

2017



Southeast
Kansas
Health
Committee

Community
Health
Assessment

Community Health
Improvement Plan

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Executive Summary

Southeast Kansas (SEK) is considered to be a rural area. Community members in the SEK area are very satisfied with their quiet small town atmospheres, yet they are able to travel two hours to an urban area to experience the urban atmosphere. The community health assessment participants revealed good jobs, economy and good schools were important in their communities. Rural residents tend to be more independent and form their own solutions for concerns. This has been demonstrated many times by the community relying on their own resources rather than waiting for external governmental assistance during natural disasters such as the Franklin tornado in Crawford County, ice storms in Cherokee County, and flooding in Montgomery and Neosho counties. During these times the communities have come together as a county as well as a region to meet the needs of community members. Likewise, these communities have learned that teamwork is needed to address other issues such as poverty, health, education, economy, and lifestyle changes. That being said, there are many issues that remain and need to be addressed.

Industry for the region consists of educational services, health care and social assistance with manufacturing and agriculture following as second and third. Agriculture is the primary industry for Chautauqua and Elk counties.

Southeast Kansas communities have watched their youth mature into young adults and leave the area for better educational and employment opportunities. The community health assessment revealed that community members thought that the schools were one of the most important aspects of their community. The unemployment rate for the region is the same as the state unemployment rate of 3.9%. Despite the fact that the unemployment rate for the region was 3.9% the regional median household income is only \$39,442.00 compared to the state of Kansas median income of \$52,405.00 which is more than 25% lower than the state.

The health concerns of the region are similar to the state, however, needs in the Southeast Kansas Region seem to be higher than the state's needs. Two examples are the state obesity rate of 34.2% with county rates ranging from 45.7% to 36.3% making the regional rate 40.4%. The adult smoking rate for Kansas is 17.8% with a regional adult smoking rate of 23.2%. The Southeast Kansas region also stood out with hospital admission rate due to unintentional injuries being almost double that of the Kansas hospital admission rate and deaths due to unintentional injuries were significantly higher than the state rate.

The region has a rate of 17.8% of uninsured as compared to the Kansas rate of 12.8%. Current legislation will have a major impact on these numbers as the region awaits the possibility of repeal of the Affordable Care Act.

The community survey identified mental health, cancers, and heart disease, and stroke as the most important health problems in their communities. Data for the region confirms these concerns. The age adjusted heart disease mortality rate for the region is 200.9 per 100,000 compared to the Kansas rate of 156.4 per 100,000. The age adjusted cancer mortality rate for the region is 188.7 per 100,000 with the Kansas rate of 164.1 per 100,000.

The work group took these factors into consideration to identify four areas to address in the Community Health Improvement plan.

The four major areas of concern identified by the regional work group are:

- 1. Chronic Disease**
- 2. Mental Health**
- 3. Drugs and alcohol**
- 4. Obesity**

Multiple partners gave of their time and energy to assist in the development of this community health assessment. These partners openly shared their talents, knowledge and beliefs during each phase of the community health assessment. Without the collaboration of the Southeast Kansas Health Committee partners, the development of this community health assessment would not have been possible. Copies of this document may be found at www.crawfordcountykansas.org, by contacting Via Christi or your local county health department.

Background

The Lower 8 Region of Southeast Kansas was formed in 2002. Originally, this region was formed to address bioterrorism, however, after several natural disasters occurred throughout the region, it was determined that the Lower 8 could broaden its scope to include the ten essential services of public health in each county (See Appendix A). The Lower 8 Region has a solid foundation and strong history of collaboration. However, through the previous community health assessment, some communities found they were more successful if the community health assessments were completed at the local level. Therefore, the Southeast Kansas Health Committee was formed from the remaining counties of Chautauqua, Cherokee, Crawford, Elk, Montgomery, and Neosho to complete a regional community health assessment and community health improvement plan. It is important to note that this community health assessment has a threefold objective: 1) Meet the needs of the participating hospitals 2) Meet the needs of participating local health departments 3) Meet the needs of the Blue Cross Blue Shield Pathways Grant. Due to this threefold objective, this assessment will contain an increased number of data sets. It was felt that by combining these surveys, the community would be more likely to participate rather than completing three separate surveys.

Regional vs. Local

The total population of the SEK Region is just below 120,000. The two largest counties in the region are Crawford and Montgomery both with a population just below 40,000. Elk has the smallest population of 2,720. With the exception of Crawford, all of the counties decreased in population according to the 2001 Census data. Crawford County saw a 2.9% increase in population. The region consists of two semi urban counties, two rural counties, and two frontier counties. Frontier counties are challenged to find available data for their community due to their size, and when the data is available there is a marked potential for the data to have a high rate of variability. For the frontier counties the regional data would be more consistent and reliable. Staffing is always a challenge in smaller health departments. Consolidation of staff for the completion of the community health assessment would not only reduce the workforce burden on all of the SEK region counties, but it would also assist with the financial burdens. Therefore, it was felt that we could consolidate our workforces, save money, save time, and have a larger impact in our region. At the same time, several counties desired to see their data at the county level as well so they could utilize the data at the local level. Therefore it was decided to complete the community health assessment as a region, but maintain individual county data to assist counties that would like to address issues more specific to their county.

The Process

A. Identification of funding sources:

No grant funding could be found to defray the costs of the community health assessment. Therefore, Crawford County Health Department and Via Christi Medical Center combined efforts to supply manpower and meeting expenses. Chautauqua, Cherokee, Crawford, Elk, Montgomery, and Neosho County Health Departments contributed to the printing of the survey and correlating the survey data.

B. Partner identification:

The second step for the region was the identification of one person per county to serve as a member of the core leadership team.

C. Model:

The next step was the selection of a community health assessment model to guide us through the community health assessment process.

D. Structure:

Establishing a structure for the completion of the community health assessment was the final step.

Phase I: Organization

In the fall of 2016 Via Christi reached out to the Crawford County Health Department to begin a community health assessment. In a previous community health assessment the Lower 8 completed an assessment as a region. However, two of the Lower 8 counties felt they had been more successful by completing a community health assessment at the local level. Therefore the Southeast Kansas Health Committee was formed and they began to lay the foundation for a regional community health assessment. The Southeast Kansas Health Committee made a special effort to invite agencies within the region to become partners in our community health assessment journey. In October 2016, partners across the region attended the Community Health Assessment Planning meeting at the Via Christi Medical Center in Pittsburg. During the next year, Crawford County Health Department and Via Christi assumed the lead of the Southeast Kansas Health Committee. A timeline was made, a key leadership team was developed, and a community health assessment model was chosen that would be utilized by the Southeast Kansas Health Community Health Assessment Committee. Kansas Health Institute was a key partner in the previous community health assessment and the core profiles of this assessment are a continuation of the Kansas Health Institute's contribution. After a brainstorming session, it was determined that Crawford County Health Department and Via Christi would serve as the organizers and the administrators from Chautauqua, Cherokee, Elk, Montgomery and Neosho County Health Departments would serve as the core team. Distance, time, and funding constraints kept other partners from participating on the core team. With past experience utilizing the Mobilizing for Action through Planning and Partnerships (MAPP) model for the Lower 8 community health assessment, the Southeast Kansas Health Committee opted to continue with the MAPP model. The MAPP model is an evidence-based model that would give a clear picture of our community by completing four different assessments. In addition, the MAPP model includes strategic planning, assists with community change, and strengthens the local public health system. Another aspect of the MAPP model is that it builds public health leadership increases the visibility of public health in the community, and looks at the community perspective therefore, creating a healthy community as an end product. Core team members identified potential partners throughout the community by a process similar to the Circles of Involvement process. This model was developed by the National Association of City County Health Officials and the Centers for Disease Control and Prevention. MAPP consists of six phases:

- I. Organizing**
- II. Visioning**
- III. Four assessments**
- IV. Identifying strategic issues**
- V. Formulating goals**
- VI. Strategies, and the action cycle**

Detailed information of the MAPP process can be found on the National Association of County and City Health Officials website, www.naccho.org.

Phase II: Visioning

The visioning process serves as a guide that leads to a shared community vision. A vision statement is essential to a community health assessment as it provides focus and purpose to partners that have achieved a shared vision for the future. The Southeast Kansas Health Committee invited community partners from six counties to attend a visioning meeting in Pittsburg at Via Christi. This meeting was facilitated by Pete Mayo, Via Christi, and Rebecca Adamson and Janis Goedeke from the Crawford County Health Department. Members present were asked the following questions:

- What are important determinants of health in our community?
- How do you envision the regional health system in the next five or ten years?
- Taking into consideration the shared vision that has been developed, what are the key behaviors that will be required of the community partners and the community in the next five to ten years to achieve the vision?
- What type of working environment is necessary to support the participants in achieving the vision?

Attendees of this meeting and following meetings can be found in Appendix B. During this meeting, regional leaders were led in a discussion of the above questions and vision and value statements were created through an active group discussion.

Vision Statement: Empowering all generations to promote social change that creates healthy communities.

Value Statement: All partners will collaboratively develop grass roots strategies, that impact policy, funding, wellness and community willingness to create change.

These statements portray the aspiration of the region to promote conscious awareness in all generations throughout the Southeast Kansas region to be an active and healthy community member.



Phase III: Four Assessments

The four assessments are very thorough and required participation throughout the region. The Health Committee of Southeast Kansas core team chose to concentrate on one assessment at a time.

A. Community Themes and Strengths Assessment: gives a picture of issues that community members feel is important to them. Community input is the key to a successful community assessment and improvement plan.

B. Community Health Status Assessment: identifies areas of concern/needs in the community and gives a reality check on the health of our community.

C. The Local Public Health System Assessment (LPHSA): assesses all entities that are integral in the local public health system. The LPHSA evaluates the competencies of the local public health system.

D. Forces of Change Assessment: identifies community forces that would impact or impede the community and the local public health system. This could be legislative, technology, legal, economics, ethical social issues, environment or political.

The Health Committee of Southeast Kansas analyzed the health status (by utilizing a continuation of the previous Community Health Assessment by Kansas Health Institute), quality of life and forces of changes assessments. The summary can be found in Appendix C.

Assessment A: Community Themes and Strengths

Asset Mapping:

The core team met to identify the assets in the community. This was done by asking each team member: “What would you miss if it wasn’t in your area?”

Asset Mapping:

Community	
Health and Wellness Coalitions	Funeral Homes
Transportation	Civic Clubs
Restaurants	Animal Rescue
Senior Centers	Food Pantries
Ministerial Alliance	Parks and Recreation
Gas Stations	Dollar General
Local Business	Utilities
Grocery Stores	Farmer’s Markets
Governmental and animal control	Housing
Library	Colleges/Vo-tech
Volunteers	Entertainment
Historic Places (museums)	Post Office
Faith Based Organizations/Churches	Commodities/Utilities
Lunches	External Programs
Fire Department	Police Department
Wesley House	Salvation Army
Safe House	
Health Care	
Local Health Care Coalition	Community Health Center
Regional Health Care Coalition	Dental Care
Health Department	Emergency Rooms
Hospitals	Urgent Care/Walk-in Clinics
Hospice	EMS
SKIL	Mosaic/Developmentally Disabled Organizations
Addiction Treatment Center	Home Health
School Nurses	Physical Therapy
Vision Care	Labs
Durable Medical Equipment Companies	Pharmacies
School	
Environment	
Sewers	Sidewalks
Green Areas	Clean water
Lighting	Roads
Gardens	Farming
Proximity of other resources	Clean Air

EPA	
Other	
4-H	Boy/Girl Scouts
Fairs	Commercial Evens
Community Foundations	YMCA
Cell Phones	Television
Media	Social Media
Tourism	WIC
Family	Respite/Adult Day Care
DCF	Kaw Valley
Child Care	Children
Grandparents	Early Childhood Programs
Health Start Home Visitor Program	Parents as Teachers
Family Planning	Lunch Programs
Summer lunch programs/backpack	Birth to 3
Adoptions	
VIE Clinic	
Safety	
Police Department	Fire Department
Crisis Line	Health Officer
Kansas Attorney General	Environmental
Kansas Department of Health and Environment	Storm Shelters
National Guard	CERT Teams
Kansas Bureau of Investigation	Federal Bureau of Investigation
D.A.R.E Program	School Resource Officers
Safe Neighborhoods	

Quality of Life Survey:

Focus groups and community meetings have not been successful in our region, therefore the core team opted to develop a survey tool to acquire community views. Each team member was trained on the specific tool utilized and was responsible for distributing the tool in their local community. Efforts were made at both the local and regional levels to distribute the survey tool. To assist the region in collecting the results, Southeast Education Center in Greenbush developed a scan-Tron survey where data could be easily extracted. The Core Team distributed the quality of life survey as extensively as possible throughout the region. Surveys were available in an electronic format where team members forwarded the survey to list-serves with requests to forward it to anyone in the community. Hard copies were available at local libraries, each local health department, and at some local businesses. In addition, a Spanish version was also made available due to the percentage of Spanish speaking individuals in Crawford and Montgomery counties. The media was also utilized and several web links were available. The results of the survey are available in Appendix E.

Assessment B: Community Health Status

Core Indicators Profile:

The core indicators profile provides a snapshot of key measures of demographics and health status within the region. The core indicators will be utilized with other data in the community health assessment to develop a comprehensive understanding of health in the region. These profiles should assist the region in the identification of more specific community health issues and priorities.

The core team selected indicators that were based on three criteria: need, statistical significance and relevance to the entire region. Indicators chosen by the core team were demographics, social and economic factors, education, mortality, violence and injury, disease and poor health, health behaviors, access to care, heart disease, cerebrovascular disease, diabetes, tobacco use, injury hospital admission rate, hospital admission rate, bacterial pneumonia hospital admission rate, COPD hospital admission rate, immunization rates and maternal child health. Several of these indicators were available on a regional basis. When county data was available comparisons were made by county, as well as regional, and state comparison. Again, due to the small population in our frontier counties, data for all counties was not available for all indicators. It should be noted that regional data includes data from Labette and Wilson counties that did not participate in this assessment, but are part of the Lower Eight Region. Data from the core indicators was taken from the Kansas Information for Communities, Kansas Health Matters, US Census Bureau's American Community Survey, and the Kansas responses to the Behavioral Risk Factor Surveillance (See Appendix D).

Assessment C: National Public Health System Performance Standards

Although not recognized by the community, the public health system consists of more than the local public health department. The local public health system includes all organizations/service agencies that impact the health status of the community. The National Public Health System Performance Standards Assessment was intended to help assess what activities are being accomplished in the region, what is the capacity of the local public health region and how well the local public health system is providing the essential services. The Southeast Kansas Health Committee relied on their experience from the previous community health assessment to assist in the preparation for the National Public Health System Performance Standards assessment. Health Care Committee members were divided into two groups and were led in their responses to the National Public Health System Performance Standards Assessment by Rebecca Adamson and Janis Goedeke from the Crawford County Health Department. LPHPSP scores were generated by an excel spreadsheet from the CDC.

The Southeast Kansas Region was strongest at Essential Service number 2, diagnose and investigate health problems and Essential Service number 3, empower and educate. With the weakest link being Essential Service number 10: Research/Innovations. The table below lists the key results of the NPHPSP Assessment. A condensed report can be found in Appendix G. (For the full report, please contact the Crawford County Health Department.)



Southeast Health Committee NPHPSP* Results

*National Public Health System Performance Standards Assessment

	Essential Public Health Service Score	Score
1	Monitor Health Status To Identify Community Health Problems	75.0
2	Diagnose And Investigate Health Problems and Health Hazards	97.2
3	Inform, Educate, And Empower People about Health Issues	97.2
4	Mobilize Community Partnerships to Identify and Solve Health Problems	92.7
5	Develop Policies and Plans that Support Individual and Community Health Efforts	54.2
6	Enforce Laws and Regulations that Protect Health and Ensure Safety	65.1
7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	90.6
8	Assure a Competent Public and Personal Health Care Workforce	56.6
9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	70.8
10	Research for New Insights and Innovative Solutions to Health Problems	47.2
	Overall Performance Score	74.2



Assessment D: Forces of Change

The Forces of Change Assessment is utilized to evaluate opportunities and threats and current/pending policies and practices that will affect the region's health. Janis Goedeke and Rebecca Adamson from the Crawford County Health Department facilitated the forces of change assessment meeting. Forces of Change were categorized as legislative, technology, legal, economics, ethical social issues, environment, or political. Some of the common denominators that occurred during the brainstorming session were changes to the Affordable Care Act, opening of the Kansas Crossing Casino, poor local economy, pharmaceutical costs and lack of work force. The detailed work sheet can be found in Appendix F.

Phase IV: Identify Strategic Issues

Rebecca Adamson and Janis Goedeke from the Crawford County Health Department led in the identification of the strategic issues in March of 2017. After a review of the MAPP process and presentation of the core profile data by Pete Mayo from Via Christi, the participants were led in a quality improvement process where sticky dots were placed by the top three issues during a group discussion. After the strategies were identified participants were divided into counties and community health improvement plans were made according to each county's need.

Strategy #1 Chronic Disease:

Provide personalized education to empower the citizens in our communities to prevent and manage chronic disease through accountability and environmental and cognitive changes.

Strategy #2 Mental Health

Provide training to medical providers and staff to be onsite screeners for early intervention for mental health issues.

Strategy #3 Alcohol/Drug Use

Train medical providers in Screening, Brief Intervention, and Referral to Treatment (SBIRT) to enhance the early identification and referral of early substance abuse.

Strategy #4 Obesity

Implement community outreach initiatives to address health factors leading to obesity.

Phase V: Formulating Goals and Strategies

Goals and strategies will be found in the Community Health Improvement Plan document twenty seven.

Phase VI: Strategies and Action Cycle

The strategies and action cycle will be a continual process of addressing the objectives identified in the community health assessment. Those endeavors will be documented elsewhere.



Community Health Improvement Plan

Approximately thirty community leaders from Chautauqua, Cherokee, Crawford, Elk, Montgomery, and Neosho counties met in October 2016 at Via Christi in Pittsburg, Kansas to develop a regional Community Health Improvement Plan. It was felt that a regional plan would have a larger impact in the area, help to save time, create staff collaboration, and stretch the dollar. The task for the regional community leaders was to develop a community health improvement plan from the community health assessment.

Chronic Disease – Healthy Behaviors

Chronic disease was defined as heart disease/stroke, diabetes, cancer and smoking. Chronic disease will be interchanged with *healthy behaviors* from this point forward in order to correlate the strategies with Healthy People 2020. The participating counties in Southeast Kansas were less healthy than the state of Kansas according to the following indicators:

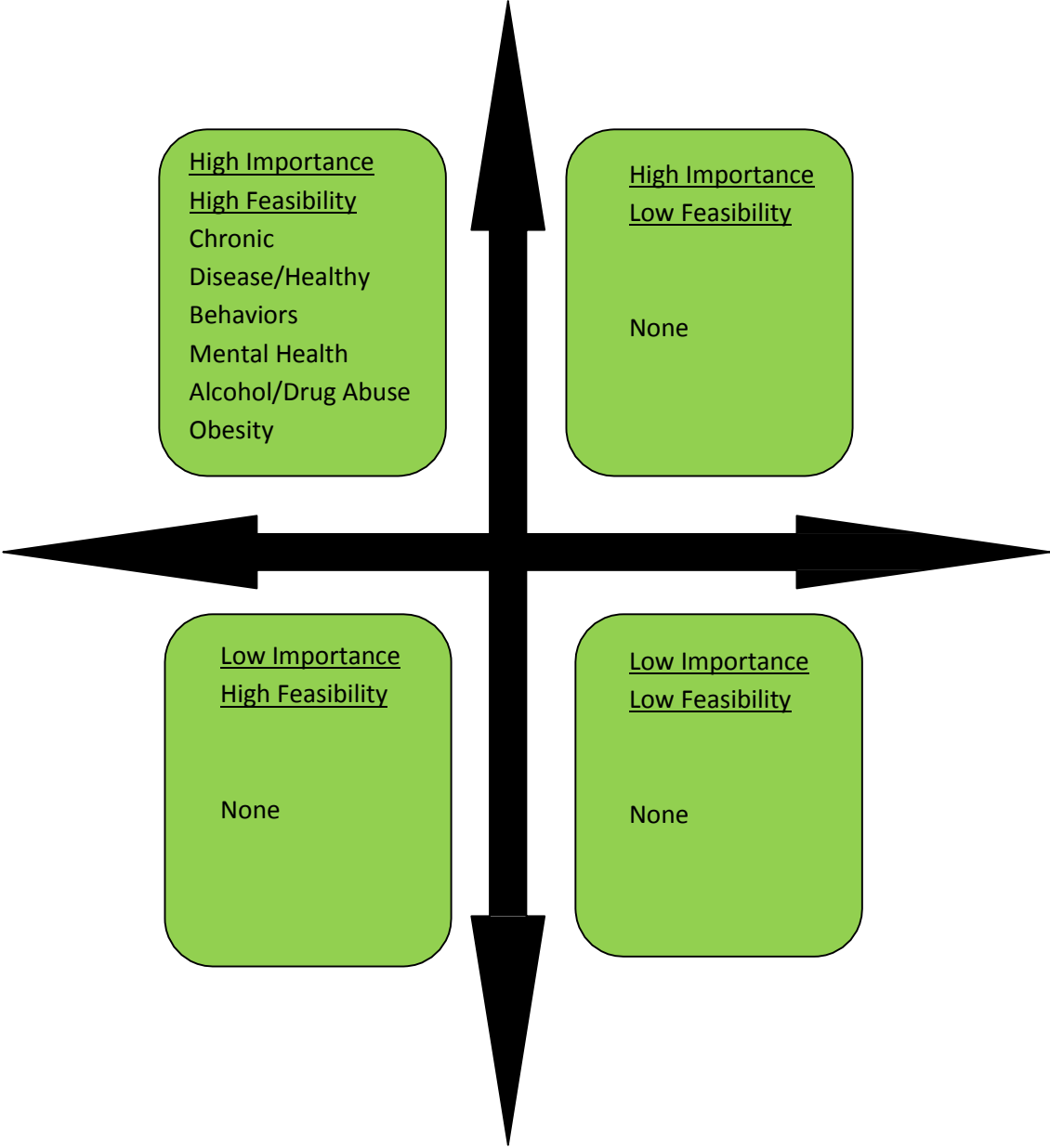
Indicator	Regional Value	Kansas Value
Cancer Diagnosis	8.6%	7.1%
Diabetes Diagnosis	13%	9.7%
Age adjusted heart disease mortality rate	200.9	156.4
Adult Smoking Rate	23.2%	17.8%

Mental health concerns were chosen by nearly forty percent of all region respondents as one of the three most important health problems in their community. It was the most prevalent choice by far. According to the National Institute of Mental Health, (NIMH) approximately one in five adults in the United States experiences mental health illness. NIMH data also shows that 6.9% of adults have at least one major depressive episode a year, and 18.1% of adults experience an anxiety disorder.

The third strategy identified was alcohol/drug use. A majority of respondents in the community health assessment chose drug abuse as one of the most risky behaviors in their community. Alcohol abuse as one of the most a risky behaviors was also chosen by a wide margin. Core profiles coincide with survey findings as the regional rate for adult binge drinking in 2015 was 15.4 compared to the state rate of 15.6. Drug arrests for the region were 396, and out of those 213 were in Crawford County.

The fourth strategy was obesity. Again the core profiles indicate that the rate of obese adults in the region is higher than the rate of obese adults in the state with the rates being 40.4 % and 34.2% respectively. Multiple survey participants identified being overweight, poor eating habits and lack of exercise as a concern.

The Core Team discussed the four priorities of the community health assessment at length. Utilizing the Matrix Feasibility Grid the priorities were placed as listed below.



Feasibility Matrix

Using the feasibility matrix, the core group felt the four priorities of **chronic disease/healthy behaviors, mental health, alcohol/drug abuse and obesity** were the priorities that could be impacted.

The alignment of the regional objectives with the Healthy People 2020 objectives is crucial for a unified and successful approach to addressing the identified priorities. In the following pages you will find the goals, objectives, indicators and strategies that are proposed for the Southeast Kansas participating counties.

Priorities, Goals, Objectives, and Strategies

Priority #1: Chronic Disease/Healthy Behavior

The priority issue began as chronic disease, and the group defined chronic disease as heart disease/stroke, diabetes, cancer and smoking. The region was higher in age adjusted heart disease mortality rates than the state rate with the region rate of 200.9 per 100,000 people compared to the state rate of 156.4. This was also true of the cancer diagnosis rate of 8.6% in the region compared to the state rate of 7.1% The diabetes diagnosis rate is also of concern to the region as the regional value is 13% compared to the state rate of 9.7%. In addition, the adult smoking rate for the region is 23.2% compared to the state rate of 17.8%. It was determined the best way to reduce heart disease, diabetes, and strokes would be to empower the individuals to manage their own chronic disease. Through chronic disease self-management education courses, individuals can feel empowered to control their health outcomes.

Healthy People 2020 Healthy Behavior Objectives

HDS-10.4 Increase the proportion of adults with hypertension who meet the recommended guidelines for physical activity

HRQOL/WB-1 Increase the proportion of adults who self-report good or better health

HRQOL/WB-1.1 Increase the proportion of adults who self-report good or better physical health

HDS-11 Increase the proportion of adults with hypertension who are taking the prescribed medications to lower their blood pressure

HDS-12 Increase the proportion of adults with hypertension whose blood pressure is under control

HDS-14 (Developmental) Increase the proportion of adults with elevated LDL-cholesterol who adhere to the prescribed LDL-cholesterol lowering management lifestyle changes and, if indicated, medication

HDS-14.1 (Developmental) Increase the proportion of adults with elevated LDL cholesterol who adhere to the prescribed cholesterol-lowering diet

HDS-14.2 (Developmental) Increase the proportion of adults with elevated LDL cholesterol who adhere to the prescribed cholesterol-lowering physical activity

HDS-14.3 (Developmental) Increase the proportion of adults with elevated LDL cholesterol who adhere to the prescribed cholesterol-lowering weight control

HDS-14.4 (Developmental) Increase the proportion of adults with elevated LDL cholesterol who adhere to the prescribed cholesterol-lowering drug therapy

Priority #2 Mental Health

Mental Health was chosen by forty percent of the survey respondents when asked what is an important factor for a healthy community. Mental health concerns affect the community economically, socially, and culturally. To visualize the effects of mental illness see Appendix H.

Healthy People 2020 Mental Health Objectives

MHMD-11 Increase depression screening by primary care providers

MHMD-11.1 Increase the proportion of primary care physician office visits where adults 19 years and older are screened for depression

MHMD-11.2 Increase the proportion of primary care physician office visits where youth aged 12 to 18 years are screened for depression

Priority #3 Alcohol and Drug abuse

Alcohol and drug abuse was chosen by the survey respondent as an issue in their community. Crawford, Cherokee and Neosho counties are above the state rate of 15.6% for binge drinking. In addition, Cherokee, Montgomery and Neosho counties are higher than the state rate of 11.3% per hundred thousand for drug poisoning.

Health People 2020 Substance Abuse Objectives

SA-8 Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year

SA-8.1 Increase the proportion of persons who need illicit drug treatment and received specialty treatment for abuse or dependence in the past year

SA-8.2 Increase the proportion of persons who need alcohol and/or illicit drug treatment and received specialty treatment for abuse or dependence in the past year

SA-8.3 Increase the proportion of persons who need alcohol abuse or dependence treatment and received specialty treatment for abuse or dependence in the past year

SA-9 (Developmental) Increase the proportion of persons who are referred for follow-up care for alcohol problems, drug problems after diagnosis, or treatment for one of these conditions in a hospital emergency department (ED)

Priority #4 Obesity

The survey respondents selected being overweight as one of the most important risky behaviors. Core profile indicators show that all counties in the Southeast Health Committee region are significantly higher than the Kansas rate of 34.2%.

Healthy People 2020 Healthy Nutrition (Nutrition and Weight Status Objectives)

NWS-5 Increase the proportion of primary care physicians who regularly measure the body mass index of their patients

NWS-5.1 Increase the proportion of primary care physicians who regularly assess body mass index (BMI) in their adult patients

NWS-6 Increase the proportion of physician office visits that include counseling or education related to nutrition or weight

NWS-6.1 Increase the proportion of physician office visits made by patients with a diagnosis of cardiovascular disease, diabetes, or hyperlipidemia that include counseling or education related to diet or nutrition

NWS-6.2 Increase the proportion of physician office visits made by adult patients who are obese that include counseling or education related to weight reduction, nutrition, or physical activity

NWS-6.3 Increase the proportion of physician visits made by all child or adult patients that include counseling about nutrition or diet

NWS-7 (Developmental) Increase the proportion of worksites that offer nutrition or weight management classes or counseling

NWS-8 Increase the proportion of adults who are at a healthy weight

NWS-9 Reduce the proportion of adults who are obese

Southeast Kansas Health Committee Community Improvement Plan

Crawford County: Mental Health

Strategy	By 4/30/2018	By 4/30/19	By 4/30/20
Strategy	A Mental Health Representative can present a training to the LEPC meeting.	Hospitals can send staff to Mental Health First Aid Training for staff in order to have on-site sources for screeners.	Have Providers trained in Mental Health First Aid to do screenings in office or E.D.
Indicators	A Mental Health Representative is scheduled to attend and present education opportunity to the LEPC members.	Hospital Staff are to be educated on Mental Health First Aid and sources to do screenings.	Providers are trained and able to identify patients in need of mental health.
Barriers	Cost and time away from work to provide education.	Cost and time away from work to provide education.	Cost and time away from work to provide education.
Evidence Based	Mental Health First Aid	Mental Health First Aid	Mental Health First Aid
Lead Agency(s)	Crawford County Mental Health	Crawford County Mental Health	Crawford County Mental Health
Resources	Crawford County Mental Health	Crawford County Mental Health/ Hospital Staff	Crawford County Mental Health /Providers

Southeast Kansas Health Committee Community Improvement Plan

Crawford County: Mental Health/ Substance Abuse

Strategy	By 4/30/2018	By 4/30/19	By 4/30/20
Strategy	A Mental Health Representative can present a training to the LEPC meeting.	Hospitals can send staff to SBIRT Training for staff in order to have on-site sources for	Have Providers trained in SBIRT to do screenings in office or E.D.
Indicators	A Mental Health Representative is scheduled to attend and present education opportunity to the LEPC members.	Hospital Staff are to be educated on SBIRT and are sources to do screenings.	Providers are trained and able to identify patients in need of substance abuse.
Barriers	Cost and time away from work to provide education.	Cost and time away from work to provide education.	Cost and time away from work to provide education.
Evidence Based	SBIRT	SBIRT	SBIRT
Lead Agency(s)	Crawford County Mental Health	KDADS- SBIRT Training/ Crawford County Mental Health can educate Hospitals on resources and need for SBIRT and Mental Health FIRST Aid.	KDADS- SBIRT Training/ Crawford County Mental Health can educate Hospitals on resources and need for SBIRT and Mental Health FIRST Aid.
Resources	Crawford County Mental Health	Hospital Staff/ Crawford County Mental Health/ KDADS	Providers/ KDADS

Southeast Kansas Health Committee Community Improvement Plan

Crawford County: Chronic Disease

Strategy	By 4/30/2018	By 4/30/19	By 4/30/20
Strategy	Diabetes Self Management/ Heart Disease Management	Medication Assistance Program	Staff trained at multiple facilities for DSME, CDSME, PSME,HSME
Indicators	Conduct 2 of each in the 1st year.	Grant Funding and disbursement	Staff from Via Christi Hospital, Crawford County Health Department, Wesley House, Crawford County Mental Health, Girard Hospital
Barriers	Attendance/ Transportation/Communication	Funds- Grant Money	Staff time away from work and cost of training.
Evidence Based	Stanford University	Stanford University	Stanford University
Lead Agency(s)	Crawford County Health Department/ Via Christi	Wesley House/ KFMC	Crawford County Health Department/ Crawford County Mental Health/ Wesley House/Girard Medical Center/Via Christi Hospital
Resources	Wesley House/Crawford County Mental Health/Cardiac Rehab- Via Christi/ Girard Medical Center/KFMC	Wesley House/Crawford County Mental Health/Cardiac Rehab- Via Christi/ Girard Medical Center/KFMC	Wesley House/Crawford County Mental Health/Cardiac Rehab- Via Christi/ Girard Medical Center/KFMC

Appendix A

American Public Health Association 10 Essential Public Health Services

American Public Health Association

10 Essential Public Health Services

1. **Monitor** health status to identify community health problems.
2. **Diagnose and investigate** health problems and health hazards in the community.
3. **Inform, educate, and empower** people about health issues.
4. **Mobilize** community partnerships to identify and solve health problems.
5. **Develop policies and plans** that support individual and community health efforts.
6. **Enforce** laws and regulations that protect health and ensure safety.
7. **Link** people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. **Assure** a competent public health and personal healthcare workforce.
9. **Evaluate** effectiveness, accessibility, and quality of personal and population-based health services.
10. **Research** for new insights and innovative solutions to health problems.

