

COMMUNITY HEALTH IMPROVEMENT PLAN



ASOTIN COUNTY HEALTH DISTRICT

2026 - 2028

Asotin County
Health District
Team Included:

SAMANTHA BINGMAN

BETH CONLAN M.ED

AMBER DAHMAN

AMY FINNEY

LAURIE HERSEY M.ED

COLLIN JURRIES

LINDSEY LAND

KAITLANN MCFARLAND

MIKE O'DELL

BRADY WOODBURY MPH

Administrator

LORA GITTINS

Deputy Administrator

BOB LUTZ MD, MPH

Local Health Officer

Community Health
Improvement Plan
conducted by Heidi
Berthoud Consulting.
Team Included:

HEIDI BERTHOUD MPH

Principal Consultant,
Writing Lead

JANESSA GRAVES PHD, MPH

Quantitative Data Lead

KRISTINA SPAID

Visual Designer

ANGIE SCHIRTZINGER

Community Health Project
Coordinator

ACKNOWLEDGEMENTS

TABLE OF CONTENTS

EXECUTIVE SUMMARY	05	ON-SITE SEWAGE (SEPTIC) EDUCATION METRICS	23
WHAT IS A CHIP?	06	WORK ALREADY IN PROGRESS	25
WHY DEVELOP A CHIP?	07	OPPORTUNITIES FOR ENHANCED COLLABORATION	29
HOW WE CHOSE OUR PRIORITIES	08	TIMELINE	30
PRIORITY 1: AGING IN PLACE	10	NEXT STEPS	31
PRIORITY 2: SUBSTANCE USE & OVERDOSE PREVENTION	13	CONCLUSION	33
PRIORITY 3: ON-SITE SEWAGE (SEPTIC) EDUCATION	17	INDICATION TABLES	34
METRICS FOR SUCCESS	20	REFERENCES	41
AGING IN PLACE METRICS	21		
SUBSTANCE USE & OVERDOSE PREVENTION METRICS	22		



EXECUTIVE SUMMARY

Asotin County Health District's (ACHD) Community Health Improvement Plan (CHIP) represents a strategic commitment to improving the health and well-being of all county residents. Through comprehensive community engagement and data-driven analysis, ACHD has identified three priority focus areas where we can make the greatest direct impact:



Aging in Place



**Substance Use
& Overdose
Prevention**



**On-Site Sewage
(Septic)
Education**

These priorities emerged from our 2023-2024 Community Health Assessment (CHA), which gathered input from community members, multiple focus groups, and interviews with community leaders. While the community identified housing and mental health services as critical needs, ACHD is continuing to partner with community organizations who are working on those areas while focusing on areas we can more directly impact.

This CHIP is built upon the foundation of the CHA and represents the transition from understanding community health needs to taking coordinated action to address them.



WHAT IS A CHIP?

A Community Health Improvement Plan (CHIP) is a strategic road map that outlines how we will address some of the most pressing health priorities over a defined period, typically 3-5 years. Unlike a comprehensive health assessment that identifies all health issues, a CHIP focuses on resources and efforts on a select number of priorities where meaningful progress can be achieved.

The CHIP serves as:

- ✦ **A Strategic Framework:** Providing clear direction for public health efforts and resource allocation
- ✦ **A Collaborative Tool:** Bringing together diverse stakeholders from healthcare, education, social services, business, and community organizations
- ✦ **An Action Plan:** Moving beyond data collection to concrete strategies and measurable outcomes
- ✦ **An Accountability Mechanism:** Establishing goals, time lines, and metrics to track progress

WHY DEVELOP A CHIP?

RESPONDING TO COMMUNITY-IDENTIFIED HEALTH NEEDS

Our 2023-2024 Community Health Assessment (CHA) revealed significant health concerns that demand attention. While 77% of survey respondents rated Asotin County as a "good" or "very good" place to live, community members also identified challenges around mental health, housing availability, access to healthcare services, and substance use.

CREATING A COORDINATED APPROACH TO HEALTH IMPROVEMENT

Rather than addressing health issues in isolation, a CHIP creates an organized framework that aligns efforts across multiple organizations and sectors, reducing duplication, and maximizing impact.

FOSTERING CROSS-SECTOR COLLABORATION

Health is influenced by factors far beyond healthcare. Housing, education, employment, transportation, and social connections all play critical roles in a person's health. The CHIP provides a structure for different sectors to work together toward common goals.

ENSURING EFFICIENT USE OF RESOURCES

In a rural county with a small population and limited resources, strategic focus is essential. The CHIP helps ACHD and community partners direct funding, staffing, and infrastructure toward priorities where we can achieve the greatest benefit.

ESTABLISHING ACCOUNTABILITY THROUGH MEASURABLE GOALS

The CHIP sets specific, measurable objectives with defined timelines, allowing ACHD and community partners to track progress, celebrate successes, and adjust strategies as needed.

BUILDING ON COMMUNITY-IDENTIFIED STRENGTHS

Asotin County has a lot of community support and dedicated community members. We heard that community members appreciate a supportive, tight-knit community; approachable, knowledgeable leadership; a strong business community; and beautiful geography. The CHIP leverages these strengths while addressing areas of need.

