was their number one health concern. Only 17% of people indicated they met the federal recommendations of physical activity, engaging in moderate activity four or more times a week. Nearly half (48%) stated they engaged in moderate activity 1-3 days a week and the rest (34%) stated they did not engage in any moderate activity. This trend was virtually the same for all groups, with only those ages 65 and older engaging in more physical activity than the rest of the groups. Over half (52%) stated they liked to hike/walk, followed by running (8%) and swimming (7%).

Barriers to physical activity were discussed by both the focus groups and the survey respondents. The top three responses were weather, transportation, and cost/access to these resources. Focus group participants echoed this by stating:

"I think that things you said are not accessible in a disability way, but to a lot of the community that don't have the money. They can't go to the CARC. They can't go to the state park because it costs money..."

The survey asked people to indicate how often they access the parks, recreation & leisure resources, and physical activity facilities. The majority stated that they never accessed these resources or if they did, it was not more than once a month. Additionally, over 50% of people indicated they never visited the CARC for physical activity. Strategies to increase access were discussed in both the survey and focus groups. The top solutions were to lower the cost of activities (48%), 24% stated more facilities need to be built throughout the County, 18% want more choices and 10% wanted extended hours.

Schools and their impact on physical activity were discussed. The majority of people (70%) felt that schools had a positive impact on the physical activity of students. Specifically, people felt that schools:

- **Provide a wide range of physical activity options (81%)**
- **Engage students in an adequate amount of activity during PE (75%)**
- **Maintain equipment at least somewhat well (82%)**
- **Promote physical activity in elementary (87%), middle (72%) and high (72%) schools**

However, similar to the nutrition findings, focus groups participants were in disagreement about the adequacy of physical activity in schools. Some stated that the equipment in schools were not well maintained, while others discussed what they perceived to be inadequate activities in schools. This was not seen in all focus groups but was a discussion or debate in many.

Physical Activity (Cont.)

While the physical activity offerings of the school system were extolled, many of the focus groups believed that youth did not engage in enough. Many groups discussed the negative impact video games and other technology had on physical activity. People felt that youth spent too much time on these devices and not enough time outdoors. Further, they felt that the weather and lack of family resources contributed to this trend.

Finally, the health care response to physical activity was explored. Participants were asked about how often their doctor addresses physical activity. Approximately half (52%) of people stated their doctor did discuss physical activity with them but only 21% stated their doctor "prescribed it" as part of their health regimen.

Chronic Disease

One hundred thirty-five people indicated their top health concern was the prevention and management of chronic disease. Individuals were asked to indicate if they had ever been told they were at risk for or been diagnosed with certain chronic health conditions. Overall, the top three conditions people were at risk for were high blood pressure (55%), high cholesterol (46%), and being overweight (43%). These were the same conditions people were also likely to indicate they had been diagnosed with. Finally, people were likely to state that they had family diagnosed as being overweight (43%), having high blood pressure (42%), and/or high cholesterol (33%).

People were asked about available community resources to control chronic disease and their likelihood of using them. The resources indicated they would be most likely to access included health insurance resources (76%), followed by the Living Well program (74%). After that, the majority of people (more than 50%) indicated they would not at all be likely to access any of the community resources available. The most common reason was lack of affordability, belief they do not need a program or that resources were not near their home.

When asked about the healthcare response to chronic disease, the majority of people (67%) stated their doctor talked about chronic disease with them or had done so over the past year (72%). Looking at other resources, 49% stated they were likely to access Mountain Laurel, 64% stated they were likely to access the Garrett County Health Department, and 68% stated that they were likely to access Garrett Regional Medical Center. The top reasons for not accessing these facilities were the facilities not being located near their home, lack of resources to address chronic disease, hours, and not being qualified for health services.

Finally, the participants were asked to indicate whether or not they believe schools were addressing chronic disease with students. Participants indicated they felt schools were accommodating students with special needs (83%), but were not necessarily educating them on the signs and symptoms of different illnesses (68%). In the focus groups, chronic disease education in schools was not specifically discussed; rather participants spoke more about the other health concerns discussed above.

Community Health

After answering the questions associated with their top individual/family health concern, people were asked to indicate their top health concern for the county. Table R-2 shows the results:

Health	Number	Percent
Drugs and alcohol	315	41%
Physical activity	140	18%
Nutrition	129	17%
Chronic Disease	106	14%
Mental Health	43	6%
Tobacco	33	4%

Table R-2

As shown, 41% of people ranked drugs and alcohol as the number one community health concern, followed by physical activity (18%), nutrition (17%) and chronic disease (14%). Unlike the individual health concerns, drugs and alcohol were ranked number one across all groups. Similar to the individual health concerns, only a few participants were concerned about the mental health and tobacco activity of Garrett County residents. Below we discuss the findings from the drugs and alcohol section because physical activity and nutrition responses mirror those seen in the individual health section.