Appendix B

Regional Participants

Regional Participants

Chautauqua County

Annie Blankinship, Health Department
Joleen Edens, Health Department
Sandy Williams, Sedan EMS
Jeanie Beason, Health Department

Cherokee County

Betha Elliot, Health Department
Theresa Cassidy, Health Department
Jodie Grant, Mercy Hospital
Bev Davis, Crossland Construction
Laura Samford, Laura's Fitness & Beauty
Christina Holmes, K-State Extension

Crawford County

Janis Goedeke, Health Department
Rebecca Adamson, Health Department
Hope Harmon, Health Department
Debra Anthony, Health Department
Brad Stroud, Live Well
Pete Mayo, Via Christi
Jamie Cravens, Via Christi
Naomi Powers, Via Christi
Carrie Amershek, Via Christi
Tawny Sandifer, Via Christi
Lori Billesbach, Via Christi
Sandy Krusech, Via Christi
Michelle Williams, Sedan City Hospital
Patricia Boore, Girard Medical Center
Michele Hart, Girard Medical Center
Jamie Malle, Girard Medical Center
Marcee Binder, Wesley House
Dawn McNay, Community Health Center of SEK
Jan Schiefelbein, Pittsburg State University
Debbie Noble, Community Mental Health
Amy Glines, Community Mental Health Center
Madison Richard, PSU Nursing Student
Haley Gregg, PSU Nursing Student
Kennedy Reves, PSU Nursing Student

Kathryn Lundstrom, PSU Nursing Student
Faith Davolt, PSU Nursing Student

Elk County

Kandy Dowell, Health Department
Jenny McDaniel, Rolling Prairie
Extension

Montgomery County

Carolyn Muller, Health Department

Neosho County

Teresa Starr, Health Department
Stephanie Henry, Health Department
Murry Satterfield, Faith House Shelter

Lower 8 Region

Lee Miller

Kansas Department of Health and Environment

Courtney Koenig, KDHE
Erin Fletcher, KDHE

Appendix C

Southeast Kansas Health Committee Health Profile Summary of Findings

Health Committee of Southeast Kansas Community Health Profile Summary of Findings

Local health departments from the six counties in the Lower 8 of Southeast Kansas Public Health Preparedness Region (“Lower 8 Region”) are conducting a community health assessment (CHA) as a regional collaborative effort. Four assessment approaches have been employed to gather and analyze information related to community health within the region:

A data profile providing historical and current information on a key set of core indicators.

1. A community survey soliciting input from residents about their perceptions of quality of life and health issues in the community.
2. Forces of Change exercises conducted at the regional level.
3. National Public Health Performance Standards Program.

Data collection has been largely completed by the Southeast Kansas Health Care Committee members with guidance from a previous assessment that Kansas Health Institute prepared. Detailed reports for each of the assessments accompany this summary.

The assessments provide a broad view of health and health-related issues within the region. At the regional level, the following themes emerge across the assessments.

Need for Economic Improvement Concerns about unemployment, jobs and adequate wages surfaced as a predominant theme across the assessments. Good jobs and a healthy economy were chosen by nearly half of all respondents as one of their top three most important factors for a healthy community. The core indicators profile aligns with some of these concerns. Median household incomes in all of the participating counties in Southeast Kansas are below the state median, and some are substantially so. Additionally, the core indicators profile shows that educational attainment rates are lower in the Southeast Kansas participating counties than in Kansas as a whole, even with the presence of Pittsburg State University in Crawford County. Higher educational attainment could increase opportunities for higher-paying jobs in the region. Individuals who have higher income levels may find it easier to make healthy choices regarding food and exercise, and may be more capable of paying for and utilizing the health care system.

Substance Abuse

Drug and alcohol abuse were cited as the most important “risky behavior”. These concerns were mostly related to youth engaging in the use of drugs and alcohol. There were 397 drug-related arrests in the Southeast Kansas participating counties in 2015. The core indicators profile shows that adult binge drinking rates are higher than the state average, and the smoking rate in the participating counties is higher than the state average.

From the Forces of Change assessments, perceptions of how the repeal or changes to the Affordable Care Act would affect residents, both positively and negatively, were clearly evident. Also evident was the concern of pharmaceutical costs.

Although the Community Health Assessment is being conducted at the regional level, many of the measures included in the three assessments show significant variability among the eight counties in the region and suggest that some county-specific targeting and planning of interventions may be warranted. Some of those county-level distinctions follow.

Chautauqua County: Chautauqua County and Elk Counties have the highest median age. This county also has the highest proportion of the population not in the labor force. This combination suggests an elderly and retired population. Additionally, the core indicators profile shows an extremely high rate of motor vehicle crash deaths.

Cherokee County: Cherokee County has the highest five-year mortality rates in the region. Cherokee County was also the highest in the region for smokeless tobacco use with 12.8% which is double of the state rate of 5.6%.

Crawford County: As the most populous county in the region, Crawford County also has the youngest population and has a somewhat different profile of issues than the other counties. Although Crawford County has the highest proportion of population with a bachelor or graduate degree, it is below the regional average for median income.

Elk County: Because Elk County is the least populous county in the region, and several indicators did not have enough data to report. However, it is evident from the core indicators profile that Elk County has the lowest median income in the region. Additionally, there is a high proportion of the workforce in the agriculture, forestry, fishing, hunting and mining industries as well as a very high rate of deaths due to unintentional injuries, and the two may or may not be connected.

Neosho County: Neosho County has high rates of infant mortality, with 6.6 deaths per 1,000 live births between 2011 through 2015. The region's rate is 5.4 per 1,000 and the state rate is 6.2 per 1,000. Finally, the percent of infants fully immunized by 24 months in Neosho County was the lowest in the region at 38.3 percent.

Montgomery County: Montgomery County is the second most populous and most diverse of all the counties in the region. It has the highest percentage of black and non-white Hispanic residents than any other county in the Southeast Kansas counties. Montgomery County also has the highest unemployment rate, at 5.2 percent. Montgomery County also has the highest rate of violent crime.

Taken together, the results of the three assessment approaches provide important insight into the health status and areas or improvement within the Southeast Kansas Health Committee Region and will provide a solid foundation from which the region's stakeholders may begin to identify priorities and intervention strategies.

Appendix D

Southeast Kansas Health Care Committee Core Indicators Profile

Southeast Kansas Health Care Committee

Core Indicators Profile

Introduction

The purpose of the core indicators profile is to provide insight into some of the key measures of demographics and health status of the communities of the Southeast Kansas Health Care Committee. These indicators will be compared with the information collected through the community health assessment (CHA) to assist the Southeast Kansas Health Care Committee in developing a more comprehensive understanding of the health of their community. This information will then be utilized to prioritize specific health concerns for the community.

The following categories are included in this profile:

1. Demographics
2. Social and Economic Factors
3. Education
4. Mortality
5. Violence and Injury
6. Disease and Poor Health
7. Health Behaviors
8. Access to Care
9. Maternal and Child Health

The majority of indicators for this profile were also considered in the 2014 Community Health Assessment and Community Health Improvement Plan. These indicators were previously selected based on three criteria: need, statistical significance, and relevance to the region. Several chronic health condition indicators were added to provide additional information about medical needs of the community.

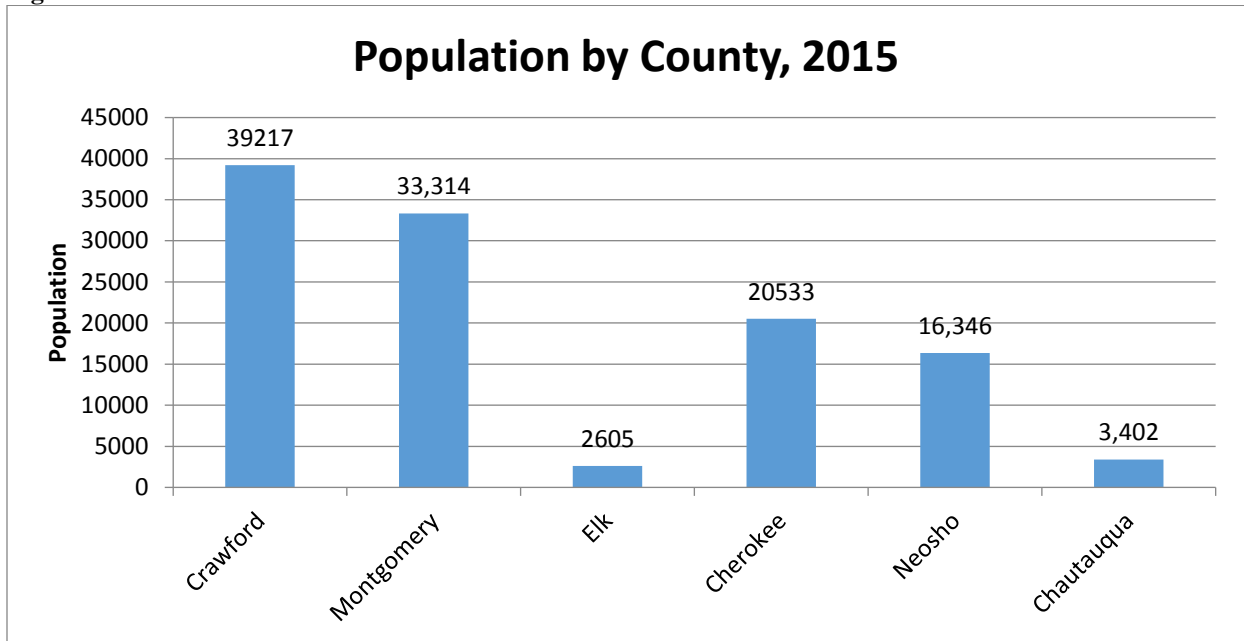
When available, data is presented for all six counties in the Southeast Kansas Health Care Committee, the region, and the state. Due to the small population size of some of the counties, data for some indicators was not available for all counties. The majority of the data used in this profile was collected from the U.S. Census Bureau's American Community Survey (ACS), Kansas Information for Communities (KIC), Kansas Health Matters, and the Kansas responses to the Behavioral Risk Factor Surveillance System (BRFSS) survey.

1. Demographics

Population

According to the 2015 ACS estimates, the total population for the Lower 8 Region is 117,432. Elk and Chautauqua counties are the least populated and experienced the greatest population percentage loss during this period. Crawford County is the most populous of the counties. There was a 4.8% population decrease in the Lower 8 from 2010-2015. Similar to the 2014 Community Health Assessment findings, each county's population declined with the exception of Crawford County.

Figure 1



Source: U.S. Census Bureau, Population Estimates, July 2015

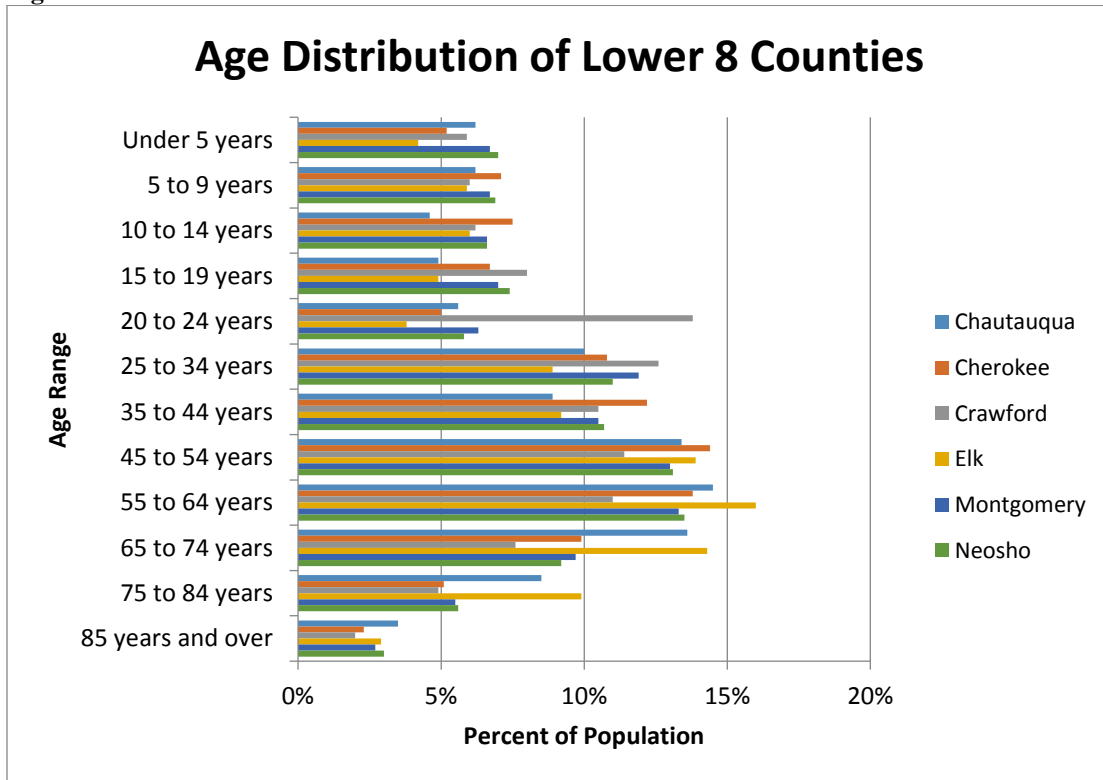
Population Change, 2010-2015			
	2010	2015	Percent Change
Chautauqua	3,669	3,402	-7.30%
Cherokee	21,603	20,533	-5%
Crawford	39,134	39,217	0.20%
Elk	2,882	2,605	-9.60%
Montgomery	35,471	33,314	-6.10%
Neosho	16,512	16,346	-1%
Region	121,281	117,432	-4.80%
Kansas	2,853,118	2,907,289	1.90%

Source: U.S. Census Bureau, American Community Survey, 2011-2015

Population by Age

There are slight variations in the age profiles from county to county in the Lower 8 Region. Chautauqua and Elk Counties display the highest median age and Crawford County has the lowest median age. Most of the counties display similar age distribution with the exception of Crawford County and their large number of 20-24 year old's. This variation may be explained by the presence of Pittsburg State University and its student population. As a result, the median age of Crawford County is also lower than the other counties in the region.

Figure 2



Source: U.S. Census Bureau, American Community Survey, 2011-2015

Population by Race and Ethnicity

The 2015 ACS estimates that 90.9 percent of the population of the Lower 8 counties identifies as being white, non-Hispanic. The second largest race grouping is American Indian/Alaska Native with 2.5 percent of the population region wide. Additionally, 3.9 percent of the region identifies as being of Hispanic ethnicity. Overall, the region is less racially and ethnically diverse than the overall Kansas population. Montgomery County is the most diverse, 5.1 percent of the population identifies as being black or African American and 6.0 percent identifies as being Hispanic or Latino.

Table 2

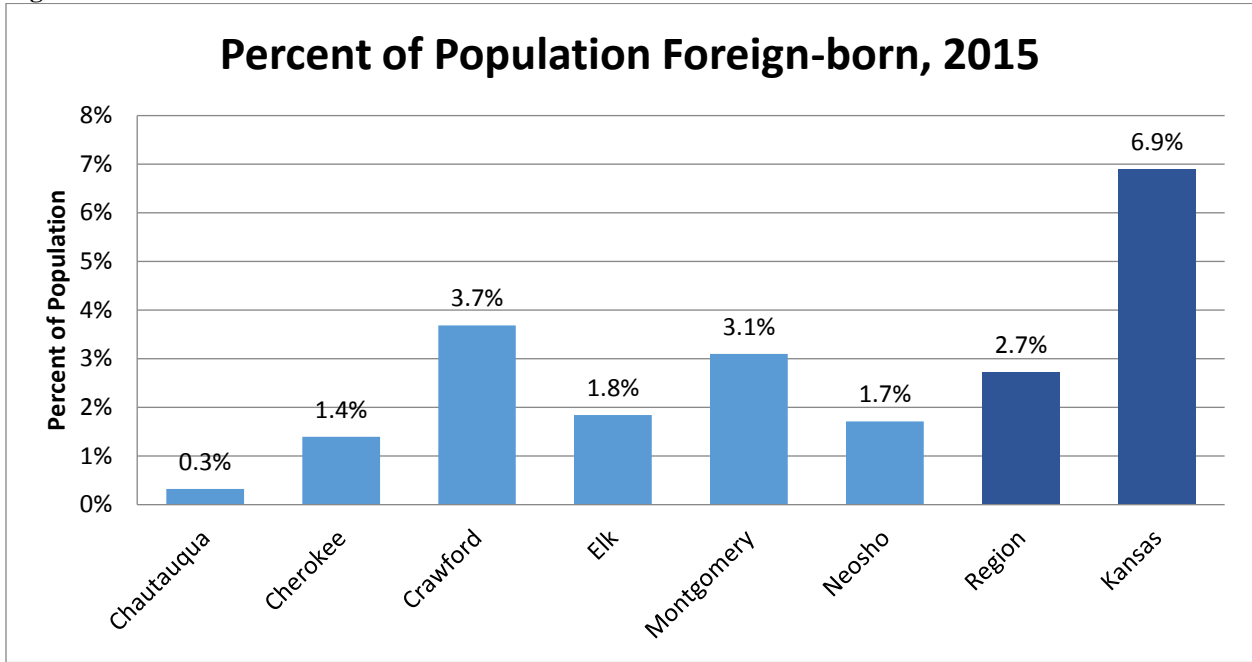
	Race						Ethnicity	
	White	Black/ African American	American Indian/ Alaska Native	Asian	Native Hawaiian/ Pacific Islander	Other	Two or more races	Hispanic or Latino
Chautauqua	88.4%	0.6%	6.0%	0.0%	0.0%	0.0%	5.0%	1.6%
Cherokee	90.2%	0.6%	3.6%	0.5%	0.0%	0.4%	4.7%	2.2%
Crawford	92.1%	2.1%	0.5%	1.5%	0.0%	0.7%	3.1%	5.0%
Elk	94.4%	0.8%	1.7%	0.4%	0.0%	0.4%	2.3%	3.8%
Montgomery	85.5%	5.1%	2.7%	0.9%	0.2%	0.4%	5.1%	6.0%
Neosho	94.6%	1.2%	0.6%	0.0%	0.1%	0.4%	2.9%	4.9%
Region total	90.9%	1.7%	2.5%	0.6%	0.0%	0.4%	3.9%	3.9%
Kansas	85.2%	5.8%	0.8%	2.6%	0.1%	2.2%	3.3%	11.2%

Source: U.S. Census Bureau, American Community Survey, 2011-2015

Place of Birth

The population in the Lower 8 Region that was born outside of the United States is 2.7 percent which is lower than the statewide estimate of 6.9 percent.

Figure 3

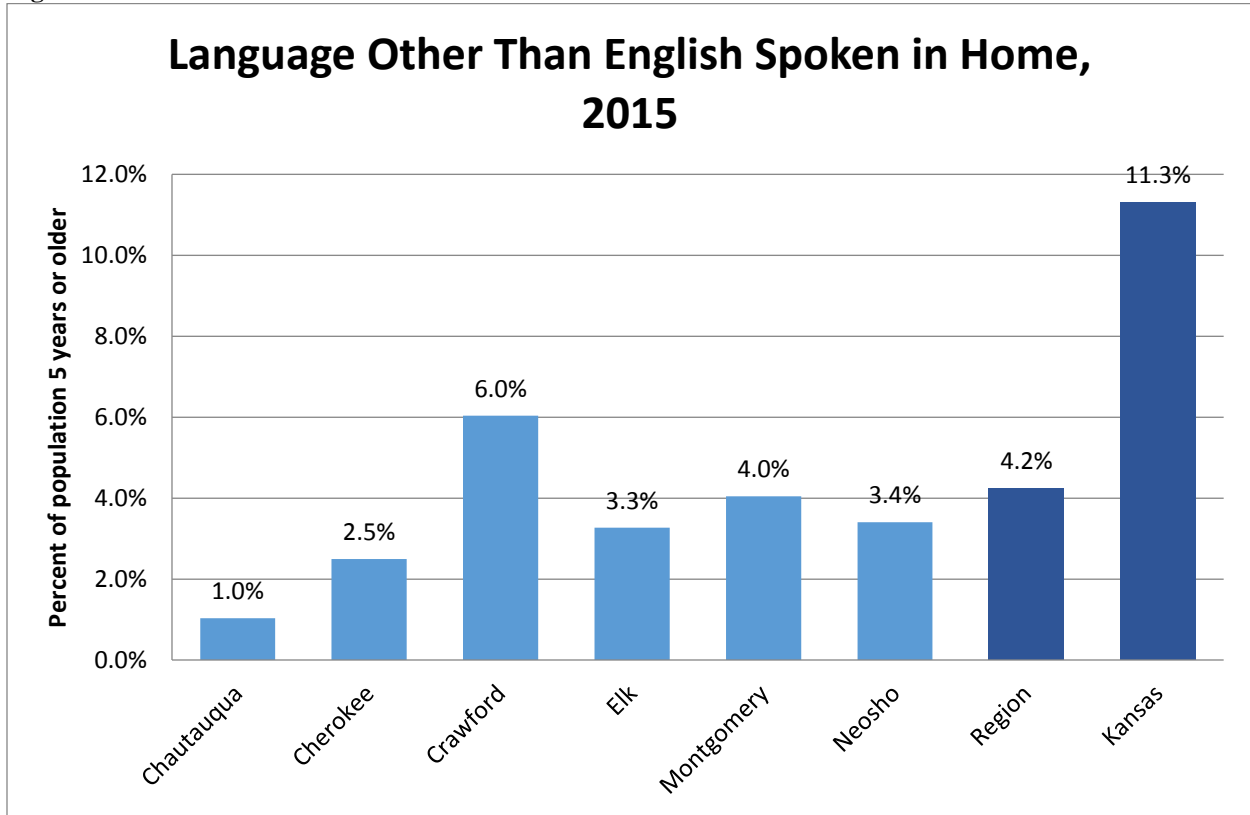


Source: U.S. Census Bureau, American Community Survey, 2011-2015

Language Spoken in the Home

The percentage of the population in the Lower 8 Region that is older than five years of age and speaks a language other than English in the home is 4.2 percent. Crawford County has the highest percentage of non-English speaking households at 6.0 percent. All the counties are well below the Kansas average of 11.3 percent.

Figure 4

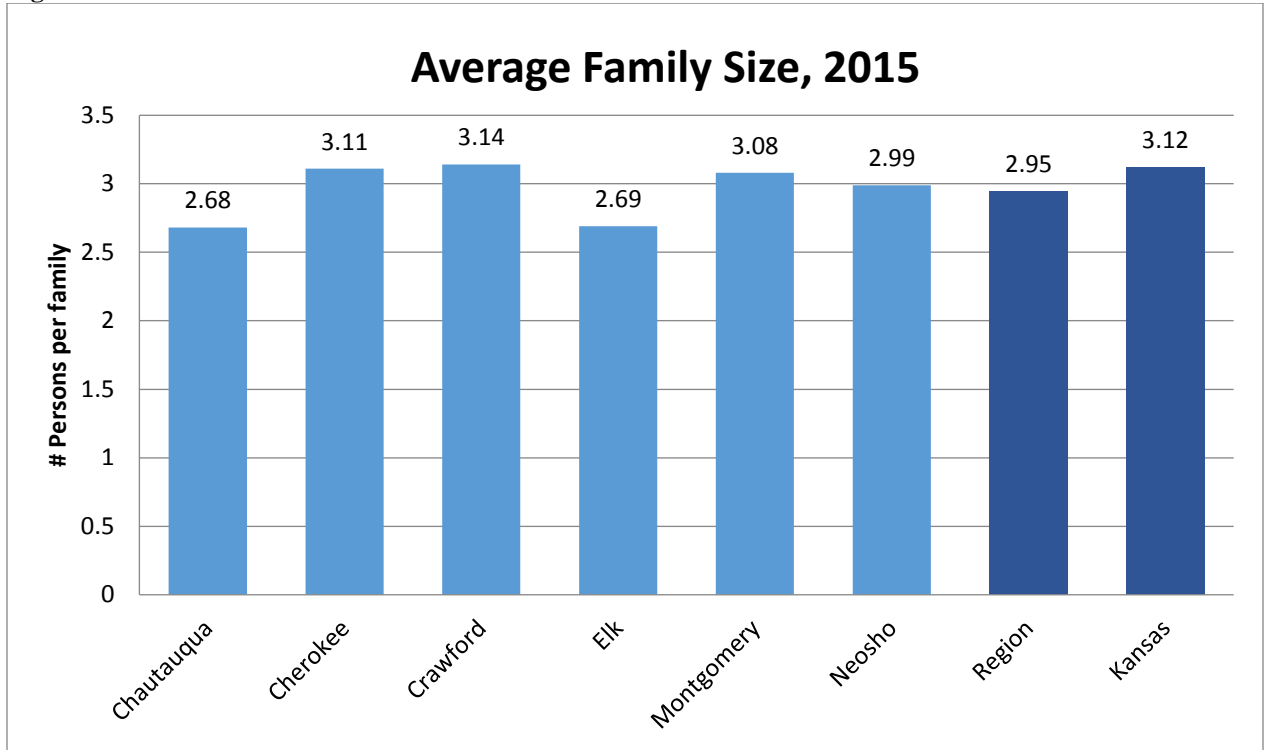


Source: U.S. Census Bureau, American Community Survey, 2011-2015

Family Size

The average family size in the Lower 8 Region is 2.95 people which is close to the state average of 3.12. Crawford County displays the largest family size at 3.14. Chautauqua County has the smallest family size at 2.68 with Elk County a close second at 2.69.

Figure 5

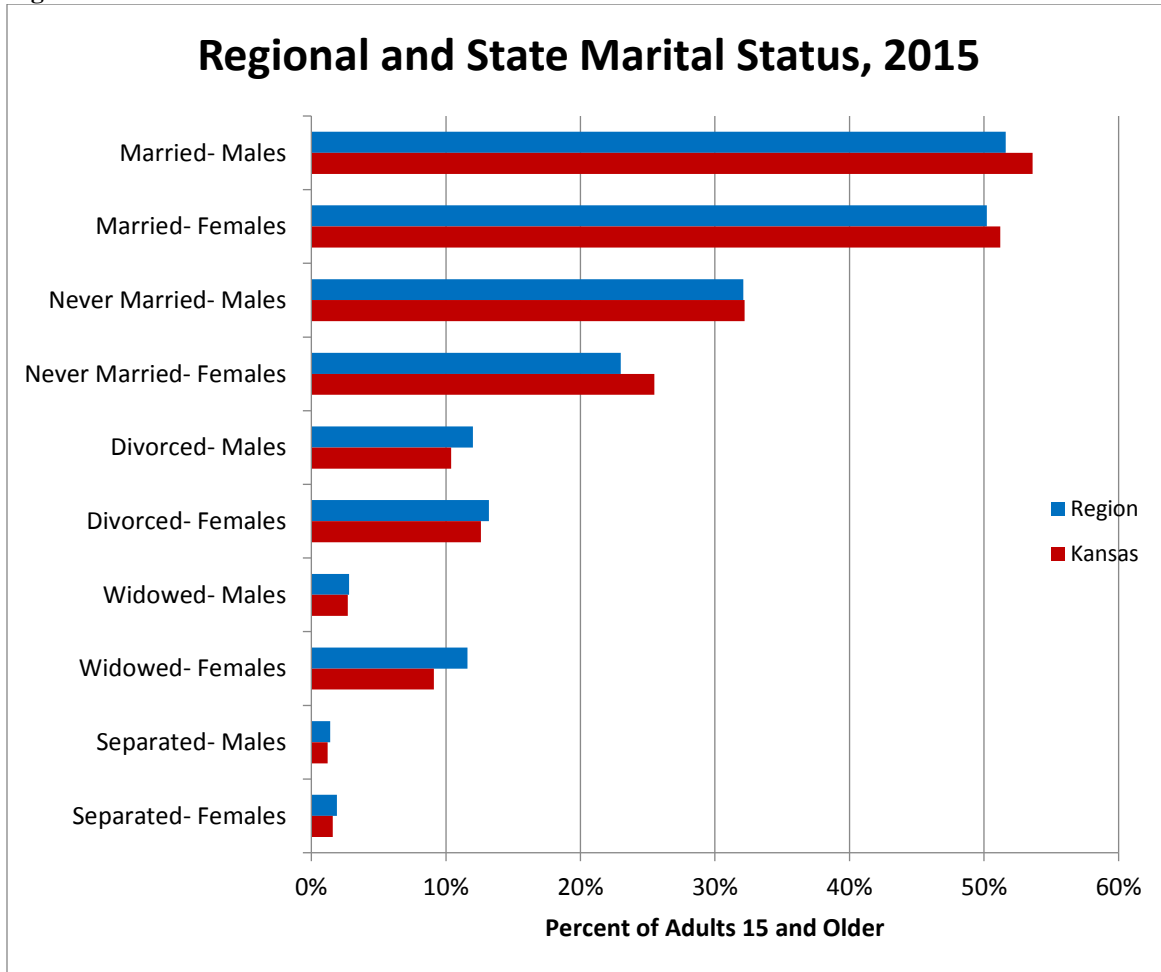


Source: U.S. Census Bureau, American Community Survey, 2011-2015

Marital Status

The majority of adults over the age of 15 that live in the Lower 8 Region are married. There are slightly more un-married males than females. 32.1 percent of males in the region have never been married compared to 23.0 percent of females. There are more divorced (13.2 percent) or widowed (11.6 percent) females than males (12 percent and 2.8 percent, respectively). Overall, the marital status of the Lower 8 Region is similar to the state as a whole.

Figure 6

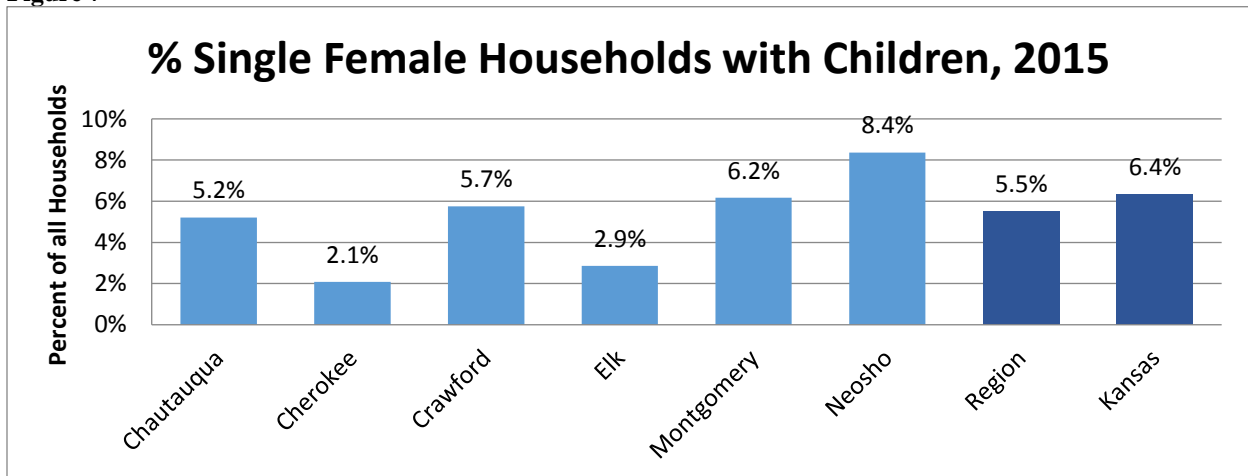


Source: U.S. Census Bureau, American Community Survey, 2011-2015

Single-Parent Households

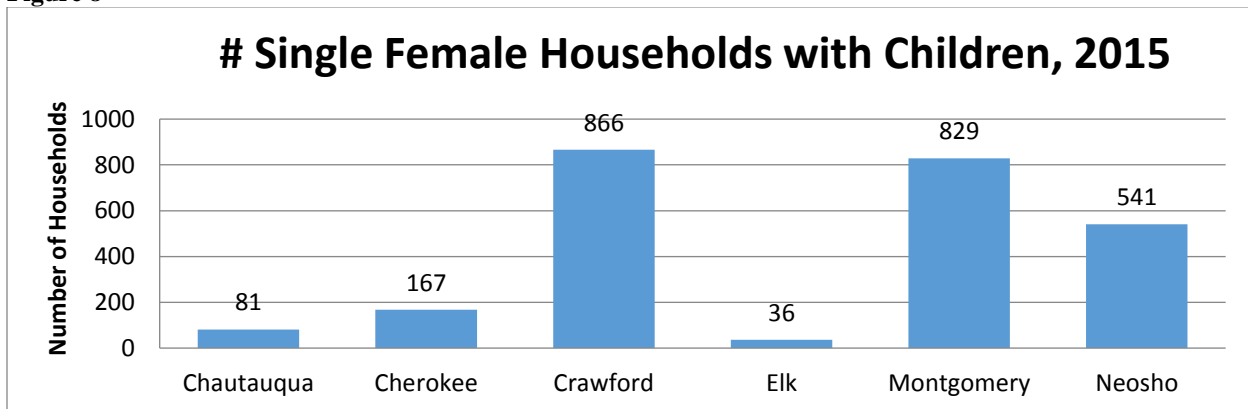
The National Center for Law and Economic Justice reports that single-parent households are at increased risk for economic difficulties. They estimate that up to 30.6 percent of households headed by single women in the United States live in poverty.¹ The percentage of single female households with children in the Lower 8 Region is below the Kansas average. The only county that was higher than the states average was Neosho at 8.4 percent. Cherokee County had the lowest percentage at 2.1 percent. Crawford County reported the largest number of single-mother households at 866. Elk County had the smallest number at 36 single-mother households.

