Community Health Improvement Plan

GARFIELD COUNTY PUBLIC HEALTH

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GARFIELD COUNTY
PUBLIC HEALTH

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//01. EXECUTIVE SUMMARY

A Community Health Improvement Plan (CHIP) is a long-term plan to address the most important health needs in our community.

This plan builds on the needs uncovered in our Community Health Assessment (CHA) and was created through collaboration between healthcare providers, community organizations, educators, and residents to improve the health of everyone in our area.

HOUSING

CHILD CARE

MENTAL HEALTH AWARENESS AND ACCESS TO SERVICE

Our planning process involved gathering data about community health, talking with community members about their concerns, and working with partners to develop solutions. Through this work, we identified key health priorities that need attention in our community, two of which we will prioritize for the CHIP: improving access to child care and enhancing mental health education and awareness. For each of these priorities, we developed specific goals and strategies to create positive change.

We will implement these improvements over the next several years, with regular check-ins to make sure we're making progress and adjusting our approach as needed.

//02. PURPOSE & PLANNING

A CHIP is more than just a document — it's a way to bring our community together to make positive changes in health and well-being. Following the MAPP 2.0 (Mobilizing for Action through Planning and Partnerships) framework, we approached this work as a community-driven process focused on reducing health inequities and improving health for everyone.

HOW WE CREATED THIS PLAN

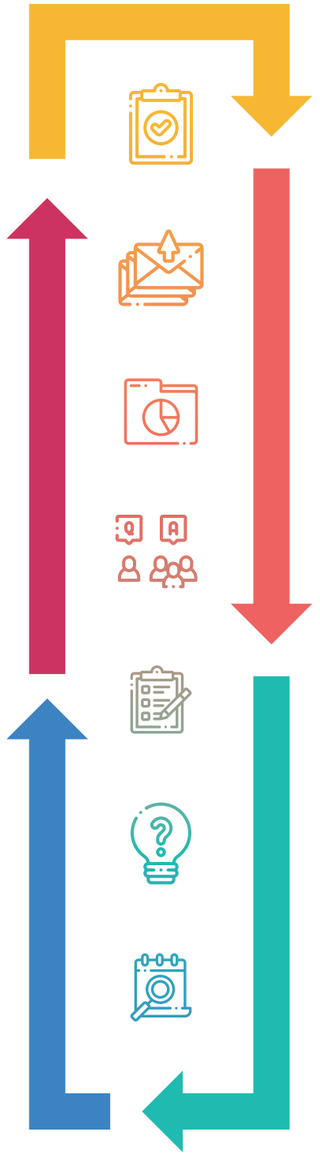
Through our Community Health Assessment (CHA) process, we built a strong team that brought together community members, healthcare providers, and local organizations. It was important to us that our team truly represented all parts of our community to ensure everyone's voice would be heard

Next, we worked to understand our community's health needs. This involved gathering health data and listening to community members' experiences. We looked carefully at how health issues affect different neighborhoods and groups in our area, which helped us get a complete picture of our community's needs.

With this understanding, we then worked together to choose our priorities. We combined what we learned from community members with our health data to identify the most pressing health needs in our area. This helped us focus our attention on the issues that matter most to our community and where we could make the biggest difference.

Finally, we developed clear goals and strategies, mapped out specific steps for making improvements, and identified partners who could help with the work. Throughout this entire process, we made sure to make decisions with our community, not just for our community, focusing on creating lasting, positive changes in health.

CHA/CHIP LIFE CYCLE 2023-2027



1. **ASSESS COMMUNITY HEALTH NEEDS**
   2023, Community Health Improvement Plan
2. **SHARE WHAT WE LEARNED**
   2024, community data walk
3. **IDENTIFY WHAT TO PRIORITIZE**
   2024, prioritize our focus areas
4. **ENGAGE COMMUNITY PARTNERS**
   2024-2025, engage our community partners to support our priorities
5. **ANNUAL COMMUNITY HEALTH DATA SUMMARY**
   2024-2026, summary of key community health indicators
6. **ADJUST AND RESPOND**
   2025-2026, review data and progress and adjust as needed
7. **PLAN OUR NEXT COMMUNITY HEALTH ASSESSMENT**
   2026-2027

Our Community Health Assessment (CHA) revealed several important community health needs, including access to child care, housing affordability, and mental health support. Through careful analysis and prioritization with our community, we identified three key priorities where we believe we can make the most significant impact:

CHILD CARE

Access to affordable, quality child care emerged as a critical need for families in our community.

MENTAL HEALTH EDUCATION AND AWARENESS

Our community expressed a strong need for better mental health resources and education.