HOW WE CHOSE OUR PRIORITIES

The selection of our three priority focus areas—Aging in Place, On-Site Sewage Education, and Substance Use & Overdose Prevention—followed a rigorous, multi-step process that combined quantitative data analysis with qualitative community input.

STEP 1

COMMUNITY HEALTH ASSESSMENT (CHA)

Between 2023 and 2024, ACHD conducted a comprehensive Community Health Assessment that included:

- ✦ **Community Survey:** 775 respondents provided insights about health status, concerns, and priorities
- ✦ **Focus Groups:** In-depth discussions with diverse community members
- ✦ **Key Informant Interviews:** Conversations with community leaders across sectors
- ✦ **Secondary Data Analysis:** Review of health statistics, demographics, and trends

The CHA identified four overarching community health needs:

1. **Mental Health**
2. **Housing and Aging in Place**
3. **Access to Health Care Services**
4. **Substance Use**

STEP 2

PRIORITIZATION CRITERIA

We evaluated potential priority areas using a comprehensive framework organized into three categories:

Significance & Impact

- ✦ **Burden of the Issue:** How many people are affected, and what is the severity of consequences if unaddressed?
- ✦ **Health Equity Impact:** Does the issue disproportionately affect vulnerable populations? Would addressing it help reduce health disparities?

Feasibility & Resources

- ✦ **Resource Availability:** Do we have access to necessary funding, staffing, and infrastructure?
- ✦ **Community Readiness:** Is our community prepared to address this issue now? Is there community willingness and support?

Alignment & Synergy

- ✦ **Alignment with Existing Initiatives:** How well does this priority align with other community initiatives or strategic plans?
- ✦ **Potential for Cross-Sector Collaboration:** Can multiple sectors work together on this issue?
- ✦ **Policy Leverage:** Is there potential for policy changes that could support sustainable improvement?

STEP 3

COMMUNITY LEADER ENGAGEMENT

Following initial data analysis, ACHD engaged community leaders through:

- ✦ **Prioritization Surveys:** Gathering input on barriers, facilitators, and organizational capacity for each potential priority area
- ✦ **Data Walks:** Interactive poster sessions where community members could review data, ask questions, and provide feedback
- ✦ **Direct Conversations:** One-on-one discussions with agency leaders about collaboration opportunities

STEP 4

STRATEGIC DECISION-MAKING

While the CHA clearly identified mental health and housing as critical community concerns, ACHD recognizes that these complex issues require systemic, multi-agency approaches that extend beyond the health district's direct capacity. Rather than attempt to lead in areas where we lack the necessary resources and expertise, ACHD made the strategic decision to:

1. **Partner and Support:** Collaborate with community organizations already working on housing and mental health initiatives
2. **Focus Resources:** Concentrate our staff and resources on areas where we can make the greatest direct impact
3. **Emphasize Alignment:** Select priorities that align with public health core functions and available evidence-based interventions

This approach reflects our commitment to efficiently using public resources and being honest about where we can deliver meaningful results.

FINAL PRIORITY SELECTION

Through this comprehensive process, three priorities emerged as optimal focus areas for ACHD:



Aging in Place:

Supporting seniors' ability to remain in their homes safely and independently



Substance Use & Overdose Prevention:

Reducing substance-related harms through prevention, harm reduction, and support for recovery



On-Site Sewage (Septic) Education:

Protecting water quality and public health through proper septic system maintenance

These priorities scored highly across all evaluation criteria: they affect significant portions of our population, align with ACHD's capabilities and mandate, and offer strong potential for community collaboration and measurable impact.

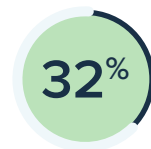
PRIORITY

AGING IN PLACE

WHAT THIS IS

Aging in place refers to the ability of older adults to live safely, independently, and comfortably in their own homes and communities as they age, rather than moving to care facilities. This priority addresses the multiple factors that enable successful aging in place, including access to healthcare and home health services, transportation, social connections, home safety modifications, and management of chronic health conditions.

WHY THIS MATTERS



Asotin County has a significantly aging population, **with 32% of residents aged 60 or older**. This is higher than many comparable communities. This demographic trend presents both challenges and opportunities for our community's future.

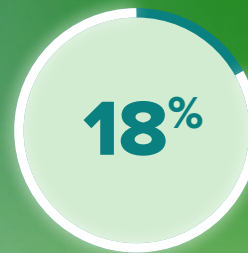
(Source: ACS 5-Year estimates, Table S0101, 2018-2022)

KEY DATA POINTS:

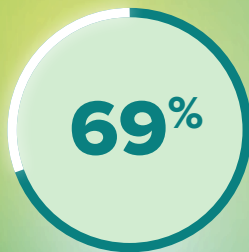


Nearly 20% of adults 75+ report independent living difficulties (compared to 23% statewide)

Source: Subject Tables S1810



Of occupied housing units consist of residents 65+ living alone (compared to 11% statewide)



Of grandparents who live with their grandchildren also care for them. (compared to 28% statewide)

Note about grandparents caring for grandchildren. This represents the percentage of grandparents living with their own grandchildren who are also responsible for them. In Asotin County, 396 grandparents live with their own grandchildren, of whom 274 (69%) are responsible for them. This compares to 28% statewide.