Figure 7



Source: U.S. Census Bureau, American Community Survey, 2011-2015

Figure 8



Source: U.S. Census Bureau, American Community Survey, 2011-2015

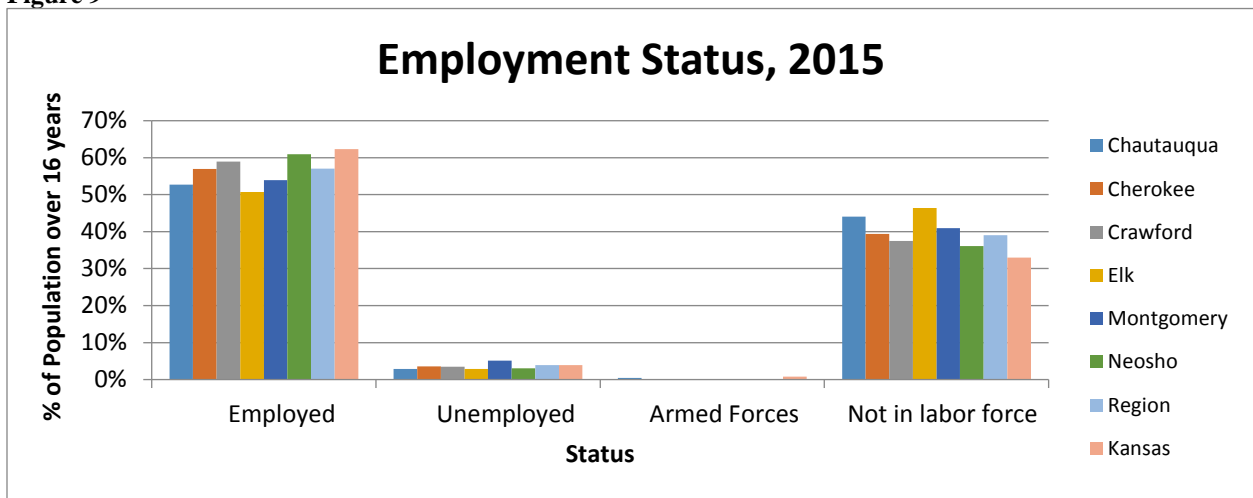
¹National Center for Law and Economic Justice, <http://nclej.org/snapshot/poverty-in-the-united-states>

2. Economics

Employment Status

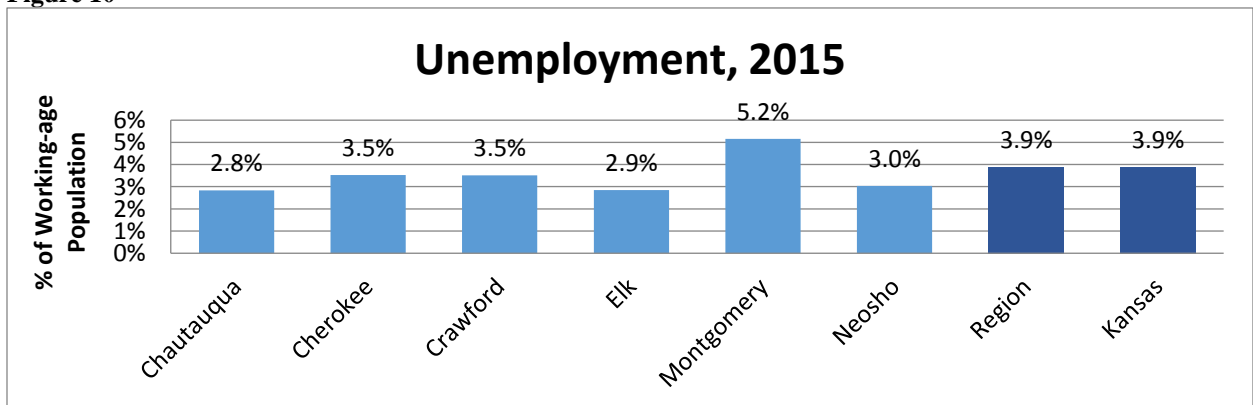
There are currently 92,955 people in the Lower 8 Region that comprise the working-age population (16 years and older). Thirty nine percent of the region’s population is not in the labor force. This total is slightly higher than the Kansas average of 33 percent. Not being a part of the labor force can be due to various reasons including being elderly, retired, a student, or those not looking for work. A person who is not in the labor force is not the same as a person who is unemployed. An unemployed person is in the labor force but is unable to find work. The unemployment rate for the Lower 8 Region in 2015 was identical to the state average of 3.9 percent. The employment rate for the Lower 8 Region was 57 percent which was slightly lower than the Kansas average of 62.3 percent.

Figure 9



Source: U.S. Census Bureau, American Community Survey, 2011-2015

Figure 10

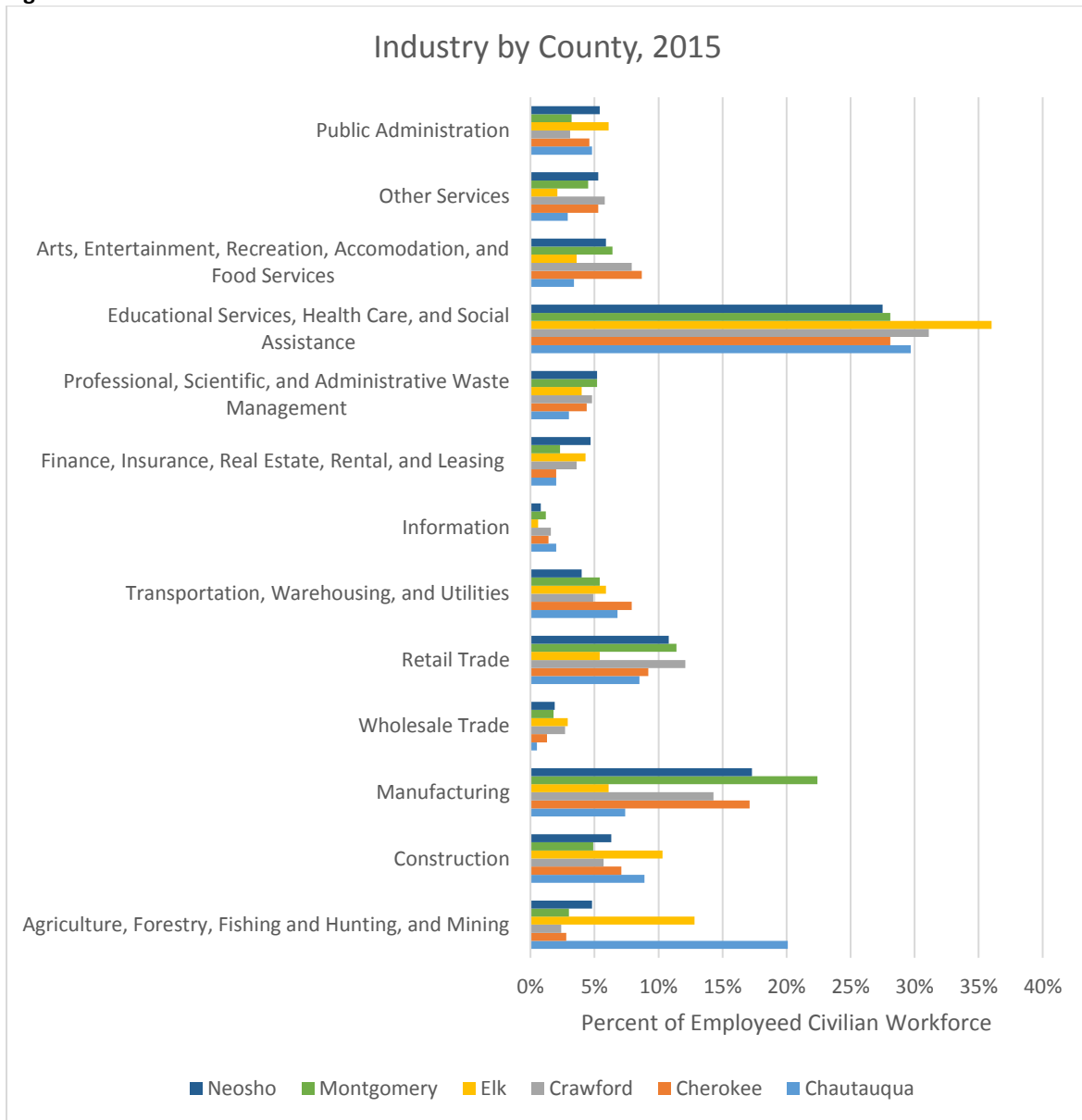


Source: U.S. Census Bureau, American Community Survey, 2011-2015

Industry/Employer

The most common source of employment in the region is educational services, health care, and social assistance. Manufacturing and retail are the next two most common sectors. Profiles are similar in most of the Lower 8 Region with the exception of Chautauqua County with 20.10 percent of their population employed in agriculture, forestry, fishing, hunting, and mining category.

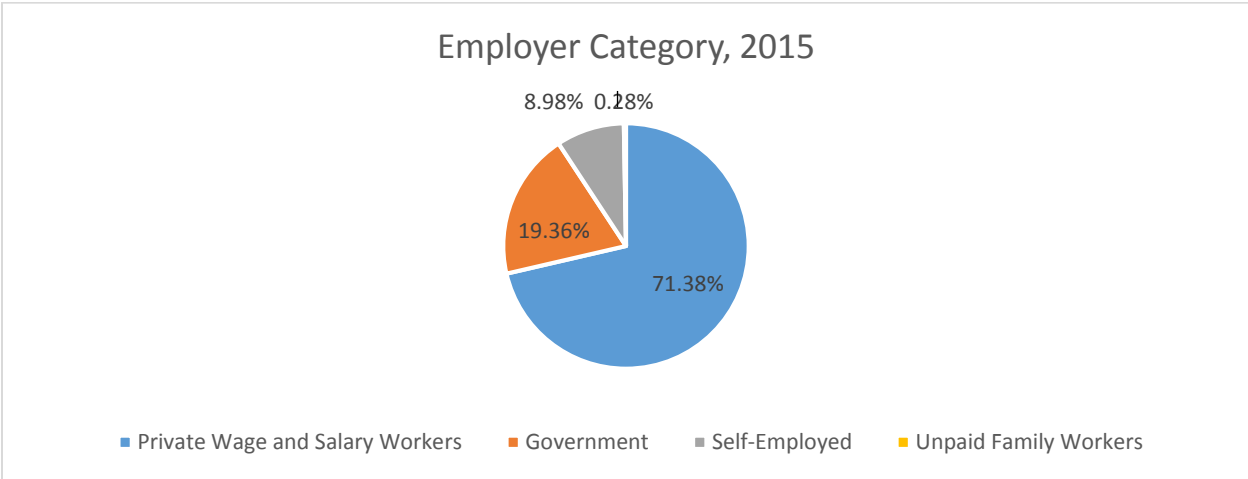
Figure 11



Source: U.S. Census Bureau, American Community Survey, 2011-2015

The majority of workers in the Lower 8 Region are employed by private businesses. Government employees account for 19.36 percent of the population. Almost nine percent are identified as self-employed and small percentages are considered unpaid family workers.

Figure 12



Source: U.S. Census Bureau, American Community Survey, 2011-2015

Commute to Work

Research shows that people who spend more time commuting to work are more likely to weigh more, have decreased cardiorespiratory fitness, and have metabolic risk factors. People who have to travel more than 15 miles to work every day are also less likely to fulfill exercise recommendations and are more likely to be obese. Meanwhile, hypertension is linked to traveling more than 10 miles to work.² The majority (80.7 percent) of workers in the region drive alone to work. An additional 9.7 percent carpool. Only 4 percent walk to work. The modes of commute to work are similar across all counties.

Table 3

Commuting to Work, 2015	
Mode of Commute	Percent
Car, Truck, or Van -- Drove Alone	80.70%
Car, Truck, or Van -- Carpool	9.70%
Public Transportation (Excluding Taxi-Cab)	0.10%
Walked	4.00%
Other Means	1.60%
Worked at Home	3.60%

Numbers of workers 16 years and over: 52,343

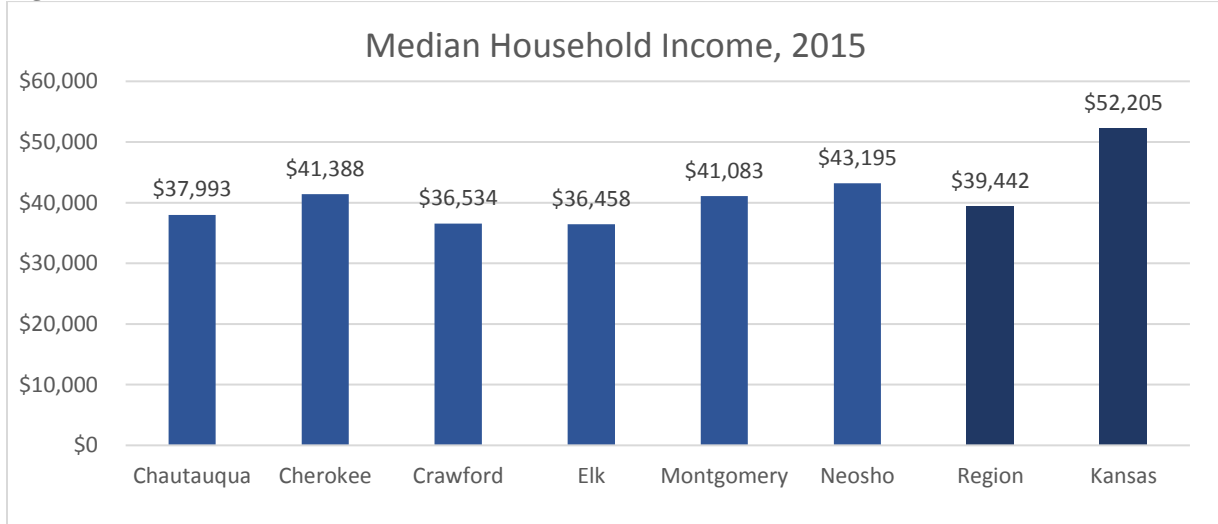
Source: U.S. Census Bureau, American Community Survey, 2011-2015

²Hoehner, C.M., Barlow, C.E., Allen, P., and Schootman, M. (2012). Commuting distance, cardiorespiratory fitness, and metabolic risk. *American Journal of Preventative Medicine*.

Income

The median household income for the Lower 8 Region in 2015 was \$39,442. This is substantially lower than the Kansas median household income of \$52,205. Neosho County has the highest median household income of \$43,195 and Elk County has the lowest at \$36,458.

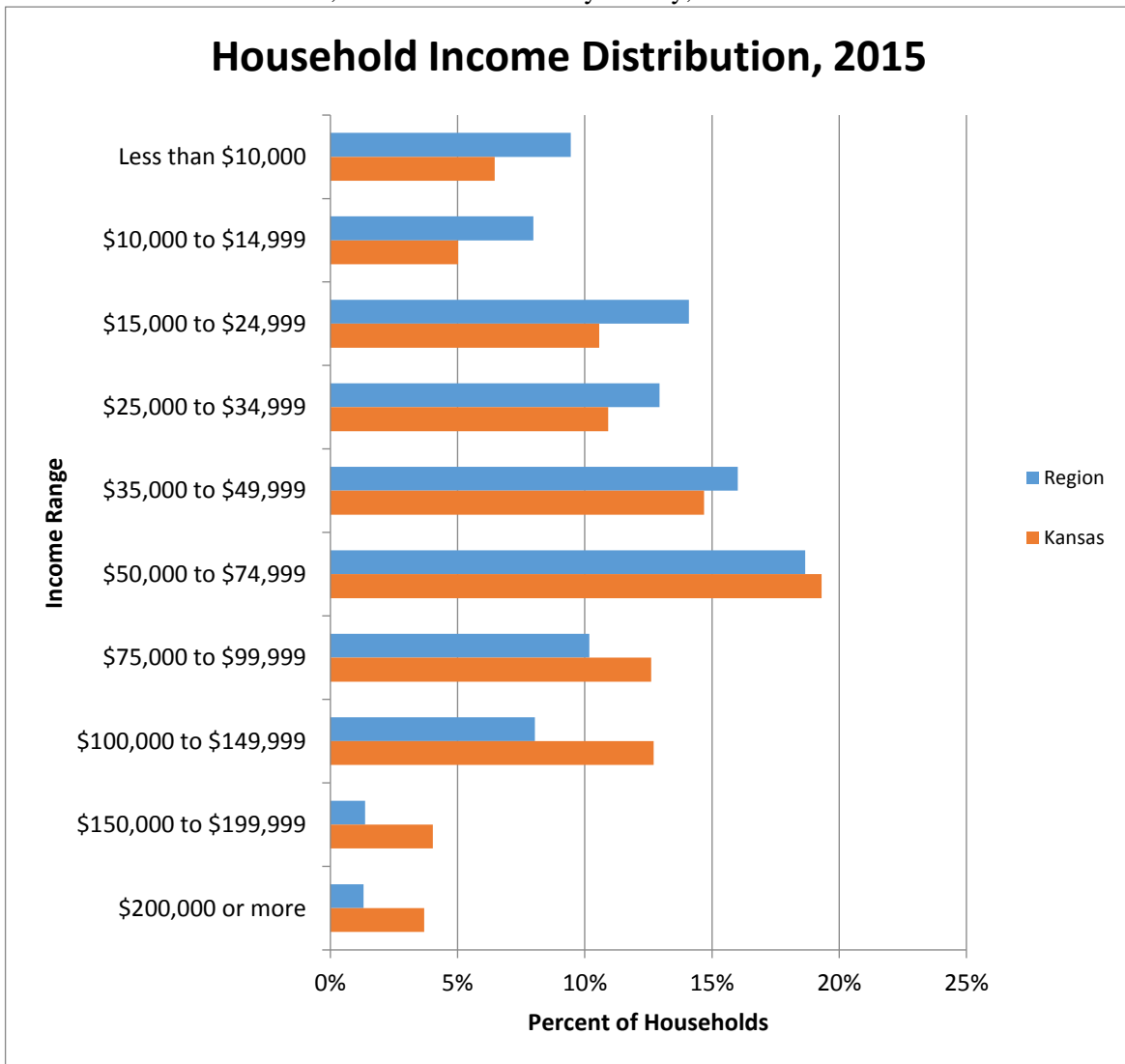
Figure 13



Source: U.S. Census Bureau, American Community Survey, 2011-2015

In the Lower 8 Region, the greatest percentage of households fell within the \$50,000-\$74,999 income range followed by the \$35,000-\$49,999 income range. These results are similar to the income distribution at the state level. In contrast, however, is that a greater percentage of households fall into the lower income ranges compared to Kansas averages. Nine percent of Lower 8 Region households have an income of \$10,000 or less annually and eight percent fall within the \$10,000-\$14,999 income range.

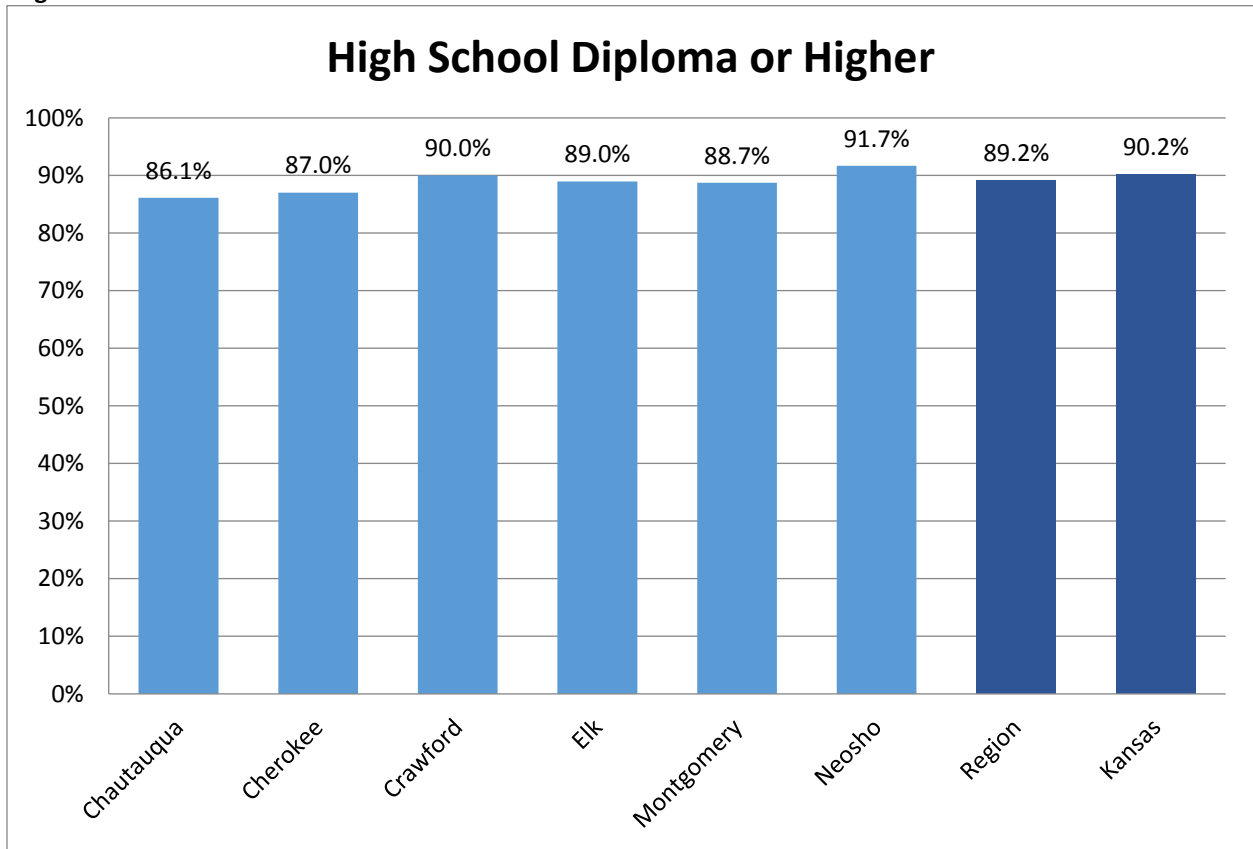
Figure 14
 Source: U.S. Census Bureau, American Community Survey, 2011-2015



3. Education

Education level is closely linked to opportunities for employment and wages,³ which are associated with improved health outcomes. The percentage of the population age 25 and over with a high school diploma in the Lower 8 Region is 89.2 percent. This is similar to the state average of 90.2 percent. Overall, there is little variance in the percentages from county to county.

Figure 15

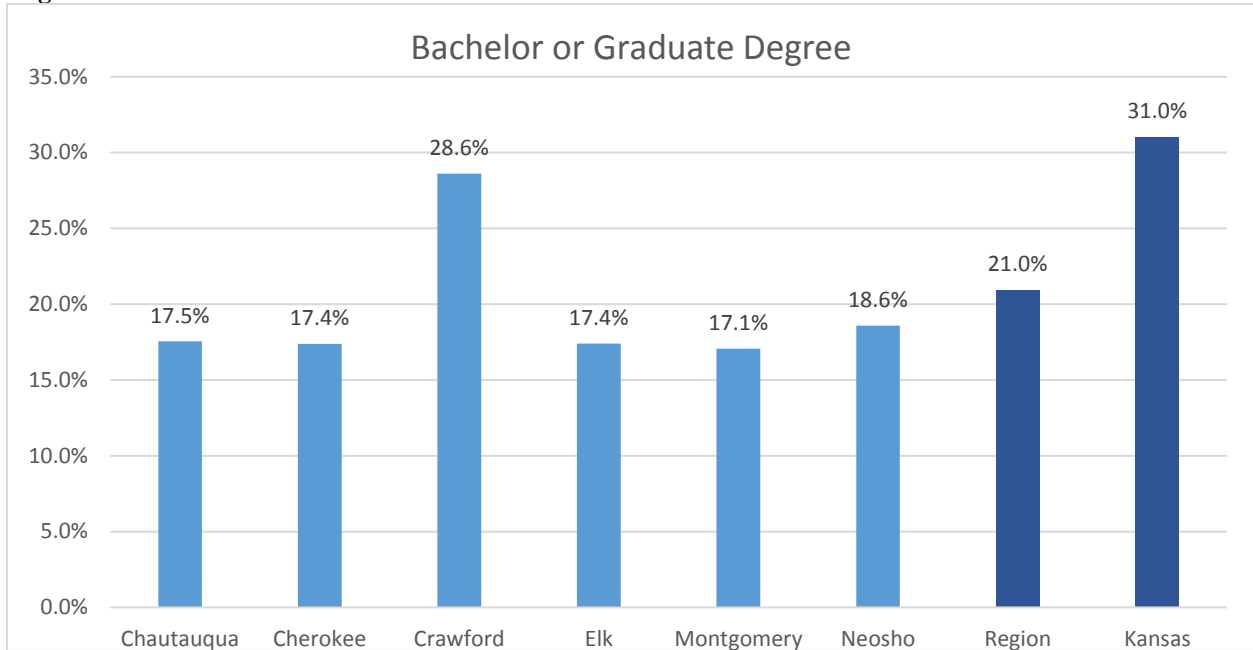


Source: U.S. Census Bureau, American Community Survey, 2011-2015

³United States Department of Labor, Bureau of Labor Statistics, http://www.bls.gov/emp/ep_chart_001.htm

Assessment of the attainment of a university-level education (bachelor’s degree, and graduate or professional level) reveals that most of the counties in the Lower 8 Region are substantially lower than the Kansas average. The exception is Crawford County with a percentage of 28.6 however, this may be due to the presence of Pittsburg State University.

Figure 16



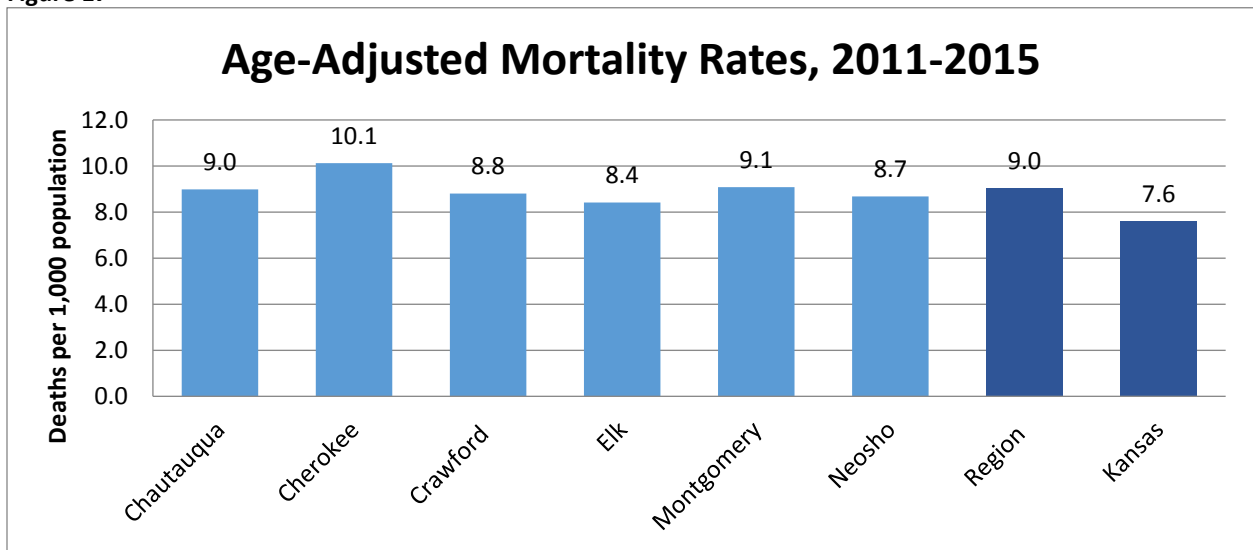
Source: U.S. Census Bureau, American Community Survey, 2011-2015

4. Mortality

Age-Adjusted Mortality Rates

Mortality rates are calculated as the number of deaths that occur in a defined time per 1,000 people. There are many factors that can affect mortality rates but age is the most influential. Crude mortality rates should be evaluated with caution due to the difference in age composition of the population. By “age-adjusting” mortality rates allowances are made for differences in age distribution. Upon comparison of the age-adjusted mortality rates of the region, Cherokee County has the highest mortality rate of 10.1 deaths per 1,000 people and Elk County is the lowest at 8.4. Every county in the Lower 8 has a higher age-adjusted mortality rate than the Kansas average.

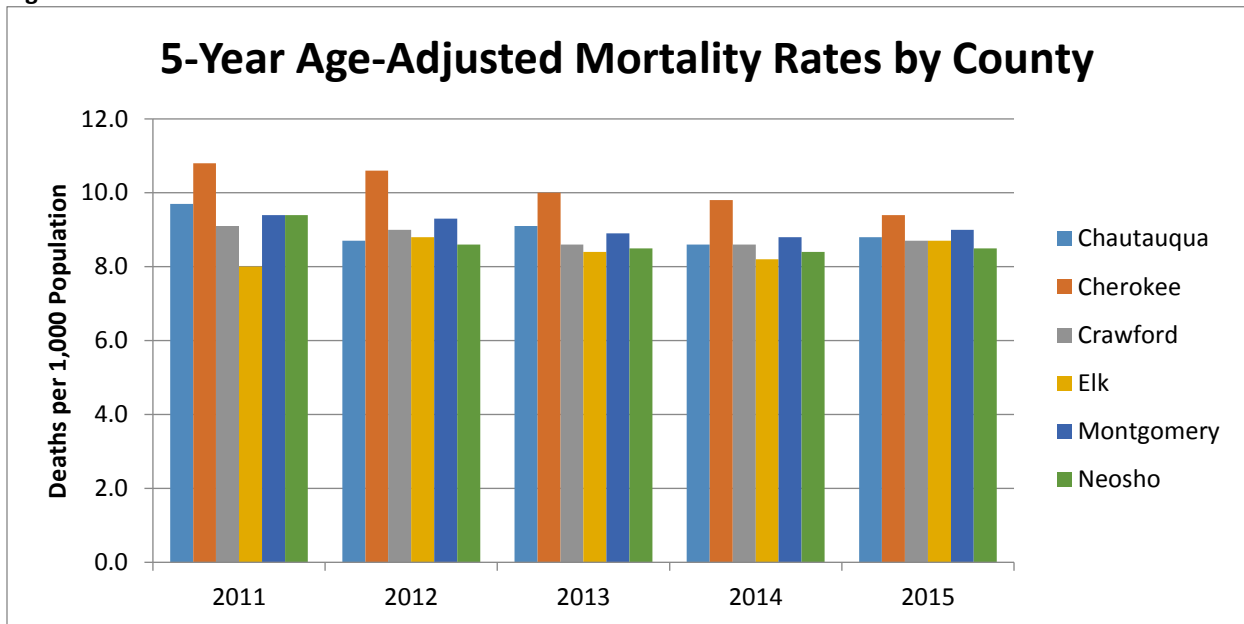
Figure 17



Source: U.S. Census Bureau, American Community Survey, 2011-2015

Review of the five year mortality rates for the Lower 8 Region shows age-adjusted mortality rates have remained constant for many of the counties. Cherokee County has the highest rates although they have declined from 10.5 deaths per 1,000 people in 2010 to 9.4 deaths in 2015. Neosho County reports the lowest age-adjusted mortality rates over the five year period.

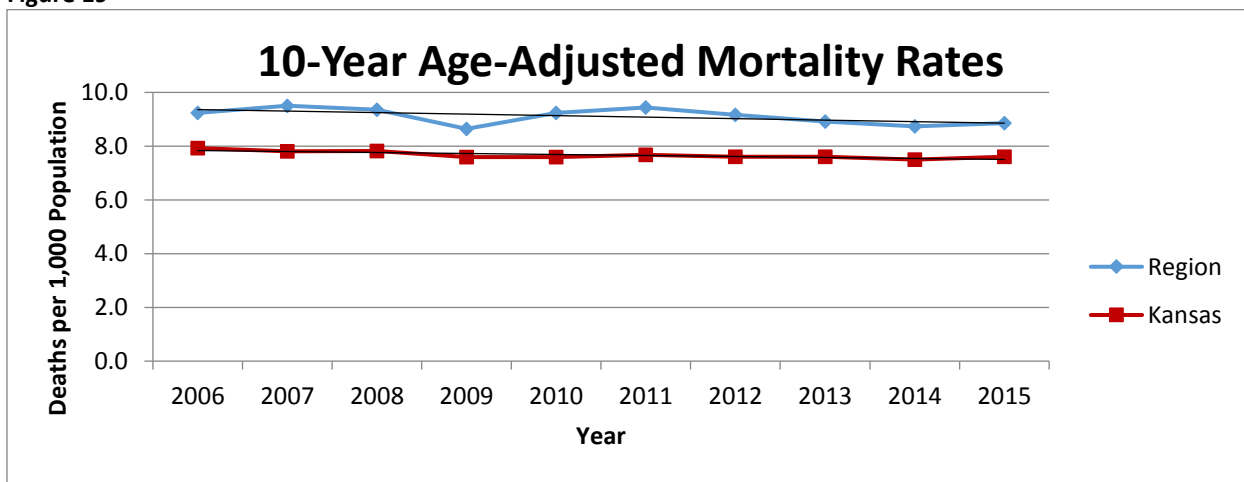
Figure 18



Source: U.S. Census Bureau, American Community Survey, 2011-2015

Age-adjusted mortality rates for the Lower 8 Region have remained relatively steady over the last 10 years. These rates have remained consistently higher than the state average.

Figure 19

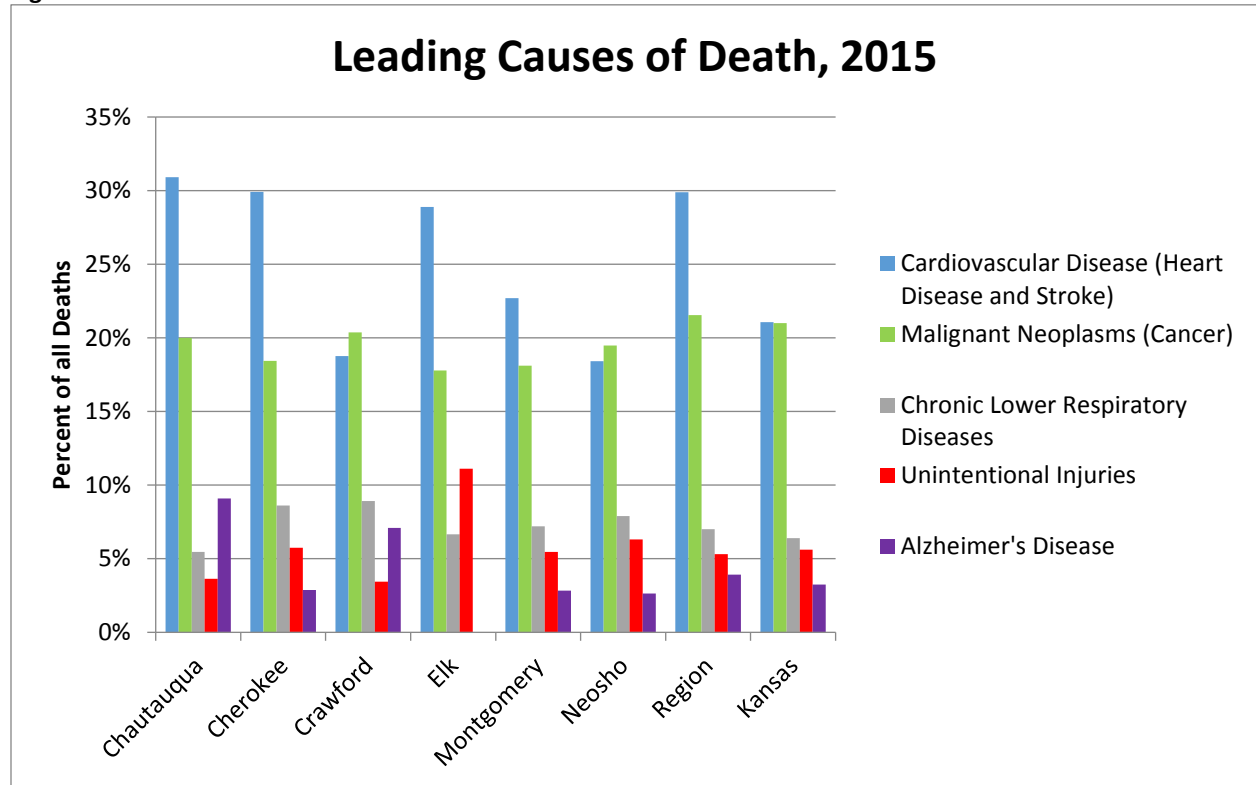


Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Causes of Death

The top five leading causes of death for Kansas residents in 2015 were cardiovascular disease (heart disease and stroke), malignant neoplasms (cancer), chronic lower respiratory diseases, unintentional injuries, and Alzheimer's disease. Among the region, cardiovascular disease and malignant neoplasms were the top two leading causes of death in every county.