COMMUNITY ENGAGEMENT-BRINGING PUBLIC HEALTH TO THE COMMUNITY

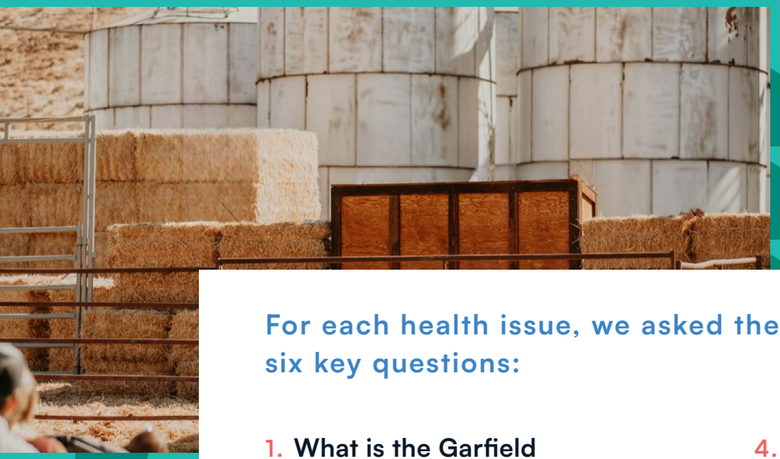
Through our CHA, we had the opportunity to share the work of public health with the community and we want to continue this in our CHIP.

These priorities emerged through our data analysis and extensive community input. While other community needs are also important, focusing our efforts on these two areas will allow us to create meaningful, sustainable improvements in our community's health and well-being.

HOW WE CHOSE OUR PRIORITIES

To select our health priorities, we used a structured approach. We brought together staff from the health district to score each potential health issue using a prioritization matrix. This matrix helped us look at each issue from multiple angles.

	Child Care	Mental Health-Education & Awareness	Community Engagement-Bringing Public Health to the Community
What is the GCHD organizational capacity to support this need directly?	Medium and Growing	Medium and ongoing	High
Is there existing infrastructure in place to support this need?	No, but building the infrastructure	Yes and growing	Yes
Are there established relationships or partners to support or address this need	Yes and building	Yes	Yes
Is there ongoing investment ($ or otherwise) in place or available to support this need?	Yes!	Yes!	Yes!
Was this previously a focus area?	Not identified through the previous CHA process	No	Yes



For each health issue, we asked the group to consider six key questions:

1. **What is the Garfield County Health District's organizational capacity to support this need directly?**
2. **Is there existing infrastructure in place to support this need?**
3. **Are there established relationships or partners to support or address this need?**
4. **Is there ongoing investment ($ or otherwise) in place or available to support this need?**
5. **Was this previously a CHIP focus area (if applicable)?**
6. **Was this a priority from previous CHA? (if applicable)**

We used a simple yes/no scoring system where participants discussed and rated each question. The conversation for each question also included discussion about: How serious are the consequences if we don't address it? Do we have the ability to make meaningful change? Is our community ready to work on this issue? Would addressing this issue help reduce health disparities? And finally, how important is this to our community members?

This approach helped us have focused discussions about each issue and understand different perspectives. For example, some issues might affect fewer people but have very serious consequences, while others might affect many people but already have good support systems in place. Additionally, some issues, like housing, were beyond the scope of the health district to address and although it's an important issue, in our prioritization process we chose not to focus on housing.

After scoring all the issues we discussed the results as a group to make sure our final priorities reflected both the scoring and our community's values and needs.

//03. SHARING WHAT WE LEARNED

Throughout this process, we included voices from our community.

COMMUNITY DATA WALK

One of our most important community engagement activities was a data walk. A data walk is an interactive event where community members explore and discuss information about their community's health in an engaging, conversation-based format.

We set up several stations around a large room, each focusing on different health topics. At each station, we displayed charts, graphs, and key findings from our CHA using large posters with clear visuals. The information was presented in simple, everyday language, and we included questions to guide discussion.

Community members moved from station to station in small groups. At each stop, trained facilitators helped guide conversations about what the data meant to participants and how it reflected their lived experiences. We encouraged everyone to share their stories and insights about the numbers they saw. For example, when looking at data about access to mental health services, residents shared their personal experiences accessing care for themselves or a family member.

Participants also discussed potential solutions to the health challenges shown in the data. This helped us understand how community members interpret the health data and what solutions they think might work best in their neighborhoods.

We made sure to include people from all parts of our community by:

- **Holding multiple data walks at different times**
- **Offering refreshments**
- **Making the space accessible for people with disabilities**

After the data walks, we gathered all the comments, stories, and suggestions to help inform our health improvement priorities and strategies. This approach helped us combine statistical data with community wisdom and ensure our plan reflects what matters most to local residents.

//04. WHAT WE HEARD FROM THE COMMUNITY DURING OUR DATA WALKS

What are the TOP 3 things you learned about our communities health?

- I did not know that so many were worried about losing their minds,
- We have a safe place to live.
- All ages in our community seem to be aware of the need for licensed child care
- Provider turnover concern Mental health being referred to as “awareness” The childcare facility progress!
- How many of these needs and assessments are linked together
- Housing Access Concerns. I know we have had limited availability in the past but there seem to be many available now. Hard to know what we as a community can do about marker prices/ interested rates
- 43% want better wages, more benefits and job opportunities
- Childcare is significant and linked to employment concerns

What are the TOP 3 things you learned about our communities health?

- Provider turnover concerns
- 21% reported safety concerns about their current home
- Provider turnover seems like something we can do better with... finding out why there is such a big turnover and address those issues.
- Just solidified that public health, economics, housing, mental health and childcare are all linked.
- Didn’t realize how strategic you were targeting community engagement. Warms my heart. People want to belong and be connected.
- Childcare may be more ‘easily” solved than other issues, thanks to grants, etc.
- More farmers are coming!!! So fast to have the measure of progress. That corn image of participants is IMPRESSIVE. Shows so much promise in how easy it is. People want to belong

Was there any data or information that surprised you? If so, why?