(Source: ACS 5-Year estimates, DP02, 2019-2023)

ACHD'S ROLE AND APPROACH

ACHD will work to support aging in place through:

PARTNERSHIP DEVELOPMENT

Collaborating with home health agencies, senior centers, transportation providers, and housing organizations

EDUCATION AND OUTREACH

Providing information about fall prevention, chronic disease management, and available resources

PROGRAM COORDINATION

Connecting seniors and caregivers with existing services and identifying service gaps

POLICY SUPPORT

Advocating for policies and programs that support aging populations

DATA MONITORING

Tracking indicators related to senior health and independence



PRIORITY

**SUBSTANCE
USE &
OVERDOSE
PREVENTION**

WHAT THIS IS

Substance use and overdose prevention encompass strategies across the full continuum of care, from preventing substance use before it starts, to reducing harm for people who use substances, to supporting individuals in recovery. This approach recognizes that effective responses must include prevention education, harm reduction interventions like naloxone distribution, and access to treatment and recovery support services.

WHY THIS MATTERS

Substance use, including alcohol, cannabis, prescription medications, and illicit drugs affects individuals, families, and entire communities. While not unique to Asotin County, substance use disorders and overdoses represent a significant and growing public health challenge. ACHD aims to reduce substance-related deaths, connect people to help, and coordinate community efforts to address this complex public health challenge.

KEY DATA POINTS:



11-15
ANNUALLY

Non-fatal opioid hospitalizations
(2022-2024)



14 → **15**
IN 2022 **IN 2024**

Opioid deaths: Increased

THE SPECTRUM OF SUBSTANCE USE RESPONSE

Effective substance use prevention and reduction approaches address the full continuum of need:



Prevention:

Interventions before someone develops a substance use disorder (they may be using substances but not to a problematic level)



Overdose Prevention:

Interventions designed to improve the health of people who have a substance use disorder and may or may not be interested in quitting (e.g., naloxone distribution, safe disposal programs, education)



Recovery Support:

Resources for people actively trying to quit or who have quit (e.g., treatment programs, support groups, peer support)

ACHD'S ROLE AND APPROACH

ACHD will address substance use and overdose through:

PREVENTION AND EDUCATION

School and community-based prevention programs; naloxone distribution, safe disposal programs, education about overdose prevention programs, education about overdose prevention

DATA MONITORING

Tracking trends and sharing information with community partners

COALITION BUILDING

Convening stakeholders to coordinate efforts and reduce duplication of efforts and services.

POLICY SUPPORT

Advocating for evidence-based policies and increased treatment resources

COMMUNITY EDUCATION

Reducing stigma and increasing awareness of resources

PARTNERSHIP

Collaborating with treatment providers, law enforcement, schools, and recovery organizations

PRIORITY

ON-SITE SEWAGE (SEPTIC) EDUCATION

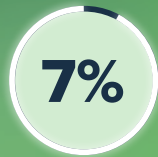
WHAT THIS IS

On-site sewage education focuses on informing homeowners how to properly maintain their septic systems through regular pumping, inspection, and care. Properly maintained septic systems protect groundwater and surface water quality, help prevent costly system failures, and safeguard public health by ensuring wastewater is treated effectively.

WHY THIS MATTERS



Approximately **50%** of Asotin County residents rely on **on-site sewage systems** (septic systems) for wastewater management.



7% of community health survey respondents were unsure whether they have septic or sewer.

Source: Asotin County Health District, 2025

IMPROPERLY MAINTAINED SEPTIC SYSTEMS POSE SERIOUS RISKS TO:

- ✘ **Groundwater Quality:** Contamination can affect drinking water sources
- ✘ **Surface Water Health:** Failing systems can pollute streams, rivers, and ponds
- ✘ **Public Health:** Exposure to untreated sewage can cause illness
- ✘ **Property Values:** System failures can result in expensive repairs and environmental cleanup
- ✘ **Environmental Protection:** Protecting our beautiful natural resources is essential to community identity and economy

COMMON ON-SITE SEWAGE PROBLEMS:

- ✘ **Inadequate system size** for home additions (basements, extra bedrooms)
- ✘ **Improper drain field protection** - people don't understand the importance of protecting reserve areas
- ✘ **Lack of regular maintenance** can result in costly repairs
- ✘ **Flushing inappropriate items** toilet paper, plugs, non-degradable materials and food items
- ✘ **Homeowner-installed systems** vs. licensed installers

ACHD'S ROLE AND APPROACH

As the local health jurisdiction responsible for on-site sewage system oversight, ACHD will take the following actions:

EDUCATION CAMPAIGNS

Develop clear, accessible materials about septic system care and maintenance schedules

COMMUNITY OUTREACH

Partner with realtors, contractors, and community organizations to reach homeowners

RESOURCE DEVELOPMENT

Create a directory of licensed septic professionals and maintenance resources

TECHNICAL ASSISTANCE

Provide guidance to homeowners about proper system care

COLLABORATION

Work with environmental organizations and water quality advocates

REGULATORY SUPPORT

Ensure appropriate permitting and inspection processes





METRICS FOR SUCCESS

Measuring progress is essential to accountability and continuous improvement. For each priority area, ACHD will track specific indicators, establish baselines, set targets, and regularly evaluate our progress.

