Del Norte & Adjacent Tribal Lands

Selected Findings from the Community Health & Wellness Survey

Tribal Residents

CCRP
California Center for Rural Policy

by The California Center for Rural Policy, Humboldt State University

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- Smith River Rancheria
- Resighini Rancheria
- Karuk Tribe
- Yurok Tribe
- Hoopa Valley Tribe

Executive Summary

The Community Health and Wellness Survey was conducted by the California Center for Rural Policy (CCRP) in 2013. The purpose of the survey was to assess community health indicators in the Del Norte and Adjacent Tribal Lands region.

The eight page written survey contained questions about wellness indicators pertaining to economics, education, health care, neighborhood built environment and social and community context.

This report contains selected findings for individuals that indicated their ethnicity was Native American. The findings presented in this report are based on 238 responses from Native American respondents from the DNATL region.

Income

Poverty is based on household income level adjusted from family size and age of family members. In 2013, for a single person under the age of 65, an income of $12,119 was the threshold for poverty. When household earnings were less than the threshold, the household is considered to be in poverty. Poverty was more prevalent in the DNATL NA population than in California.

- 35.3% of the NA survey respondents had a household income below the Federal Poverty Limit threshold
- Household income varied with education level. The median income was 3 times greater among those with a college degree when compared to respondents who did not complete high school

Food Security

Food security is a complex condition, with various level of insecurity and multiple risk factors. There was a clear connection of increased risk of food insecurity when household income fell below the Federal Poverty Limit threshold.

- 1 in 4 households in poverty experience hunger
- Risk for anxiety about the supply of food was 3 times higher in households in poverty
- Two-thirds of households in poverty could not afford to eat balanced meals
- 64% of households in poverty found that they could not afford enough food to meet their family's needs
- 18.5% used the Food Bank as a resource for food

Del Norte County has been identified as a food desert by the USDA, qualifying the region for grant funding to support programs to increase accessibility of nutritious foods

Health

Many factors contribute to quality health care, including access, coordination of care and patient engagement.

- 87% of the NA respondents had medical health insurance or access to United Indian Health Services (UIHS)
- Less than half of respondents without insurance or access to UIHS had a health care provider who was familiar with their health history
- Almost three-quarters of respondents with insurance or access to UIHS had a personal health care provider
- 85% of the NA respondents indicated that they had a source for medical care that was not an emergency room or urgent clinic
- 35% of NA who needed a referral to a medical specialist found it difficult to obtain the referral
- 93% of NA indicated that they felt like a partner in their own care and that their provider was sensitive to their values and customs
- Receiving effective care coordination and obtaining needed referrals are areas that need improving to enhance quality of care of area residents
- Only 35% of the survey respondents had healthcare that met the quality standards of Patient Centered Medical Home

Introduction

Background

Health starts were we live, learn, work and play. Health and wellness are affected by factors that are associated with place. Economic conditions in communities can influence health by affecting access to employment opportunities and health insurance. Social conditions in communities can influence health by providing resources for individuals in need, by controlling advertisement of behaviors that pose health risks like drinking and smoking and by creating programs to encourage healthy behaviors like daily physical activity. Physical conditions in communities can influence health by ensuring good quality of the air and water, by providing safe environments, and increasing access to healthy foods. The community in which we live affects our health status and even our longevity.[1-4]

Understanding the important role that place has in wellness, The California Endowment selected 14 communities in California to invest resources.[5] The criteria for selection included communities that have poor health outcomes but that also have potential for change. The California Endowment selected the 14 sites based partially on their social capital. Social capital is the collective forces of individuals, agencies and networks that can be mobilized to elicit change. Del Norte County and Adjacent Tribal Lands (DNATL) was selected as one of the 14 sites to invest resources because The California Endowment recognized that the community had the "potential to inspire policy change to create a healthy environment for all Californians".[5] The California Endowment provided funding through the Building Healthy Communities Initiative to create avenues for change that promote health in those 14 communities.

During the initial stage of the Building Healthy Communities project in DNATL, it became apparent that there were many community health indicators that could be used to measure community health, but baseline data were not available for DNATL. Through a community engagement process, a list of health indicators were identified and it was determined that baseline data was needed. From this list, the Community Health & Wellness Survey (CHWS) was created. The CHWS included measures of social determinants of health including the built environment, neighborhood cohesiveness, education level, income level, employment, food security, and quality health care. The CHWS was designed to provide a baseline measurement of determinants of health that are associated with place. Accurate baseline information about community health and wellness is critical for understanding and improving upon conditions that impact health and wellness.

The survey was developed after engagement with the DNATL community and support for the survey was sought through community agencies. Efforts were made to encourage widespread participation with particular attention to populations that are generally underrepresented in survey research. Meetings with tribal council members provided an opportunity to introduce the survey and address questions and concerns. All tribal councils in the area, including Elk Valley Rancheria, Smith River Rancheria, Resighini Rancheria, Karuk Tribe, Yurok Tribe, and Hoopa Valley Tribe provided endorsement of the survey. The surveys were made available at each tribal office. The Hmong community was engaged through an elected clan representative. The survey was translated to Hmong and was distributed to Hmong families through the clan representative. The survey was also translated to Spanish. The survey was endorsed by many area agencies, including the County of Del Norte, First 5 Del Norte, Del Norte Community Health Center, Del Norte School District, Del Norte Health Care District, Coastal Connections, and United Indian Health Services. Efforts were made to engage the community in developing, distributing and supporting the survey. Community input and endorsement for the survey was sought and underrepresented groups were provided targeted recruitment to take the survey.

The CHWS was developed to provide baseline data regarding community health indicators in DNATL. The survey results can be used to prioritize development of programs to promote improvement in determinants with the poorest outcomes. Administration of the survey in the future will allow change in social determinants to be tracked. The ultimate goal of understanding the social determinants of a community of wellness is to reduce health inequities and to "create social and physical environments that promote good health for all".[6]

1. Carlson, J.A., Sallis, J.F., Conway, T.L., Saelens, B.E., Frank, F.D., et al. (2012). Interactions between psychosocial and built enviroment factors in explaining older adults' physical activity. Preventive Medicine, 54 91), 68 – 73.
2. Meijer, M., Rohl, J., Bloomfield, K., and Grittne, U. (2012). Do neighborhoods affect individual mortality? A systematic review and meta-analysis of multilevel studies. Social Science & Medicine. 74 (8), 1204–12.
3. Pickett KE & Pearl M. (2001). Multilevel analyses of neighbourhood socioeconomic context and health outcomes: a critical review. Journal of Epidemiology Community Health. 55 (2), 111–2.
4. Renalds, A. Smith, T.H., and Hale, P.J. (2010). A systematic review of built environment and health. Family Community health, 33(1), 68-78.
5. The California Endowment. (2015). Selecting Sites. Retrieved from http://www.calendow.org/places/.
6. Healthy People 2020. (2015). Retrieved from http://www.healthypeople.gov/.

Methods

Survey Design and Sample

In the spring of 2013, a cross-sectional survey of a random sample of adults residing in Del Norte County and Adjacent Tribal Lands was conducted. An eight-page self-administered survey was developed by project administrators at the California Center for Rural Policy at Humboldt State University, in collaboration with the Building Healthy Communities Learning and Evaluation Advisory Committee in Del Norte County. The survey tool was designed to measure social determinants of health with questions about the neighborhood/built environment, social/community context, education, financial well-being, health/health care and services (including concepts of patient centered medical home and food security).

Many of the questions were based on existing surveys (National Survey of Children's Health, Behavioral Risk Factor Surveillance Survey, American Housing Survey, American Community Survey, National Health and Nutrition Examination Survey, National Center for Safe Routes to School, California Health Interview Survey, and Rural Health Information Survey) and new questions were developed as needed to inquire about social determinants of health not previously explored in this rural area of California.

The survey contained a combination of quantitative and qualitative responses. The first section of the survey contained questions specific to the adult completing the survey and their household. The second section contained questions specific to children in the household. Surveys were translated into Spanish and Hmong. Survey methods and questions were approved by the Humboldt State University Institutional Review Board.

Survey booklets with cover letters and questions in English and Spanish were mailed to all households and all post office box holders in Del Norte County and Adjacent Tribal Lands (including Hoopa, Orleans, Somes Bar, and Happy Camp). This was a bulk mailing through the U.S. Postal Service, so surveys were addressed to "residential customer" or "box holder." The cover letter requested someone in the household 18 or older to complete the survey and for only one survey to be completed per household. A self-addressed stamped envelope was included for returning the survey. Two weeks after sending the survey, a reminder post card in English, Spanish, and Hmong was sent. An incentive of a potential to win a $250 cash prize was offered.

Efforts were made to encourage widespread participation with particular attention to populations that are generally underrepresented in survey research. Meetings with tribal council members provided an opportunity to introduce the survey and address questions and concerns. All tribal councils in the area (Elk Valley Rancheria, Smith River Rancheria, Resighini Rancheria, Karuk Tribe, Yurok Tribe, and Hoopa Valley Tribe) provided endorsement, and their endorsement was stated in the cover letter. Some tribes opted to take extra steps to encourage participation among tribal members. For example, Elk Valley Rancheria sent an advance letter to tribal members encouraging participation. Resighini Rancheria and the Yurok Tribe coordinated personal contact with households to provide any needed assistance with completing the survey. The survey was also endorsed by the County of Del Norte, First 5 Del Norte, Del Norte Community Health Center, Del Norte School District, Del Norte Health Care District, Coastal Connections, and United Indian Health Services.