- Concern for safety in houses surprised me.
- Clean environment!
- Provider access, I feel like we may have turnover but there is still consistent access. It may not be the same Dr. but you can see one.
- The mental health stats. Wasn't aware of the depth of those experiences, very eye opening.
- How high the suicide rate is among farmers/farm workers
- Housing safety concerns
- 65% of people said their mental health and stress was WORSE than the year before. Crazy to me
- Concerns of losing your house - for any reason listed. Didn't realize so many were close to that

What do you see as the most pressing health issues our community should focus on addressing? Why?

- Mental health awareness
- Childcare will increase employment access
- Childcare, short and long term benefits
- Mental health access and encouraging them to see help if we can chance the stigma then we can get them more help
- Mental health/wellness stigma
- Mental health awareness from prevention, mental health promotion, to reducing stigma, to mental health promotion
- Access to mental health services - for people with Medicaid/Medicare - affordable options (sliding fee) for those without public health insurance
- Continued Community Engagement - more visibility of the community calendar

//05. OUR PLANS FOR ACTION

We developed plans for our three priority areas: improving access to child care, enhancing mental health education and awareness, and community engagement- bringing public health to the community. For each priority, our plan includes:

OUR GOALS AND HOW WE'LL ACHIEVE THEM

- **Specific, measurable goals for improvement or change**
- **Strategies that have been proven to work**
- **Key activities we'll undertake**
- **Which organizations will help with each part of the plan**

RESOURCES NEEDED

- **What we need to make these changes happen**
- **Who will provide different resources**
- **How we'll sustain our efforts over time**

UNDERSTANDING THE ISSUES

Child Care

A 2024 survey conducted in Garfield County by the Southeast Early Learning Coalition revealed significant challenges in our child care system:

- **Finding Care:** The vast majority of families struggle to find child care, with 93 families reporting it as "very difficult" and 26 finding it "somewhat difficult." Only 7 families reported finding care easily.
- **Affordability:** Most families face serious cost challenges, with 38 families calling it a "significant challenge" and 11 reporting it as a "moderate challenge."
- **Impact on Work:** Child care problems significantly affect employment - 28% of surveyed parents had to quit a job due to child care difficulties. Many others report impacts on their work schedules and career advancement.
- **Types of Care Needed:**
  - Full-day care is the most requested type
  - Before and after school care is in high demand
  - Weekend and holiday coverage is needed by many families
  - Location and scheduling flexibility are major concerns

These findings show that child care challenges affect many aspects of family life in our community, from economic stability to work opportunities. The problems are particularly acute in the Pomeroy area (zip code 99347), though families throughout the county face similar challenges.

Mental Health Education and Awareness

Many people in our community find it hard to talk about mental health. Some feel embarrassed about asking for help, while others aren't sure where to go for support. Getting mental health care can be difficult here - we don't have enough local counselors or therapists, and it can be hard to get to appointments if they're far away. In a small town where everyone knows each other, people worry about privacy when seeking help.

We do have some mental health services, including a crisis helpline and some counseling options, but we need more. We especially need providers who understand what it's like to live and work in our farming community. We also need to help more people learn about the resources we already have, like the 988-crisis line and mental health training programs.

Community Engagement- Bringing Public Health to the Community

Through our CHA, we had the opportunity to engage with our community to learn about the health issues that were important to them and to share resources and provide direct education and support. Our community let us know that this was a valuable and important part of our work and we will continue making this a priority throughout our CHIP.

//06. MEASURING OUR PROGRESS

We will track our progress using various measurements to ensure we're making a difference. These include:

- **Statistics about health outcomes**
- **Feedback from community members**
- **Annual data reports**

We chose these measurements carefully to make sure they:

- **Tell us whether we're making real progress**
- **Can be tracked consistently over time**
- **Help us understand if we're reaching all parts of our community**

//07. WHAT WE'RE DOING

We're already taking action on our priority areas, tracking our metrics to measure progress, and, gathering community feedback:

MENTAL HEALTH EDUCATION AND AWARENESS

Several initiatives are currently underway to improve mental health awareness, with a special focus on our farming community:

Farmer Appreciation Day Events:
We're tracking farmer participation at these events to measure our reach in the agricultural community.

Food Bank Integration:
We've begun including mental health awareness resources and information at our food bank, recognizing that food security and mental health are closely connected.

Community Event Surveys:
We're conducting brief surveys at community events to measure awareness of mental health resources, including knowledge of the 988-crisis line.

Training Programs:

- **QPR** (Question, Persuade, Refer) training will be offered in 2025
- **Agri Focused Suicide Prevention Training** program, formerly known as Working Minds, will provide mental health education and suicide awareness, with a special focus on the agricultural community. This will be offered in spring 2025 in partnership with local mental health provider Sarah Steele.