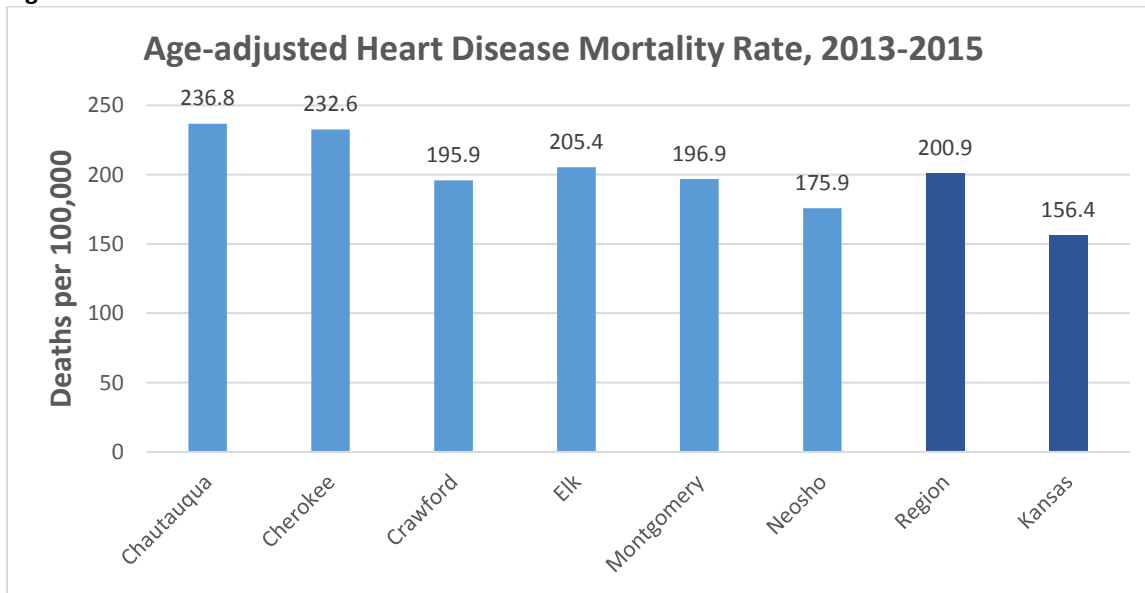
Figure 20



Source: Kansas Department of Health and Environment, Annual Summary of Vital Statistics

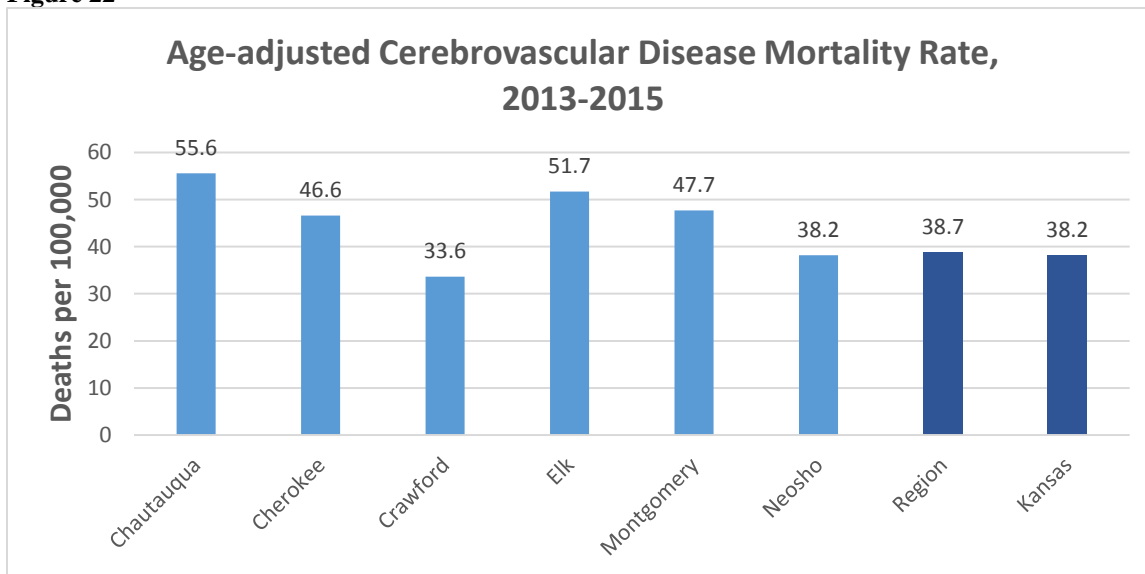
Each of the counties represented by the Southeast Kansas Health Care Committee have a higher age-adjusted heart disease mortality rate than the Kansas average. Deaths from age-adjusted cerebrovascular disease are also higher in every county with the exception of Crawford County with a rate of 33.6 per every 100,000 people. Neosho County was equal to the state average of 38.2 per 100,000 people.

Figure 21



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

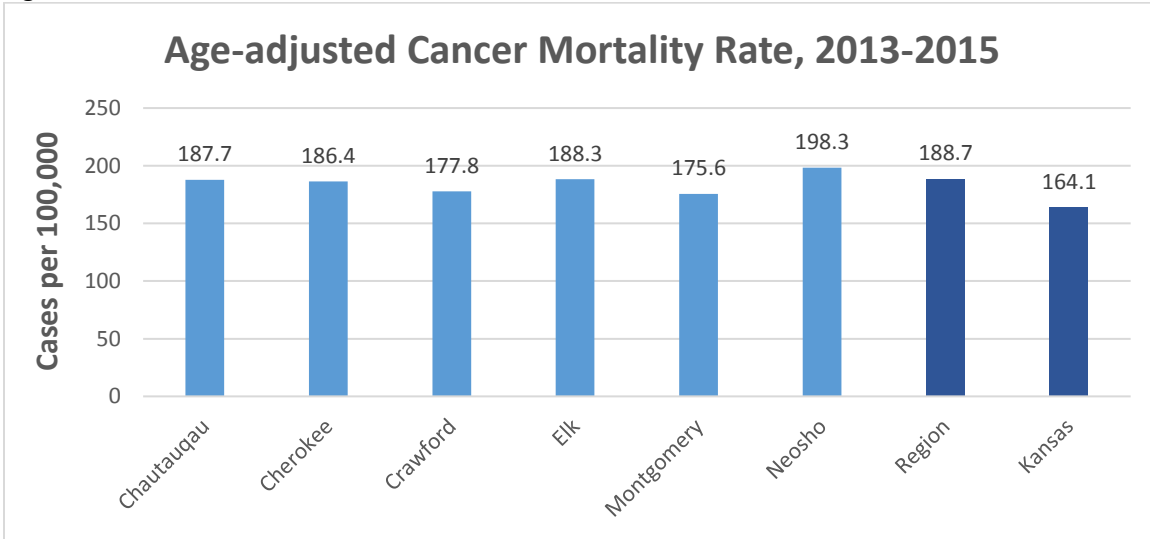
Figure 22



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

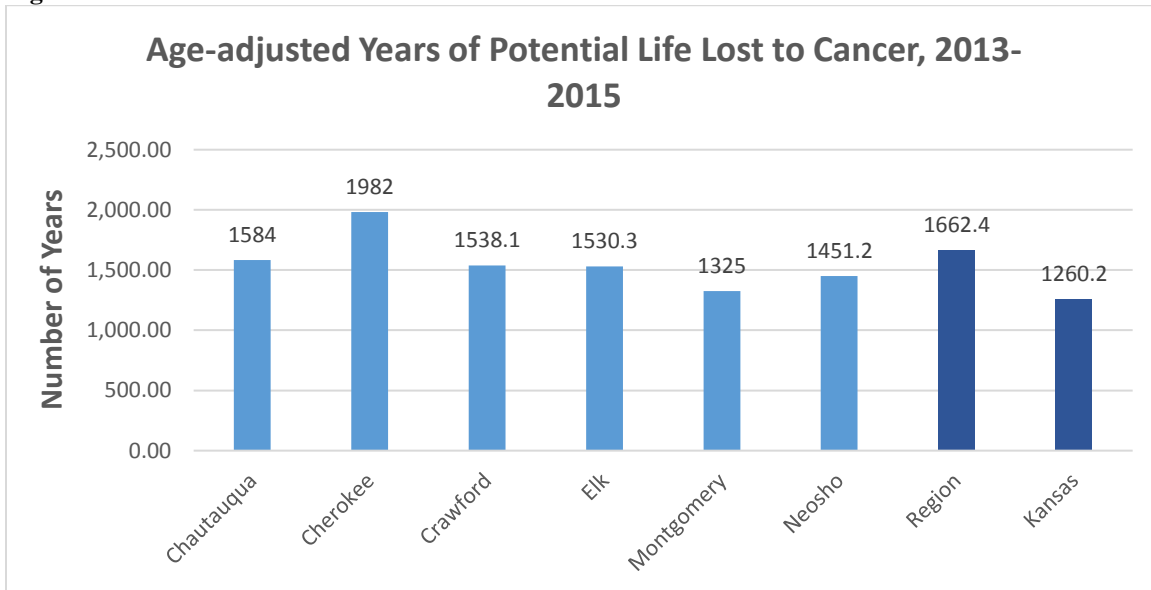
Cancer is the second leading cause of death in the region, state, and nation. In this area, age-adjusted cancer mortality rates are higher in every county than the Kansas average. The most deaths per 100,000 cases occurred in Neosho County between 2013 and 2015. Another important indicator to consider is years of potential life lost, all counties in this area report more years of potential life lost to cancer than the Kansas average (1,260.2 years). Cherokee County had the highest number of years of potential life lost with 1,982 years lost.

Figure 23



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

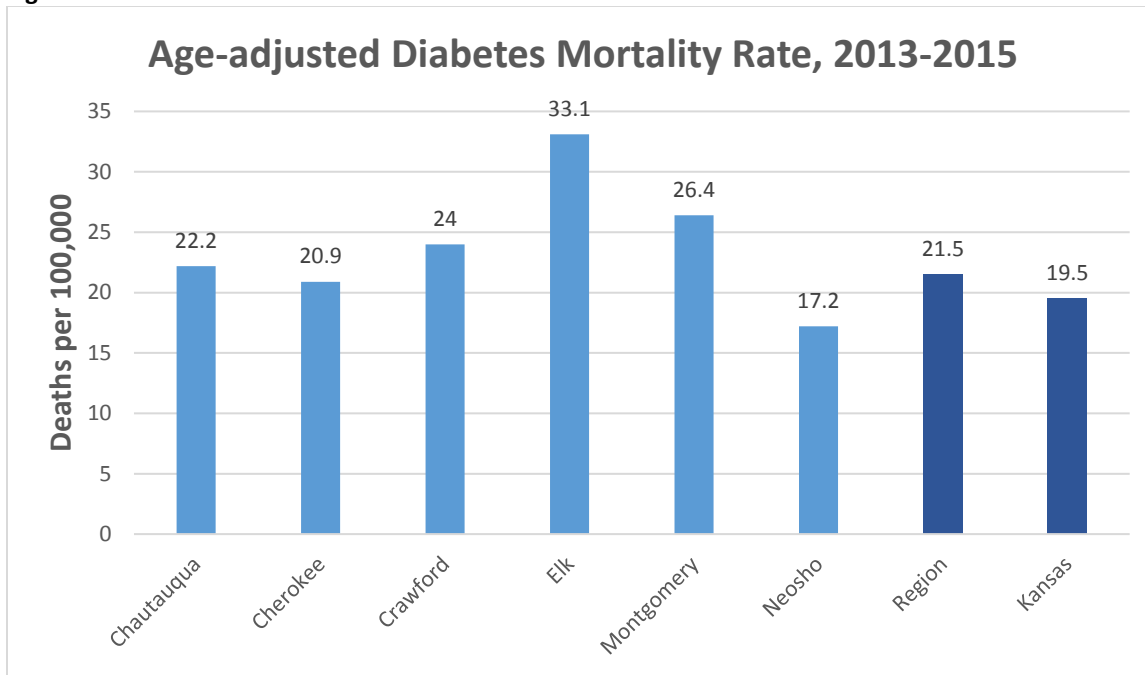
Figure 24



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

While diabetes was not listed in the top five causes of death in 2015 in Kansas, the mortality rate from diabetes is important to the health of the community. Elk County had an age-adjusted mortality rate of 33.1 deaths per 100,000 between 2013 and 2015. This result was well above the Kansas average of 19.5. One county reported a lower mortality rate than the state average as Neosho County experienced 17.2 deaths per 100,000.

Figure 25

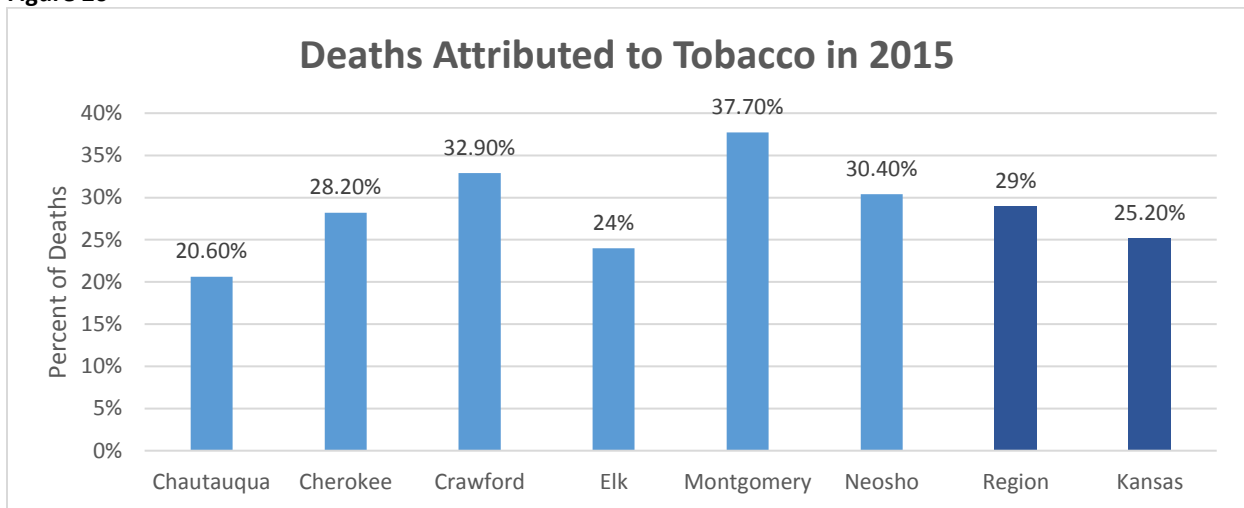


Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Tobacco-Associated Deaths

According to the Centers for Disease Control (CDC), tobacco use is the leading preventable cause of death in the United States.⁴ The mortality rate for both males and females that smoke are three times higher than an individual who has never smoked. Additionally, the use of tobacco products is linked to certain forms of cancer and cardiovascular disease. The Lower 8 Region has higher tobacco mortality rates than the state average with the exception of Elk and Chautauqua Counties. More than one third of deaths in Montgomery County can be attributed to tobacco use. These findings should be interpreted with caution due to the small sample size in some of the counties.

Figure 26



Source: Kansas Department of Health and Environment, Annual Summary of Vital Statistics, 2015

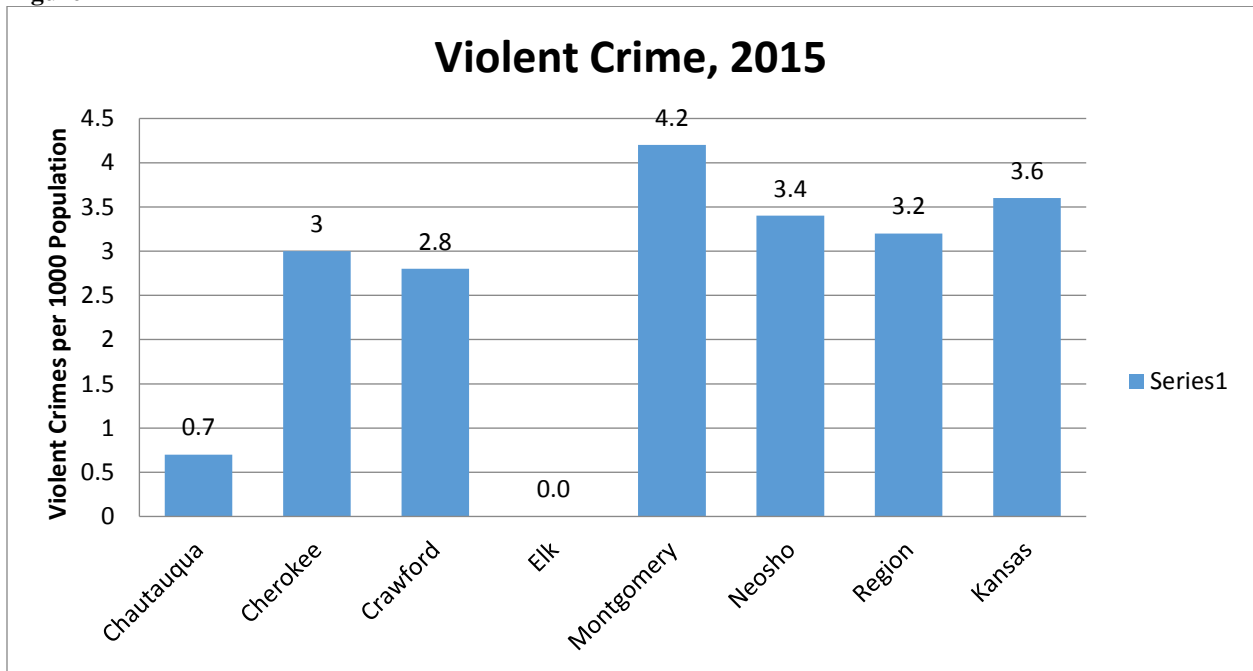
⁴Centers for Disease Control, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm

5. Violence and Injury

Violent Crime

Violence affects all age and socio-economic groups. It is a significant public health concern and can affect the overall health of the community.⁵ Violent crimes can result in physical, mental, and emotional health problems that can last a lifetime. In 2015, most of the counties in the region were below the Kansas average of 3.6 violent crimes per 1,000 residents. The exception was Montgomery County with 4.2 violent crimes reported per 1,000 residents.

Figure 27



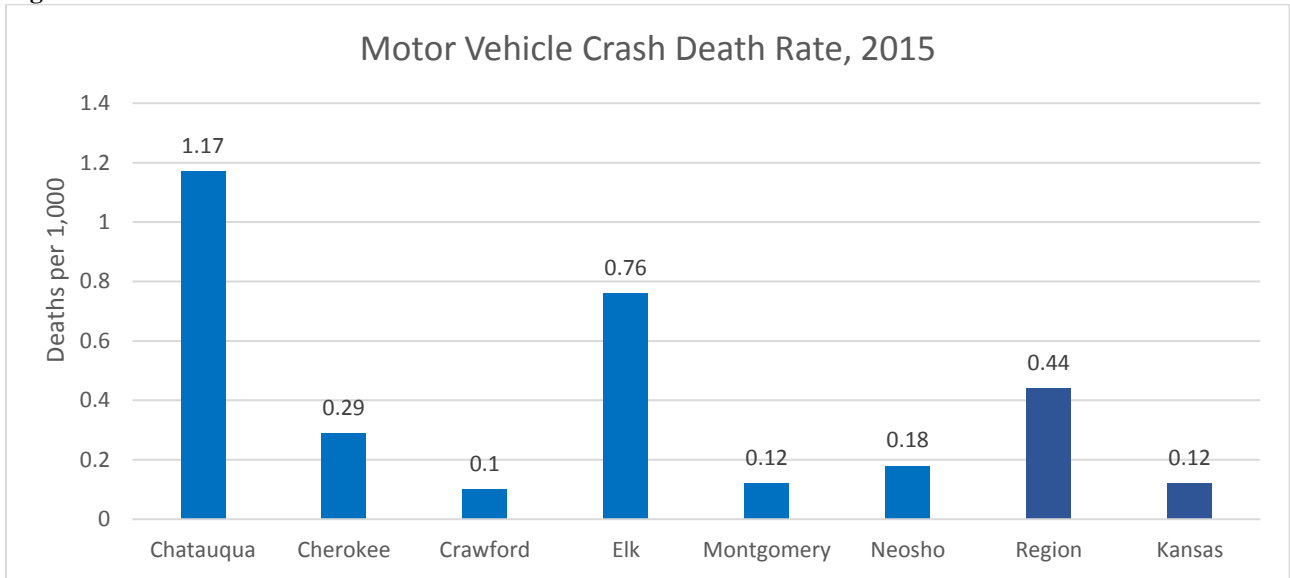
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

⁵ Centers for Disease Control, <https://www.cdc.gov/ViolencePrevention/index.html>

Motor Vehicle Crash Deaths

Motor vehicle crashes take over 30,000 lives each year in the United States. These accidents are considered a top 10 cause of death in individuals aged 1-54.⁶ The Lower 8 Region in 2015 was well above the state average with the exception of Crawford County at 0.1 and Montgomery County was equal to the Kansas average at 0.12.

Figure 28



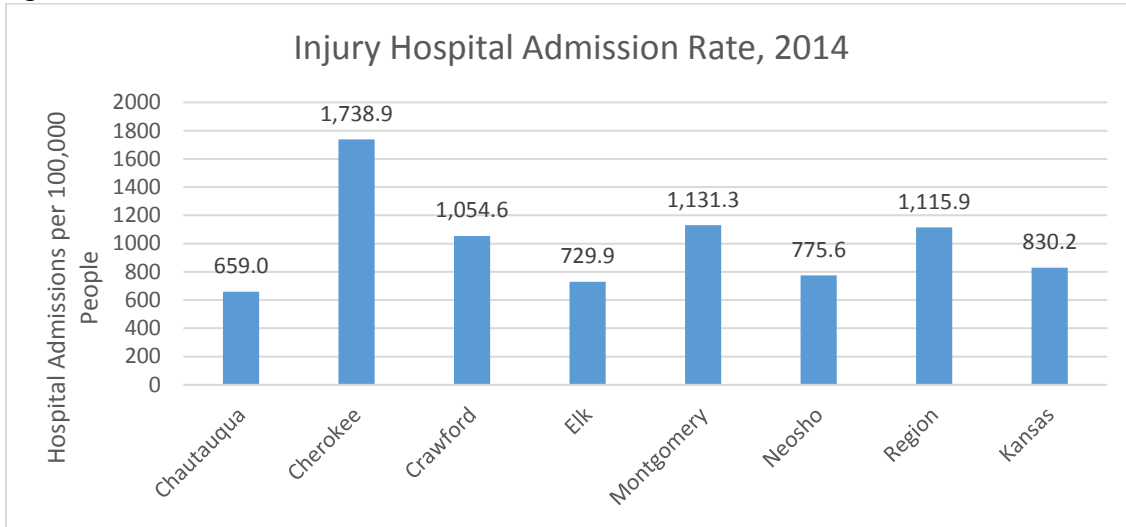
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

⁶Centers for Disease Control, <https://www.cdc.gov/motorvehiclesafety/pdf/statecosts/ks-2015costofcrashdeaths-a.pdf>

Injury

Unintentional injuries account for \$31 million in medical expenses each year in the United States.⁷ The Lower 8 Region had a large variation in admission rates for injuries in 2014. Cherokee County had the highest admission rate at 1,738.9 per 100,000 people and Chautauqua was the lowest at 659 per 100,000. Overall, three counties have a higher admission rate than the state average and three counties are lower.

Figure 29

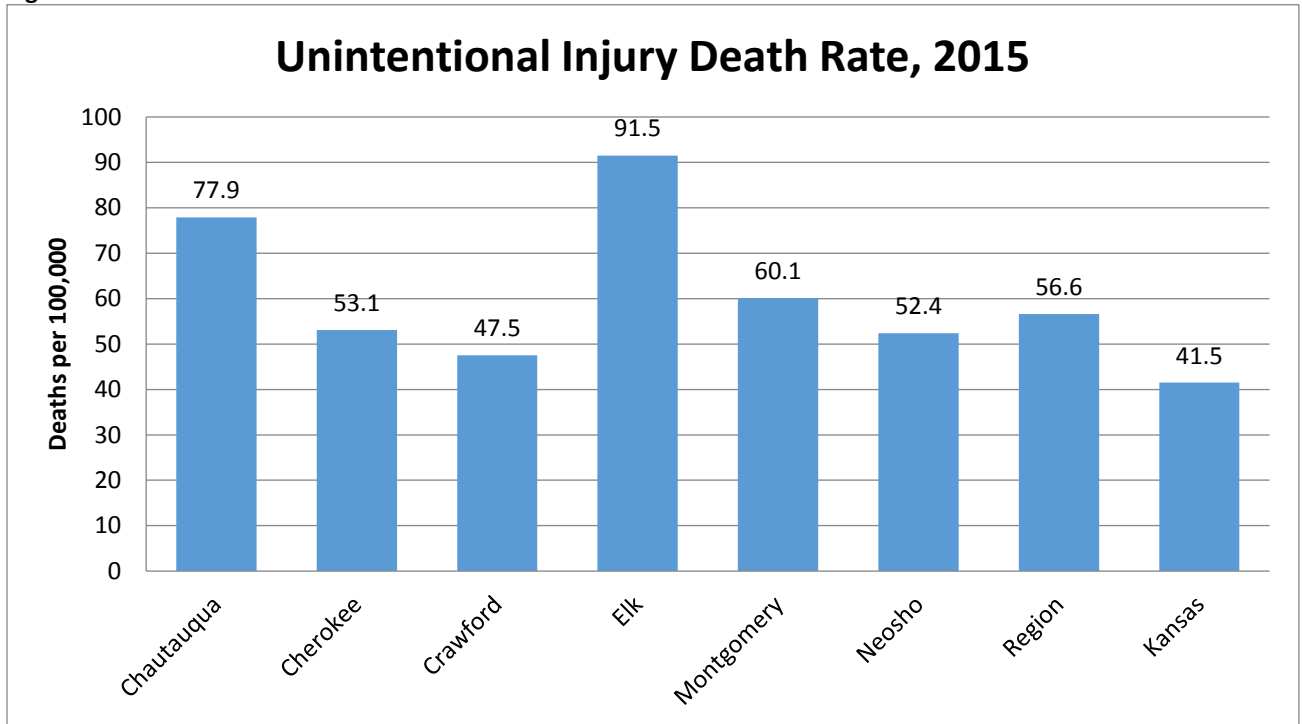


Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

⁷ Centers for Disease Control, <https://www.cdc.gov/nchs/fastats/accidental-injury.htm>

The unintentional injury death rate in the Lower 8 Region was higher than the Kansas rate in 2015. Elk County had the highest rate at 91.5 per 100,000 people and Crawford County is the lowest at 47.5 per 100,000 people. These findings should be reviewed with caution as population size must be considered.

Figure 30

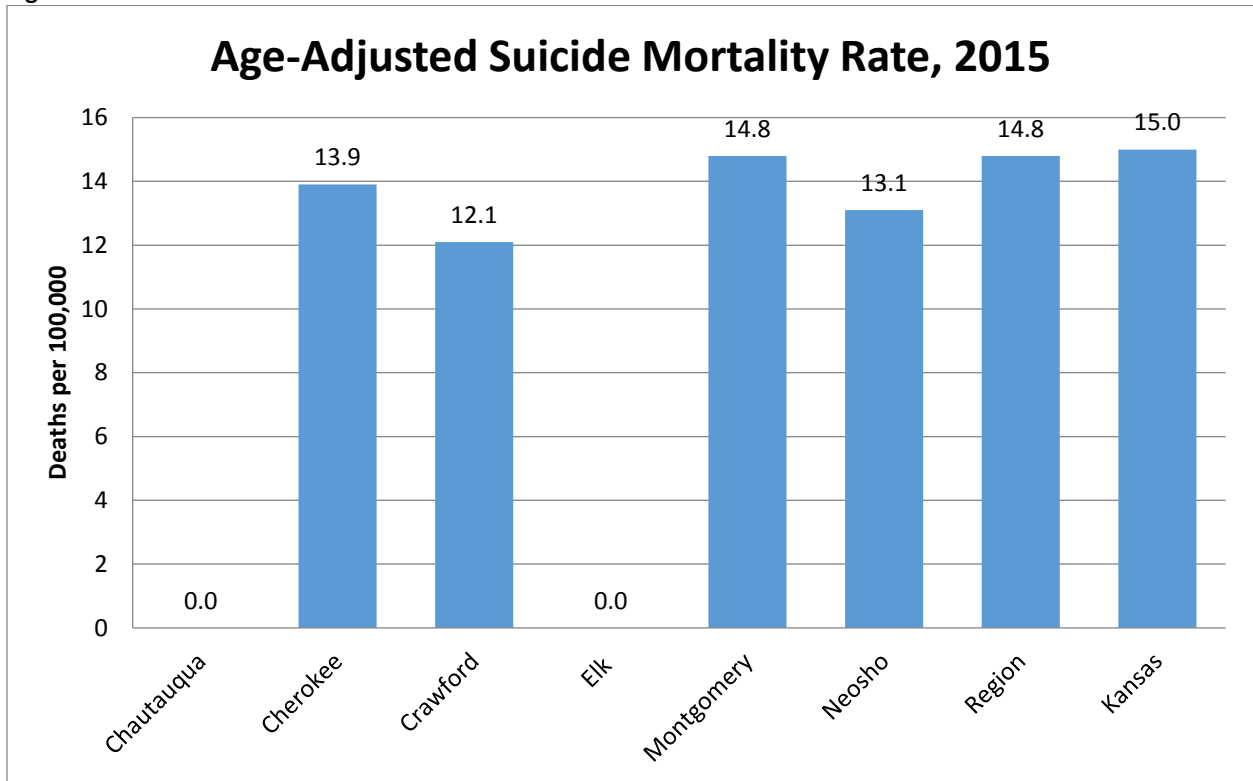


Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Suicide

Suicide is loss that affects not only families but the health of the whole community.⁸ Findings in the Lower 8 Region reveal a slightly lower suicide mortality rate at 14.8 deaths per 100,000 people compared to the Kansas average of 15.0 deaths per 100,000. Chautauqua and Elk counties both had suicide mortality rates of 0.0. These results could be impacted by the small population of these counties. Montgomery County had the highest rate at 14.8 deaths per 100,000.

Figure 31



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

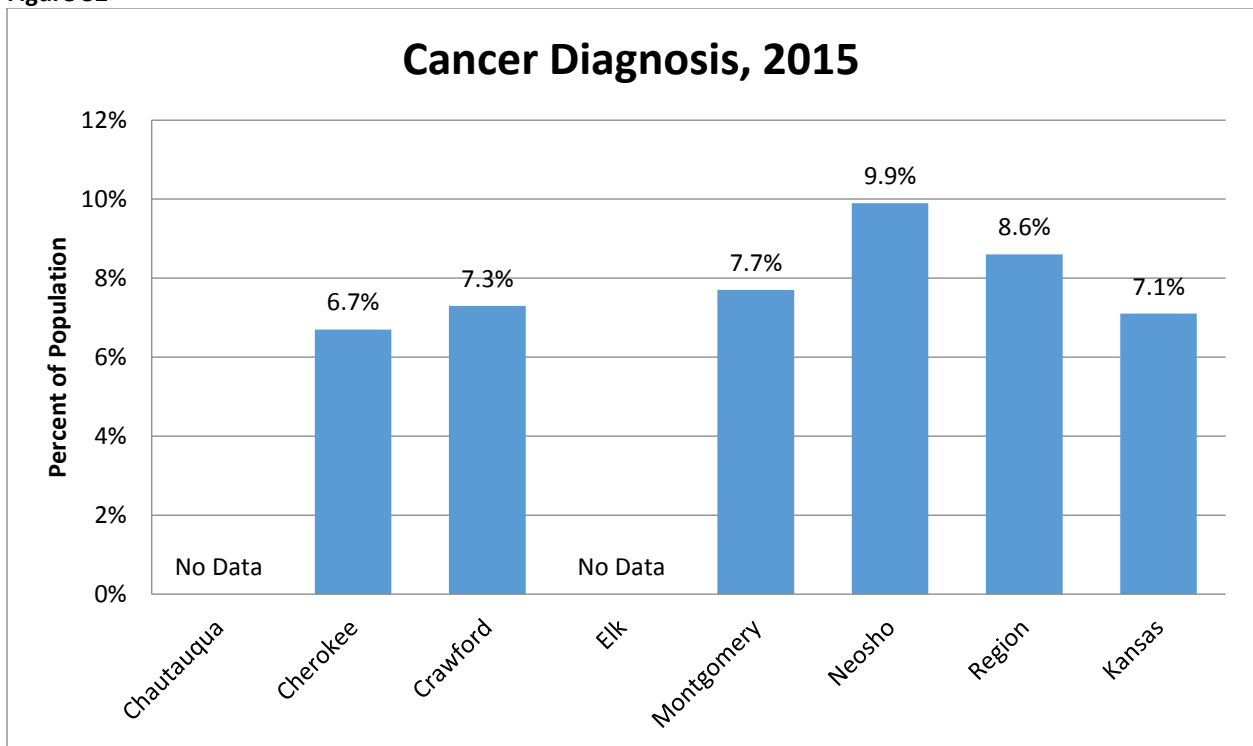
⁸ Kansas Health Matters, www.kansashealthmatters.org

6. Disease and Poor Health

Cancer Diagnosis

Cancer was the second leading cause of death in the United States, Kansas, and the Lower 8 Region in 2015.⁹ A cancer diagnosis, while often times not fatal, can be burdensome to the individual and family. Medical expenses, time lost for treatment, and mental stress have a major impact on the individual and his or her caregivers.¹⁰ Neosho County had the highest cancer diagnosis rate of 9.9% and Cherokee County had the lowest diagnosis rate of 6.7%. Data was not available for Chautauqua and Elk counties.