The Hmong community was engaged through contact with the elected clan representative and his assistant. A meeting was called with the clan leaders and surveys translated into Hmong were hand delivered to the clan

leaders for distribution to the clan families. Hmong families could either complete the survey in Hmong or English (received in the mail).

In the weeks prior to mailing the survey, a community media campaign was initiated to raise awareness about the survey and encourage participation. This included radio announcements with local voices, newspaper articles, posters, and announcements via social media networks. The Del Norte County Unified School District also sent a letter home to parents encouraging their participation in the survey.

Survey assistors were available to provide assistance to anyone requesting it. Assistors were available in person or by phone and could provide assistance in English, Spanish, or Hmong.

Analyses

Categorical Variables

Categorical variables have a limited number of possible values. These values do not have an intrinsic order. Gender is an example of a categorical variable. Frequencies (*p*) were calculated for categorical data. This provides the number of individuals in each category. Confidence intervals for frequency data were calculated and reported when possible. Confidence interval (*CI*) provides information about the uncertainty associated with the frequency data. The *CI* provides the probability that the frequency reported in the study includes the true value of the frequency. A 95% *CI* was reported. This means that the probability of observing a frequency outside this reported range is less than five percent. Wide confidence intervals indicate that the frequency being reported is less accurate when compared to frequency data with narrow *CI*.

Chi-square test of independence (χ^2) was used to determine whether two categorical variables were related. The assumptions for the Chi-square test (χ^2) were tested. The first assumption was that the variables were categorical, with two or more categories in each of the variables. For example, two categories exist for the categorical variable gender: male and female. Categorical data may have more than two categories, as in survey responses where several response options are offered (e.g. yes, no and maybe). The second assumption for the Chi-square test is that the minimum number of individuals that fall into the cross section of the categorical data must be five or more cases. For example, the number of males that answer "yes" versus "no" for a survey question, must be five or more.

When a comparison was made of two categorical variables, where each variable had only two categories, Yate's Correction of Continuity was applied to the χ^2 value to correct the overestimation of the Chi-square value.

The χ^2 value was used to determine if there was a statistically significant relationship between the categorical variables. Fischer's exact test (*FET*) for significance level was reported. A significance level (ρ) of .05 was selected for the acceptable error rate for the χ^2 tests. The ρ value represents the probability that chance could explain the result. A ρ of less than .05 indicates that there is less than a five percent chance of claiming there is a relationship between variables, when none really exists. This accepted chance of error exists for every comparison made. When multiple comparisons are made, the total risk of error increases. Since this study's purpose was descriptive in nature, the ρ was not adjusted for the multiple comparisons performed.

Odds ratio (*OR*) was reported for frequency data. The *OR* represents the odds that a particular outcome that occurred in one group, will also occur in another group. For instance, *OR* for the frequency of food insecurity in households that have incomes who live in poverty when compared to households that have higher incomes were reported. When *OR* are greater than one, the condition (e.g., poverty) is associated with higher odds of the outcome (e.g., hunger). Ninety-five percent *CI* were calculated and reported for *OR*. Odds ratios that had a 95% *CI* that spans zero were interpreted as lacking evidence for an association of the condition and the outcome.

Demographics

Of the 1741 surveys returned in this study, 238 of the respondents indicated that they were Native American. Tribal affiliation was recorded and representatives from numerous tribes were captured. While it is recognized that tribes are unique, there were insufficient cases to provide data analysis by tribal affiliation. Thus, data from all individuals from all tribal affiliations were combined for this report.

More Native American females (n = 166) than Native American males (n = 67) returned the survey. The average age of the male respondents was 54.6 years (*SD* = 16.1). The average age of the female respondents was 51.5 (*SD* = 15.4) years. More of the respondents indicated that they lived in Del Norte County (n = 141) than in Humboldt County (n = 71) or in Siskiyou County (n = 25).

Exhibit 1: Tribal Affiliation of Survey Respondents

Tribal Affiliation	n	Tribal Affiliation	n
Yurok	50	Tolowa	7
Hupa/ Hoopa	35	Resighini Rancheria	3
Karuk	23	Dual Affiliation	11
Cherokee	18	X	32
Smith River Rancheria	8	Other Affiliation	51

Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013
"X" indicates the actual response provided by some respondents to the question regarding tribal affiliation.

Education Level

The highest level of education attained by the Native American respondents was determined. The majority of the Native American respondents had at least completed high school, earning either a diploma or a high school equivalency credential (GED) (91.8%). The rates of not completing high school were not substantially different when compared to national data for the Native American population surveyed (p = 8.2% versus p = 7.5% for DNATL and national data, respectively).[1] National data indicates that Native American females are marginally more likely to complete high school when compared to males (p = 90.5% versus p = 89.3%).[1] Data from this study supports this finding, as a difference in prevalence of completion of high school between the genders was found (p = 93.3% versus p = 87.7% for females and males, respectively). Almost 16% of the survey respondents indicated that they completed at least a Bachelor's degree. Others have found 12.5% of Native Americans aged 25 to 34 years have a college degree.[2] Our data supports this finding.

Exhibit 2: Highest Education Level

Highest Education Level Attained	Females Percent (n=164)	Males Percent (n=62)
Did Not Complete High School	6.7%	12.3%
High School Certificate	7.3%	7.7%
High School Graduate	12.8%	18.5%
Vocational Training	1.2%	4.6%
Some College	55.5%	44.6%
College Degree or Higher	16.4%	12.3%

Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey, Del Norte and Adjacent Tribal Lands – 2013. This data is from the survey question, "What is the highest level of education that you have completed?"

1. Chapman, C., Laird, J., KewalRamani, A. (2010). Trends in high school dropout and completion rates in the United States: 1972–2008 Compendium Report. U.S. Department of education. NCES 2011-012.
2. Ross, T., Kenna, G., Rathbun, A. et al. (2012). Higher education: gaps in access and persistence study. U.S. Department of Education. NCES 2012-046.

Employment

The current employment status of the Native American survey respondents was evaluated. The majority of male survey respondents were not working due to a variety of reasons. A portion of Native American males indicated that they were retired (p = 26.2%), unemployed (p = 20.0%), or disabled (p = 18.5%). The prevalence of being unemployed was higher than previously reported for California state data for the Native American population (p = 9.0%, SD = 1.2%).[1] A larger percent of the females indicated they were employed (p = 45.7%) when compared to the male survey respondents (p = 32.3%). The Native American women in this survey were less likely to be retired (p = 16.9%) or unemployed (p = 9.4%) when compared to the males. The two genders had equivalent rates of disability (p = 20.0% for women and p = 18.5% for men, z *score* < 1.96). The rate of being disabled was slightly higher in the DNATL survey group of women and men when compared to California data for the Native American population (p = 16.9%, SD = 1.2%, z *score* = 2.0).[2]

Exhibit 3: Employment Status

Employment Status (n=226)	Males Percent (n=62)	Females Percent (n=164)
Retired	26.2%	16.9%
Employed	32.3%	45.7%
Unemployed	20.0%	9.4%
Disabled	18.5%	20.0%
Homemaker	0%	5.0%

Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey, Del Norte and Adjacent Tribal Lands – 2013. The data is for the survey question, "Which of the following best describes your current employment situation?"

1. U.S. Department of the Interior, Office of the Secretary Office of the Assistant Secretary – Indian Affairs. (2014). 2013 American Indian population and labor force report.
2. Cornell University (2013). Disability statistics. On-line Resource for Disability Statistics. Access at http://www.disabilitystatistics.org/reports/acs.cfm?statistic=1.

Income

Exhibit 4: Household Income by Federal Poverty Level

Federal Poverty Level	Frequency	Valid Percent
≤ 99%	47	23.2
100%-199%	49	24.1
200%-299%	31	15.3
≥ 300%	76	37.4
Missing Data	35	
Total	238	

Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey, Del Norte and Adjacent Tribal Lands – 2013. This data is calculated from family size, composition, age of family members, and household income.

The average household income of the Native American respondents was $31,369 ($SE$ = $1767). The range of income reported was from $800 to $140,000 per year. The median income was $25,000. The median income of the survey respondents from Del Norte and Adjacent Tribal Lands was lower than that previously seen in the Native American population in a national sample (median income = $35,062) and lower than the general population in Del Norte County (median income = $37, 909).[1] There was a difference in reported income between those Native American individuals who had not completed high school (median income = $10,350) and those Native American individuals who had graduated from college (median income = $30,000). Others have demonstrated that median income level is almost double for young adults who have graduated from college when compared to those who have not graduated high school.[2] These data indicate that Native American residents in DNATL have significantly lower median income than residents of all ethnicities in Del Norte County. Further, the data demonstrates that those Native Americans with a college degree have a household median income three times that of Native Americans who do not have a college degree.