CHILD CARE

We have several initiatives underway to address child care needs in our community:

Data Collection and Analysis:

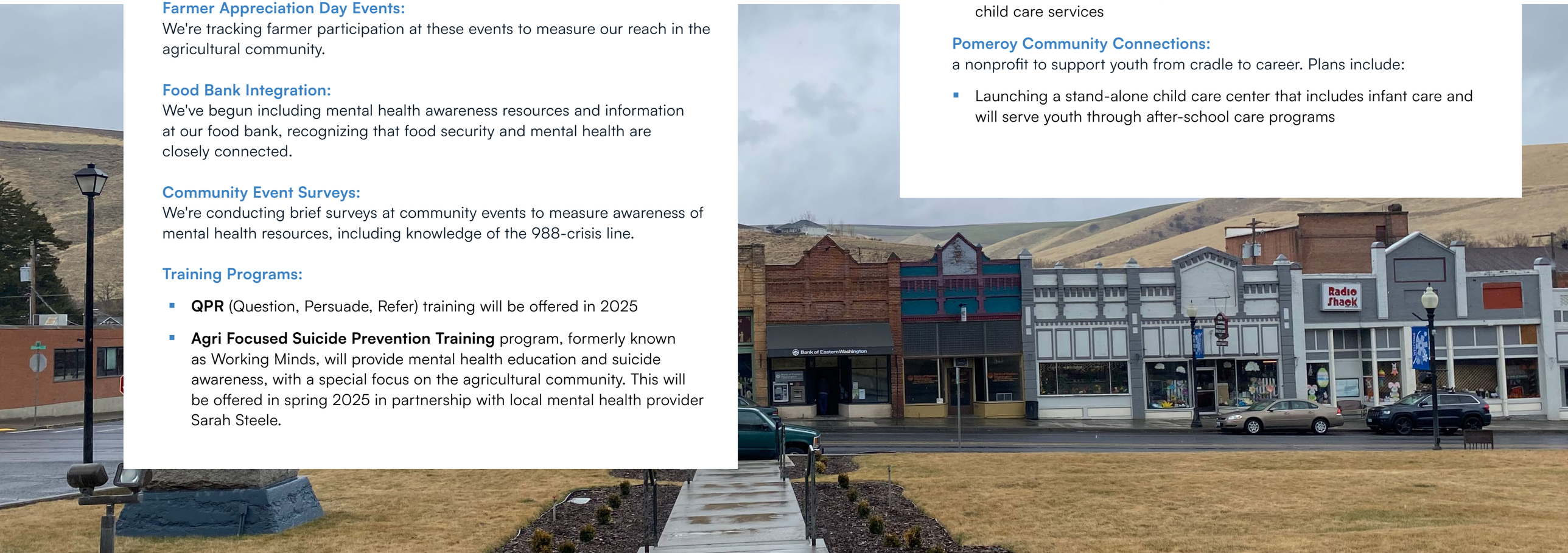
- Completed a comprehensive child care needs survey through the Southeast Early Learning Coalition
- Examining additional indicators such as single parent households and grandparents caring for young children

Support Services:

- Created a Child Care Navigator position to help families find and access child care services

Pomeroy Community Connections:
a nonprofit to support youth from cradle to career. Plans include:

- Launching a stand-alone child care center that includes infant care and will serve youth through after-school care programs



COMMUNITY ENGAGEMENT- BRINGING PUBLIC HEALTH TO THE COMMUNITY

We're continuing our community engagement work and adding new events and opportunities for engagement.

Working with our Schools

- Teaching empathy and mental health in Consumer Sciences classes
  - Developing separate approaches for boys and girls to address different needs
  - Creating lesson plans around major lifetime events and achievements to build understanding of mental health challenges
- Handing out foam basketballs, popcorn bags and pom poms with positive messages at basketball games
- Distribution of "Life is a Movie, Drug Free" t-shirts during Red Ribbon Week