Figure 32



Source: Kansas Department of Health and Environment, BRFSS 2013 data

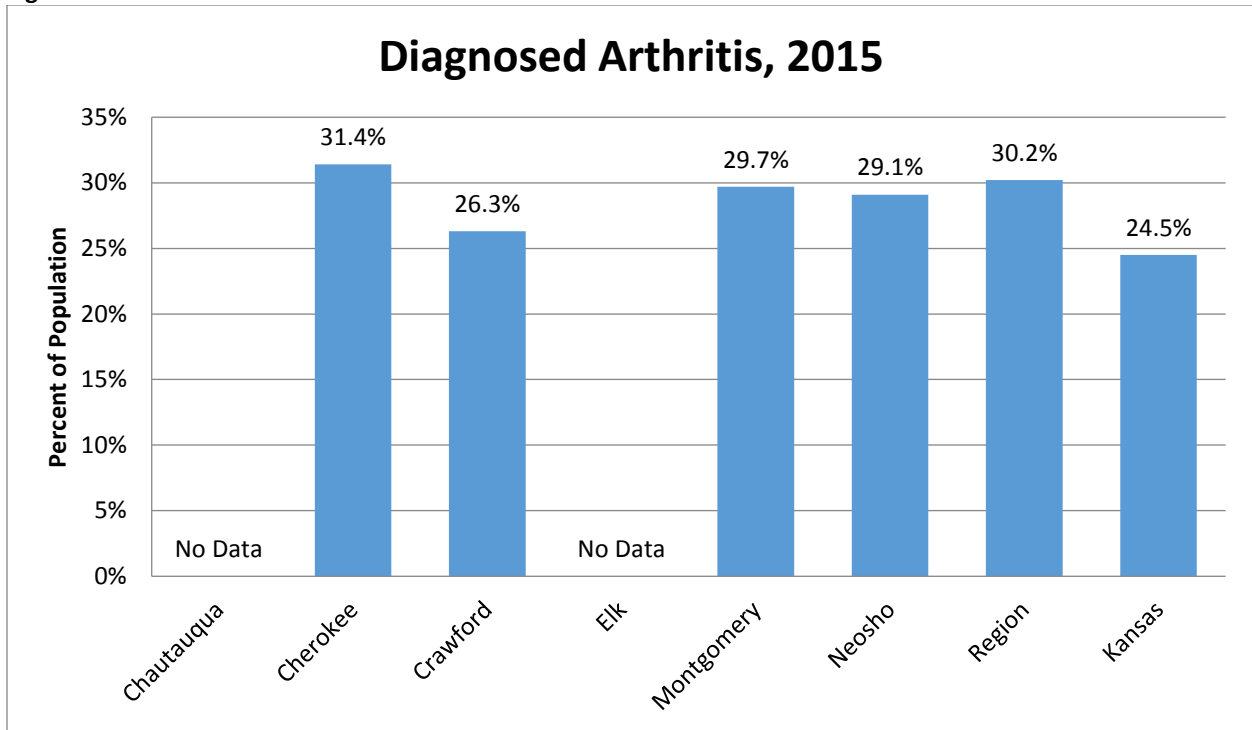
⁹ Centers for Disease Control, <https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>

¹⁰ American Cancer Society, <https://www.cancer.org/cancer/cancer-basics>

Diagnosed Arthritis

Arthritis affects more than 50 million adults in the United States with this total expected to rise to more than 78 million by the year 2040. Arthritis is a significant issue because it affects mobility and quality of life. Arthritis causes the loss of more workdays each year than illness and injury combined.¹¹ Most counties in the Lower 8 report higher arthritis diagnosis rates than the state but this may be due in part to the age of the communities. Data was not available for Chautauqua and Elk Counties.

Figure 33



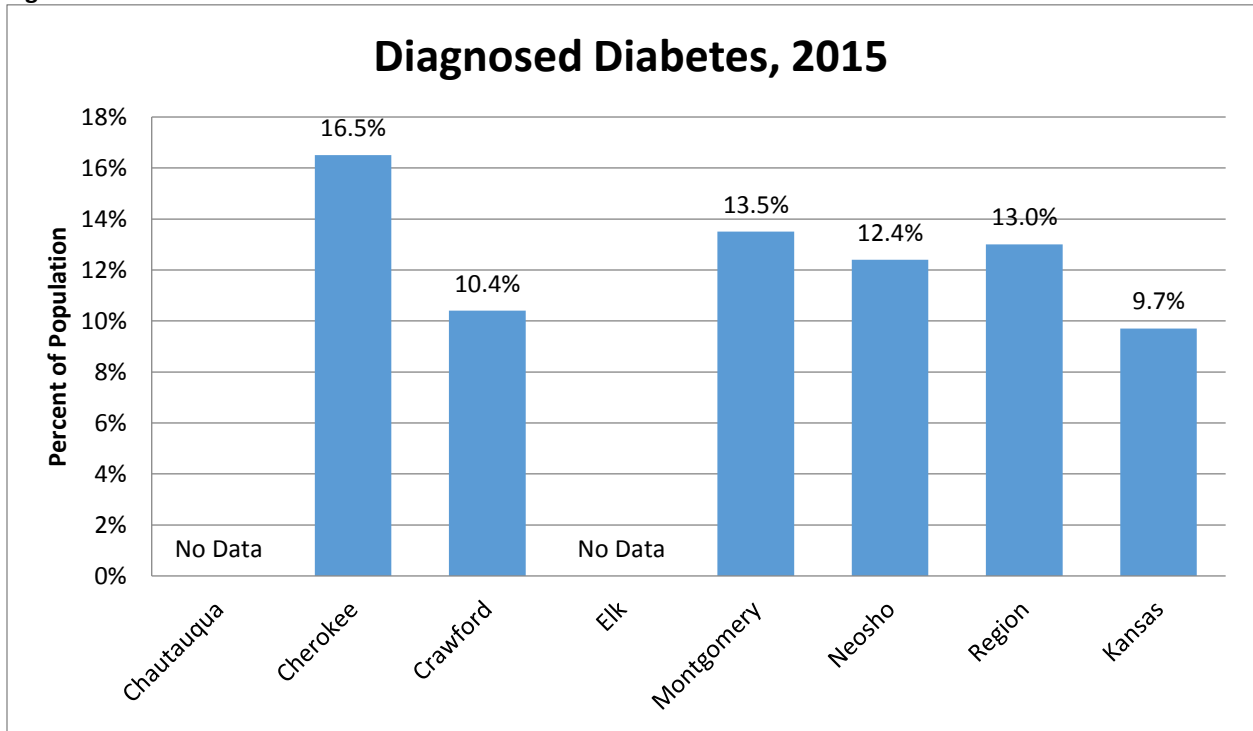
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

¹¹Arthritis Foundation, <http://www.arthritis.org/about-arthritis/understanding-arthritis/arthritis-statistics-facts.php>

Diagnosed Diabetes

Diabetes, especially Type 2 which accounts for 95 percent of cases, is linked to various health conditions like obesity and heart disease. Diabetes can affect numerous systems of the body including the heart, eyes, kidneys, and extremities.¹² All of the reporting counties in the Lower 8 displayed a higher incidence than the state average of 9.7 percent in 2015.

Figure 34



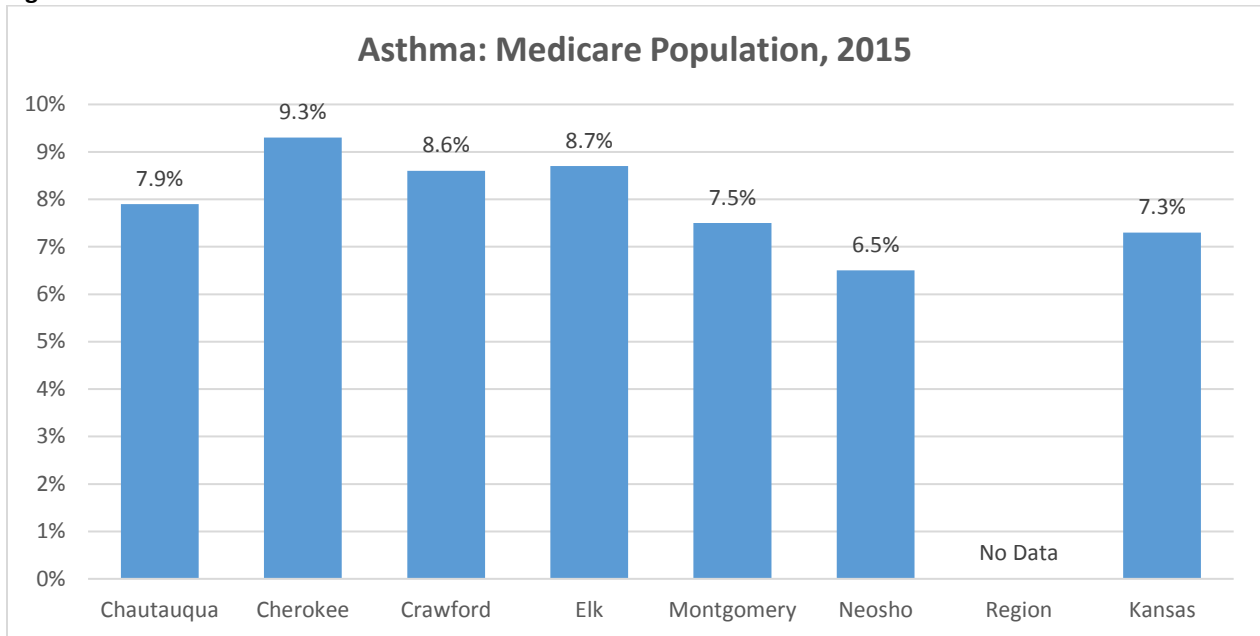
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

¹² Centers for Disease Control, <https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/diabetes-aag.pdf>

Asthma Population

Asthma is a significant health issue that can limit activity and affect the individual's quality of life. If not properly managed, asthma can result in hospitalization and even death.¹³ The population of Medicare patients with asthma in the Lower 8 Region varies. Neosho County reports a slightly lower percentage than the state at 6.5 percent. Chautauqua, Cherokee, and Montgomery Counties averages were modestly higher than the Kansas average.

Figure 35



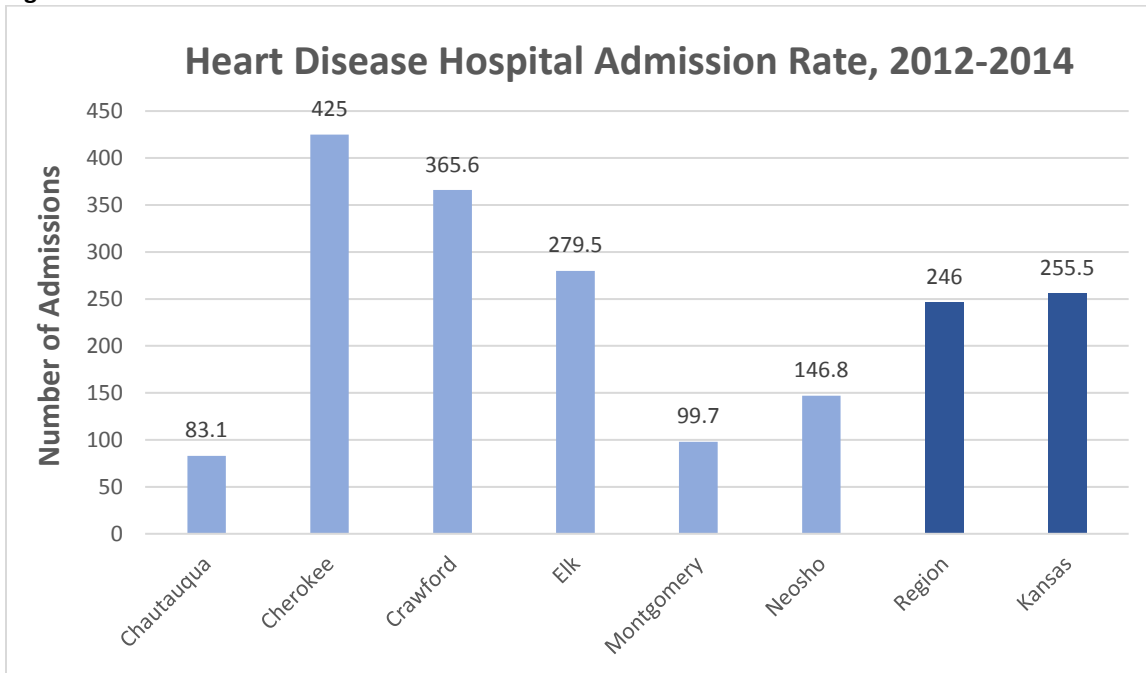
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

¹³ Centers for Disease Control, <https://www.cdc.gov/asthma/asthmadata.htm>

Heart Disease Admissions

Heart disease results in \$207 billion in expenses each year in the United States. High blood pressure, an elevated LDL cholesterol level, and smoking are the key risk factors for heart disease. According to the CDC, one half of American adults have at least one of these risk factors.¹⁴ Admission rates for heart disease in the Lower 8 are widely varied. Cherokee County has the highest admission rate at 425 per 100,000 people and Chautauqua has the lowest rate at 83.1 per 100,000.

Figure 36



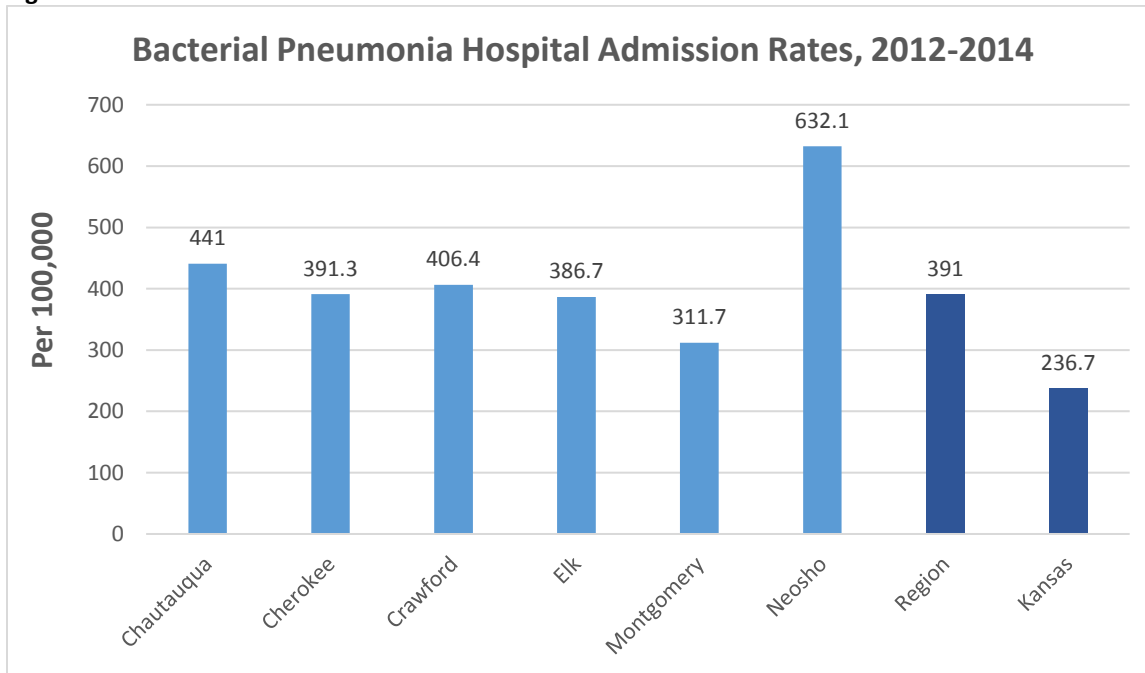
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

¹⁴ Centers for Disease Control, https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_disease.htm

Bacterial Pneumonia Admissions

Bacterial pneumonia can be a significant health problem that may result in hospitalization. Pneumonia is the leading infectious cause of death in children younger than five years old worldwide.¹⁵ All counties in the Lower 8 Region had bacterial pneumonia admission rates from 2012-14 that were higher than the state average. Neosho County had the largest number of admissions at 632.1 per 100,000 people and Montgomery County was the lowest at 311.7 admissions per 100,000 people. This average was still significantly higher than the Kansas average of 236.7 admissions per 100,000 people.

Figure 37



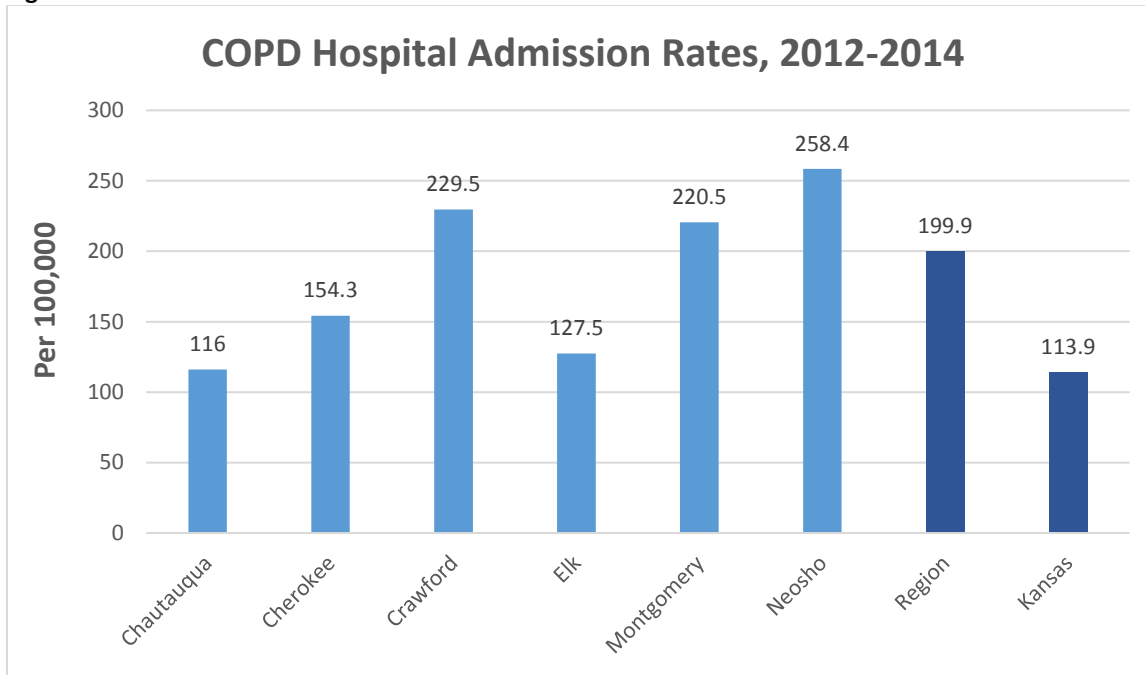
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

¹⁵ Centers for Disease Control, <https://www.cdc.gov/pneumonia/>

COPD Admissions

Chronic Obstructive Pulmonary Disease (COPD) can cause activity limitations, depression, confusion and memory loss, and an overall feeling of fair or poor health status.¹⁶ Hospitalization rates for COPD in the Lower 8 Region were higher at 199.9 admissions per 100,000 people compared to 113.9 admissions per 100,000 for Kansas. Tobacco smoke is the key risk factor for COPD development. The Lower 8 Region reports more smokers than the state average so this may help to account for the large number of COPD admissions for the region.

Figure 38



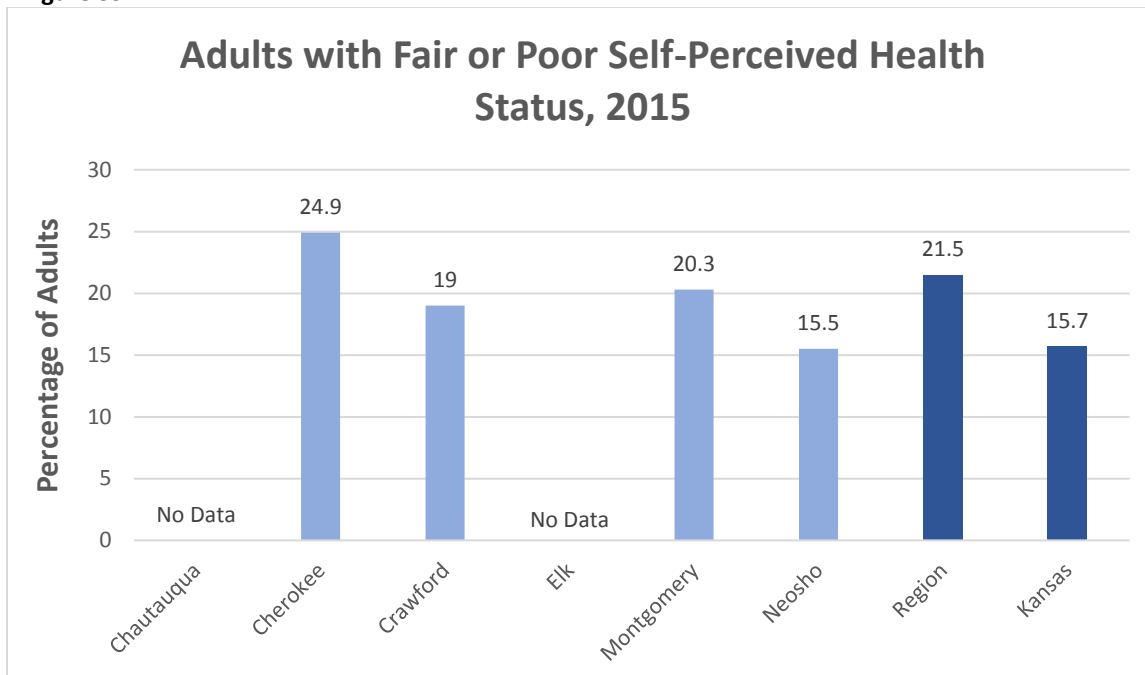
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

¹⁶ Centers for Disease Control, <https://www.cdc.gov/copd/index.html>

Perception of Health

How an individual perceives his or her overall health is important to the community. People that feel they are healthy are more inclined to be happy and participate in the community socially and economically.¹⁷ Overall, reporting counties in the Lower 8 Region perceived their health status was worse than the state average in 2015. Cherokee County reported that almost one in four people perceived they only had fair to poor health. Neosho County had 15.5 percent of their population reporting fair or poor self-perceived health status.

Figure 39



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

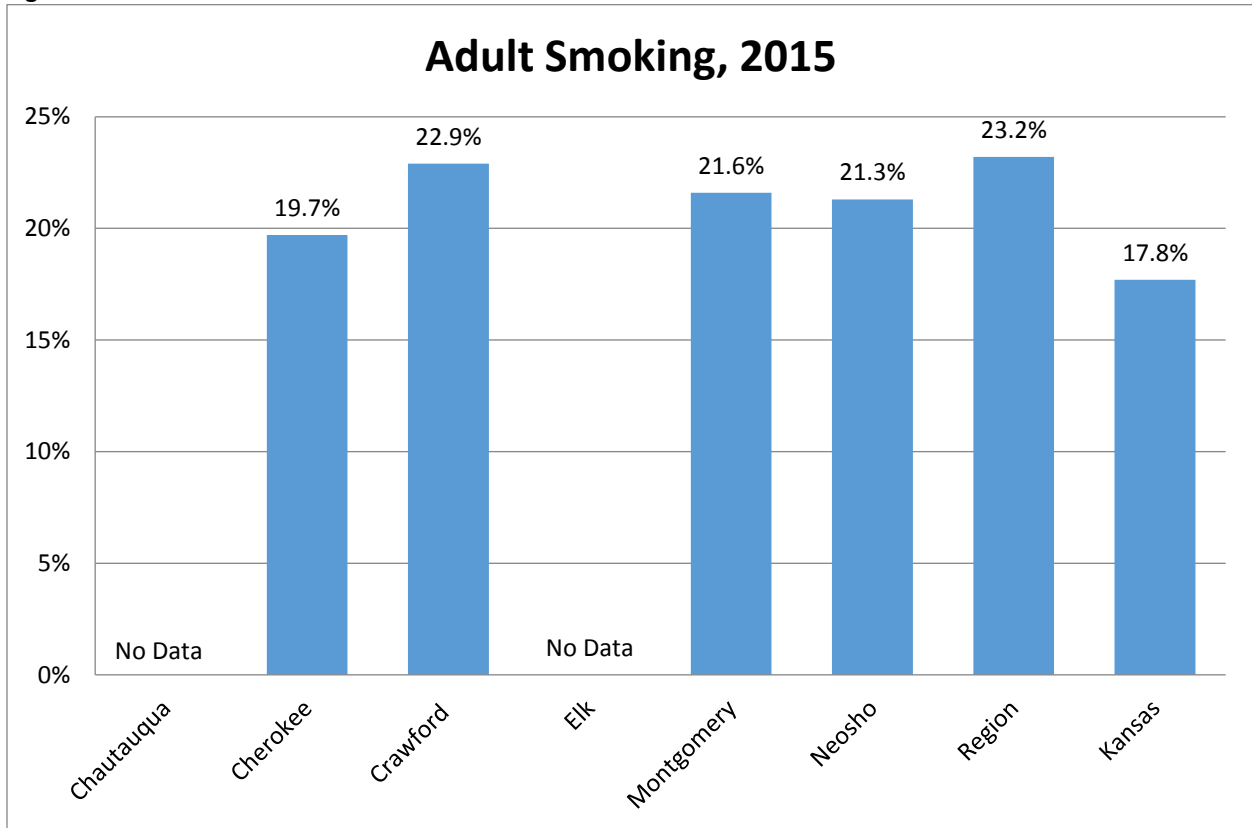
¹⁷ Kansas Health Matters, www.kansashealthmatters.org

7. Health Behaviors

Tobacco Use

Tobacco use contributes to multiple illnesses and deaths in the United States, Kansas, and the Lower 8 Region each year. Tobacco use is also one of the most preventable causes of illness and death. Areas with high prevalence of smoking also have greater chances of exposure to secondhand smoke. The Healthy People 2020 national target is to reduce the number of smokers 18 and over to 12 percent or lower.¹⁸ In 2015, Kansas was still well above this target at 17.8 percent. The reporting Lower 8 Region Counties were also higher than the target. Crawford County reported the highest percentage at 22.9 percent of the adult population and the lowest was Cherokee County at 19.7 percent. No data was available for Chautauqua or Elk counties.

Figure 40

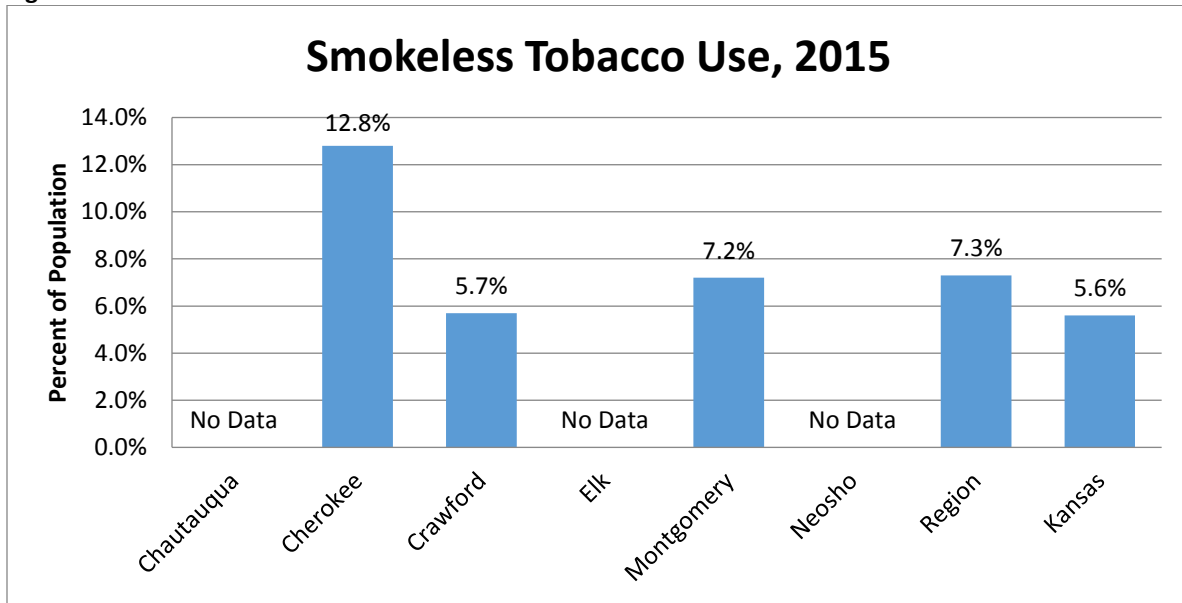


Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

¹⁸ Centers for Disease Control, https://www.cdc.gov/tobacco/basic_information/healthy_people/index.htm

Smokeless tobacco use also presents multiple health risks including cancer, nicotine addiction, diseases of the mouth, pregnancy complications, and nicotine poisoning in children. Additionally, smokeless tobacco use can increase the risk of death from heart disease and stroke.¹⁹ Use in Cherokee County is around 13 percent which is significantly higher than the Kansas average of 5.6 percent. No data was available for Chautauqua, Elk, or Neosho counties.

Figure 41



Source: Kansas Department of Health and Environment, BRFSS 2013 data

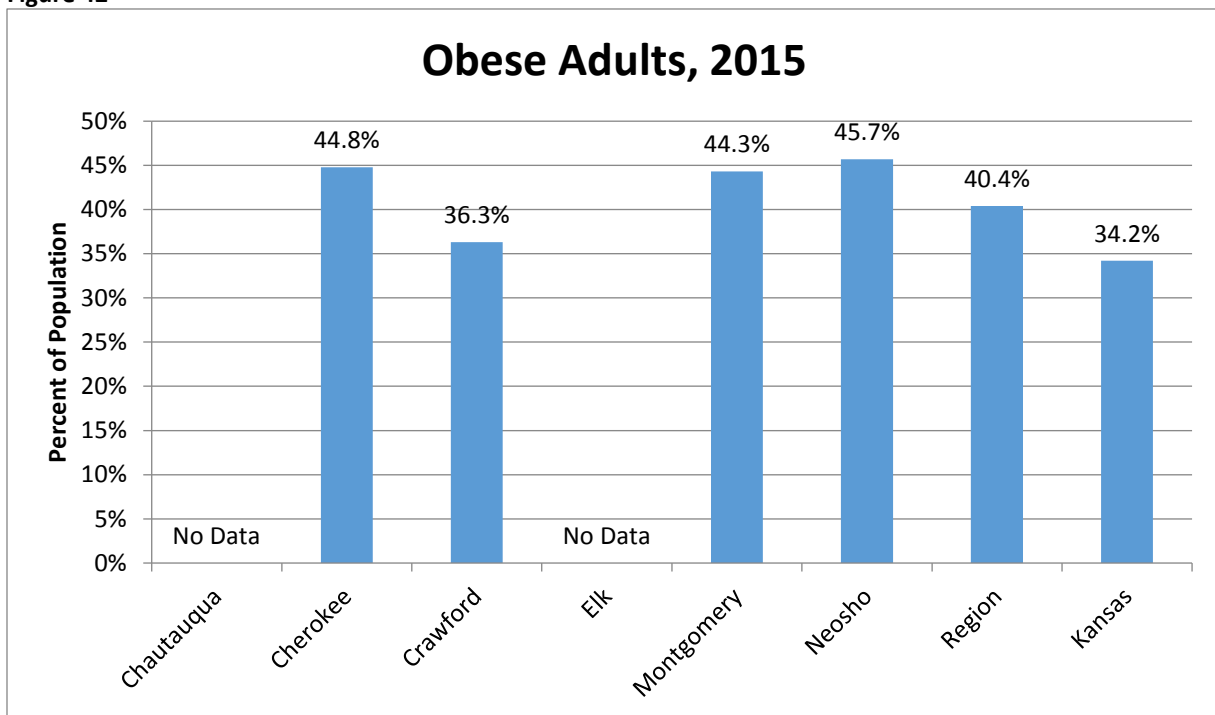
¹⁹ Centers for Disease Control, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/health_effects/index.htm

Obesity

Obesity rate can be an important indicator of the health of a community. It affects the quality of life and can result in poor mental health. Additionally, obesity can lead to several health problems including diabetes, heart disease, stroke, and some forms of cancer. The community can help to decrease the obesity rate by providing opportunities for its members to engage in physical activity and providing healthy eating options.²⁰

The reporting counties in the Lower 8 Region each displayed a higher obesity rate in 2015 than the Kansas average of 34.2 percent. Neosho County was highest at 45.7 percent and Crawford County reported an obesity rate of 36.3 percent.