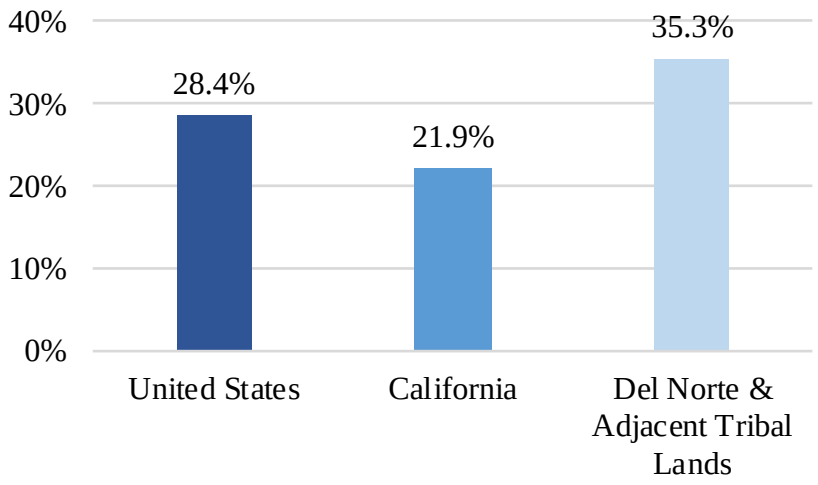
1 U.S. Census Bureau. (2013). Median household income in the past 12 months, Native American households. 2009-2013 American Community Survey 5-year Estimated. Retrieved from (http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_5YR_B19013C&prodType=table).

2 U.S. Department of Education, National Center for Education Statistics. (2015). The condition of Education 2015 (NCES 2015-144), Annual Earnings of Young Adults. Retrieved from https://nces.ed.gov/fastfacts/display.asp?id=77.

Poverty

Survey data collected in a national sample of Native Americans found that 28.4% had a household income level under the Federal Poverty Limit.[1] In California, the rate of poverty has been reported to be lower than that seen on a national level at 21.9 %.[2] Our results indicate that a larger percent of the Native American population in DNATL may live in poverty when compared to either California or national survey data, as 35.3% of the survey respondents had an income level that was below the federal poverty limit.

Exhibit 5: Poverty Rates for Native American Populations - National, State and Regional Samples



Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands 2013 and U.S. Census Bureau . (2013). American Community Survey 5-Year Estimates 2009 - 2013

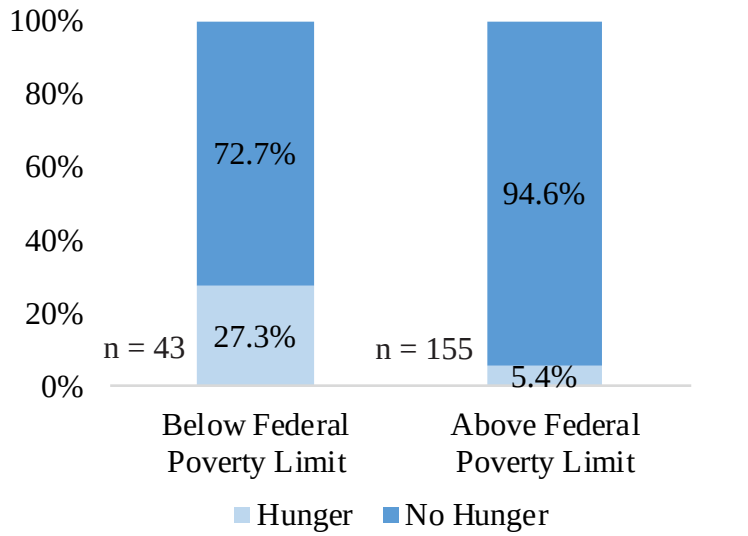
1. U.S. Census Bureau. (2013). Poverty stat in the past 12 months. 2009-2013 American Community Survey 5-Year Estimates. Retrieved from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF.
2. Maccartney, S. Bishaw, A. and Fontenot, K. (2013). Poverty rates for selected detailed race and Hispanic groups by state and place: 2007-2011. American Survey Briefs. ACSBR/11-17. Retrieved from https://www.census.gov/prod/2013pubs/acsbr11-17.pdf.

Food Security

Hunger in the House

Food security was assessed using a number of survey questions. These questions queried respondents about their family's food situation in the past 12 months. A question included in the survey was used to identify the highest risk level, Very Low Food Security.[1] This question evaluated hunger. Thirty-one of the 233 who responded to this question provided an affirmative response, indicating there were individuals in their household that experienced hunger in the past 12 months (p = 13.3%). There was a higher prevalence of hunger in households that had an income level below the poverty limit when compared to those households with an income level above the FPL (χ^2 = 8.92 (1), ρ = .003). Hunger was almost four times more likely in those who lived in poverty (*OR* = 3.9, 95% *CI* [1.6, 9.3]). Over 1 in 4 households in poverty reported their household members experienced hunger.

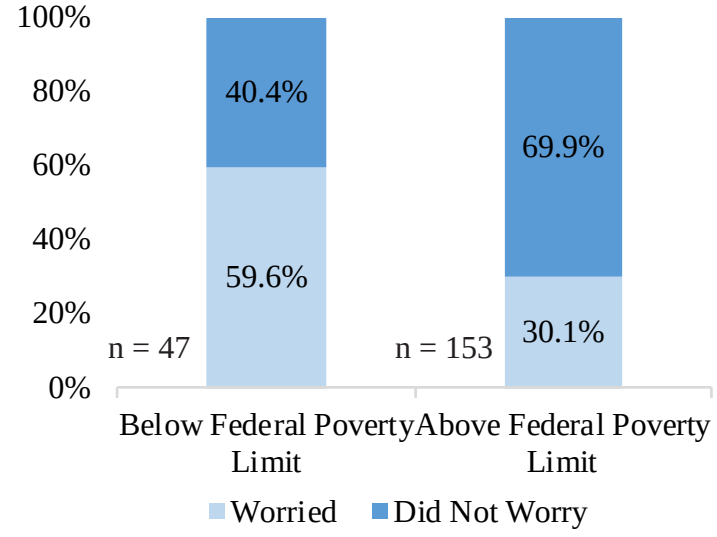
Exhibit 6: Hunger in Households by Household Income



Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013. This analysis was for the question, "In the last 12 months were you or people living in your household hungry because you couldn't afford enough food?". The analysis was restricted to respondents who answered "yes" or "no" to the question in addition to providing information necessary for determining poverty status.

Anxiety about Supply of Food

Exhibit 7: Anxiety about Food by Household Income



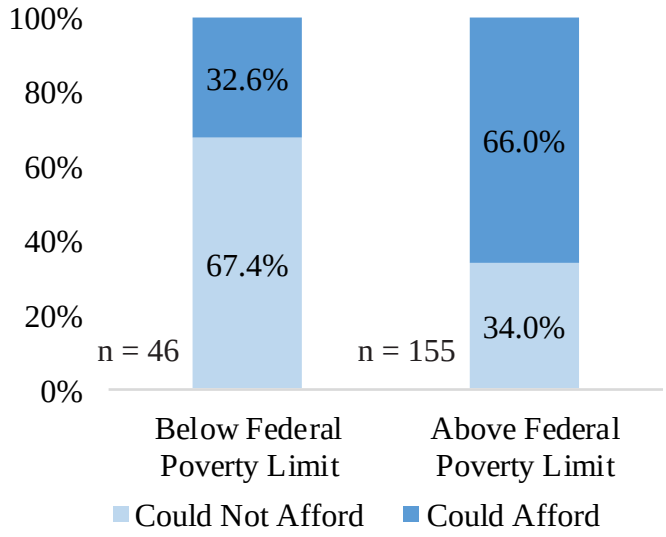
Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013. This analysis was for the question, "In the past 12 months how often did the following statement describe your family's food situation: We worried whether or food would run out before we got money to but more?". The analysis was restricted to respondents who answered "never true" or "often true" coded as true, and "sometimes true" coded as true.

One survey question was used to discriminate between individuals with some level of food insecurity from individuals with a high level of food security. This question queried the respondents as to worry about adequate supply of food. When individuals indicated that they never worry about food running out, they were considered to have a high level of food security.[1] Most individuals responded that they "never worried" that food would run out (p = 63.0%). Worry about adequate food was more prevalent in individuals who had an income below the FPL when compared to those with income level above the FPL (χ^2 = 12.2(1), ρ < .001). Six out of ten individuals living in poverty indicated that they worried that food would run out before they could afford to buy more (p = 59.6%). The risk of worrying about the food supply was over three times higher in those living in poverty than those whose household income was above the poverty limit (*OR* = 3.4, 95% *CI* [1.7, 6.5]). Our finding of greater risk of food insecurity when income is below poverty level has been previously reported in Native American populations.[2]

Quality of Food

Respondents were asked to respond to the statement, "We couldn't afford to eat balanced meals." A significantly higher portion of the Native Americans whose income was below the FPL indicated that this was "often true" or "sometimes true" when compared to Native Americans whose income was above the FPL ($\chi^2 = 14.9$ (1), $\rho < .001$). Native American whose income level was below the federal poverty limit were four times more likely to be unable to afford to eat balanced meals when compared to Native Americans whose income was above the Federal Poverty Limit (*OR* = 4.0, 95% *CI* [2.0, 8.1]).