Increasing Food Access

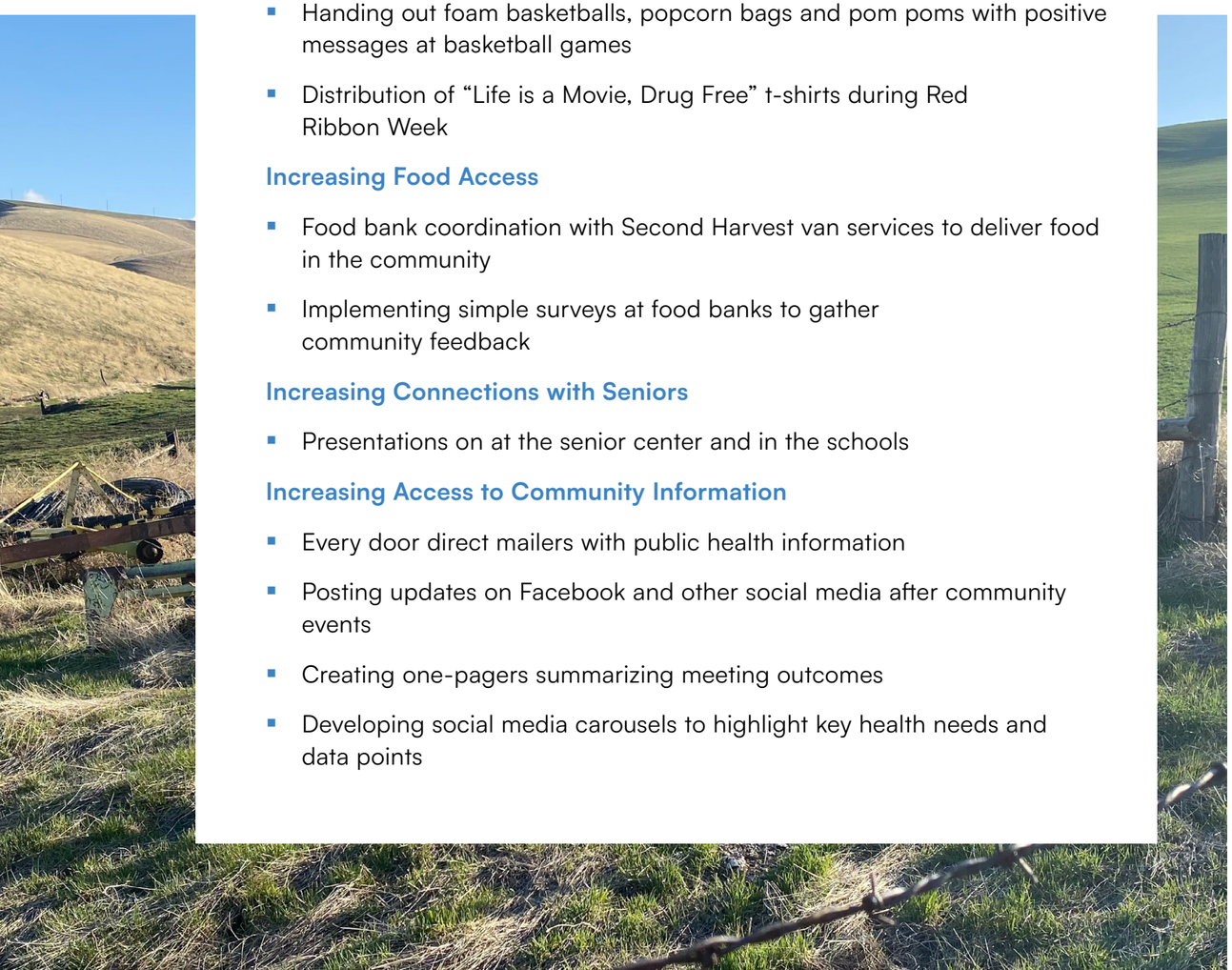
- Food bank coordination with Second Harvest van services to deliver food in the community
- Implementing simple surveys at food banks to gather community feedback

Increasing Connections with Seniors

- Presentations on at the senior center and in the schools

Increasing Access to Community Information

- Every door direct mailers with public health information
- Posting updates on Facebook and other social media after community events
- Creating one-pagers summarizing meeting outcomes
- Developing social media carousels to highlight key health needs and data points



//08. KEEPING OUR COMMUNITY INFORMED

We believe in keeping our community updated on our progress through regular communication and transparent data sharing. A key part of this commitment is our annual Community Health Data Summary.

ANNUAL COMMUNITY HEALTH DATA SUMMARY

Each year, we will publish a summary that tracks both our CHIP priorities and broader community health measures. This summary will:

- Show progress on all CHIP metrics, including both numbers and trends
- Include key health indicators from our Community Health Assessment workbook, giving a fuller picture of community health beyond just our priority areas
- Present data in clear, easy-to-understand formats with explanations of what the numbers mean
- Break down data by population groups where possible to show how different parts of our community are doing
- Highlight success stories and areas where we need to focus more attention

We will share this community data summary through:

- Our website
- Local media and social media
- Community partner organizations
- Public presentations and community meetings
- Email updates to interested community members
- Wellness newsletter

//09. ANNUAL DATA SUMMARY

As part of our Community Health Improvement Plan (CHIP), we will report quantitative data related to our key focus areas: childcare, mental health awareness, and community engagement in public health, as well as other important indicators of community health.

We will show how our data changes over time and we will use the most recent data available.

CHILD CARE

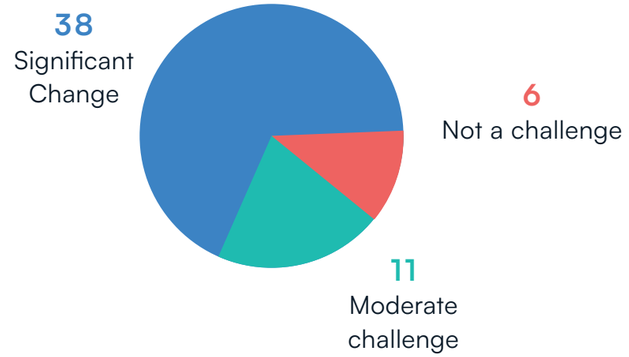
There are no licensed child care facilities in Garfield County. Work is underway to change this. See additional details about our survey findings and information about community child care needs and how we're addressing this need in our CHIP report.