Figure 42



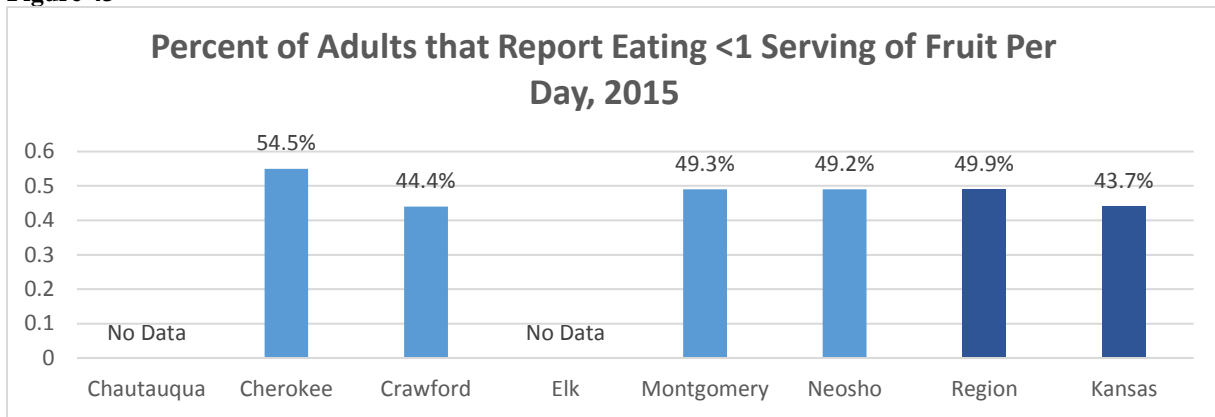
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

²⁰ Centers of Disease Control, <https://www.cdc.gov/obesity/adult/causes.html>

Healthy Foods

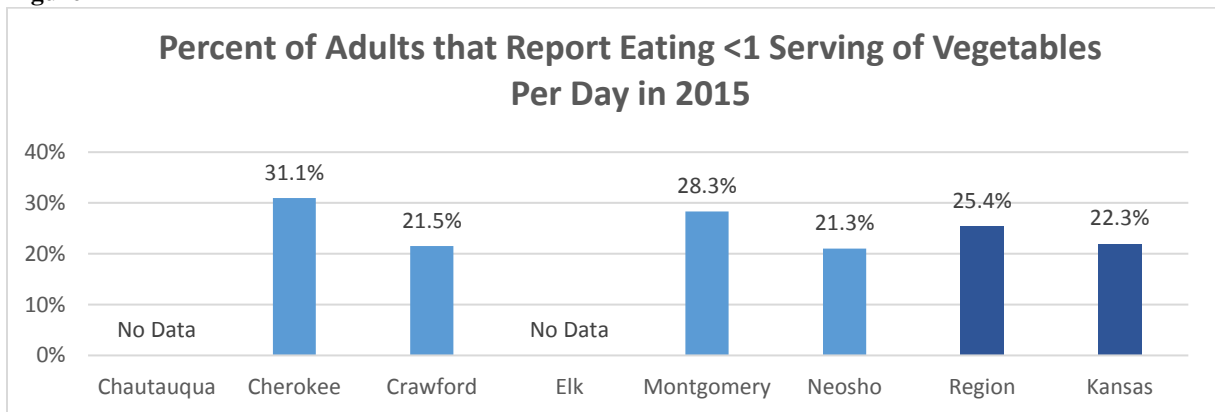
One of the keys to good health is eating a balanced diet. It can prevent chronic disease and help maintain a healthy weight. Studies show that there is a direct link between some forms of cancer and the amount and types of fruits and vegetables consumed.²¹ The U.S. Department of Agriculture recommends that for a standard 2,000 calorie diet one should consume two and one half cups of vegetables and two cups of fruits daily. Although there are significant benefits to following the guidelines, many people still do not eat the recommended servings of fruits and vegetables daily. This is particularly true for people with lower incomes and educational levels, who may be unable to access healthy foods due to actual or perceived higher costs.²² Statewide, 44 percent of the population reports that they eat one serving of fruit or less daily, the rate for the region is slightly higher. Reported vegetable intake for Kansas and the region is better with only 22 percent of the state reporting eating one serving of vegetables or less daily. The region reports a rate for vegetable consumption at 25 percent.

Figure 43



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Figure 44



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

²¹ Lin, J.S., O'Connor, E., Whitlock, E.P., Beil, T.L. (2010). Behavioral Counseling to Promote Physical Activity and a Healthful Diet to Prevent Cardiovascular Disease in Adults: A Systematic Review for the U.S. Preventative Services Task Force. *Annals of Internal Medicine*, 153(11):736-750.

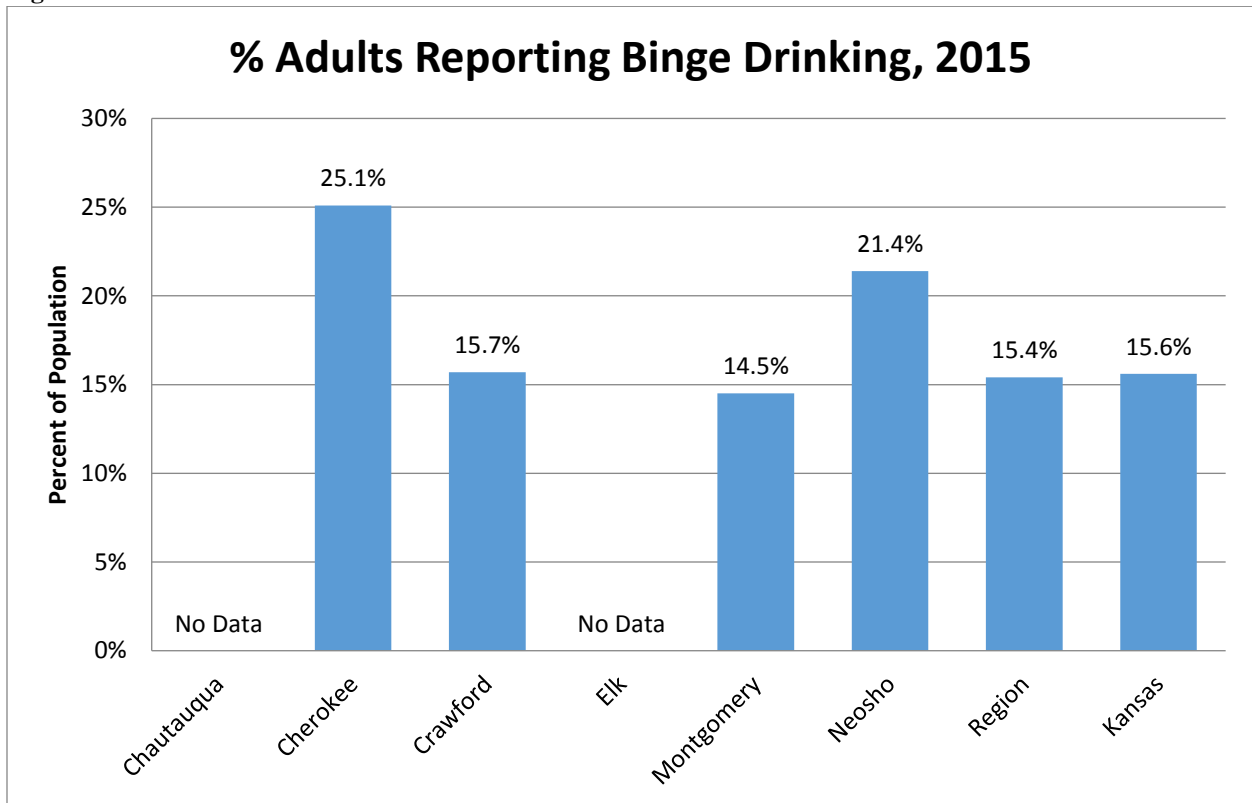
²² Dammann, K.W., and Smith, C. (2009). Factors Affecting Low-income Women's Food Choices and the Perceived Impact of Dietary Intake and Socioeconomic Status on Their Health and Weight. *Journal of Nutrition Education and Behavior*, 41(4):242-253. doi:10.1016/j.jneb.2008.07.003

Binge Drinking

This report displays the number of adults aged 18 years or older who reported binge drinking in the 30 days prior to being surveyed. Binge drinking is defined as having five or more drinks on one occasion for males and four or more drinks on one occasion for females. Binge drinking is associated with increased risk for injury, violence, liver disease, and some forms of cancer.²³ The Healthy People 2020 national target is to reduce the number of adults engaging in binge drinking to 24.3 percent.

Almost all counties reporting in the Lower 8 Region have reached the Healthy People 2020 goal. The exception is Cherokee County which is close at 25 percent. The regional average and the Kansas average were both 15 percent, both well below the national goal.

Figure 45



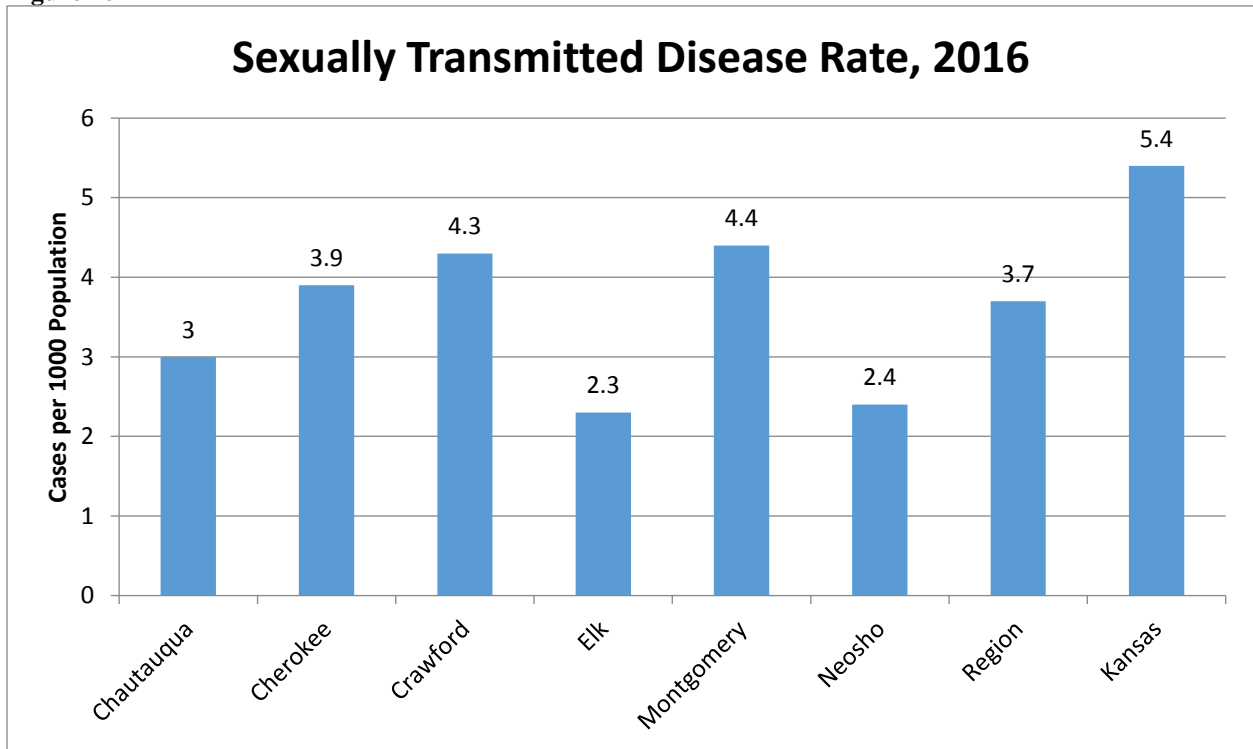
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

²³ Centers for Disease Control, <https://www.cdc.gov/alcohol/index.htm>

Sexually Transmitted Diseases

Sexual transmitted diseases (STDs) including gonorrhea, chlamydia, and syphilis can pose serious health problems when they are untreated, especially in adolescent girls and women. They can also be a significant cause of infertility in women. This indicator considers the number of reported cases per 1,000 people. Because many cases go untreated, these results may only present a fraction of the true numbers. All the counties in the Lower 8 report well below the state average of 5.4 cases per 1,000 people. Montgomery County is the highest at 4.4 and Elk County is the lowest at 2.3 cases per 1,000 people.

Figure 46

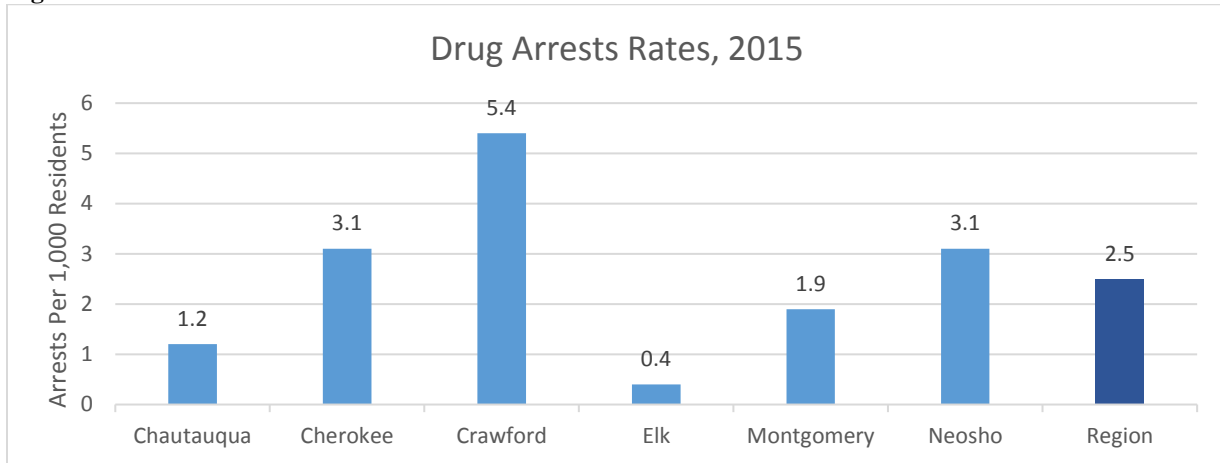


Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Drug Arrests

Substance abuse is another area for concern for a community. Drug arrest rates reflect both substance abuse and law enforcement’s response to the behavior. The Lower 8 Region had 2.5 arrests made per 1,000 residents in 2015. This number is down from the report in 2011 that indicated 3.2 arrests made per 1,000 residents. Crawford County had the largest number of arrests for drugs in 2015 with 213.

Figure 47



Source: Kansas Bureau of Investigation

Table 4

Drug Arrests, 2015	
County	# of Drug Arrests
Chautauqua	4
Cherokee	64
Crawford	213
Elk	1
Montgomery	64
Neosho	51
Region	397

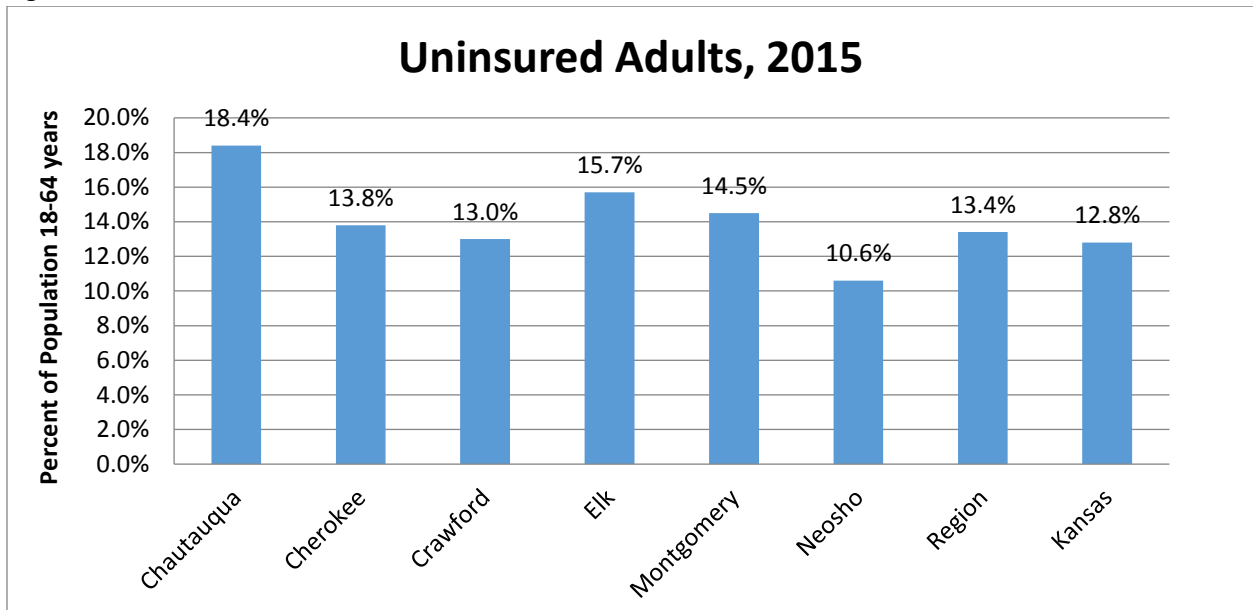
Source: Kansas Bureau of Investigation

Access to Care

Uninsured Adults

This indicator demonstrates the estimated number of adults aged 18-64 who do not have any form of health insurance. Lack of health insurance can cause extreme financial hardship and may result in the individual not seeking the medical care that they may need. Across the Lower 8 Region, un-insurance rates are higher than the state average with the exception of Neosho County which has a rate lower than the Kansas average at 10.6 percent.

Figure 48

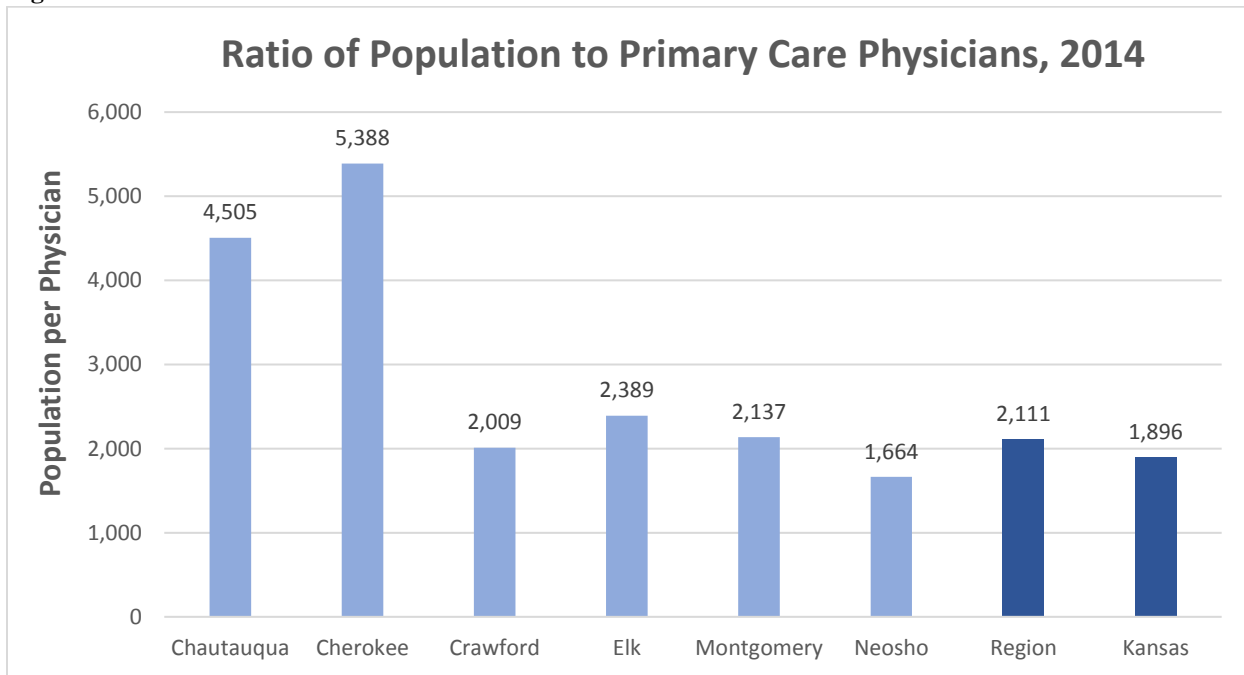


Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Access to a Primary Care Physician

Primary care physicians are vital to good preventative care. They help patients coordinate their care and can assist in decreasing hospitalizations.²⁴ When individuals lack access to a primary care physician, their health and wellness may be affected. Most of the counties in the Lower 8 Region have primary care physician ratios close to the state average. The exceptions are Cherokee County with 5,388 people per physician and Chautauqua County with 4,505 people per physician.

Figure 49



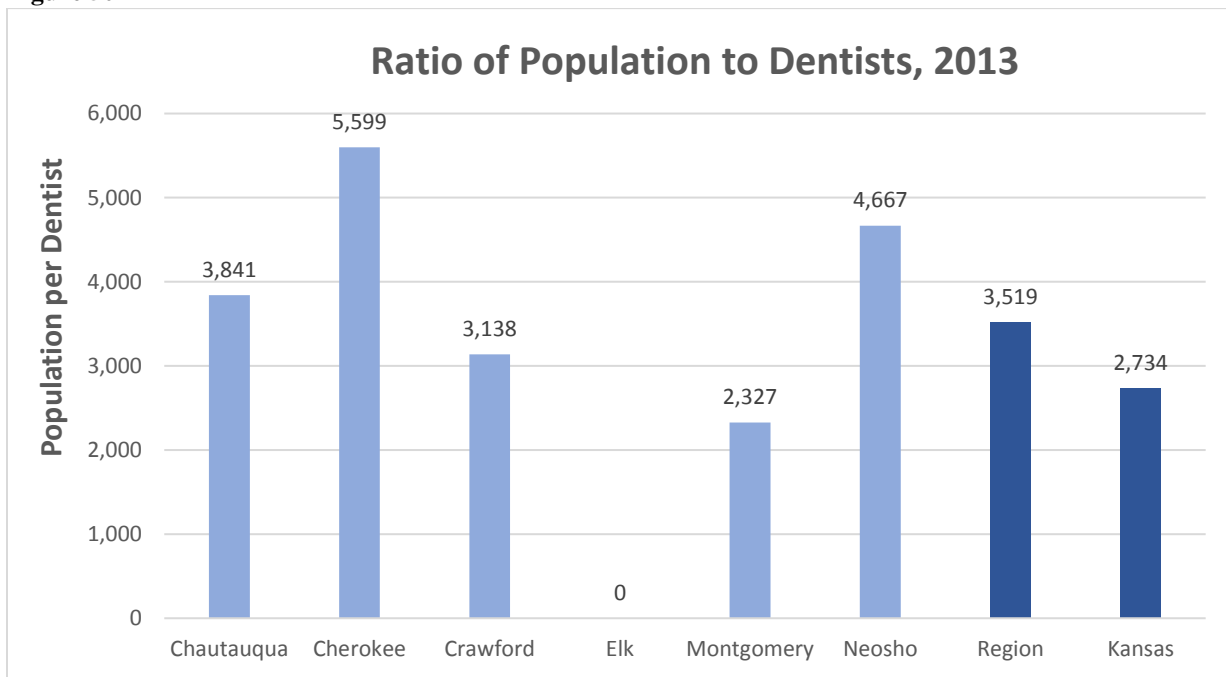
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

²⁴ Kansas Health Matters, www.kansashealthmatters.org

Dental Access

Dental health affects an individual’s medical health and can cause significant issues when left untreated. It is estimated that one third of adults in the United States have untreated tooth decay. Tooth decay is the most prevalent chronic infectious disease in children. It is estimated that up to one half of children between the ages of 12-15 have tooth decay. When communities lack access to dental care it can be difficult for them to maintain good dental health. This indicator shows the availability of a dentist for every 1,000 people. Most of the counties in the Lower 8 Region have less access to dental care than the Kansas average, the exception is Montgomery County with 2,327 people per dentist.

Figure 50



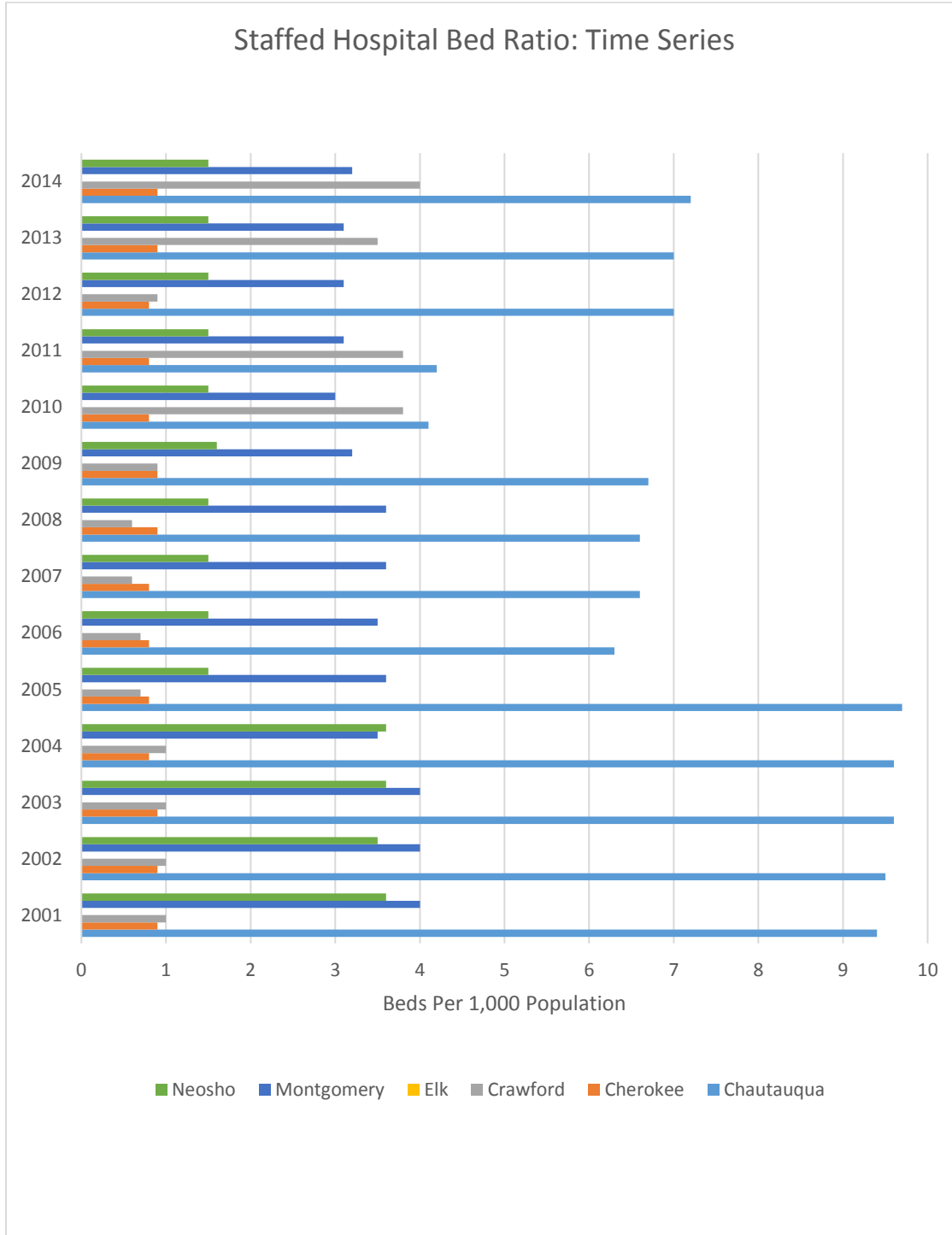
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

²⁵ Kansas Health Matters, www.kansashealthmatters.org

Staffed Hospital Bed Ratio

This indicator shows the number of available staffed hospital beds. As the American population continues to age, this indicator will become more important to communities nationwide. It is important to review these findings cautiously as some counties have a small sample size.

Figure 51



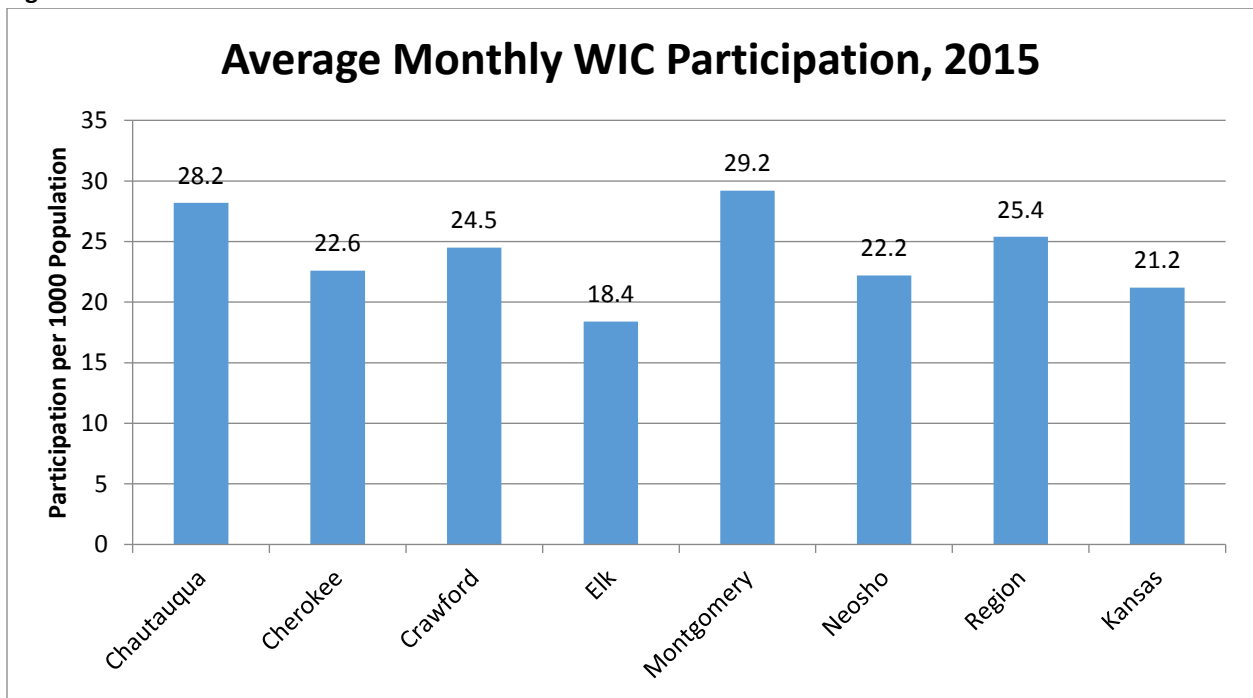
Source: U.S. Census Bureau, American Community Survey, 2011-2015

WIC Participation

Women, Infants, and Children (WIC) is a supplemental nutrition program that provides nutrition education and assistance with purchasing specific food items to low-income pregnant women, lactating mothers, infants, and children up to five years old. Households may qualify for assistance if their income is 185 percent of the federal poverty level or less.

The Kansas Health Matters data system calculates WIC participation rates by averaging the number of women and children participating monthly divided by the total population in thousands. Results may be skewed since these rates are calculated based on total population and not the population who would be eligible to participate in the WIC program.

Figure 52



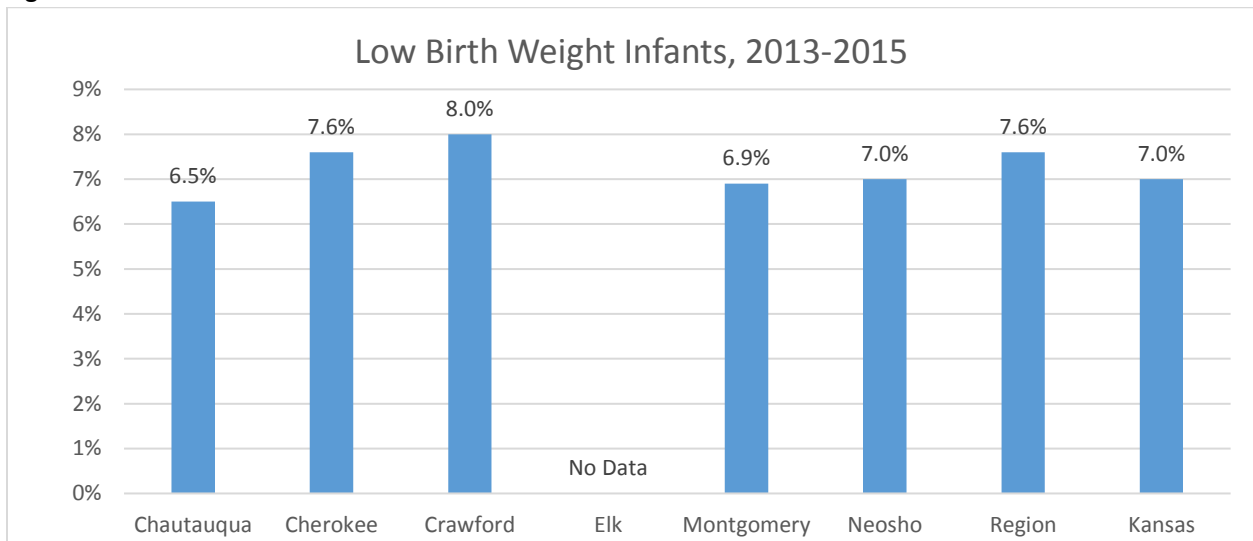
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

9. Maternal and Child Health

Low Birth Weight Infants

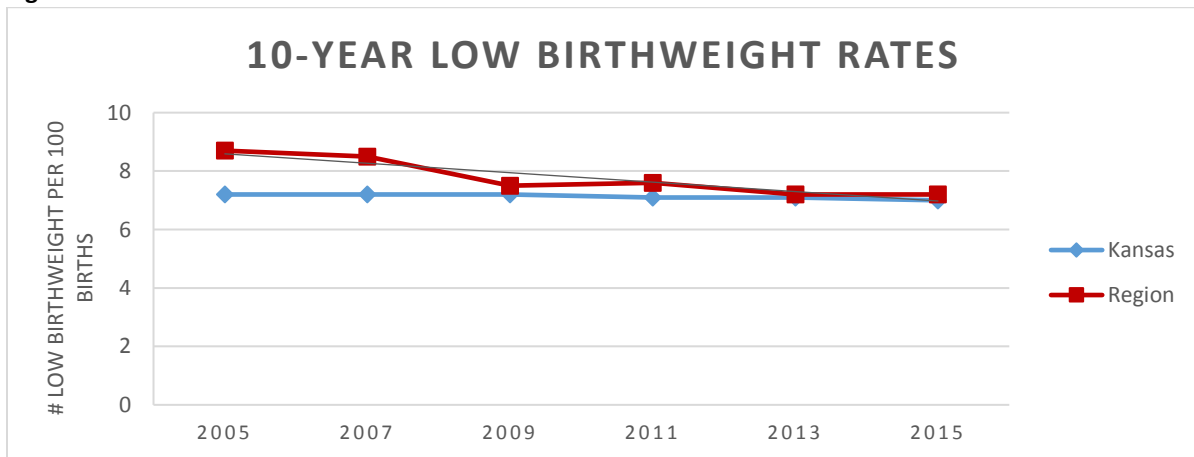
Infants weighing 2,500 grams (5 pounds, 8 ounces) or less when born are considered “low birth weight” babies. These infants are at greater risk to require more specialized medical care and are more prone to long-term disabilities and infant death.²⁶ Chautauqua County and Montgomery County display lower averages than the Kansas average. Crawford County reports the highest number with 8 low birth weight infants per 100 live births. Due to the low number of births in some counties year to year comparisons should be interpreted cautiously. The ten year trend of the region may provide more accurate information. Overall, the region has seen a significant decrease in low birth weights over the ten year period.