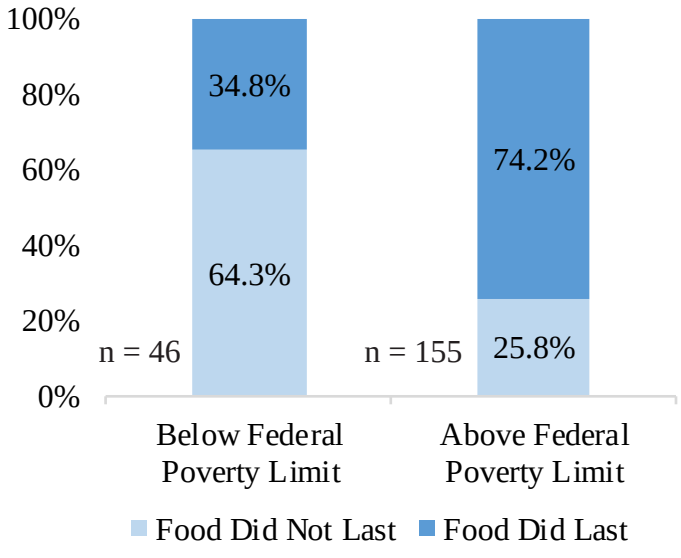
Exhibit 8: Balanced Meals by Household Income



Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013. This analysis was for the qestion, "In the past 12 months how often did the following statement describe your family's food situation: We could not afford to eat balanced meals." The analysis was restricted to respondents who answered "never true" or "often true" coded as true, and "sometimes true" coded as true.

Quantity of Food

Exhibit 9: Food did not Last by Household Income



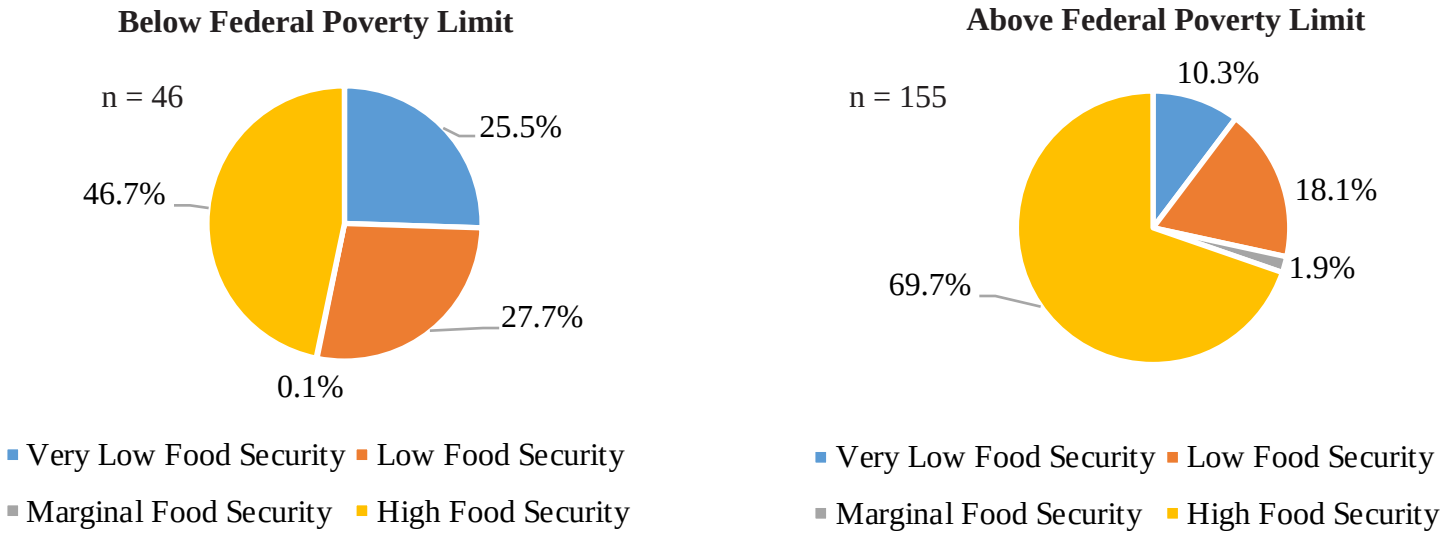
Source: Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands 2013. This analysis was for the question, "In the past 12 months how often did the following statement describe your family's food situation: The food that we bought just didn't last, and we didn't have enough money to get more food?". The analysis was restricted to respondents who answered "never true" or "often true" coded as true, and "sometimes true" coded as true.

Food security was also assessed by evaluating adequate access to food. Access to food was assessed by having the participants respond to the following statement: "The food that we bought just didn't last, and we didn't have enough money to get more food." Over one-third indicated that food did not last and they did not have enough money to get more ($p = 34.8\%$). Thus, more than three in ten Native American individuals who live in DNATL experience food shortage in their household. The survey results revealed that food shortage is more common in households with income below the FPL when compared to households with income above the FPL ($\chi^2 = 22.6$ (1), $\rho < .001$). Native American households with income below the FPL were almost 5 times more likely to indicate that the food they bought just did not last (*OR* = 5.4 95% *CI* [2.7, 10.9]).

Food Security Status

The distribution of the Native American participants into the various food security categories as defined by the United States Department of Agriculture (USDA) was assessed. There was a different distribution pattern of food security between Native Americans who lived in households above the poverty limit when compared to Native Americans who lived in households below the FPL ($\chi^2 = 11.5$ (3), $p = 0.009$). A greater portion of the households whose income was above the FPL had high food security when compared to Native American households that lived in poverty.

Exhibit 10: Food did not Last by Household Income



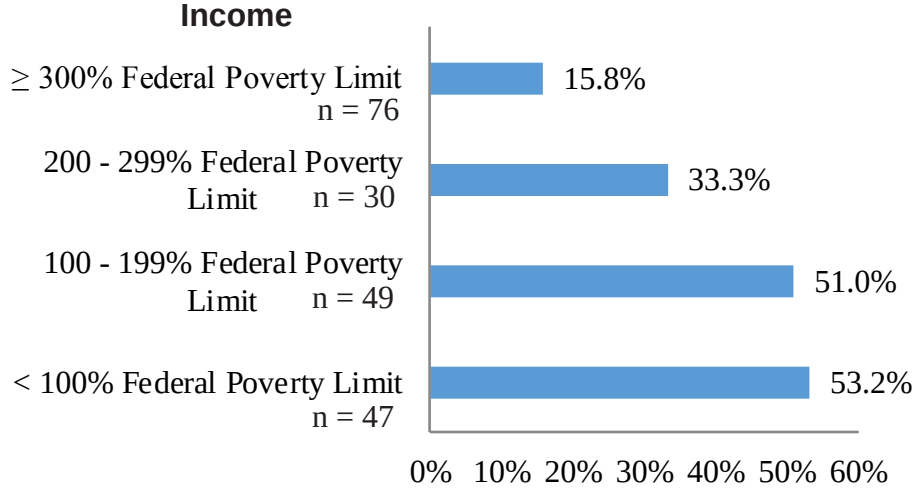
Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013. This analysis was for the questions regarding the family's food situation in the past 12 months.

USDA's Revised Labels of Food Security			
General Categories	Detailed Categories		
	Old Label	New Label	Description of Household Condition
Food Security	Food Security	High Food Security	No problems with food access
		Marginal Food Security	1 or 2 reported problems with food access – worry over food or food not lasting
Food Insecurity	Food Insecurity without Hunger	Low Food Security	Reduced quality, variety or desirability of food – unable to provide balanced meals
	Food Insecurity with Hunger	Very Low Food Security	Reduced food intake - hunger

The United States Department of Agriculture (USDA) developed a schemata that describes categories of food security status of households.[1] Households that do not have problems with accessing adequate food, do not have reduced quality or desirability of food, and do not have any worries or anxiety about food are classified as having High Food Security. Households that have worry or anxiety about food, but have adequate resources to buy food and do not reduce the quality of the food they eat are classified as having Marginal Food Security. Households that worry about food and have to alter the quality or desirability of food are classified as having Low Food Security. Households that have hunger or lack the resources to purchase enough food are classified as having Very Low Food Security.

To allow for analysis of differences between the prevalence of food security category by income level, food security groups were collapsed. The individuals in the categories of food security of Very Low Food Security, Low Food Security, and Marginal Food Security were combined so that the effect of income on food security could be evaluated. There was a significant difference in prevalence in households with High Food Security versus the combined lower levels of food security, when income level was taken into account (χ^2 = 24.5(3), $\rho < .001$). Over one-half of the Native Americans whose income level was below the FPL threshold did not live in households with High Food Security (p = 53.3%). This was true for one-half of the Native Americans whose income level was between 100-199% of FPL, most often considered as low income. The risk of not having high food security was not only evident in households with income levels below the FPL, but was also evident in households with income levels over 199% of the FPL.