We are tracking two types of indicators;

PRIMARY

which means the indicators that ACHD can monitor or impact directly, and

SECONDARY

which are the indicators that ACHD can't directly control but are being monitored because of their importance to local public health.





PRIMARY

INDICATORS:

Number of SAIL (Stay Active and Independent for Life) classes held annually

- ✘ Baseline (2025): 94
- ✘ Target (2028): Increase by 50%

Data Source: ACHD

Number of partnerships supporting aging in place initiatives

- ✘ Baseline (2025): 1
- ✘ Target (2028): 5

Data Source: ACHD

SECONDARY

INDICATORS:

Percentage of adults 75+ reporting independent living difficulties

- ✘ Baseline (2019-2023): 20%
- ✘ Target (2028): Monitor trend

ACS 5-Year Estimates Subject Table S1810

Percentage of occupied housing units with residents 65+ living alone

- ✘ Baseline (2021): 14%
- ✘ Target (2028): Monitor trend; maintain access to support services

Data Source: American Community Survey 5-Year Estimates

Number of fall-related emergency department visits among seniors

- ✘ Target (2028): Monitor trend; maintain access to support services

Availability of transportation services for seniors

- ✘ Target (2028): Monitor trend; maintain access to support services

TRACKING

METHODS:

- ✘ Annual review of census and health data
- ✘ Partnership assessments
- ✘ Program participation tracking
- ✘ Focus groups with older adults

SUBSTANCE USE & OVERDOSE PREVENTION METRICS

PRIMARY

INDICATORS:

Number of naloxone kits distributed

- ✘ Baseline (2025): 501 naloxone kits in 2025
- ✘ Target (2028): Increase by 25%

Data Source: ACHD

Number of individuals trained by ACHD in naloxone administration

- ✘ Baseline (2025): 0
- ✘ Target (2028): 20

Data Source: ACHD

SECONDARY

INDICATORS:

Number of opioid-related deaths (3-year rolling count, any opioid)

- ✘ Baseline 2021- 2024: 19 → 28
- ✘ Target (2028): Monitor trend

Data Source: Washington Department of Health Opioid and Drug Overdose Dashboard

Number of non-fatal opioid hospitalizations (3-year rolling count, any opioid)

- ✘ Baseline 2021-2024: 14 → 14
- ✘ Target (2028): Monitor trend

Data Source: Washington Department of Health Opioid and Drug Overdose Dashboard

WHY DO WE USE A ROLLING COUNT? A rolling count is used to show a trend over more than one year when the data in each year are very different. The rolling count helps us quickly see if there is a trend, particularly if one year has a very high or very low number.

TRACKING

METHODS:

- ✘ State surveillance data monitoring
- ✘ Program participation tracking
- ✘ Partnership assessments
- ✘ Treatment provider capacity assessments



ON-SITE SEWAGE EDUCATION METRICS

PRIMARY

INDICATORS:

Number of people pumping their tank for Operation and Maintenance (O/M) purposes

- ✦ Baseline (2026): develop goal after 2026

SECONDARY

INDICATORS:

Number of septic system inspections completed

Number of septic system failures reported

Number of community education events conducted

NOTE: We are developing these indicators through this CHIP process and will have more data to share in subsequent years.

TRACKING

METHODS:

- ✦ Program tracking and documentation
- ✦ Permit and inspection records review

Cross-Cutting Metrics

In addition to priority-specific indicators, ACHD will track several cross-cutting measures:

- ✦ **Partnership Strength:** Number and quality of collaborative relationships
- ✦ **Community Engagement:** Participation in CHIP-related activities and programs
- ✦ **Resource Leverage:** Funding and in-kind contributions secured for priority areas

Reporting on Broader Community Health Indicators

While this CHIP concentrates on three strategic priorities where ACHD can have the greatest direct impact, we recognize that community health includes much more than these areas. Each year, ACHD will publish a community data snapshot that tracks progress on our CHIP priorities and reports on other important public health indicators identified by community members. These may include mental health metrics, access to healthcare, school immunization rates, homelessness, food security, maternal and child health indicators (such as WIC participation), food safety inspection outcomes, and other emerging health issues.





WORK

One of the strengths of this CHIP is that it builds upon existing momentum. Numerous organizations are already working on initiatives related to our priority areas, creating opportunities for collaboration, coordination, and amplification of impact.

ALREADY IN

PROGRESS



AGING IN PLACE

Current Initiatives

TRANSPORTATION SERVICES

Public Transportation Benefit Area (PTBA) provides public transportation, though routes and schedules remain limited

Volunteer driver programs

Medical transportation through Medicaid and insurance programs

HOME HEALTH AND SUPPORT SERVICES

Multiple home health agencies serve Asotin County

Meals on Wheels provides nutrition support

Visiting nurse services for medical care at home

SENIOR CENTERS AND PROGRAMS

Valley Community and Senior Center offers activities, meals, and social connection