Figure 53



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Figure 54



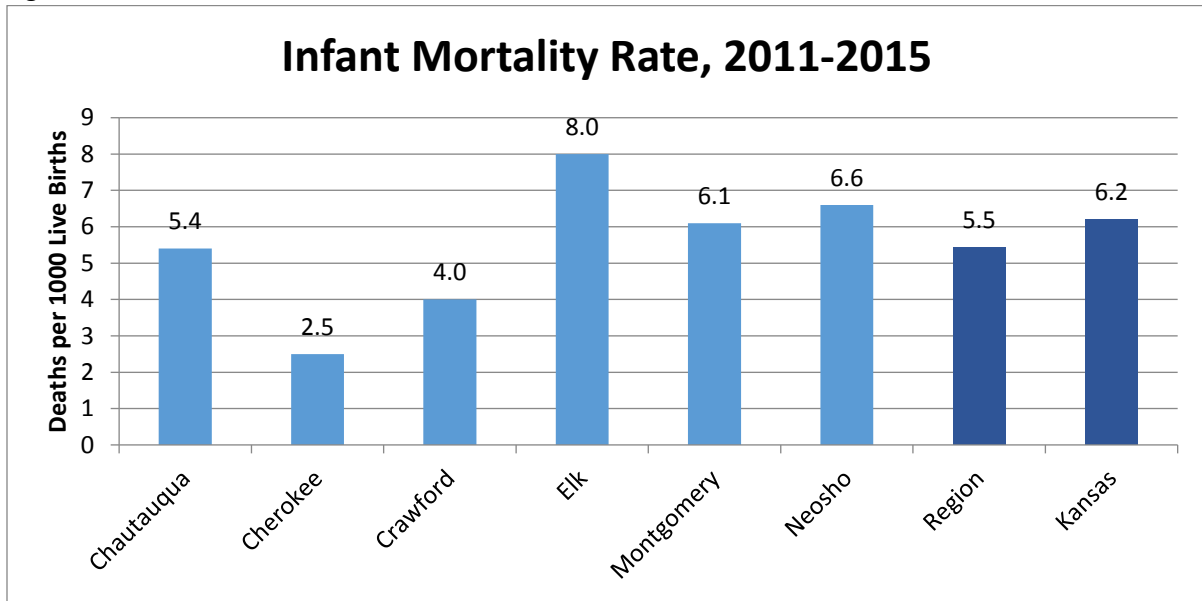
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

²⁶ Centers for Disease Control, <https://www.cdc.gov/nchs/fastats/birthweight.htm>

Infant Mortality Rates

Infant mortality is defined as death that occurs prior to one year of age. The infant mortality rate is the number of infant deaths per 1,000 live births. The leading causes of death for infants include birth defects, pre-term birth, sudden infant death syndrome (SIDS), maternal complications during pregnancy, and injuries. Infant mortality rates are often accurate indicators of the health and well-being of the general population.²⁷ Regional results are slightly lower than state results for 2011-2015. Individual county rates should be interpreted with caution due to the small sample size.

Figure 55



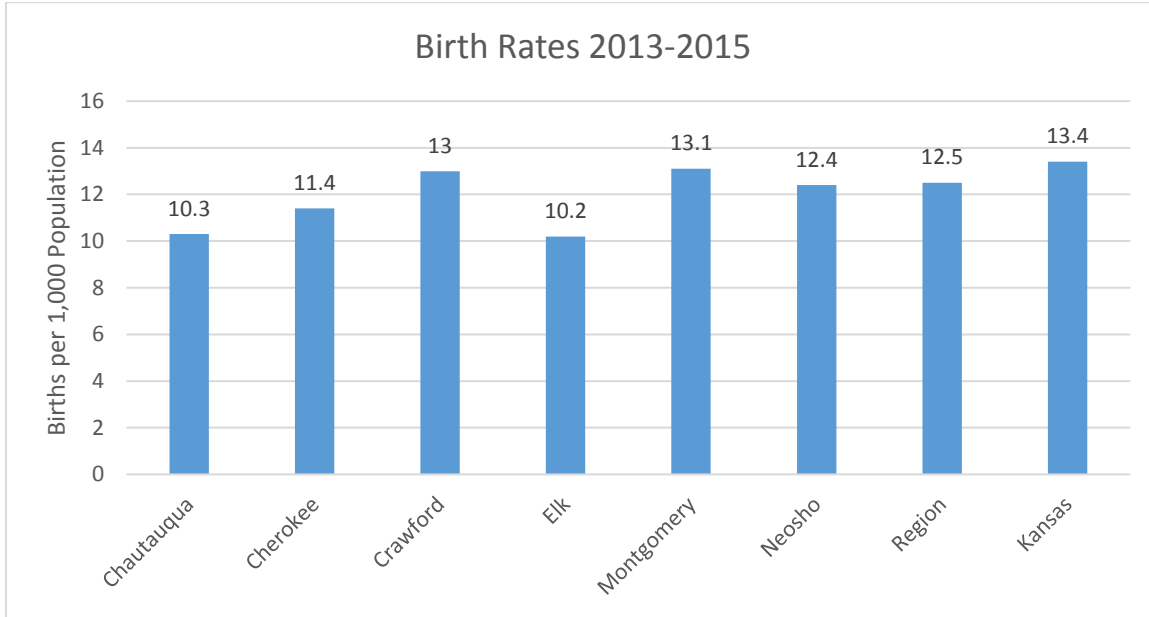
Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

²⁷ Centers for Disease Control, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

Birth Rates

Birth rates can be an indicator of population growth. The birth rate for the Lower 8 Region was 12.5 births per 1,000 people which is less than the Kansas average of 13.4. Elk County and Chautauqua County displayed the lowest rates while Crawford County and Montgomery County had the highest.

Figure 56

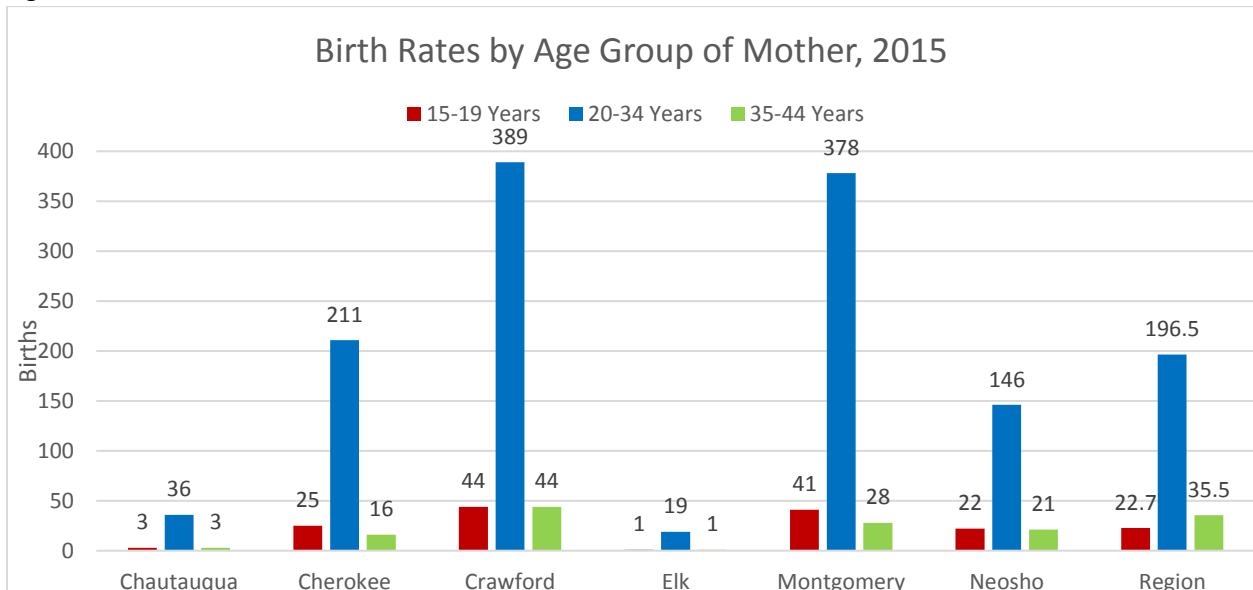


Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Birth Rates by Maternal Age

The 20-34 year maternal age group displays the majority of births in the region and in each county. The age of the mother can be an indicator of increased stressors. Pregnancies in the 15-19 year old age group can cause social and economic costs for the individual, family and community. Birth rates in this age group have been declining nationwide over the last several years.²⁸ This trend is also occurring in the Lower 8 Region.

Figure 57



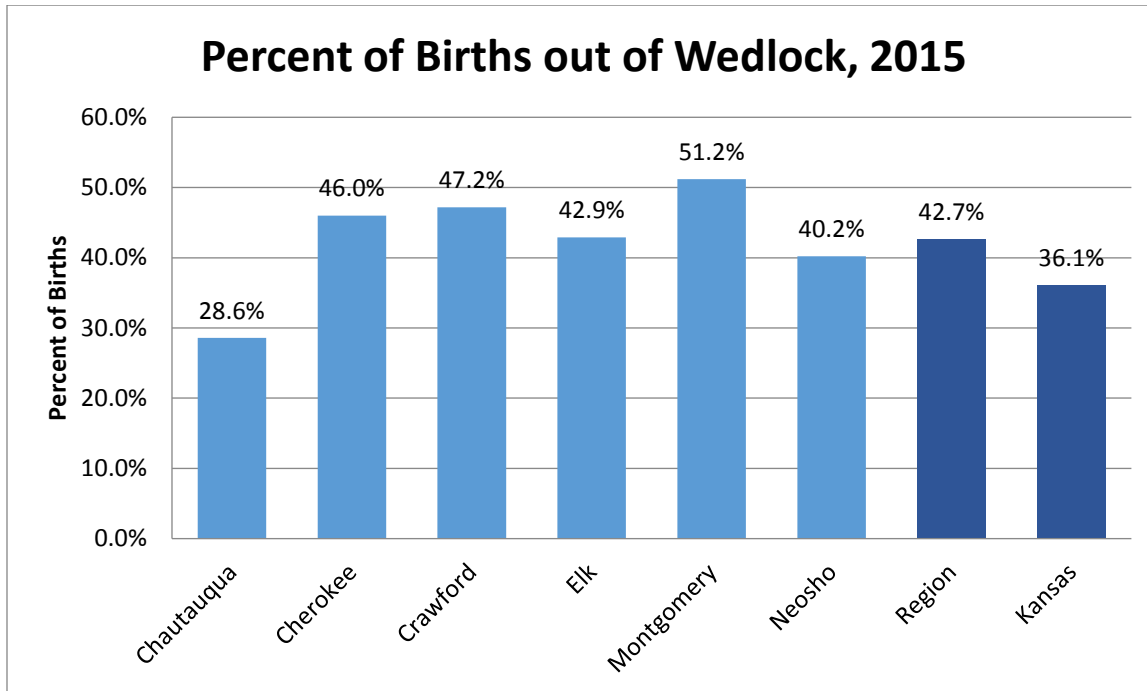
Source: Kansas Department of Health and Environment, Annual Summary of Vital Statistics, 2015

²⁸ Centers for Disease Control, <https://www.cdc.gov/teenpregnancy/about/index.htm>

Births to Unmarried Women

This indicator is used to measure potential social and economic stressors. Pregnancies in unmarried women may or may not be planned. Unplanned pregnancies are associated with more negative outcomes including higher risk of economic hardships. The percentage of births out of wedlock in the region in 2015 was higher than the state average. Individual county results should be interpreted with caution due to small population in some areas.

Figure 58



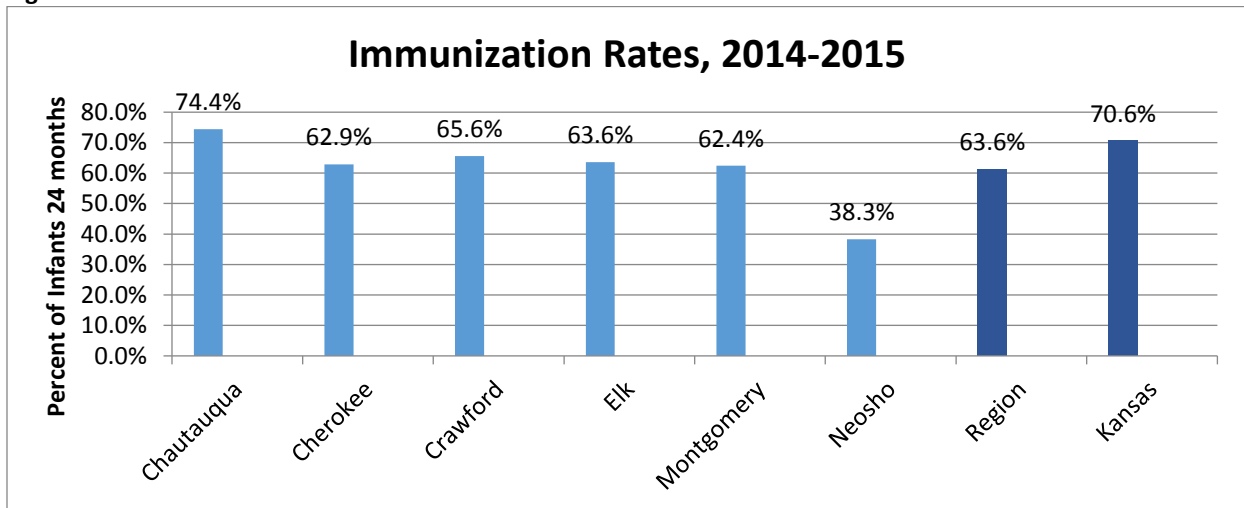
Source: Kansas Department of Health and Environment, Kansas Annual Summary of Vital Statistics, 2015

Immunization Rates

Vaccinations are important to the health of a community. Not only do they protect the individual receiving the vaccine, they provide protection to those who may not have the ability to be vaccinated due to age or immune status. Vaccinations can also protect future generations by reducing or eliminating diseases.²⁹ Nationwide there has been an increase in under vaccinated or unvaccinated individuals. There has also been an increase in illnesses like measles, mumps, and pertussis.

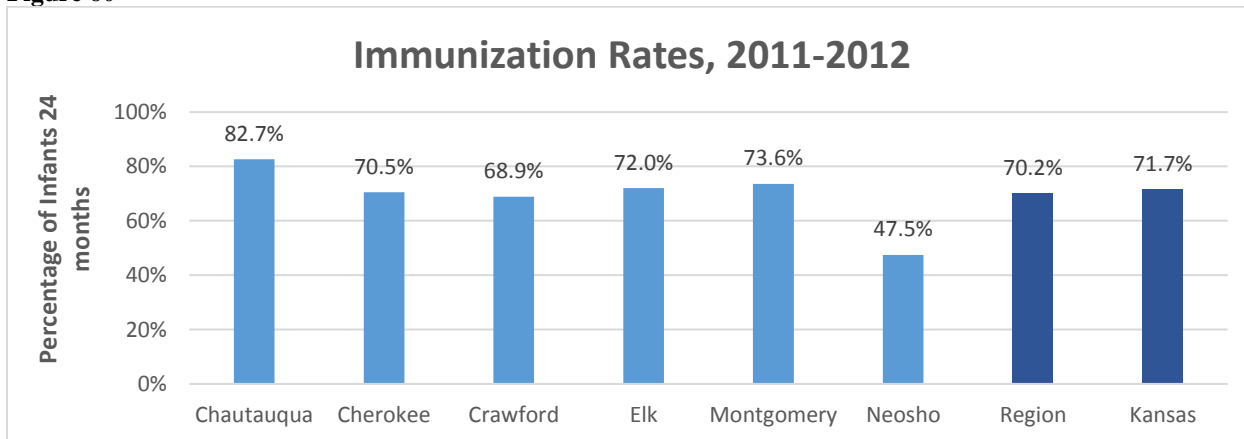
Immunization rates are based on the percentage of infants fully immunized by 24 months. The only county in the Lower 8 Region that had a higher immunization rate than the Kansas average (70.6 percent) was Chautauqua County with an immunization rate of 74.4 percent. Neosho County had the lowest immunization rate at 38.3 percent. The 2011-2012 results are included to show the universal decline in immunizations in the region.

Figure 59



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

Figure 60



Source: Kansas Health Matters, www.kansashealthmatters.org, 2017

²⁹ Vaccines.gov, https://www.vaccines.gov/more_info/features/five-important-reasons-to-vaccinate-your-child.html

Sources:

- ¹National Center for Law and Economic Justice, <http://nclej.org/snapshot/poverty-in-the-united-states>
- ²Hoehner, C.M., Barlow, C.E., Allen, P., and Schootman, M. (2012). Commuting distance, cardiorespiratory fitness, and metabolic risk. *American Journal of Preventative Medicine*.
- ³United States Department of Labor, Bureau of Labor Statistics, http://www.bls.gov/emp/ep_chart_001.htm
- ⁴Centers for Disease Control, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/tobacco_related_mortality/index.htm
- ⁵Centers for Disease Control, <https://www.cdc.gov/ViolencePrevention/index.html>
- ⁶Centers for Disease Control, <https://www.cdc.gov/motorvehiclesafety/pdf/statecosts/ks-2015costofcrashdeaths-a.pdf>
- ⁷Centers for Disease Control, <https://www.cdc.gov/nchs/fastats/accidental-injury.htm>
- ⁸Kansas Health Matters, www.kansashealthmatters.org
- ⁹Centers for Disease Control, <https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>
- ¹⁰American Cancer Society, <https://www.cancer.org/cancer/cancer-basics>
- ¹¹Arthritis Foundation, <http://www.arthritis.org/about-arthritis/understanding-arthritis/arthritis-statistics-facts.php>
- ¹²Centers for Disease Control, <https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/diabetes-aag.pdf>
- ¹³Centers for Disease Control, <https://www.cdc.gov/asthma/asthmadata.htm>
- ¹⁴Centers for Disease Control, https://www.cdc.gov/dhdsp/data_statistics/fact_sheets/fs_heart_disease.htm
- ¹⁵Centers for Disease Control, <https://www.cdc.gov/pneumonia/>
- ¹⁶Centers for Disease Control, <https://www.cdc.gov/copd/index.html>
- ¹⁷Kansas Health Matters, www.kansashealthmatters.org
- ¹⁸Centers for Disease Control, https://www.cdc.gov/tobacco/basic_information/healthy_people/index.htm
- ¹⁹Centers for Disease Control, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/health_effects/index.htm
- ²⁰Centers of Disease Control, <https://www.cdc.gov/obesity/adult/causes.html>
- ²¹Lin, J.S., O'Connor, E., Whitlock, E.P., Beil, T.L. (2010). Behavioral Counseling to Promote Physical Activity and a Healthful Diet to Prevent Cardiovascular Disease in Adults: A Systematic Review for the U.S. Preventative Services Task Force. *Annals of Internal Medicine*, 153(11):736-750.
- ²²Dammann, K.W., and Smith, C. (2009). Factors Affecting Low-income Women's Food Choices and the Perceived Impact of Dietary Intake and Socioeconomic Status on Their Health and Weight. *Journal of Nutrition Education and Behavior*, 41(4):242-253. doi:10.1016/j.jneb.2008.07.003
- ²³Centers for Disease Control, <https://www.cdc.gov/alcohol/index.htm>
- ²⁴Kansas Health Matters, www.kansashealthmatters.org

²⁵ Kansas Health Matters, www.kansashealthmatters.org

²⁶ Centers for Disease Control, <https://www.cdc.gov/nchs/fastats/birthweight.htm>

²⁷ Centers for Disease Control, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm>

²⁸ Centers for Disease Control, <https://www.cdc.gov/teenpregnancy/about/index.htm>

²⁹ Vaccines.gov, https://www.vaccines.gov/more_info/features/five-important-reasons-to-vaccinate-your-child.html

Appendix E

Health Committee of Southeast Kansas Community Survey Analysis and Findings

Southeast
Kansas
Community
Health
Assessment

2016

Results of a survey conducted in fall 2016 by county health departments concerning the health needs and concerns facing residents of six southeast Kansas counties (Chautauqua, Cherokee, Crawford, Elk, Montgomery, and Neosho)



Prepared by the Research and Evaluation Department
at the Southeast Kansas Education Service Center – Greenbush

Southeast Kansas Community Health Assessment: Regional Overview

Introduction

During the fall of 2016, a coalition of county health departments contracted with the Southeast Kansas Education Service Center to administer a survey of Chautauqua, Cherokee, Crawford, Elk, Montgomery, and Neosho County residents. The survey asked respondents about a wide variety of health needs and challenges. The survey was available in both English and Spanish and in scannable paper and electronic formats. The following report is based on the responses of the 1,608 respondents.

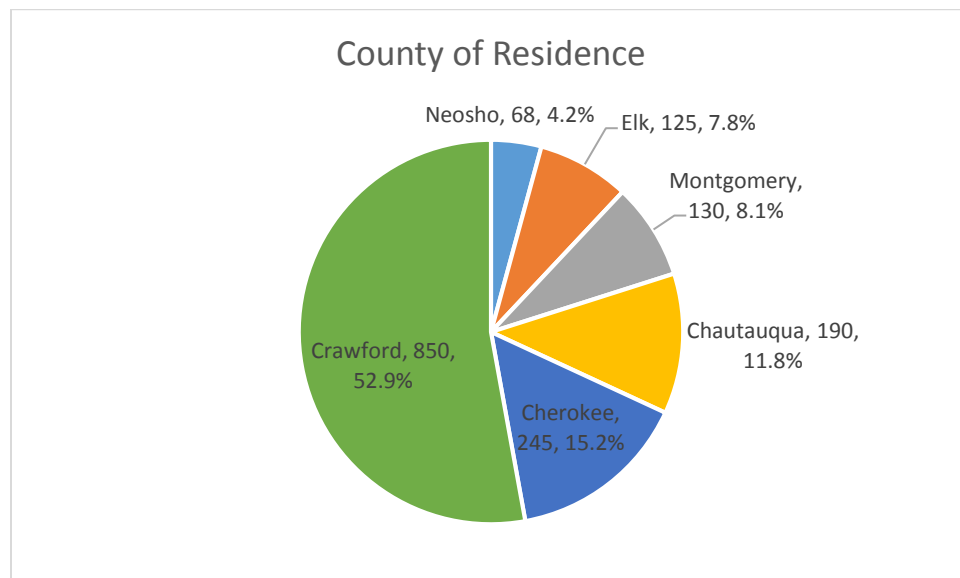
The survey consisted of four sets of questions. Respondents were first asked to rate the overall health of their community and to indicate whether they feel their community has various features that contribute to healthy living. Then they were asked to indicate whether a wide range of health and wellness factors had been a concern for them or someone in their household within the past year. Next, respondents were directed to select from a list their top three most important factors for a healthy community, health problems in their community, and risky behaviors in their community. Following some demographics questions, respondents answered a final set of questions asking whether they needed (and whether they received) medical, dental, mental health, substance use, or prenatal care.

Results summary

- **Demographics**
 - More than half of all respondents were Crawford County residents, and more than three-fourths were female.
- **Factors contributing to healthy communities**
 - Most respondents agreed it is easy to find healthy foods such as whole-grain and low-fat products in their communities.
 - Less desirable responses were seen in response to statements about pedestrian and bicyclist safety.
- **Awareness of health initiatives**
 - Most respondents indicated they were not aware of smoking cessation efforts in their communities, and most were not aware of the Pathways to a Healthy Kansas initiative.
- **Health and well-being concerns**
 - Nearly one-third of respondents said “Health insurance” was a major concern for them or someone in their household within the past year. “Drug/alcohol abuse prevention/education” was also a “major concern” for many respondents.
- **Most important factors for a healthy community**
 - “Good jobs and healthy economy” was chosen by nearly half of all respondents as one of their top three most important factors for a healthy community. “Good schools” and “Low crime/safe neighborhoods” were also chosen by many respondents.

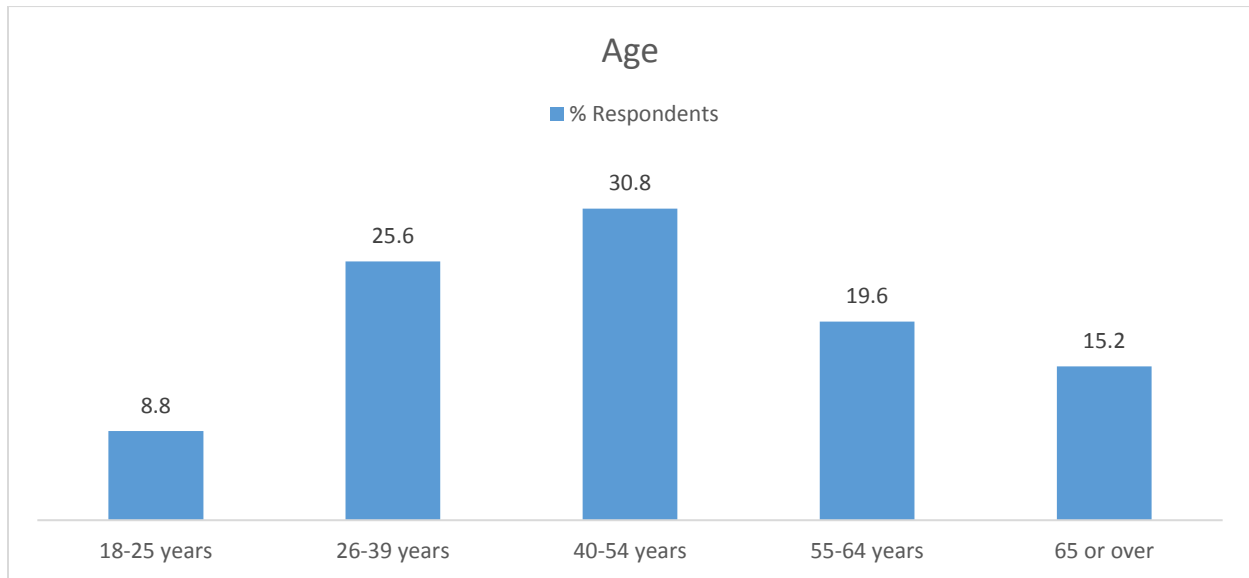
- **Most important health problems**
 - “Mental health problems” and “Cancers” were each chosen by more than 40% of respondents as one of the three most important health problems in their communities.
 - A substantial portion of respondents chose the “Other” option, and many of their written answers referenced drug and/or alcohol use.
- **Most important risky behaviors**
 - Most respondents chose “Drug abuse” as one of the three most important risky behaviors in their communities, and more than half chose “Alcohol abuse.” “Being overweight” – along with “Poor eating habits” and “Lack of exercise,” which are related – was also chosen by many respondents.
- **Need for care**
 - 95.2% of those who said they needed medical care in 2015 said they were able to access treatment.
 - Of the 81.5% of respondents who said they needed dental care in 2015, 11.4% said they did not receive it.
 - Nearly one in five respondents said they needed mental health care in 2015. Of those, nearly one-fourth said they did not receive it.
 - While few respondents said they needed treatment for substance abuse care, the majority of those indicating they did need treatment said they did not receive it.

Demographics

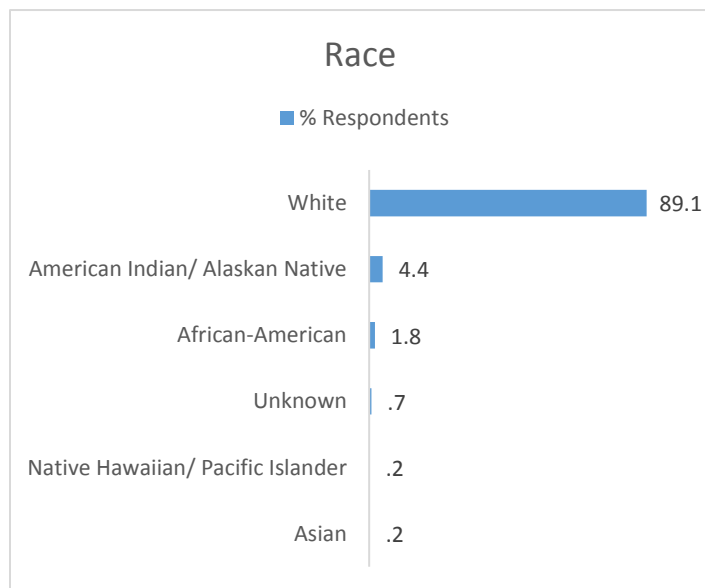
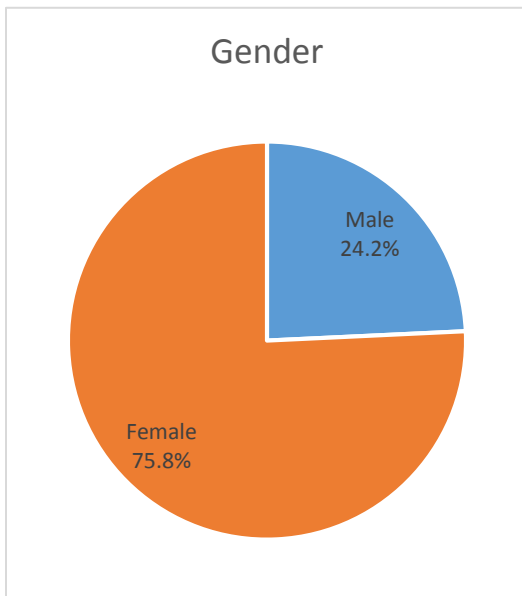


The chart above shows the distribution of responses by county. The three counties with the most responses were Crawford with 850 respondents (52.9%), Cherokee with 245 (15.2%) and Chautauqua with 190 (11.8%). Neosho County had the fewest respondents (68, or 4.2% of the total). Note that the survey was not administered in Montgomery or Leflore County. As the large number of responses from

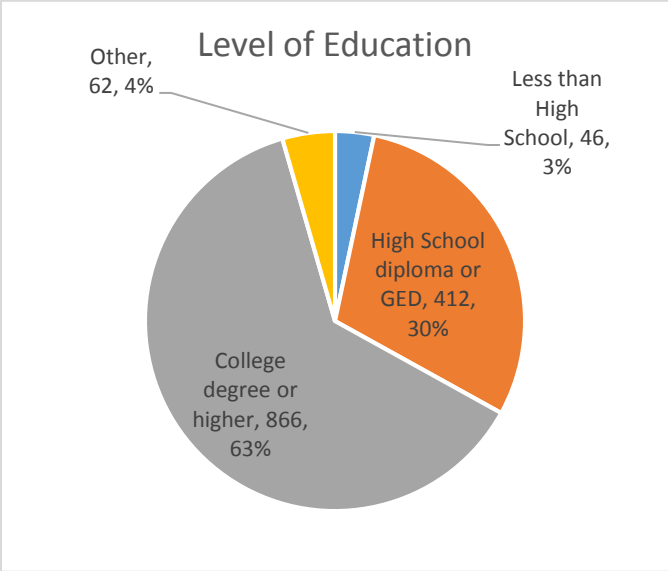
Crawford County might skew the overall data, it is advised to also examine each county's data separately.



The chart above shows the age ranges of those that completed the survey. The largest percentage of respondents fell in the 40-54 category (30.8%), followed by the 26-39 category (25.6%). The smallest percentage of respondents fell into the 18-25 category (8.8%). The survey was not administered to anyone under the age of 18.