Exhibit 11: Less than Optimal Food Security by Household Income



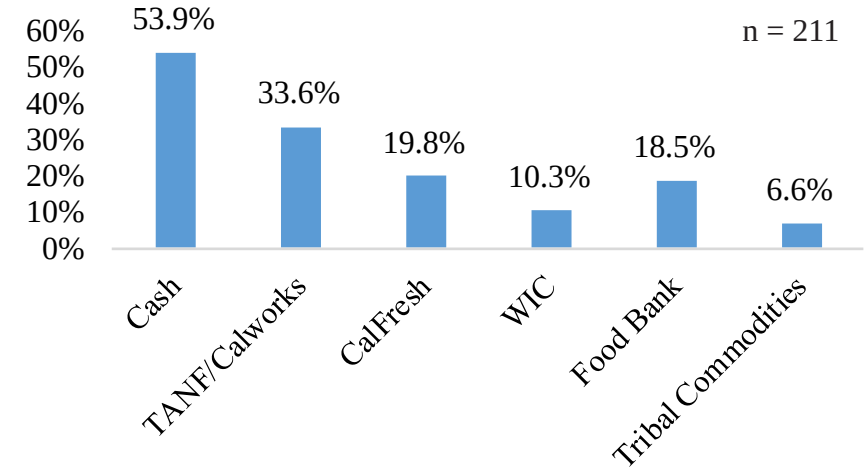
Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013. This analysis was for the questions regarding the family's food situation in the past 12 months. Analysis included only those who answered each of food security questions and who provided adequate data to compute Federal Poverty Limit for the household.

1. USDA. (2014). Measurement. Retrieved at http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx#security.
2. Ziliak, J.P. and Haist, M. (2013). The Causes, Consequences and Future of Senior Hunger in America. University of Kentucky Center for Poverty Research. Retrieved from http://www.mowaa.org/document.doc?id=13.

Funding Sources for Food

The survey asked respondents to indicate which types of funding sources they used to purchase or obtain food. Cash was the most prevalent funding resource to obtain food (p = 53.9%).

Exhibit 12: Funding Sources used to Obtain Food



Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013. Total percent is greater than 100% because each respondent could provide multiple resources used to obtain food.

Access to Food

Some communities lack access to healthy food options. The USDA has defined these communities as food deserts. The USDA has defined food deserts as census tracts where ≥ 20% of the population has an income below the federal poverty limit or where ≥ 33% of the population lives 10 miles or more from a large grocery store.[1] Del Norte County has been identified as a food desert based both on the USDA low-income criteria and the low-access criteria.[2] This survey targeted a large geographic area encompassing both rural and pioneer territories, and this is reflected in the wide range of time that participants indicated that it took them to get to a grocery store (range = 0 – 300 min with a median time of 10 minutes). The data was trimmed to remove extreme cases, where travel time was greater than 132 min (this represents time that is greater than 3 standard deviations from the mean). The average travel time to the grocery store from the trimmed data was 23 minutes (*SD* = 30). These results appear to support the USDA's recognition that the Del Norte County census tract is a food desert. The lack of available healthy food options was also demonstrated in the finding that only 52.5% of the respondents indicated that access to fresh fruits and vegetables were available to them in their neighborhood or community. The high prevalence of food insecurity in the Native American population in the DNATL should be targeted for further evaluation and intervention development. Interventions that address both proximity and financial constraints on access to food should be explored, as both these issues may be contributing to food security in the DNATL community.

Del Norte County has been identified as a food desert based both on the USDA low-income criteria and the low-access criteria[2]... only 52.5% of the respondents indicated that access to fresh fruits and vegetables were available to them in their neighborhood or community.

1. United States Department of Agriculture (2014). Food deserts. Accessed at http://apps.ams.usda.gov/fooddeserts/fooddeserts.aspx
2. United States Department of Agriculture (2014). Food Access Research Atlas. Accessed at http://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas.aspx

Health Care

Oral Health

Access to dental health care was evaluated using a number of questions from the survey. Over two-thirds of the Native American respondents indicated that they had received dental care, for any reason, in the past 12 months (p = 68.1%). The CDC reports similar results, with 61.6% of adults (all ethnicities included) between 18 and 64 years having seen a dentist in the previous year.[1] The majority of the Native American respondents indicated that they had a particular dentist or dental clinic that they usually go to get dental care (p = 83.1%). Despite recommendations for twice a year dental cleaning, only 51.3% of the Native American respondents indicated that they had dental cleaning within the past year. Most of the Native American respondents had dental care in the past year, but did not receive the recommended frequency of dental cleaning.

Health Encounters

Respondents provided information regarding encounters with primary care medical providers, specialists, mental health providers and dental care providers. Most of the Native Americans indicated that they had seen their primary care provider for either sick or well care in the past 12 months (p = 90.3%). There was no statistical difference in prevalence of seeing a medical provider the past year when Native Americans whose income placed them above the poverty limit were compared to Native Americans whose income placed them below the poverty limit. However, individuals without insurance or access to United Indian Health Services (UIHS), a nonprofit health organization providing services to tribal communities, were less likely to have seen a health care provider in the past 12 months when compared to Native American individuals with health insurance or UIHS access (χ^2 = 28.5 (1), $\rho < 0.001$). Almost half of the Native American respondents indicated that they were seen by a specialist in the past 12 months (p = 48.7%). A small minority of the Native American survey respondents indicated that they had seen a mental health specialist in the past year (p = 15%). Of those receiving mental health care, 77.1% indicated that they were either very satisfied or somewhat satisfied with the services received.

Unmet Healthcare Needs

Participants answered a question regarding access to healthcare when needed. The majority of Native Americans indicated that they were able to get the healthcare they needed (p = 75.5%). Those without health insurance were less likely to have received needed medical care when compared to those with health insurance (χ^2 = 28.5(1), $\rho <$ .001). Over one-third of those without medical insurance or access to UIHS were not able to get the healthcare that they needed. Experts indicate that lack of insurance represents a barrier to receiving health care. This barrier can lead to unmet health needs, to less frequent preventative services, and to greater hospitalization rates.[1] Our data support these experts' conclusions.

1. Healthy People 2020 (2015). Retrieved at http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services).

Travel Time

The distance to medical care or dental care can represent a barrier to receiving timely services for individuals who live in rural areas. The average travel time to see a medical provider in this study was 35 minutes (*SD* ± 57 minutes). Travel time to the medical appointments ranged from 1 to 480 minutes. Data from the 2001 National Household Travel Survey indicates that the average trip for medical or dental care was 22 minutes for rural residents.[1] Our data indicate that for the Native American in DNATL, average travel time to medical appointment was seven minutes longer. Research has found that 24% of rural residents travel up to 50 miles for medical care.[2] Our data shows that only 15.6% of Native Americans in DNATL travelled at least 1 hour to get to medical appointments. Thus, the prevalence of Native Americans in this study who travelled an hour or more to get to medical visits may be less when compared to other rural residents. However, almost one-quarter of the Native Americans in this study indicated that transportation was an issue in meeting their health care needs (p = 23.5%). Transportation and travel time to health care facilities may represent an undue burden to DNATL Native American residents.

1. Probost, J.S., Laditka, S.B, Wang, J., & Johnson, A. O. (2006). Mode of Travel and actual Distance traveled for medical or Dental Care by Rural and Urban Residents. South Carolina Rural Health Research Center. Retrieved at http://rhr.sph.sc.edu/report/SCRHRC_ModeofTravel_Exec_Sum.pdf.
2. Edelman, M.A. & Menz, B.L. (1996). Selected comparisons and implication of a national rural and urban survey of health care access, demographics, and policy issues. Journal of Rural Health 12 (93), 197-205.

Patient-Centered Medical Home

Quality of medical care has been linked to number of variables. These variables have been clustered into a concept known as patient centered medical home (PCMH). The National Survey of Children's Health (NSCH) has created a PCMH measure that is a composite of five components.[1] These components include the following:

1. There is a personal care provider
2. There is a usual source of care
3. Referrals are obtained when needed
4. There is care coordination when needed
5. Care is family-centered

1. The Child and Adolescent Health measurement Initiative Oregon Health & Science University. (2012). Measuring Medical Home for Children and Youth. Retrieved from http://www.childhealthdata.org/docs/medical-home/mhmanual_withappendices-updated-12-7-10-pdf.pdf).

Personal Care Provider

Having a personal care provider is seen as a vital component to the concept of medical home. A personal care provider was defined by American Academy of Pediatrics[1] as a health provider who is familiar with the patient's health history. Of the 238 Native American respondents, 159 indicated that they had a personal care provider (p = 68.2%). Others have shown that in rural communities there is a higher prevalence of having a personal care provider than found in this study (p = 78%).[2] Individuals with medical insurance or access to UIHS indicated that they had a personal care provider more often than individuals without medical insurance (p = 71.3% versus p = 44.8%, for insured and uninsured, respectively) ($\chi^2 = 7.0(1)$, $\rho = 0.008$). There was no statistical difference in prevalence of having a personal care provider in the past year for Native Americans whose income placed them above the poverty limit when compared to Native Americans whose income placed them below the poverty limit. This finding indicates that insurance had a greater influence on having a personal care provider than income.