Various community organizations provide senior programming

Faith communities offer pastoral care and support networks

HEALTHCARE ACCESS

Telehealth expansion has improved access to specialty care

Local healthcare providers offer geriatric services

Case management services help coordinate care



SUBSTANCE USE

Current Initiatives

PREVENTION

School-based prevention programs in local districts

Youth development programs

Community coalitions addressing underage substance use

SAFETY

Naloxone availability through pharmacies and some community organizations

Safe medication disposal sites

Education about overdose prevention

TREATMENT AND RECOVERY

Outpatient substance use treatment services available locally

Inpatient treatment requiring travel to other communities

Support groups (AA, NA, Al-Anon) meeting regularly

Peer support and recovery coaching through some providers

SYSTEMS COORDINATION

Criminal justice diversion programs

Healthcare provider screening and intervention

Crisis response partnerships



ON-SITE SEWAGE

Current Initiatives

ACHD PROGRAMS

Permitting and inspection of on-site sewage systems

Technical assistance for homeowners and installers

Enforcement of health and safety standards

Maintenance of records and system inventory

EDUCATIONAL EFFORTS

Some community organizations have incorporated septic education into environmental programs

Real estate professionals sometimes provide information during property transactions

Local wastewater professionals offer maintenance advice

WATER QUALITY PROTECTION

Conservation districts monitor water quality

Environmental organizations conduct watershed education

State agencies provide technical resources

OPPORTUNITIES FOR ENHANCED COLLABORATION

This CHIP creates a framework for strengthening coordination among existing efforts:



Information Sharing:

Regular communication about programs, resources, and gaps



Joint Programming:

Collaborative events and initiatives that leverage multiple organizations' strengths



Resource Coordination:

Reducing duplication and filling service gaps



Collective Impact:

Aligning efforts toward common goals with shared metrics



Advocacy:

Unified voice on policy and funding priorities

The CHIP follows a cyclical process that ensures continuous assessment, action, and improvement over the next few or several years.

ASSESS
Publish Community Health Assessment (CHA)

PRIORITIZE
CHIP Focus Areas

ENGAGE
the Community, Agencies & Organizations

REPORT
Annual Community Data Snapshot

SHARE
What We Learned

REPORT
Annual Community Data Snapshot

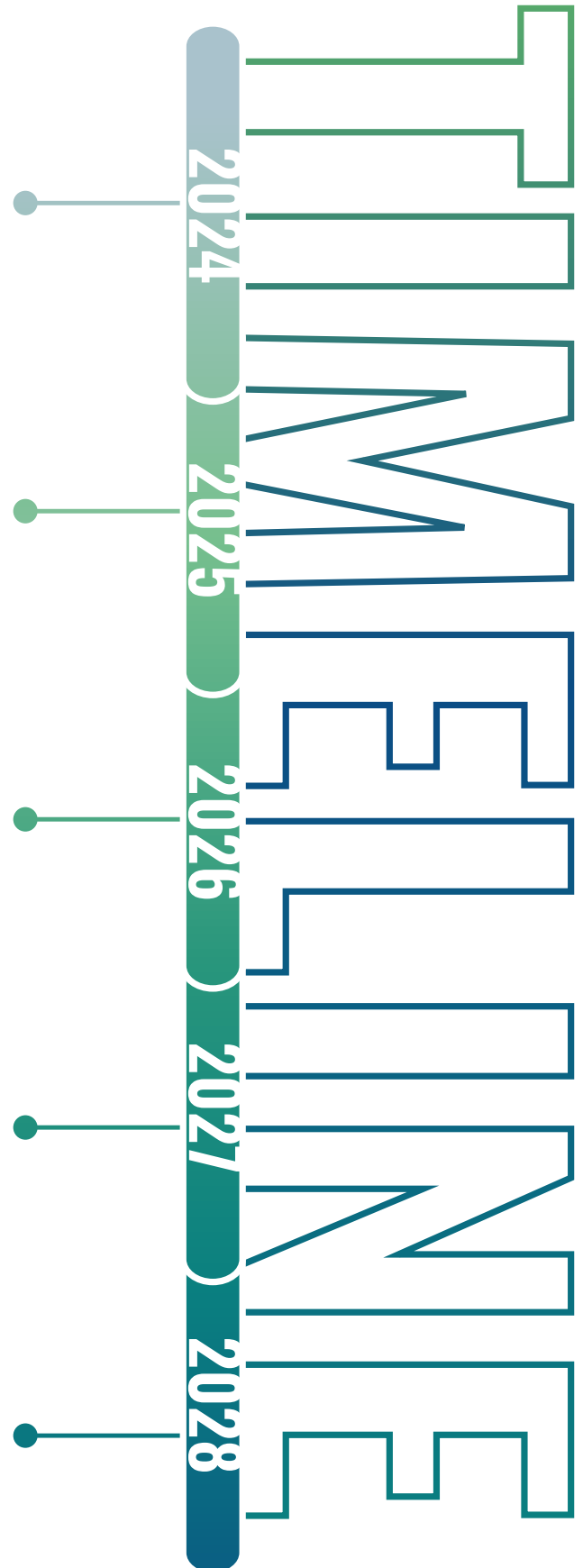
REVIEW
Data & Our Progress

SHARE
What We Learned

REPORT
Annual Community Data Snapshot

PLAN
Next CHA

ASSESS
Conduct CHA





NEXT STEPS

FOR ASOTIN COUNTY HEALTH DISTRICT

First Steps in 2026 (~ 3 Months):