Child Care Survey Summary of Results

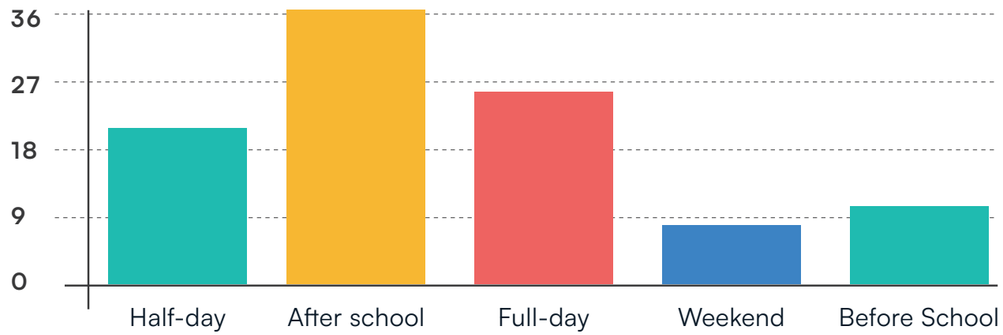
This survey was conducted in Garfield County, Washington in 2024 by the Southeast Early Learning Coalition.

DIFFICULTY IN FINDING CHILD CARE

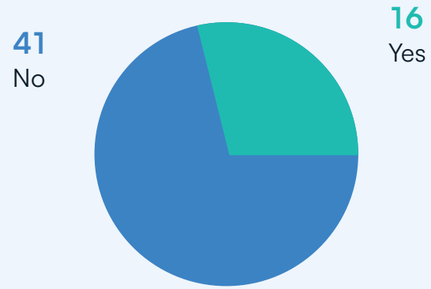
AFFORDABILITY CHALLENGES



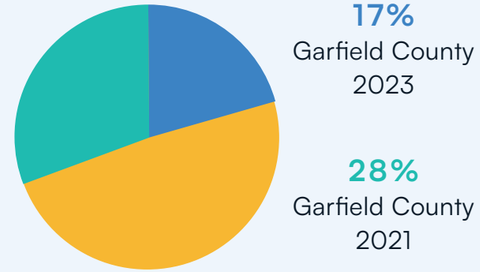
TYPES OF CARE NEEDED



HAD TO QUIT JOB DUE TO CHILD CARE



PERCENTAGE OF GRANDPARENTS CARING FOR GRANDCHILDREN



MENTAL HEALTH — ADULTS AND YOUTH

In 2023 the ratio of people to mental health providers for each person in the county has increased, meaning there was still one provider for more people. We know there is now one more provider in the county delivering mental health services for the community.

INDICATOR NAME	GARFIELD COUNTY 2021	GARFIELD COUNTY 2023
Population to provider ratio for Mental Health Providers	2,290:1	2,360:1

INDICATOR NAME	GARFIELD COUNTY 2021	GARFIELD COUNTY 2022 & 2023	COMPARISON
Prevalence of depression among adults aged >=18 years	12%	33%	Higher ↑
Percentage of adults who report 14 or more days of poor mental health in the past month	4%	7%	Higher ↑
Percentage of 10th grade students who made a plan on how they would attempt suicide in the last 12 months	36%	18%	Much Lower ↓↓
Percentage of 10th grade students who reported being bothered by not being able to stop or control worrying for several days or more in the last 2 weeks.	61%	45%	Much Lower ↓↓
Percentage of 10th grade students who reported that when feeling sad or hopeless, they did not have adults to which they could turn for help	71%	8%	Much Lower ↓↓

Sources: County Health Rankings, Behavioral Risk Factor Surveillance System (BRFSS), Healthy Youth Survey 2023

OPIOIDS

INDICATOR NAME	GARFIELD COUNTY 2020	GARFIELD COUNTY 2023	COMPARISON
Rate of opioid prescriptions per 100	71.3	43.9	Much Lower ↓↓

Source: CDC Opioid Dispensing Rate Data, 2023

ALCOHOL USE

INDICATOR NAME	GARFIELD COUNTY 2020	GARFIELD COUNTY 2023	COMPARISON
Percentage of adults reporting heavy alcohol consumption (adult men having 2 or more drinks per day and adult women having 1 or more drinks per day)	23%	3%	Much Lower ↓↓

Source: Behavioral Risk Factor Surveillance System (BRFSS)

FOOD INSECURITY

INDICATOR NAME	GARFIELD COUNTY 2020	GARFIELD COUNTY 2022	COMPARISON
Percentage of people who have food insecurity	12%	15%	Higher ↑
Percentage of children (<18 years) who have food insecurity	19%	24%	Higher ↑

Source: CDC Opioid Dispensing Rate Data, 2023

PERMITS

TYPES	2016	2022	2023
Food Establishment Permits	19	9	13
Temp. Food Permits	17	12	19
Pumper Permits	2	4	3
Septic Permits	9	3	12

Source: Garfield County Public Health District, 2024

TYPES	2024
Food Establishment Permits	11
Temp. Food Permits	24
Pumper Permits	2
Septic Permits	12
Food Handler Card in Office	5
Online Food Handler Card	74
Catering Permits	3
Soil Certifications	6
Death Certificates	4
Birth Certificates s	28

Source: Garfield County Public Health District, 2024

HOUSING

In 2023 there were 1,052 occupied housing units in Garfield County a slight increase from 1,004 occupied units in 2021.

14% of housing units in Garfield County were vacant in 2023, a decrease from 18% in 2021.