1. American Academy of Pediatrics. (2002). The Medical Home. Pediatrics. 110 (10), 184-186.
2. Gamm, L.D., Hutchinson, L.L., Dabney, B. J. and Dorsey, A. M. eds. (2003) Rural Health People 2010: A Companion Document to Healthy People 2010. Volume 1. College Station, Texas: The Texas A&M University System Health Science Center, School of Rural Public Health, Southwest Rural Health research Center.

Usual Source of Care

Another component of medical home pertains to access to usual source of care. The majority of Native Americans in the survey indicated that they had a usual source of care that was not the emergency department, urgent care center, or a retail clinic (p = 84.7%). The prevalence of having a usual source of care was slightly lower than others have reported for rural residents (p = 89%).[1] However, the prevalence of having a usual source of care was slightly higher than previously reported for Native Americans in a national survey (p = 83.7%).[1] There was no statistical difference in the proportion of population with a usual source of care when comparing those with and without medical insurance, and when comparing those whose income was above or below the FPL. These findings are different from others who have reported that those who live in poverty or wo do not have insurance are less likely to have a usual source of care.[1] The DNATL area clinics appear to be providing access to care, regardless of financial capability or insurance coverage, to area residents.

Exhibit 13: Usual Source of Care by Insurance Status

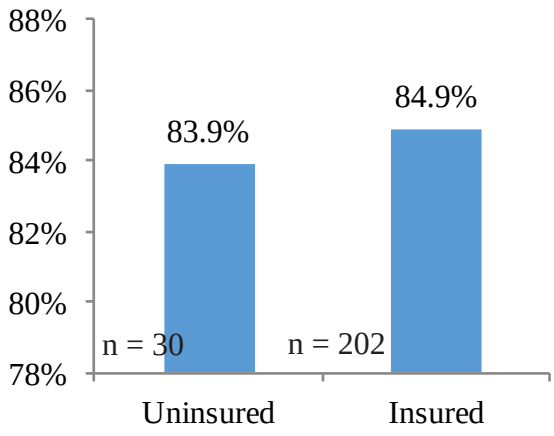
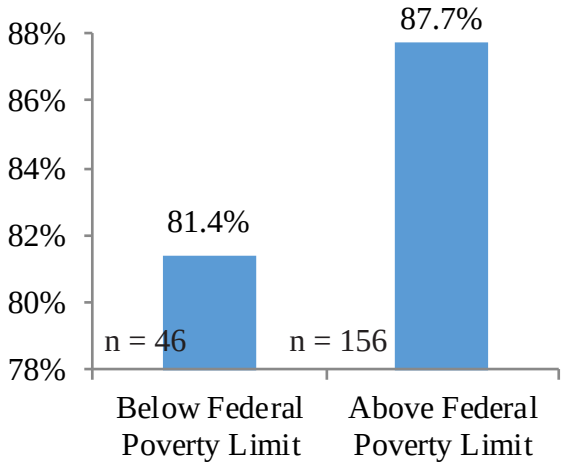


Exhibit 14: Usual Source of Care by Household Income



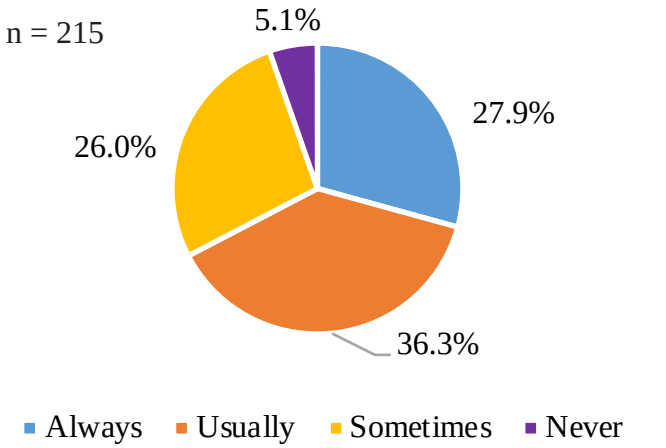
Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013. This analysis was for the survey question regarding usual source of care. Care provided at urgent clinic and emergency facilities do not meet the criteria for patient centered medical home.

1. Agency for Healthcare Research and Quality. Usual Source of Healthcare and Selected Population Characteristics, United States, 2012. Medical Expenditure Panel Survey Household Component Data.

Timely Care

Access to timely care can influence whether a usual source of care can be utilized. When care is needed right away, and it is not available at a usual source of care, medical consumers must resort to using alternate medical facilities like urgent care centers or emergency care facilities. In this group, 27.9% indicated that they were 'always' able to get an appointment for care they needed right away. Another 36.3% indicated that they were 'usually' able to get an appointment for care they needed right away. The prevalence of receiving timely care for DNATL Native Americans is lower than previously reported in a national survey.[1] National data indicates a higher prevalence of "always" (p = 52.2%) or of "usually" (p = 20.2%) able to get an appointment when needed.[1] These results indicate that the area clinics are providing timely access to care, which can help prevent DNATL residents from utilizing health care facilities outside their usual source of care.

Exhibit 15: Timely Access to Medical Care



Source: California Center for Rural Policy. (2016). Community Health and Wellness Survey Del Norte and Adjacent Tribal Lands - 2013. This analysis was for the survey question, "During the past 12 months, when you phoned to get an appointment for care you needed right away, how often did you get an appointment as soon as you thought you needed?".

1. Agency for Healthcare Research and Quality. Usual Source of Healthcare and Selected Population Characteristics, United States, 2012. Medical Expenditure Panel Survey Household Component Data.

Referrals

The third component of PCMH addresses the ability to obtain needed referrals. The majority of Native American respondents needed a referral to specialty services in the past year (p = 66.7%). Most of those individuals who needed a referral indicated that it was not difficult to get the referral (p = 64.8%). There was not a difference in the frequency of obtaining required referrals between those with and without insurance and those above and below the FPL.

Family Centered Care

The fourth component of a medical home addresses the concept of family centered care. This component consist of questions that asks the respondent about their relationship with their personal care provider. The questions ask if their provider makes them feel like a partner in care, if their provider listens to them carefully, if their provider spends enough time with them, if their provider gives them enough information about their health condition, and if their provider is sensitive to their values and customs. A person is deemed as having family centered care if they feel that these actions 'always' or 'usually' occur. Most of the Native American respondents indicated that they experienced these family-centered ideals 'always' or 'usually' with their healthcare provider (p = 92.6%). There was no statistical difference in the proportion of the sample with family centered care between those with and without insurance or between those above and below the FPL. The medical community in DNATL appears to be successfully providing family centered care to Native American residents.

Effective Care Coordination

The fifth component of a medical home evaluates care coordination. Care coordination was assessed in individuals who had seen both a primary care provider and at least one specialist in the past 12 months. If the survey respondent indicated that they 'always' or 'usually' got as much help as they wanted with arranging or coordinating their care, they were considered as having effective care coordination. Forty-two percent of the Native American respondents did not need care coordination. The majority of Native American respondents who may have needed care coordination obtained the support that they needed (p = 70.8%). However, almost 17% of the respondents failed to meet the standard defined by PCMH for effective care coordination (p = 16.8%). Issues that contribute to failure to achieve effective care coordination should be evaluated so that effective interventions to improve care coordination could be implemented.

Medical Home

Among the Native Americans who returned the survey, only 34.6% met the NSCH criteria as having a medical home in all five components of this construct. There was no statistical difference in the portion of the population with a medical home when comparing those individuals with or without insurance, or when comparing those individuals who have an income above or below the FPL. Personal care provider and access to needed referral are the two components of PCMH that have the greatest prevalence of not meeting PCMH standards. Avenues to enhance access to personal care providers and access to needed referrals should be explored.

Exhibit 16: Prevalence of Meeting the Criteria of Medical Home in each of the Five Components

	Meets Patient Centered Medical Home Criteria percent (n)	Does Not Meet Patient Centered Medical Home Criteria percent (n)	Missing n	Did not need the service n
Personal Care Provider	66.8% (159)	31.1% (74)	5	
Usual Source of Care	83.6% (199)	15.1% (36)	3	
Access to Needed Referral	64.7% (154)	32.4% (77)	3	4
Effective Care Coordination	42.4% (101)	16.8% (40)		97
Family Centered Care	92.6% (199)	7.4% (16)	23	

Appendix

Del Norte & Adjacent Tribal Lands Community Health & Wellness Survey

Dele vuelta a la hoja para espanol

Thank you for completing this important survey to help us understand and improve health and healthcare in your community. Participation in this survey is voluntary, anonymous, and confidential. Please have an adult (18 or older) in your household complete the survey and return it in the postage paid envelope by **May 30, 2013**. **Only complete one survey per household**. Answer the following questions about yourself. If you have children, please also complete the child section.