- ✘ Finalize and publish this CHIP report
- ✘ Present CHIP to Board of Health, community leaders, and stakeholders
- ✘ Establish working groups for each priority area
- ✘ Identify funding opportunities and resource needs

Ongoing Actions (Next 6-12 Months):

- ✘ Launch initial programs and activities for each priority
- ✘ Establish data collection and tracking systems
- ✘ Begin developing educational materials and resources
- ✘ Build or strengthen partnerships
- ✘ Begin community awareness campaigns

Ongoing Commitments:

- ✘ Regular reporting to community and stakeholders
- ✘ Continuous evaluation and adaptation
- ✘ Annual community data snapshots
- ✘ Partnership cultivation and maintenance
- ✘ Advocacy for resources and policies supporting priorities

FOR COMMUNITY PARTNERS

We invite you to:

- ✘ Review this CHIP and identify where your organization's work aligns
- ✘ Contact ACHD to explore collaboration opportunities
- ✘ Share information about programs and services with your networks
- ✘ Participate in working groups and coalition meetings
- ✘ Provide feedback and ideas for addressing priorities
- ✘ Help us track progress and evaluate impact

FOR COMMUNITY MEMBERS

You can contribute by:

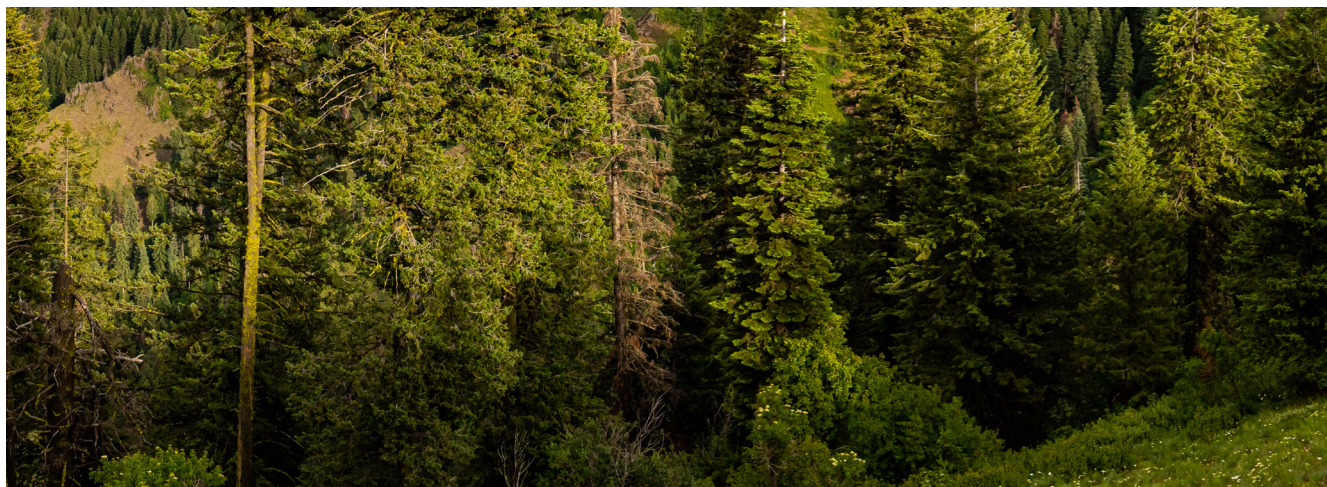
- ✘ Learning about CHIP priorities and sharing information with others
- ✘ Accessing resources and programs as they become available
- ✘ Participating in community surveys and feedback opportunities
- ✘ Volunteering with organizations working on priority areas
- ✘ Advocating for policies and resources that support community health
- ✘ Taking personal actions aligned with priorities (e.g., maintaining your septic system, checking on senior neighbors, safely storing medications)

STAYING CONNECTED

Follow ACHD's progress on the CHIP:

- ✘ Website: achd.org
- ✘ Facebook: [Asotin County Health District](https://www.facebook.com/AsotinCountyHealthDistrict)
- ✘ Instagram: [@asotincountyhealthdistrict](https://www.instagram.com/asotincountyhealthdistrict)
- ✘ Phone: 509-243-3344
- ✘ Email: achd@ac-hd.org
- ✘ Address: 719 5th Street, Clarkston, WA 99403

Annual community data snapshots will be published each year, providing updates on our progress toward goals and highlighting community health indicators beyond the CHIP priorities.





CONCLUSION

This Community Health Improvement Plan represents more than a document—it is a commitment to action, collaboration, and continuous improvement in service for all Asotin County residents. By focusing on Aging in Place, On-Site Sewage Education, and Substance Use & Overdose Prevention, ACHD and community partners will address significant health needs while building on existing strengths and assets. These priorities offer opportunities for meaningful impact, leverage available evidence-based strategies, and align with community concerns and organizational capacity.

The success of this CHIP depends on collective effort. No single organization can address complex health challenges alone. Through partnership, coordination, and shared commitment, we can improve health outcomes, reduce disparities, and enhance quality of life for all community members.

We recognize that health is affected by many factors, including those outside the healthcare system. Our environment—where we live, work, learn, and play—along with our economic opportunities, social connections, and physical surroundings, all influence health and well-being. This CHIP aims to address health comprehensively, collaborating across sectors and systems to create conditions where everyone can succeed.