INDICATOR NAME	GARFIELD COUNTY 2021	GARFIELD COUNTY 2023	COMPARISON
Percentage of RENTAL households that spend 35% or more of their household income on rent.	22%	40%	Much Higher ↑↑
Percentage of households WITH a mortgage that spend 35% or more of their household income on housing.	27%	25%	Lower ↓
Percentage of occupied housing units that are owned by occupier (owner-occupied)	78%	77%	About the Same ≈
Percentage of households that spend 50% or more of their household income on housing.	9%	11%	Higher ↑
Percentage of households with at least 1 of 4 housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.	11%	10%	About the Same ≈
Percent of Occupied homes that are rentals (renter-occupied)	22%	23%	About the Same ≈
Percentage of older adults (>65 yo) living alone in homes	20%	20%	Same =

Sources: BACS 5-Year Estimates Data Profiles (DP04), Washington State Office of Financial Management, ACS 5-Year Estimates Data Tables (B25140), County Health Rankings (using data from U.S. Department of Housing and Urban Development (HUD))

FOOD ACCESS: SECOND HARVEST FOOD BANK

MONTH	2024 FAMILIES (1 OR MORE PEOPLE IN A HOUSEHOLD)	2024 MEALS
January	212	7567
February	259	7684
March*		
April	229	8081
May	222	8150
June	189	8098
July	187	8118
August	195	8318
September	224	6992
October	200	7118
November	245	7313
December*		
Total	2162	77439

Source: Second Harvest mobile food bank
*Months with no data means Second Harvest was not available that month

IMMUNIZATIONS

GRADE	2022	2023	2024
Kindergarten	100%	97%	100%
7th Grade	60%	55%	83%
K-12	92%	91%	92%

Source: Pomeroy School District, 2024-2025 school year

POMEROY SCHOOL DISTRICT ENROLLMENT

YEAR	ELEMENTARY	JUNIOR AND HIGH SCHOOL
2017-2018	**172**	**149**
2018-2019	**168**	**151**
2019-2020	**165**	**144**
2020-2021	**170**	**146**
2021-2022	**202**	**154**
2022-2023	**210**	**147**
2023-2024	**198**	

Source: Pomeroy School District, 2024-2025 school year

//10. NEXT STEPS AND FUTURE PLANNING

Our work doesn't end with creating this plan. Over the next three years, we will:

MONITOR OUR PROGRESS

We will track all activities and measure our success on each priority issue. This includes:

- Following up with partners on their committed activities
- Collecting data on our chosen metrics
- Identifying what's working well and what needs adjustment
- Making changes to our approach when needed
- Attendance numbers at events and trainings
- Feedback from program participants
- Changes in awareness and knowledge about resources

SHARE UPDATES WITH THE COMMUNITY

We will keep our community informed through:

- Regular community meetings and data walks to share progress
- Our annual community health data summary
- Updates at partner organization meetings
- Ongoing collection of community feedback

THREE-YEAR CYCLE

This CHIP will guide our work for the next three years. At the end of this period, we will begin our next Community Health Assessment process. This timing allows us to:

- Make meaningful progress on our chosen priorities
- Gather enough data to see if our efforts are working
- Build strong partnerships and programs
- Learn what approaches work best in our community

Starting our next Community Health Assessment after three years will help us identify new or changing health needs in our community and adjust our priorities accordingly.

//10. APPENDICES

APPENDIX A: METHODOLOGY

To ensure our Community Health Improvement Plan is based on current, accurate information, we used several methods to gather and analyze data:

DATA COLLECTION

1. Quantitative Data Updates
   - Updated our Community Health Assessment data workbook with the latest information from state and local sources
   - Included current health statistics, demographic data, and social determinants of health measures
   - Focused on gathering data that could be broken down by different population groups and geographic areas

2. Child Care Survey
   - Analyzed results from a specialized survey about child care needs and access
   - Survey was developed and conducted by Garfield County Public Health District
   - Provided specific insights into local family needs and challenges

3. Community Input
   - Conducted data walks where community members could interact with health data and share their perspectives
   - Gathered direct feedback through community meetings and conversations
   - Documented stories and experiences that helped explain the numbers we were seeing

DATA ANALYSIS

We used a combination of approaches to analyze all this information:

1. Human Analysis
   - Public health professionals reviewed and interpreted data
   - Community partners helped provide context for findings
   - Local experts in specific health areas offered their insights
   - Public health staff reviewed content for accuracy

2. Technology Tools
   - We used artificial intelligence tools to help process and summarize large amounts of data
   - Applied statistical analysis told to identify trends and patterns
   - Created visualizations to help make the data more understandable

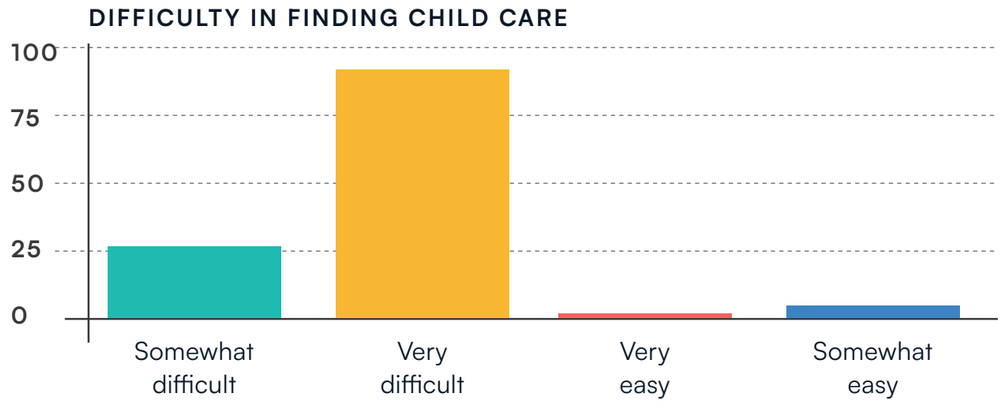
This mixed-methods approach helped us:

- Verify our findings through multiple sources
- Understand both the numbers and the stories behind them
- Identify patterns that might not be obvious from just one type of data
- Ensure our conclusions reflected both objective measures and community experiences

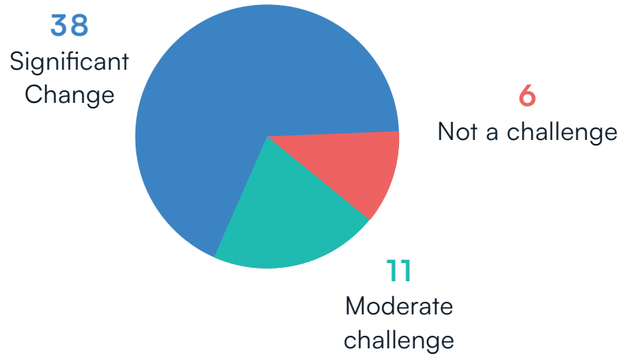
APPENDIX B: DATA COLLECTION DETAILED RESULTS

CHILD CARE SURVEY SUMMARY OF RESULTS

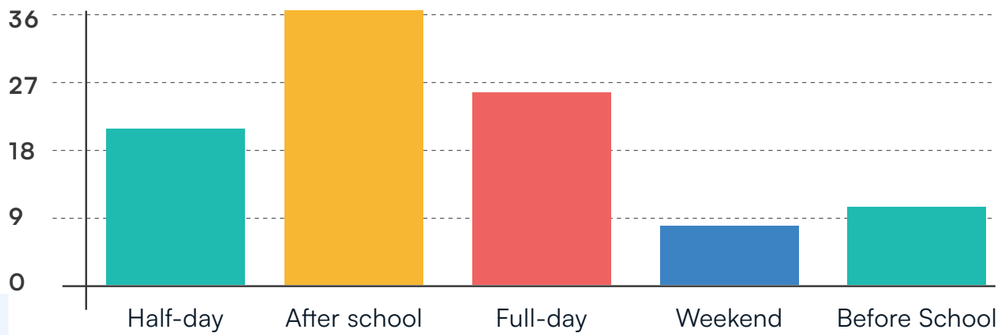
This survey was conducted in Garfield County, Washington in 2024 by the Southeast Early Learning Coalition.



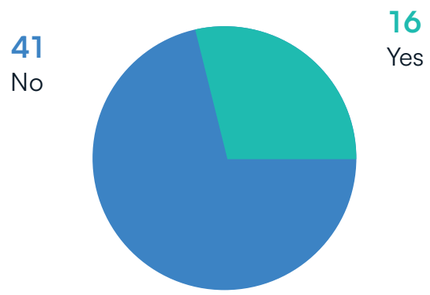
AFFORDABILITY CHALLENGES



TYPES OF CARE NEEDED



HAD TO QUIT JOB DUE TO CHILD CARE



APPENDIX B: DATA COLLECTION DETAILED RESULTS CONT'D

SURVEY STRUCTURE:

The survey collects detailed information about household composition, child care needs, challenges, and preferences

Key Areas Covered:

- Household demographics (number of children by age group)
- Child care arrangements and needs
- Time periods when care is needed (full-day, half-day, before/after school, etc.)
- Challenges in finding and maintaining child care
- Impact on work and career
- Geographic and economic factors

Notable Findings from Initial Data:

- Most respondents are English-speaking
- Many families report finding child care "somewhat difficult" or "very difficult"
- Common challenges include:
  - Finding affordable child care
  - Location/proximity to home or work
  - Finding care during needed hours
  - Impact on work schedules and career advancement

MORE DETAILED ANALYSIS

Difficulty in Finding Care:

The vast majority of respondents report difficulties with child care:

- 93 responses indicated "Very difficult"
- 26 responses indicated "Somewhat difficult"
- Only 7 responses total indicated it was easy (2 "Very easy" and 5 "Somewhat easy")

Affordability Challenges:

This is a major concern for most families:

- 38 families report it as a "Significant challenge"
- 11 report it as a "Moderate challenge"
- Only 6 report it as "Not a challenge"
- 2 indicated it was "Not applicable"

Impact on Employment:

Out of 57 responses regarding job impact:

- 16 respondents (28%) had to quit a job due to child care difficulties
- 41 respondents (72%) had not quit jobs, but many still reported other work impacts

Geographic Context:

- Most respondents are from the Pomeroy area (zip code 99347)
- Some families need care in different locations from where they live, particularly those working in Lewiston/Clarkston area

Types of Care Needed:

- Full-day care is the most commonly needed arrangement
- There's significant demand for before/after school care
- Weekend and holiday coverage is also needed by many families

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