1) Within the past 12 months, were you able to get the healthcare (including mental healthcare) you needed?
☐ Healthcare not needed ☐ Yes ☐ No → If No, please explain why_____
_____

2) What types of health insurance do you have? ***Please check all that apply.***
☐ None
☐ Private insurance
☐ Medicare
☐ Medi-Cal
☐ Other government plans such as: Healthy Families, Family Planning Access Care and Treatment (PACT), County Medical Service Program (CMSP).
☐ Other (please explain)_____

3) A personal doctor or nurse is a health professional who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician's assistant. Do you have one or more persons you think of as your personal doctor or nurse?
☐ Yes ☐ No ☐ Don't Know

4) Is there a place that you USUALLY go to when you are sick or you need advice about your health?
☐ No ☐ Don't Know

☐Yes →**If Yes,** What kind of place do you go to **most often**? ***Please check one.***
☐Doctor's Office/Health Center/Clinic/Indian Clinic
☐Hospital Outpatient Department
☐Hospital Emergency Room or Urgent Care
☐Retail Store Clinic or "Minute Clinic"
☐School (Nurse, Athletic Trainer, Etc.)
☐Friend/Relative
☐Mexico/Other Locations out Of United States
☐Oregon
☐Some Other Place_____
☐Do Not Go to One Place Most Often
☐Don't Know

5) During the past 12 months did you see a doctor, nurse, or other health care professional for any kind of medical care, including sick care, well-check-ups, physical exams, and hospitalizations?
☐ Yes ☐ No ☐ Don't Know
If No or Don't Know skip to question #12

6) During the past 12 months, when you phoned to get an appointment for care you needed **right away**, how often did you get an appointment as soon as you thought you needed?
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know ☐ Does Not Apply

7) During the past 12 months, when you phoned to get an appointment for a **check-up or routine care**, how often did you get an appointment as soon as you thought you needed?
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know ☐ Does Not Apply

8) During the past 12 months, how often did your doctors or other health care providers help you feel like a partner in your care?
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know

9) During the past 12 months, how often did your doctors or other health care providers listen carefully to you?
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know

10) During the past 12 months, how often did your doctors or other health care providers spend enough time with you?
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know

11) Information about your health or health care can include things such as the causes of any health problems, how to care for yourself now, and what changes to expect in the future. During the past 12 months, how often did you get the specific information you needed from your doctors or other health care providers?
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know

12) When you are seen by doctors or other health care providers (including mental health), how often are they sensitive to your family's values and customs?
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know ☐ Does Not Apply

13) During the past 12 months, did you need a referral to see any doctors or receive any services?

☐ No ☐ Don't Know
☐ Yes ➝ **If Yes,** How difficult was it to get the referral? ***Please check one.***
☐ Not difficult ☐ Slightly difficult ☐ Very difficult ☐ Don't Know

14) Mental health professionals include psychiatrists, psychologists, psychiatric nurses, clinical social workers, and therapists/counselors. During the past 12 months, have you received any treatment or counseling from a mental health professional?
☐ Yes ☐ No ☐ Don't Know

15) Overall, how satisfied are you with the mental health services in your community?
☐ Very Satisfied ☐ Somewhat Satisfied ☐ Somewhat Dissatisfied ☐ Very Dissatisfied
☐ Don't Know

16) Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care. During the past 12 months, did you see a specialist (other than a mental health professional)?
☐ Yes ☐ No ☐ Don't Know

17) Does anyone help you arrange or coordinate your care among the different doctors or services that you use?
☐ Yes ☐ No ☐ Don't Know ☐ Does Not Apply

18) During the past 12 months, how often did you get as much help as you wanted with arranging or coordinating your care?
☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know ☐ Does Not Apply

19) Overall, how satisfied are you with the communication among your doctors and other health care providers?
☐ Very Satisfied ☐ Somewhat Satisfied ☐ Somewhat Dissatisfied ☐ Very Dissatisfied
☐ Don't Know ☐ No Communication Needed or Wanted

20) Do you regularly go outside your county for health services?
☐ Yes ☐ No

21) During the past 12 months, did you see a dentist for any kind of dental care, including check-ups, dental cleanings, x-rays, or filling cavities?
☐ Yes ☐ No

22) Is there a particular dentist or dental clinic that you usually go to if you need dental care or dental advice?
☐ Yes ☐ No ☐ Do Not Go to One Place Most Often

23) To the best of your knowledge when did you last have your teeth cleaned at a dentist's office?
☐ Within the past year ☐ 1-2 years ago ☐ 2-5 years ☐ 5 or more years ago
☐ Don't Know ☐ Never

24) What county do you live in?

☐ Del Norte ☐ Humboldt ☐ Siskiyou ☐ Other_____

25) What town or community/village do you live in? _____

26) What zip code do you live in?_____

27) What type of building/structure do you live in? ***Please check one.***

☐ House ☐ Duplex ☐ Building with 3 or more units
☐ Mobile home/trailer ☐ Other _____

28) Do you own or rent your home? ***Please check one.***

☐ Owned or being bought by someone in household ☐ Rent ☐ Other arrangement

29) In your home, do you currently have Internet access?

☐ No ☐Yes →**If Yes,** what type(s) of Internet access? ***Please check all that apply.***

☐ Cable modem from Charter Communications ☐ Satellite
☐ DSL from Frontier, AT&T or Verizon ☐ Cellular broadband
☐ Tsunami or other wireless company ☐ Don't Know
☐ Dial-up ☐ Other _____

30) In your home, do you currently have phone access?

☐ No ☐Yes →**If Yes,** what type(s) of phone access? ***Please check all that apply.***

☐ Land line from Frontier, AT&T or Verizon ☐ VoIP
☐ Charter Communications ☐ Don't Know
☐ Cellular ☐ Other _____

31) What is your primary mode of transportation? ***Please check one.***

☐ Walk ☐ Bicycle ☐ Public Transportation ☐ Car/Truck ☐ Other_____

32) Approximately how long does it usually take to get to the following places from your home?

The store where you usually buy food? _____ (specify minutes or hours)
The place you usually go for healthcare (if applicable)? _____(specify minutes or hours)
The place you usually go for dental care (if applicable)? _____(specify minutes or hours)

33) How many automobiles, vans, and trucks are kept at home for use by members of your household?

☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

34) Is transportation a problem in meeting the health needs of you or your family?

☐ No ☐ Yes →If Yes, please explain why_____

35) Please indicate how much you agree with the following statements:

	Mostly True	Mostly False	Don't Know
a) My neighbors and I talk about community problems and how to solve them.	☐	☐	☐
b) The sidewalks, trails, and crosswalks in my neighborhood/community are in good condition.	☐	☐	☐
c) During bad weather, there are public indoor facilities my neighbors and I can use close by.	☐	☐	☐
d) There are clean parks, playgrounds or green spaces that I feel safe going to in my neighborhood/community.	☐	☐	☐
e) There are places in my neighborhood/community where I can get fresh fruits and vegetables year-round.	☐	☐	☐

36) **In your home** do you currently have:

	Yes	No	Don't Know
a) A computer?	☐	☐	☐
b) Hot and cold running water?	☐	☐	☐
c) A flush toilet?	☐	☐	☐
d) A bathtub or shower?	☐	☐	☐
e) A sink with a faucet?	☐	☐	☐
f) A stove or range?	☐	☐	☐
g) A refrigerator?	☐	☐	☐
h) A washing machine?	☐	☐	☐
i) A clothes dryer?	☐	☐	☐
j) A source of electricity?	☐	☐	☐
k) A working electrical outlet or wall plug in every room?	☐	☐	☐
l) Exposed wiring?	☐	☐	☐
m) Holes in the floor?	☐	☐	☐
n) Open cracks or holes in the inside walls or ceilings?	☐	☐	☐
o) Holes or open cracks or crumbling in the foundation?	☐	☐	☐
p) Water leaks (from inside or outside)?	☐	☐	☐
q) Broken windows?	☐	☐	☐
r) Mold on an area greater than the size of a dollar bill?	☐	☐	☐

37) In the last 12 months were you or people living in your household ever hungry because you couldn't afford enough food?
☐ Yes ☐ No ☐ Don't Know

38) Please indicate how often the following statements describe your/your family's food situation.

In the last 12 months:	Often True	Sometimes True	Never True	Don't Know
a) We worried whether our food would run out before we got money to buy more.	☐	☐	☐	☐
b) The food that we bought just didn't last, and we didn't have enough money to get more food.	☐	☐	☐	☐
c) We couldn't afford to eat balanced meals.	☐	☐	☐	☐

39) In the last 12 months, which of the following resources did members of your household use to purchase or obtain food?
Please check all that apply

☐ Cash from employment or savings
☐ Cash or benefits from SSI/SSDI
☐ WIC coupons
☐ Cash or benefits from TANF or CalWORKS
☐ CalFresh (formerly called food stamps)
☐ Local Food Bank
☐ Other_____

40) Please indicate how often the following statements describe your situation this past year.