Chronic Disease

Chronic disease was chosen by 14% as the number one health concern in Garrett County. Individuals who selected this were likely to self-report either being at risk or diagnosed with a chronic health condition. The three most common conditions were high blood pressure, high cholesterol and being overweight. Similar to the individual health section, people believed that others with chronic health conditions either didn't want help (27%) or could not afford the local community resources (23%).

Drugs and Alcohol

The use and abuse of drugs and alcohol was perceived to be vast. Ninety-four percent felt that people engaged in moderate to heavy drug use throughout the week, with only eight people saying it was uncommon. Of those drugs being abused, the top drugs were alcohol (89%), marijuana (84%) and opiates (72%). Focus group participants believed this was partially due to the lack of activities and resources in the county. One stated:

"They are going to do drugs or smoke because there is not enough physical activity, good diets, lack of programs, lack of social time, lack of nature time..."

When asked about who was abusing drugs and alcohol, people agree that the problem transcended age and socioeconomic status. There was agreement that the problem started in youth and was likely to increase as individuals got older. One person said:

"It transcends age and socioeconomic status. There's a ton of it in the schools, but I know a lot of people that are 20 to 40 and I know a lot of older people. I don't think with that particular drug it matters."

Additionally, many focus group participants felt that the drugs were not intrinsic to Garrett County, but were created by non-residents.

"I think they believe a lot of it's being brought here from the cities, because you've got the Interstate."

Drugs and Alcohol (Cont.)

When asked about the healthcare response to drug and alcohol use, 78% believe the Garrett County Health Department was likely to address these issues, followed by Garrett Regional Medical Center (69%), primary care doctors (58%) and Mountain Laurel (56%). Outside of these specific health care resources, people were asked about knowledge of treatment services and likelihood they were being used. Table R-3 shows the results. As shown, people felt those in need of services were most likely to both be aware of and use the Garrett County Health Department, followed by the emergency room, methadone clinics and 12-step recovery programs.

Resource	How aware are people? (somewhat to very)	How Likely are people to use? (somewhat to Very)
12 Step Programs	52%	47%
Celebrate Recovery	19%	23%
Primary Care Doctors	50%	38%
Methadone Clinics	54%	58%
Garrett County Health Department	75%	64%
Emergency Room	64%	53%
Other Resources	23%	27%

Table R-3

Finally, people were asked about their opinion on barriers to seeking treatment. Almost half, or 46%, felt that those with drug and alcohol dependencies did not want help or treatment, followed by fear or shame (22%) and lack of awareness about different resources. This was partially seen in the focus group responses, with people saying the following:

"User is stigmatized, not treated as a normal patient with a chronic disease."

"Well, I think part of it, from my knowledge of it, is a lot of it's intrinsic on the person. They have to kind of hit rock bottom and make the conscious choice that they want to change rather than be mandated to change or be pressured into trying to change."

DISCUSSION

Perceptions of Life in Garrett County from Focus Group Data

When answering the question, "What do you like most about living in Garrett County?" There was a consistent trend across the population. Virtually all of the following were reported in each focus group:

Open Space: The concept of having plenty of room. This supports the census statistic of 46 people per square mile. Uncongested commutes, no traffic, clean air, and the ability to find solitude.

Outdoor Recreation: Enjoying ample opportunities to experience nature. Availability for hiking, fishing, hunting, mountain biking, and ORV/ATV riding opportunities, mostly on private land. People also enjoy the four seasons.

Great Place to Raise a Family: With its small town feel, the close communities are evidenced by people helping others. There are families staying in the area through multiple generations- "everyone knows everyone." Accountability is present and there are ample faith based communities for family involvement. In general, low crime rates and lack of violence were also discussed.

The Weather: This was both a positive and negative. Those who enjoyed cooler temps and didn't mind the snow touted the weather as positive, while all enjoyed the cooler summers. Isolation, and what some referred to as hibernation is a real problem since the winter season is so long.