As we implement this plan over the coming years, we remain committed to:

- ✦ **Data-Informed:** Basing our strategies on sound evidence while measuring progress and adjusting based on what we learn
- ✦ **Integrity:** Being honest and transparent about our processes, successes, and challenges
- ✦ **Compassion:** Ensuring all community members, especially those facing the greatest barriers, can access services and support
- ✦ **Optimism:** Believing in our collective ability to create positive change and improve public health outcomes
- ✦ **Developing Community:** Working together across organizations, sectors, and perspectives to strengthen community capacity and engagement

Thank you to everyone who contributed to this CHIP. We appreciate community members who shared their experiences and insights, leaders who provided data and expertise, organizations already working to improve community health, and the Board of Health and ACHD staff who are committed to this vision.

THIS IS YOUR COMMUNITY DATA.

THIS IS YOUR COMMUNITY'S FUTURE.

LET'S WORK TOGETHER TO MAKE IT HEALTHY.

Community Health

DATA SNAPSHOTS

Demographics

Indicator Name	Asotin County	Washington State
Median age of population	46	38
Percentage of grandparents living with grandchildren who are responsible for caring for grandchildren	69%	28%

Sources: ACS 5-Year Estimates Subject Table S0101, 2019-2023; ACS 5-Year Estimates Data Profile DP02, 2019-2023

Economic Factors

Indicator Name	Asotin County	Washington State
Percentage of children enrolled in public schools that are eligible for free or reduced-price lunch	57%	n/a
Percentage of people living at or below the US federal poverty level	15%	10%
Percentage of households receiving Food Stamps/SNAP in the last 12 months	19%	11%

Source: OSPI, 2024-2025 school year; ACS 5-Year Estimates Subject Table S1701, 2019-2023; ACS 5-Year Estimates Subject Table S2201, 2019-2023

Education

Indicator Name	Asotin County	Washington State
Percentage of adults ages 25-44 with high school graduate or higher	91%	83%
Percentage of teens and young adults ages 16-19 neither working nor in school	17%	7%
Percentage of ninth-grade cohort that graduates in four years	74%	82%

Source: ACS 5-Year Estimates Subject Table S1501, 2019-2023; County Health Rankings, 2019-2023; OOSPI Report Card Graduation 2024-2025

Community Health

DATA SNAPSHOTS

Food and Nutrition

Indicator Name	Asotin County	Washington State
Total WIC authorized case load	425	n/a

Source: WA DOH, FY 2025

Health and Wellbeing

Indicator Name	Asotin County	Washington State
Percentage of children under age 18 who have food insecurity	24%	12%
Proportion of children in public schools who are homeless	4%	4%

Sources: Feeding America Action, 2023; OSPI Enrollment Report Card, 2024-2025 School Year

Health Care Access and Utilization

Indicator Name	Asotin County	Washington State
Age-adjusted percentage of adults reporting having a health care provider	80%	83%
Age-adjusted percentage of adults who report visiting a dentist, dental hygienist or dental clinic within the past 12-24 months	73%	67%

Sources: BRFSS, 2022.

Community Health

DATA SNAPSHOTS

Health Conditions

Indicator Name	Asotin County	Washington State
Age-adjusted percentage of adults who report they have been told by a doctor, nurse or other health care professional that they have asthma	13%	11%
Percentage of older adult population 65 years and over with an independent living difficulty	12%	13%
Percentage of older adult population 75 years and over with an independent living difficulty	20%	23%
Percentage of population (all ages) with an independent living difficulty	9%	6%
Percentage of households with one or more people with any disability	34%	26%
Age-adjusted percentage of adults reporting their general health status as poor	14%	15%
Age-adjusted percentage of adults reporting poor physical or mental health keeping them from completing usual activities	17%	10%

Sources: ACS 5-Year Estimates Subject Table S1810, 2017-2021, 2019-2023; BRFSS/CHAT, 2022

Mortality

Indicator Name	Asotin County	Washington State
Age-adjusted mortality due to accidental drowning and submersion per 100,000	1	2
Age-adjusted mortality due to unintentional injuries (accidents) (per 100,000)	82	68

Sources: CHAT - Mortality module (external cause), 2022-2024

Community Health

DATA SNAPSHOTS**Housing**

Indicator Name	Asotin County	Washington State
Percentage of rental households that spend 35% or more of their household income on rent	35%	40%
Percentage of households who spend 50% or more of their household income on housing	12%	14%
Percentage of occupied housing units that are owner-occupied	74%	64%
Percentage of occupied housing units wherein the household consists of a householder 65 years and over living alone	18%	11%

Sources: ACS 5-Year Estimates Data Profiles (DP04), 2019-2023; County Health Rankings (using ACS data), 2019-2023; ACS 5-Year Estimates Data Profiles (DP04), 2019-2023; ACS 5-Year Estimates Subject Table S2501, 2019-2023

Mental Health

Indicator Name	Asotin County	Washington State
Age-adjusted percentage of adults who report they have been told they have depressive disorder including depression, major depression, dysthymia, or minor depression	26%	26%
Percentage of 8th grade students who attempted suicide within the previous 12 months	12%	9%