In the last 12 months:	**Always**	**Usually**	**Sometimes**	**Never**	**Does Not Apply**
a) How often did you feel lonely or isolated?	☐	☐	☐	☐	☐
b) How often did you get the social and emotional support you needed?	☐	☐	☐	☐	☐
c) How often did **you** feel safe from violence (physical, verbal or sexual) in **your home**?	☐	☐	☐	☐	☐
d) How often did you feel **your family** was safe from violence (physical, verbal or sexual) in **your home**?	☐	☐	☐	☐	☐
e) How often did **you** feel safe from violence (physical, verbal or sexual) in your **neighborhood/community**?	☐	☐	☐	☐	☐
f) How often did you feel **your family** was safe from violence (physical, verbal or sexual) in your **neighborhood/community**?	☐	☐	☐	☐	☐
g) How often were you worried or stressed about having enough money to pay your rent/mortgage?	☐	☐	☐	☐	☐
h) How often were you worried or stressed about having enough money to buy nutritious meals?	☐	☐	☐	☐	☐

41) In the last 12 months how often did you participate in cultural activities (such as festivals, ceremonies, music, dance)?
☐ None ☐ 1-4 times ☐ 5-11 times ☐ 12 or more times ☐ Don't know

42) In the past 12 months, how often did you do any unpaid volunteer work or community service?
☐ None ☐ 1-4 times ☐ 5-11 times ☐ 12 or more times ☐ Don't know

43) In what year were you born?_____

44) What is your gender? ☐ Male ☐ Female ☐ Other _____

45) Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

46) What is your race? ***Please check all that apply.***
☐ White ☐ Black/African American ☐ Asian→describe_____
☐ American Indian →print name of enrolled tribe_____
☐ Other_____

47) Which of the following best describes your current employment situation? ***Please check one.***
☐Employed by an organization/company/business ☐Unemployed, looking for work ☐Disabled
☐Self-employed ☐Unemployed, not looking for work ☐Homemaker
☐Retired ☐Student ☐Other _____

48) What is your best estimate of your household's total income **per year** before taxes? _____

49) Including yourself, how many people are supported by the household income reported in the previous question?
Number of people_____

50) How many people total (including yourself) currently live in your household? _____*people*

51) Of the people living in your household, how many are: 0-5 years old?_____ 25 to 64 years old?____
6 to 17 years old?_____ 65 years or older? ____
18 to 24 years old? _____

52) What is the highest level of education that you have completed? ***Please check one.***

☐ Did not complete high school
☐ GED/ High School certificate
☐ High school graduate
☐ Vocational training
☐ Some college (no degree)
☐ Associate degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Graduate or professional training beyond Master's Degree.
☐ Other _____

Thank you for your time. Please complete the child section if you have children under 18 in your household.

Child Section

If you have a child under 18 years of age living in your household,
please answer the following questions to help us better understand their needs**.**
If you have more than one child please complete this for the child that had the most recent birthday.

C1) How old is the child that you are answering these questions for? _____Years _____Months

C2) Within the past 12 months, were you able to get your child the healthcare (including mental healthcare) they needed?

☐ Healthcare not needed ☐ Yes ☐ No → If No, please explain why_____
_____

C3) What types of health insurance does your child have? ***Please check all that apply.***

☐ None
☐ Private insurance
☐ Medicare
☐ Medi-Cal
☐ Other government plans such as: Healthy Families, Family Planning Access Care and Treatment (PACT), County Medical Service Program (CMSP).
☐ Other (please explain)_____

C4) A personal doctor or nurse is a health professional who knows you well and is familiar with your health history. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician's assistant. Does your child have one or more persons you think of as their personal doctor or nurse?

☐ Yes ☐ No ☐ Don't Know

C5) Is there a place that your child USUALLY goes when he/she is sick or you need advice about his/her health?

☐ No ☐ Don't Know

☐Yes →**If Yes,** What kind of place does he/she go to **most often**? ***Please check one.***

☐Doctor's Office/Health Center/Clinic/Indian Clinic
☐Hospital Outpatient Department
☐Hospital Emergency Room or Urgent Care
☐Retail Store Clinic or "Minute Clinic"
☐School (Nurse, Athletic Trainer, Etc.)
☐Friend/Relative
☐Mexico/Other Locations out Of United States
☐Oregon
☐Some Other Place_____
☐Does Not Go to One Place Most Often
☐Don't Know

C6) During the past 12 months did your child see a doctor, nurse, or other health care professional for any kind of medical care, including sick-child care, well-child check-ups, physical exams, and hospitalizations?

☐ Yes ☐ No ☐ Don't Know

If No or Don't Know skip to question #C12

C7) During the past 12 months, how many times did your child see a doctor, nurse, or other health care provider for *preventive* medical care such as a physical exam or well-child checkup? _____times ☐Don't Know

C8) During the past 12 months, how often did your child's doctors or other health care providers help you feel like a partner in his/her care?

☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know

C9) During the past 12 months, how often did your child's doctors or other health care providers listen carefully to you?

☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know

C10) During the past 12 months, how often did your child's doctors or other health care providers spend enough time with him/her?

☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know

C11) Information about a child's health or health care can include things such as the causes of any health problems, how to care for a child now, and what changes to expect in the future. During the past 12 months, how often did you get the specific information you needed from your child's doctors or other health care providers?

☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know

C12) When your child is seen by doctors or other health care providers (including mental health), how often are they sensitive to your family's values and customs?

☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know ☐ Does Not Apply

C13) During the past 12 months, did your child need a referral to see any doctors or receive any services?

☐ No ☐ Don't Know

☐Yes →**If Yes,** How difficult was it to get the referral? ***Please check one.***

☐ Not difficult ☐ Slightly difficult ☐ Very difficult ☐ Don't Know

C14) Mental health professionals include psychiatrists, psychologists, psychiatric nurses, clinical social workers, and therapists/counselors. During the past 12 months, has your child received any treatment or counseling from a mental health professional?

☐ Yes ☐ No ☐ Don't Know

C15) Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care. During the past 12 months, did your child see a specialist (other than a mental health professional)?

☐ Yes ☐ No ☐ Don't Know

C16) Does anyone help you arrange or coordinate your child's care among the different doctors or services that he/she uses?

☐ Yes ☐ No ☐ Don't Know ☐ Does Not Apply

C17) During the past 12 months, how often did you get as much help as you wanted with arranging or coordinating your child's care?

☐ Always ☐ Usually ☐ Sometimes ☐ Never ☐ Don't Know ☐ Does Not Apply

C18) Overall, how satisfied are you with the communication among your child's doctors and other health care providers?

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Somewhat Dissatisfied ☐ Very Dissatisfied
☐ Don't Know ☐ No Communication needed or wanted

C19) Do your child's doctors or other health care providers need to communicate with his/her child care providers/early intervention program, school, or special education program?

☐ No ☐ Don't Know

☐Yes ➞**If Yes,** Overall, how satisfied are you with that communication? ***Please check one.***

☐ Very Satisfied ☐ Somewhat Satisfied ☐ Somewhat Dissatisfied ☐ Very Dissatisfied
☐ Don't Know ☐ No Communication needed or wanted

C20) During the past 12 months, did your child have a toothache, decayed teeth, or unfilled cavities?

☐ Yes ☐ No ☐ Don't Know

C21) Is there a particular dentist or dental clinic that your child USUALLY goes to if he/she needs dental care or dental advice?

☐ Yes ☐ No ☐Does Not Go To One Place Most Often

C22) During the past 12 months, did your child see a dentist for any kind of dental care, including check-ups, dental cleanings, x-rays, or filling cavities?

☐ Yes ☐ No ☐ Don't Know

C23) During the past 12 months, how many times did your child see a dentist for *preventive* dental care, such as check-ups and dental cleanings? _____times ☐Don't Know

C24) Has your child received dental care through the Mobile Dental Van at their school?

☐Yes ☐ No ☐ Does not apply (child not in school) ☐ Don't Know

C25) Does your child attend school?

☐Yes ➞**If Yes, what school?** _____ ☐ No➞ **If No, you are finished with the survey.**

C26) On most days, how does your child **arrive** at school?

☐ Walk ☐ Family vehicle (only children in your family)
☐ Bike or Skate ☐ Carpool (children from other families)
☐ School Bus ☐ Other _____

C27) On most days, how does your child **leave** from school?

☐ Walk ☐ Family vehicle (only children in your family)
☐ Bike or Skate ☐ Carpool (children from other families)
☐ School Bus ☐ Other _____

C28) How far does your child live from school?

☐ Less than ¼ mile ☐ 1 mile up to 2 miles
☐ ¼ mile up to ½ mile ☐ More than 2 miles ➞ about how many miles? _____
☐ ½ mile up to 1 mile ☐ Don't know

C29) How long does it normally take your child to get to school?

☐ Less than 5 minutes ☐ 11-20 minutes
☐ 5-10 minutes ☐ More than 20 minutes➞ about how many minutes?_____
☐ Don't know

End of survey. Thank you for your time.
Please return the survey in the enclosed postage paid envelope with your raffle entry.

CCRP
California Center for Rural Policy

Join us online...

Please join us in an on-line discussion about Native American health in Del Norte and Adjacent Tribal Lands. Contribute to the living document by commenting on the research findings, sharing innovative programs and discussing policy implications. To read comments and post your own, please visit our website, www.humboldt.edu/ccrp.

Join us in the community...

The California Center for Rural Policy will continue to share research results with the community through briefs, reports and meetings. We plan to engage the community in dialogue about potential solutions and policy recommendations to address identified problem areas. We hope you will join us as we work together to improve health in our region. If you would like to receive information from CCRP please contact us to get on our mailing list: (707) 826-3400 or ccrp@humboldt.edu

Join us in collaboration...

CCRP welcomes opportunities to collaborate with community partners for more in-depth research on this topic.

The California Center for Rural Policy at Humboldt State University is a research center committed to informing policy, building community, and promoting the health and well-being of rural people and environments.

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