Targeted Health Areas

The health of Garrett County residents and community is dynamic and somewhat disconnected. Individual needs and concerns center around the prevention of chronic disease via physical activity and nutrition education, with minimal focus on tobacco and behavioral health issues. Conversely, residents believe that the greater community needs the most assistance in the prevention of behavioral health issues. This is seen with the prioritization of individual and community concerns, with 36% of people saying that physical activity and 33% nutrition were important, and 41% saying the community needs behavioral health services, especially related to substance abuse.

Targeted Health Areas (Cont.)

Research shows that to prevent chronic disease, a large part of the focus needs to be on the creation of healthy behaviors and the modification of unhealthy ones (World Health Organization, 2010). This is typically done through emphasizing healthy eating and physical activity. As shown in the survey data, only 17% of respondents are physically active and likely meeting the national guidelines for activity. Similarly, 33% of respondents say the majority of meals are healthy and reflect the FDA nutrition guidelines.

However, this trend was not consistent across the population. Similar to other communities, those with lower incomes ($35,000 or less a year) indicate that they either could not afford or lacked access to healthy food options. Physical activity was also limited in this population because of cost and access issues (transportation, weather, etc.) to local parks and facilities. These barriers likely contribute to the high rate of chronic disease seen in Garrett County residents.

This divide in physical activity rates and healthy eating habits was not readily apparent or understood by all Garrett County residents. Focus group participants were divided on their perception of accessible healthy food and physical activity options for the greater population. Those whose household income was greater than the county average, had positions of influence and/or were of a white collar background viewed Garrett County as having many healthy and affordable options for all citizens. Those participants who were from a limited resource background and/or worked with limited resource individuals reported food deserts and limited access to available resources.

Additionally, focus group participants discussed the effect that poor nutrition and low physical activity had on children. The education sector focus group participants discussed the number of children who came to school hungry. Data supports this belief- 100% of the county schools qualify for free and reduced meals for students. Further, many of the community at large and community organization focus groups talked about backpack meal programs, where low-resource youths are given backpacks with nutritious foods to help feed them over the weekends. Finally, participants suggest that while the schools technically follow school nutrition guidelines for lunches, the free breakfast did not.

Physical activity was a concern for youth. The survey results and focus group perceptions revealed that while schools may have opportunities for youth to be physically active, these were diminished in the community. Reasons varied from social (playing video games) to economic (high cost of gyms and other facilities) to nature (weather patterns). While possible to overcome these barriers, it is difficult for youth from low-resource families to secure the resources necessary.

Interestingly, tobacco use was not seen as a concern by the community. Approximately 3-4% of people felt this health behavior was a concern for either them or the community. The rationale for this perception was elucidated in the focus groups. Participants from virtually all focus groups discussed tobacco as being a rite of passage for youth and part of local culture, especially for those in farming and blue-collar industries.

Vaping, e-cigarettes, and smokeless tobacco options were seen as safer alternatives to smoking. One participant from the community organization sector discussed how he used vaping to quit cigarettes because it was a safer alternative. This viewpoint is reflective of a nationwide trend where people are using vaping and e-cigarettes to quit smoking. However, research is showing that vaping and e-cigarettes often contain more nicotine than traditional tobacco products and youth are engaging in these activities because it is a perceived safer option (American Lung Association, 2016; Mello, Bigman, Sanders-Jackson, and Tan, 2016). This is contrary to recent research which shows that vaping is likely to have both short-term and long-term health effects on the user.

Targeted Health Areas (Cont.)

Perhaps the most surprising finding was the concern over substance abuse and mental health issues. While research shows that these two are often co-occurring disorders, people ranked substance abuse as their number one health concern and mental health as fifth. Further, substance abuse was identified by two times more people than the second ranked health concern and seven more times than mental health.

The focus groups gave some insight into this ranking. Most focus groups, unless they worked directly with health care consumers, were not able to discuss the impact of mental health on their county. However, nearly all discussed at length the influence drugs and alcohol were having on the local community. People discussed the influx of marijuana and prescription drugs, leading to greater rates of addiction. One focus group, comprised of behavioral health clients and their families, discussed how many people are introduced to drugs at a young age and become addicted within a short period of time. One participant discussed her personal journey of addiction through over-prescribing of painkillers by her physician to manage chronic pain. Prior to turning 18, this participant became addicted to pain killers, switched to heroin because of cost and ease of access, contracted Hepatitis, entered rehab and became sober. During this journey, she was put on methadone to kick the habit- however this treatment proved to be more difficult to stop than the heroin itself.