Sources: BRFSSCHAT, 2022; HYS, 2023

Community Health

DATA SNAPSHOTS

Preventative Care

Indicator Name	Asotin County	Washington State
Percentage of female Medicare enrollees under age 65 that had at least one screening mammogram	27%	19%
Age-adjusted percentage of adults who received a flu immunization in the last 12 months	34%	47%
School immunization status (% complete) - 7th grade	77%	85%
School immunization status (% complete) - K-12	76%	90%
Age-adjusted percentage of adults with visits to doctor for routine checkup within the past year among adults 18 years and over	69%	69%
Percentage of fee-for-service (FFS) Medicare enrollees with an annual wellness visit	61%	38%

Source: CMS, 2023; BRFSS/CHAT, 2022; WA DOH School Immunization Data Dashboard, 2024-2025 School Year; Centers for Medicare & Medicaid Services Office of Minority Health's Mapping Medicare Disparities (MMD) Tool, 2023

Technology

Indicator Name	Asotin County	Washington State
Percentage of households with broadband internet connection (any type)	87%	93%

Sources: ACS 5-Year Estimates Data Profile DP02, 2019-2023

Community Health

DATA SNAPSHOTS

Substance Use		
Indicator Name	Asotin County	Washington State
Percentage of 8th grade students who reported alcohol consumption in the previous 30 days	6%	4%
Rate of opioid prescriptions per 100	73	35
Age adjusted rate of opioid-related deaths per 100,000	27	29
Drug overdose hospitalization rate per 100,000 (age adjusted)	8	69
Treatment of Medicaid enrollees with OUD with buprenorphine	8%	3%
Initiation of OUD treatment with medication-assisted treatment (MAT)	7%	8%
Percentage of women giving birth who smoked during pregnancy	5%	2%
Percentage of youth (8th grade) who reported using vapes or e-cigarettes	6%	5%

Source: HYS, 2023; CDC Drug Overdose Data, 2023; CHAT - mortality module, 2022-2024; CHAT - Hospitalization module, 2023; WA Health Care Authority, 2024-Q3; CHAT - Birth Risk Factors module, 2024; HYS, 2023

REFERENCES

- U.S. Census Bureau. (2019–2023). American Community Survey 5-year estimates: Table S0101 – Age and Sex. <https://www.census.gov/programs-surveys/acs/>
- U.S. Census Bureau. (2019–2023). American Community Survey 5-year estimates: Table DP02 – Selected Social Characteristics. <https://www.census.gov/programs-surveys/acs/>
- Washington Office of Superintendent of Public Instruction. (2024–2025). Free and Reduced-Price Lunch Eligibility. <https://www.k12.wa.us>
- U.S. Census Bureau. (2019–2023). American Community Survey 5-year estimates: Table S1701 – Poverty Status.
- U.S. Census Bureau. (2019–2023). American Community Survey 5-year estimates: Table S2201 – Food Stamps/SNAP.
- U.S. Census Bureau. (2019–2023). American Community Survey 5-year estimates: Table S1501 – Educational Attainment.
- County Health Rankings. (2019–2023). Education indicators for Asotin County. <https://www.countyhealthrankings.org>
- Washington Office of Superintendent of Public Instruction. (2022). Report Card – Graduation Outcomes 2021–2022.
- Washington State Department of Health. (2024). WIC Program Annual Participation Data.
- Feeding America. (2023). Map the Meal Gap – Child Food Insecurity. <https://map.feedingamerica.org>
- Washington Office of Superintendent of Public Instruction. (2024–2025). Enrollment Report Card.
- Centers for Disease Control and Prevention. (2022). Behavioral Risk Factor Surveillance System (BRFSS). <https://www.cdc.gov/brfss/>
- Washington State Department of Health. (2022). Community Health Assessment Tool (CHAT): Hospitalizations & Morbidity.
- U.S. Census Bureau. (2017–2021; 2019–2023). American Community Survey 5-year estimates: Table S1810 – Disability Characteristics.
- U.S. Census Bureau. (2019–2023). American Community Survey 5-year estimates: Table DP04 – Housing Characteristics.
- U.S. Census Bureau. (2019–2023). American Community Survey 5-year estimates: Table S2501 – Occupancy Characteristics.
- Healthy Youth Survey. (2023). Washington State HYS Results. <https://www.askhys.net>
- Washington State DOH. (2022–2024). CHAT – Mortality Module: External Causes.
- Centers for Medicare & Medicaid Services. (2023). CMS Preventive Services Data. <https://data.cms.gov>
- Washington DOH. (2024–2025). School Immunization Data Dashboard.
- Centers for Medicare & Medicaid Services, Office of Minority Health. (2023). Mapping Medicare Disparities (MMD) Tool.
- CDC. (2023). Drug Overdose Surveillance and Epidemiology. <https://www.cdc.gov/drugoverdose>
- Washington State Health Care Authority. (2024-Q3). Opioid Use Disorder Treatment Data.
- Washington State DOH. (2024). CHAT – Birth Risk Factors Module.

THANK YOU!!!



COMMUNITY HEALTH IMPROVEMENT PLAN

Asotin County Health District

Published: February 2026

Planning Period: 2025-2028

For more information:

719 5th Street, Clarkston, WA 99403

509-243-3344 | achd@ac-hd.org

ac-hd.org