Members of the healthcare sector discussed the mental health and substance abuse issues of their patients. Providers stated that many efforts were being implemented to prevent addiction to prescription drugs; however, they admitted that not all physicians are using them. Health care providers talked about the struggle of wanting to help patients manage pain while preventing over-reliance on drugs. They stated many patients have adopted the “no pain is allowed” mentality and are choosing the quick fix of narcotics instead of pain management therapy. This puts the provider in a difficult position.

Data also revealed a gap in care- the ability to care for behavioral health patients when they are in crisis. Emergency response personnel discussed the lack of, and need for crisis training for behavioral health issues. Many shared experiences about households and/or individuals who relied on EMS to aid in a crisis with the hope of preventing its reoccurrence. Stories centered around being called to the same household repeatedly for mental health and/or substance abuse crises, taking patients to the hospital and then having them released within a few hours to a few days due to lack of services for this population. This results in a continuous cycle of crisis response with little to no hope for solutions.

When people are willing, able, or required to seek behavioral health services, there is a virtual drought within Garrett County. The survey showed that the majority of the community is unaware of mental health and substance abuse resources not residing in either the Garrett County Health Department or Garrett Regional Medical Center. Of those who were aware and may have cause to seek services, many indicated barriers to access (transportation, time and money) and social stigma kept them from seeking care. Additionally, the majority of focus groups discussed the lack of mental health providers in the community. This has led to waiting lists with local psychiatrists and social workers, inconsistent care, and over-reliance on opioids. Health care providers were frustrated and believed this lack of qualified behavioral health providers leads people to misuse and abuse drugs, thus creating a cycle of dependence.

Targeted Health Areas (Cont.)

Finally, this issue is exacerbated and magnified in youth. At the time of this study, no child psychiatrist worked in Garrett County. Many of the early behavioral health issues were seen in schools and managed by school counselors, both employed by the Board of Education and the Garrett County Health Department. School sector focus group participants conveyed frustration with both the system and the lack of behavioral health awareness by families and loved ones. They reported families who avoid seeking follow-up appointments and care for youth. The problem persists in the inability of the health care system to care for youth and the increased stigma around mental health preventing acknowledgement by the greater community.

Emergent Health Areas

For the purposes of this report, the emergent health areas are those that appeared organically through the focus group process, which were not initially identified by the Health Planning Council as being a priority to focus on and were discussed in multiple focus groups. These centered around three main issues: homelessness, access to care, and fear of others.

Homelessness:
Homelessness began to emerge as an area of concern through the school sector and community at large focus groups. The schools discussed and addressed this issue through the lens of education, with students being unable to focus and achieve due to the inconsistency in housing. This was discussed through the lack of homework and school learning preparation, hunger issues, discipline issues, lack of hygiene, and emerging behavior issues. Research suggests these behavior issues are likely caused by underlying mental health issues, which could include the stress, anxiety, and depression of not having a stable environment (Felitti et al., 1998; Felitti, 2009).

However, the issue of homelessness broke through during a low-resource focus group. Hosted at a local community site, several participants had experienced intermittent homelessness in the county. They discussed seasonal tent encampments, located both in the northern and southern ends of Garrett County, where homeless gather. Participants conveyed a lack of social resources to assist and elevate the homeless completely out of this situation. For example, one key element to eliminating homelessness is jobs and job training programs. They discussed the hardship of finding employment without having a roof over their head, clean clothes, or skills to fit positions. Garrett County has limited resources to assist, with only two shelters identified. However, one is for transitional situations requiring residents to secure jobs and pay a small monthly rent, and the other for victims of domestic violence. Further, the first shelter has a waiting list, preventing many from accessing it.

Finally, the cycle of homelessness was discussed. In terms of Garrett County, this was the shift between pure homelessness to insecure housing in terms of couch surfing, living out of cars, and residing in non-residential facilities. This issue spans across all age groups. Senior citizens who have exhausted all other resources are especially affected. One participant discussed living out of a hotel for a couple months while working at a local restaurant, while members of the school sector discussed youth being shuffled between grandparents and living out of vehicles. The school sector participants stated they helped in little ways by letting kids shower before school or washing clothing but few other resources existed. Similarly, the homeless participants stated many people, including themselves, cycle in and out of homelessness throughout the years with little hope for permanence.

Emergent Health Areas (Cont.)

Access and Linkages to Care:
A concern arose in the focus groups about the access and linkages to care. As previously discussed, Garrett County is a medically under-served area. One hospital serves all 30,000 residents. There are seven primary community-based physician offices, and four with outreach patient centers. There are few specialty care physicians, and as previously discussed even fewer mental health providers. Emergency dental care was another gap identified. These gaps in service create limited access to providers and few linkages within the community. Focus groups spoke to this; one example centered around a behavioral health crisis. Providers, emergency response professionals, and community members alike spoke about crisis patients being stabilized in the hospital and then released to the community with no behavioral healthcare resources readily available to continue treatment.

Fear and Distrust of the Others:
The “others” in sociological terms refers to those that fall outside of normal social groups. For Garrett County, the "other" consists both of non-residents and part-time homeowners who did not grow up in the area, and tourists. This group was viewed with hesitation, suspicion, and fear.

There is much tension between full-time residents who have lived in the county most of their lives and the “others”. While the county relies on the “others” for economic reasons, constituting over 50% of the tax base, focus group participants felt resources are misdirected towards this small group. Thus, this was viewed as causing further disparity of health and economic well-being. Fear and blame is therefore directed towards this group. It is not unexpected that fear would occur. Research into rural Appalachian culture shows that many do not trust outsiders and those whose beliefs do not match their own. While beneficial and protective of the community in some ways, this belief system has resulted in lack of awareness of internal community health issues and likely increases the stigmatization of people who suffer from complex health issues.

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SUMMARY

We all want the same thing... a healthier place to live, work, and play! Garrett County residents are loyal, proud and protective. They spoke up and came out to voice concerns with a desire to make sustainable changes to improve the county. They love where they live and want to maintain the attributes that make Garrett County so special.

Let's remember that although Garrett County has challenges and residents have concerns that need to be heard and acted upon, there is great work being done in the county to mitigate some of these issues. Looking at some of the health indicators from the SHIP data, Garrett County ranks very well in the state of Maryland. In a few categories we lead the state, in others we rank the lowest, but in most of the indicators we are above average compared to the other counties in the state. This speaks to the diligence and tireless work of service providers. While it is true that we can certainly work more effectively when we come together, the people who live here have a history of doing just that.

WE'RE ECO-FRIENDLY!

The 2016 Community Health Assessment appendix is now digital!

Download the full appendix at:

garrettplan.org/cha

Images from CDC, Pexels, Pixabay, and Unsplash

WE HEARD YOU!

In the last section of each focus group, participants were encouraged to "Dream Big" and if cost was not a concern what is the one thing they would do to make living in Garrett County better for the community. Below are the responses we heard consistently:

TRANSPORTATION & BETTER JOBS

Nutrition

- Greater nutrition education and exposure to healthy foods in the schools
- Cooking classes to learn easy, fast, healthy recipes
- Provide low-resources families and youth with more healthy food options
- Create connections between local farmers and schools to increase access to locally grown, healthy foods

Physical Activity

- YMCA or other low-cost gym facility
- ADA accessible trails for limited mobility people
- Convert unused buildings in towns to low-cost sites for community activities

Behavioral Health

- ***MORE RESOURCES!***
- Trained professionals , Psychiatrists who will treat children!
- Reduce stigma around Addiction and Mental Health

System Recommendations from the Expert, Dr. Brown

- Create jobs and training opportunities
- Coordinated transportation system for everyday use
- Increase mental health and addiction treatment resources
- Provide more homeless and transitional housing options
- PR campaign to educate local citizens on how their tax dollars benefit them
- Empower people from all parts of the population to participate in this process and understand the value they bring

WHAT DO YOU LOVE ABOUT LIVING IN GARRETT COUNTY?

"I enjoy spending time in the woods, hiking, dirt biking, being on the lake. It is fantastic. This allows me to relax and be one with nature and let things go."

"I think we are very blessed to have a community where everybody wants to get their hands involved and make some changes."

"We come here for the clean air and clean water."

"I like the number of organic farmers we have. From table operations, CSAs (Community Supported Agriculture) and I like that we live right next to it. We can do that if we want."

"It's a great place to raise kids!"

"I feel safe and there's not a lot of other people around, you see familiar faces and just know people because it's a small town. I like living in a small town."

Thank you!

Special thanks to all those who participate on the Health Planning Council, both agency representatives and community members. Those who take an active role in fulfilling our mission are treasured. The commitment to compliment rather than compete makes our Health Planning Council more successful in providing a community care system that is responsive to the needs of Garrett County residents and visitors alike. It's important to the Health Planning Council to collect and provide relevant information so the council and the public can make informed choices about the health of the community.

JOIN US!

PARTICIPATE IN THE DISCUSSION ONLINE AT

GARRETTPLAN.ORG

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