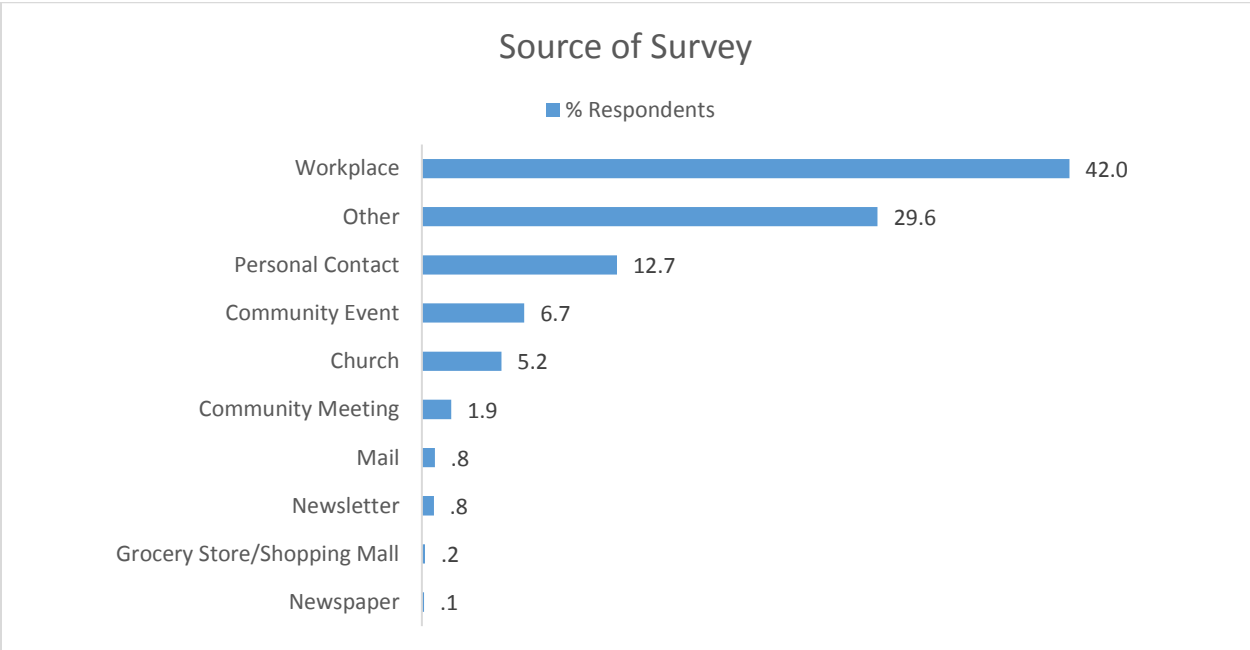


Most respondents said they were female (75.8%), and most identified as White (89.1%). About 3.5% of respondents said they were Hispanic.



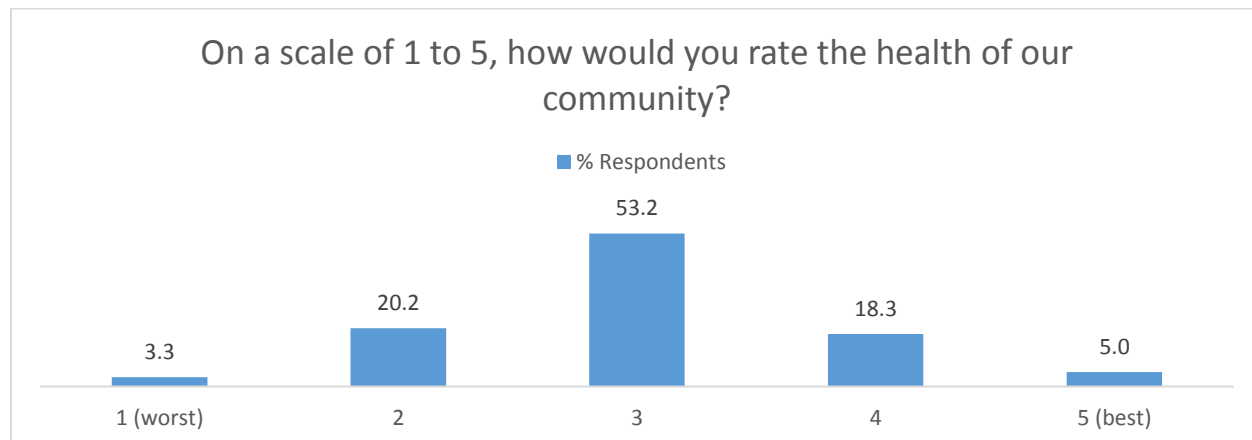
Most respondents said they had obtained a college degree or higher (see chart at left). Note that 222 respondents (13.8% of the total number) did not indicate their level of education.

As shown below, the largest portion of respondents (42.0%) said they received the survey at their workplace. The second-largest portion chose the “Other” option (29.6%). A write-in area was provided for respondents to describe the other survey source. While responses varied, many respondents indicated they received the survey at a clinic, hospital, or county health department.



Detailed results

Overall health



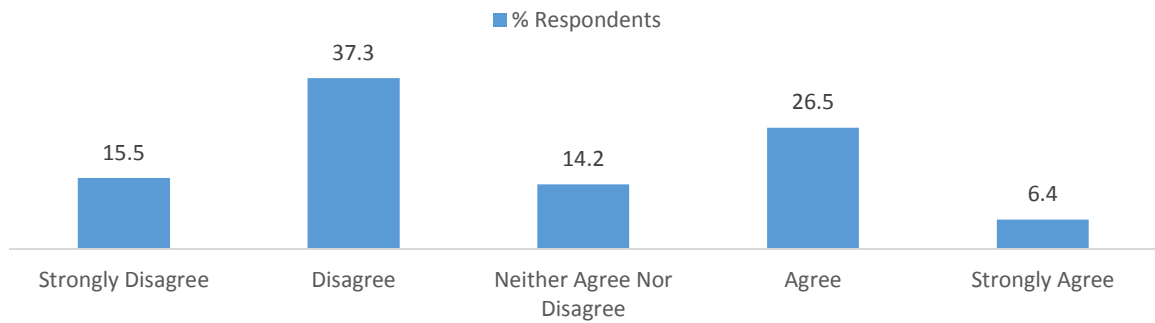
When asked to rate their community's overall health on a scale of 1 to 5 with 1 being the worst and 5 being the best, the largest portion of respondents (53.2%) chose 3, indicating they don't feel the community's health is especially good or bad. The remainder of the respondents were almost evenly split between higher and lower ratings. In total, 23.3% rated their community's health as a 4 or 5, and 23.5% rated their community's health as a 1 or 2. The mean (average) score was 3.02.

Factors contributing to healthy communities

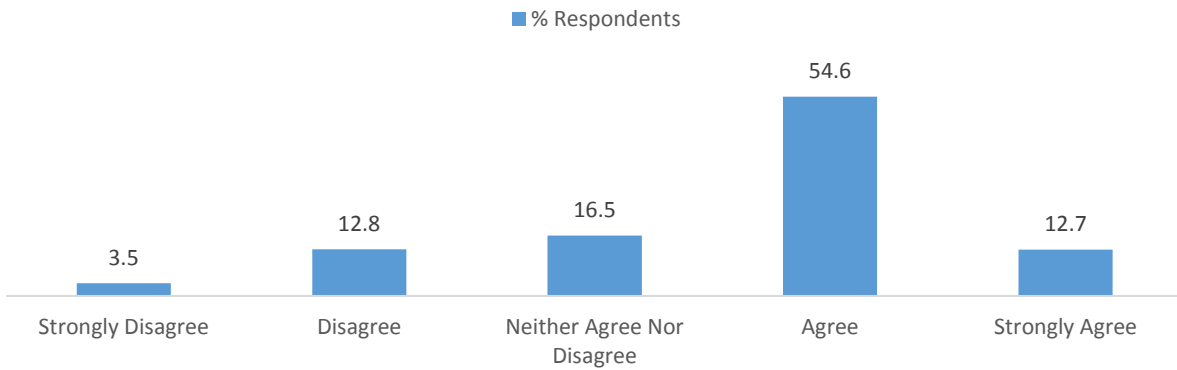
Data highlights

- More than 70% of respondents said they "Agree" or "Strongly Agree" that it is easy to find whole-grain products in their community, and more than 65% said they agreed it is easy to find low-fat products in their community
- Most respondents (67.2%) said they "Agree" or "Strongly Agree" their community has a sufficient number of parks/playgrounds.
- Two statements related to pedestrian and bicyclist safety drew the least favorable responses. One-third of respondents (33.0%) said they "Agree" or "Strongly Agree" their community has a sufficient number of sidewalks or bike/walk paths, and less than one-fourth (22.9%) said they agreed their community has adequate street lighting for walking at night.

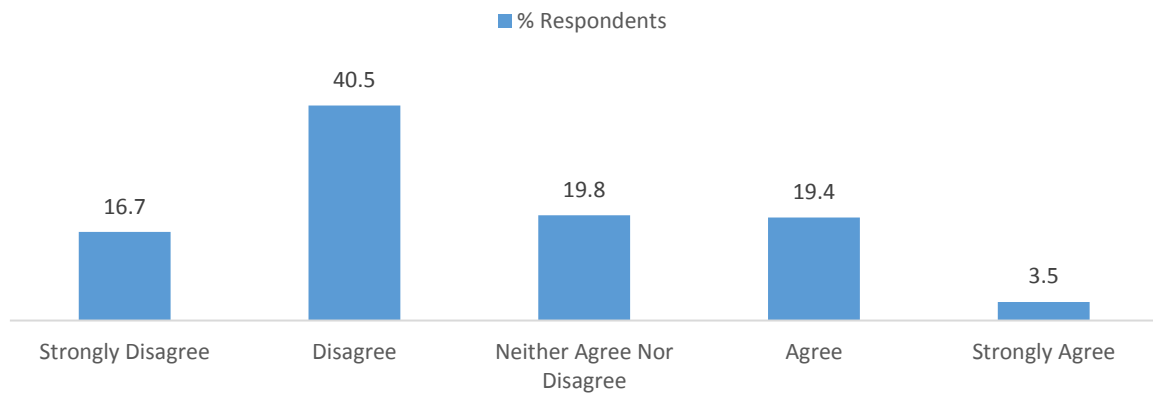
My community has a sufficient number of sidewalks or bike/walk paths.



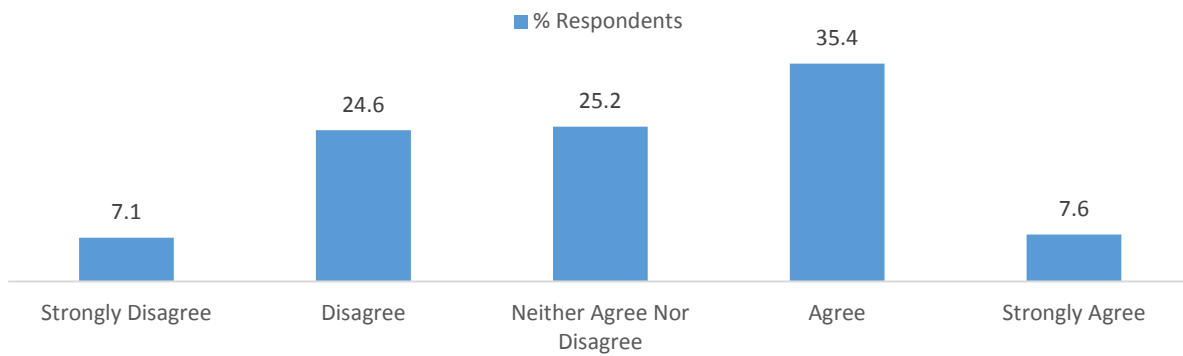
My community has a sufficient number of parks/playgrounds.



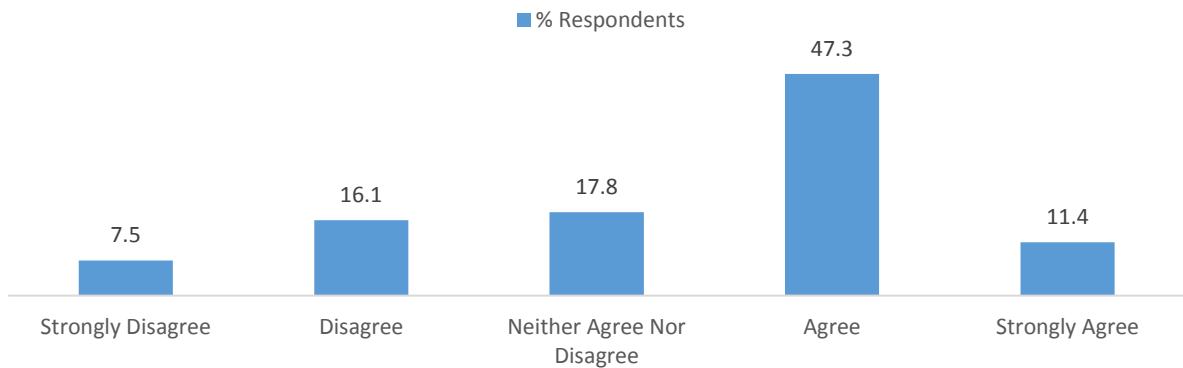
For walking at night, my community has adequate street lighting.



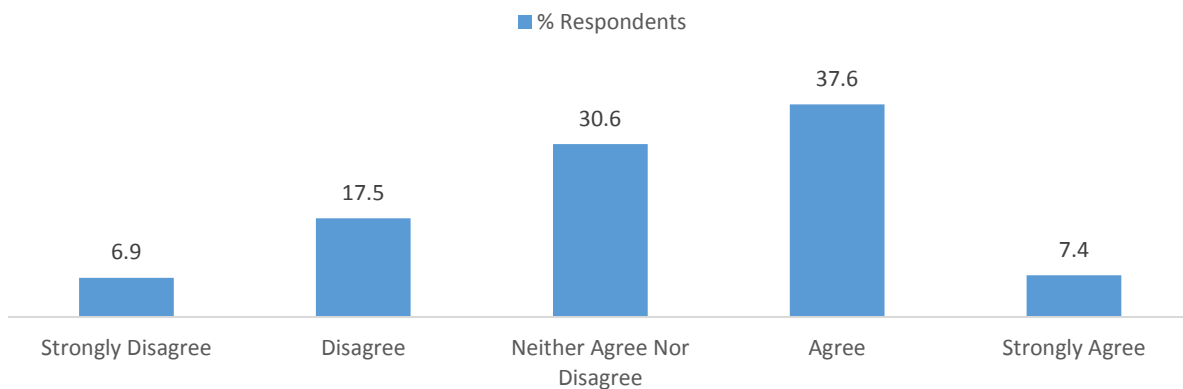
In general, my community has sufficient opportunities for physical activity.



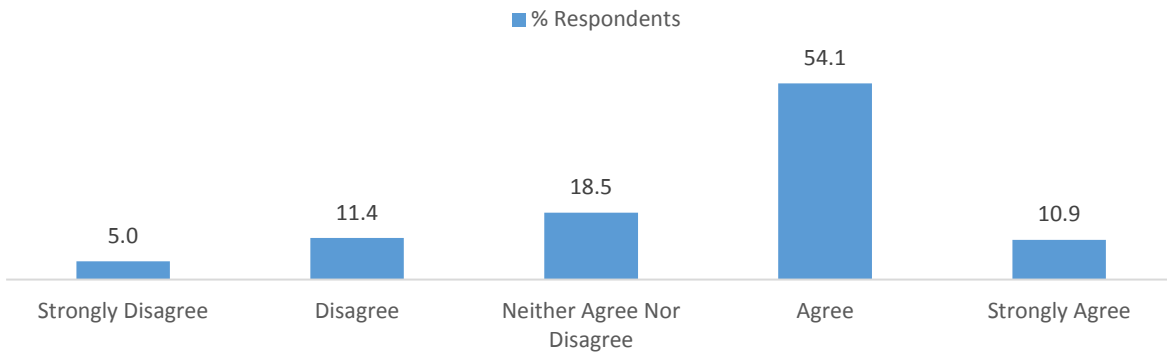
It is easy to find fresh fruits and vegetables in my community.



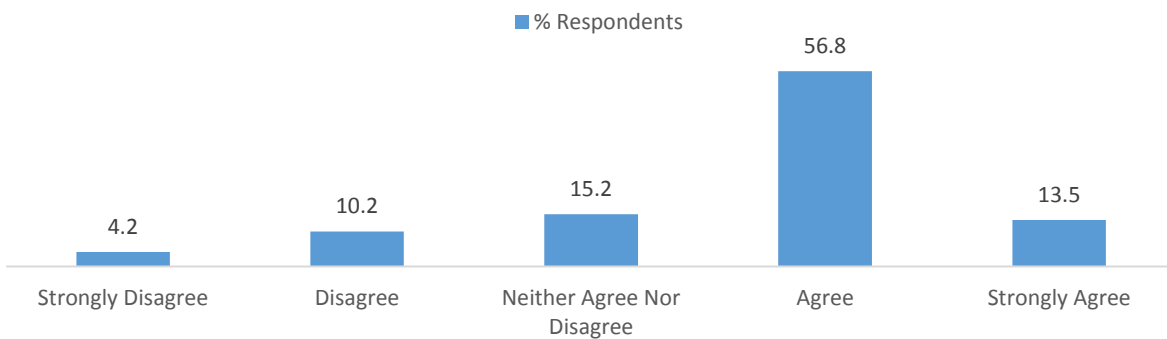
The fresh produce in my community is of high quality.



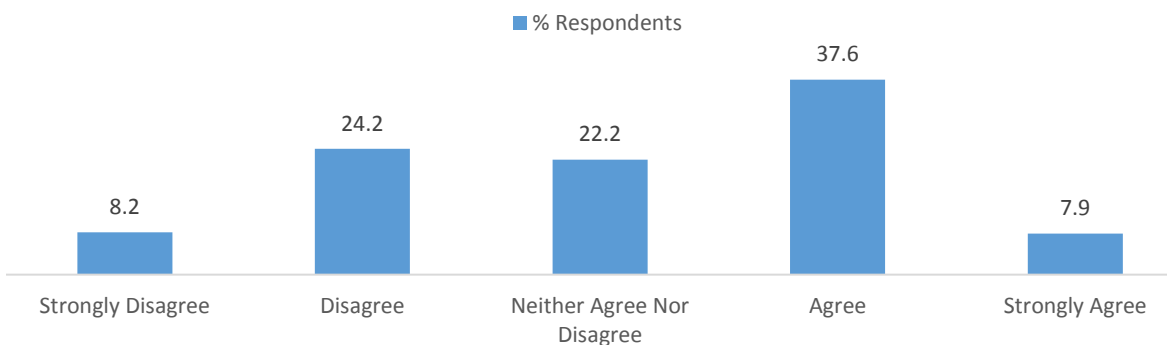
It is easy to find low-fat products, such as low-fat milk or lean meats, in my community.



It is easy to find whole-grain products, such as breads, cereals, pasta and snacks, in my community.



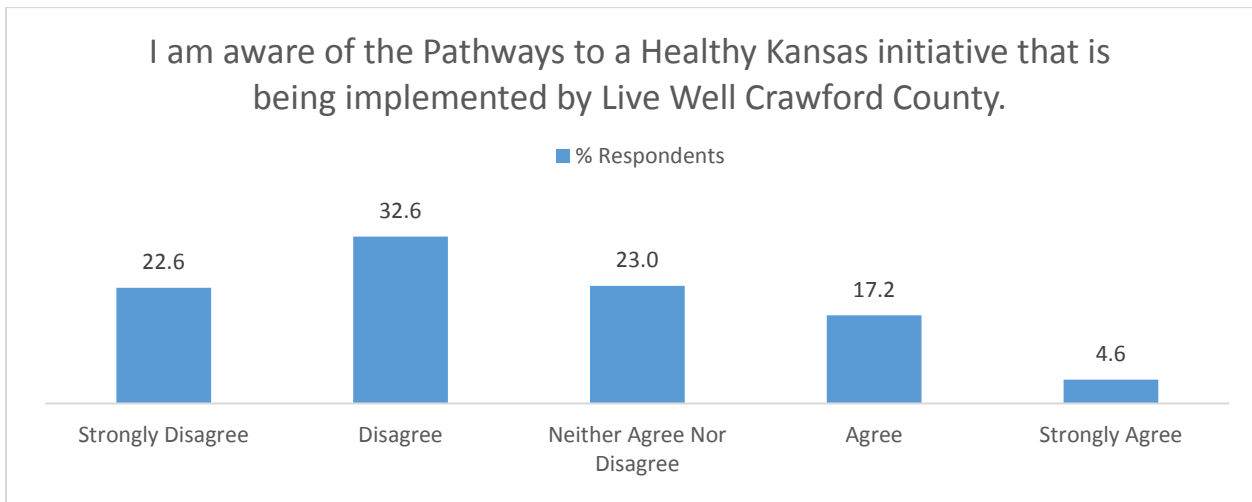
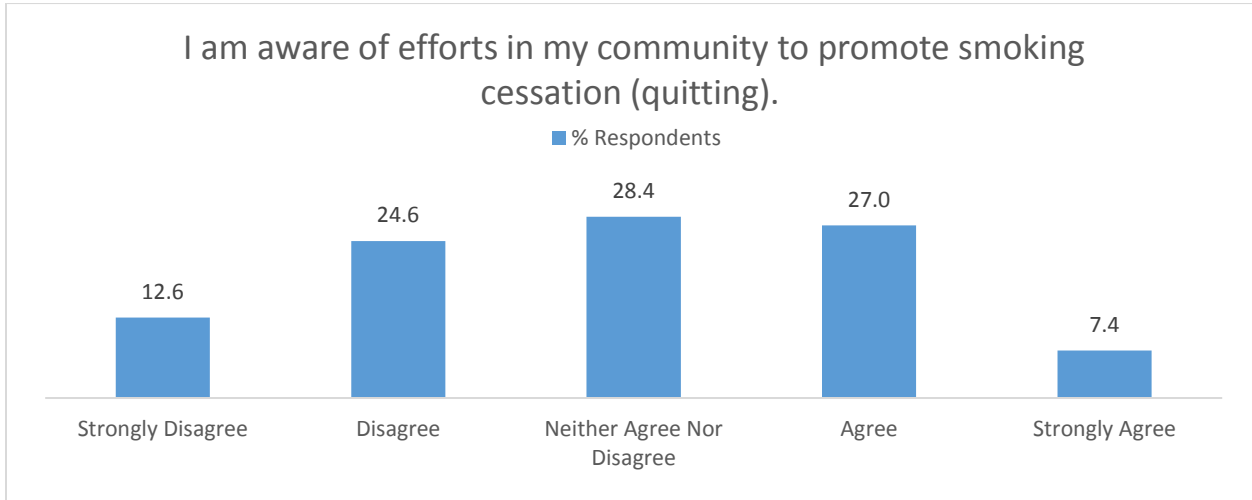
In general, my community has sufficient options for healthy eating.



Awareness of health initiatives

Data highlights

- Just over one-third of respondents (34.5%) said they “Agree” or “Strongly Agree” they are aware of efforts in their communities to promote smoking cessation.
- Less than one-fourth of respondents (21.9%) said they “Agree” or “Strongly Agree” they are aware of the Pathways to a Healthy Kansas initiative.

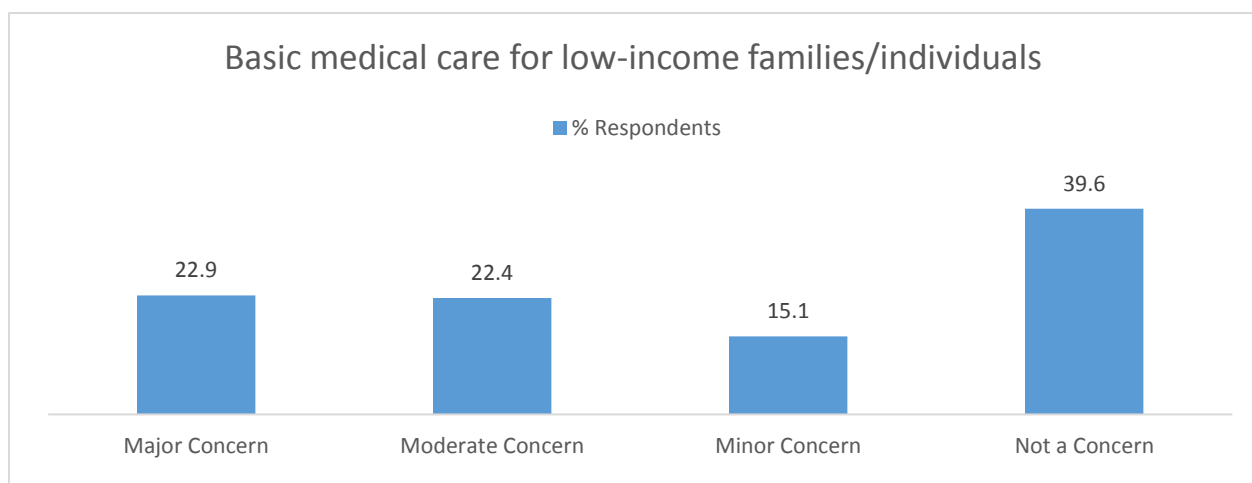
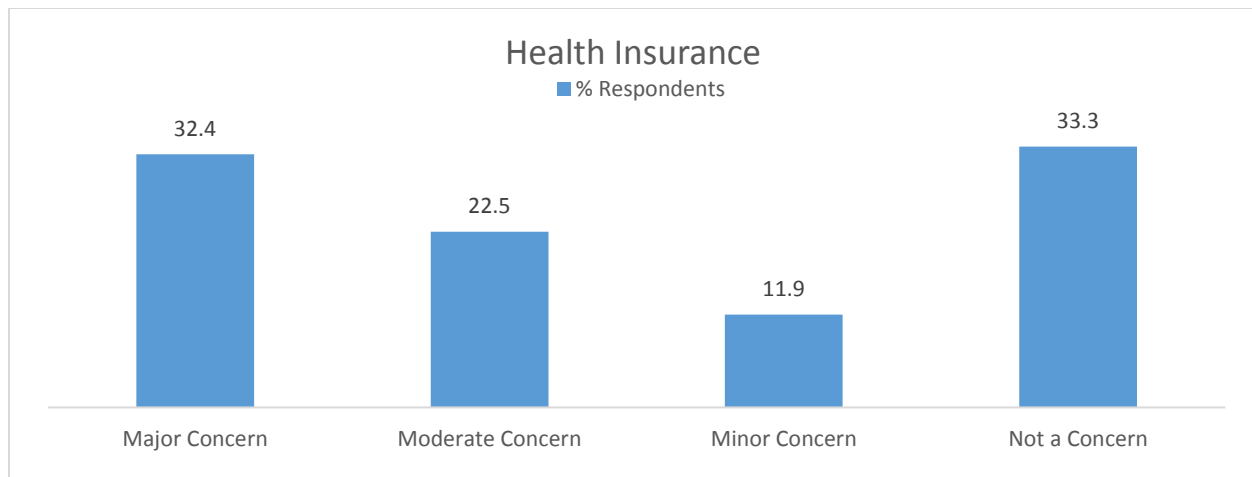


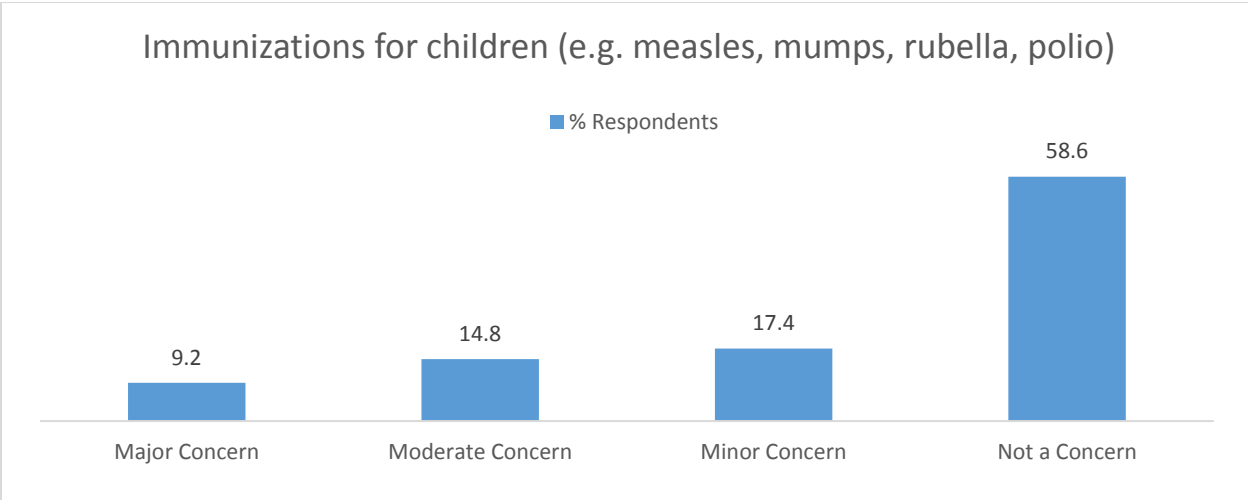
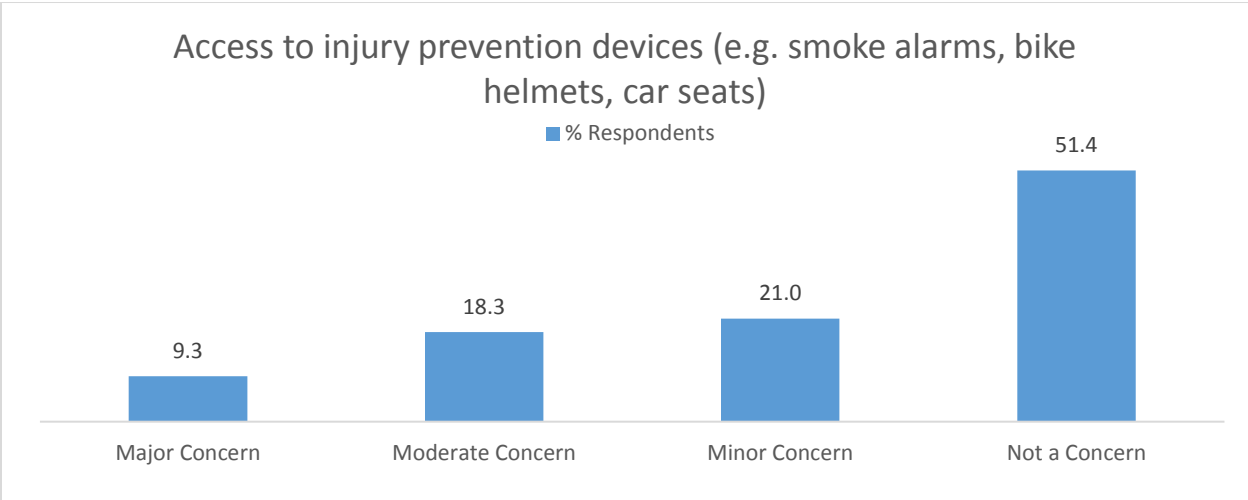
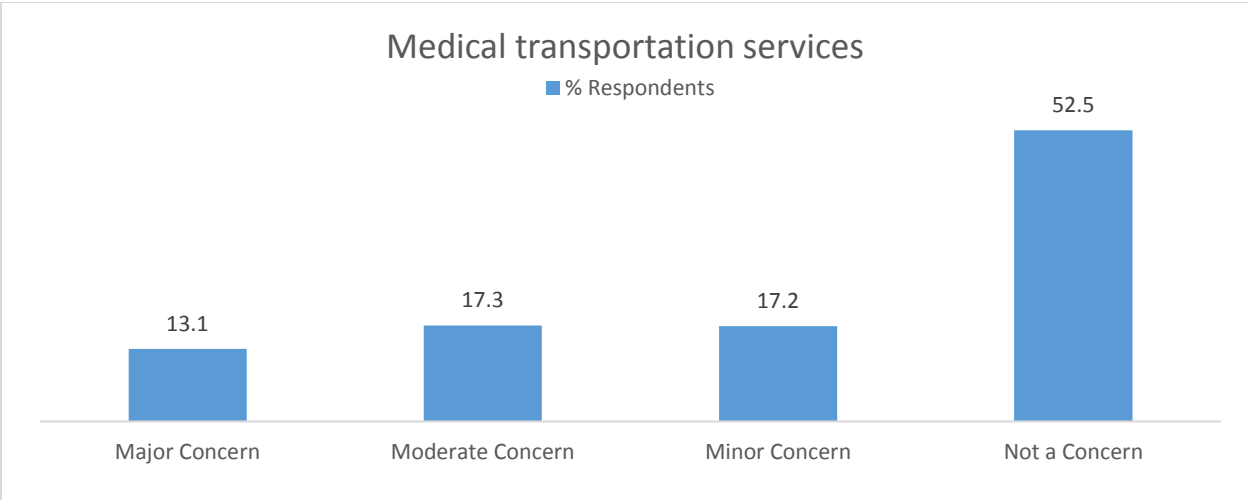
Health and well-being concerns

Data highlights

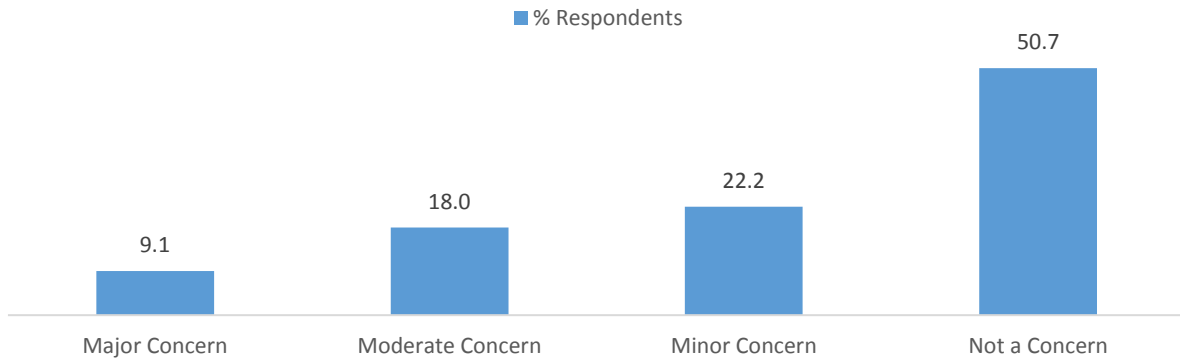
- “Health Insurance” was the topic chosen by the largest portion of respondents, with 32.4% indicating it was a “Major Concern” for them or someone in their household within the last year.
- “Drug/alcohol abuse prevention/education” was the second most prominent topic, indicated as a “Major Concern” by 23.6%.
- Other topics indicated as a “Major Concern” by 20% or more of respondents include “Teen pregnancy prevention/education,” “Counseling/mental health services,” “Medical research,” “Support for medical programs at the national level,” “Basic medical care for low-income families/individuals,” and “Treatment for life-threatening diseases.”
- Topics chosen by fewer than 10% of respondents as a “Major Concern” include “Immunizations for adults,” “Immunizations for children,” “Access to injury prevention devices,” and “Health education programs.”

For each concern below, please tell whether - in the past 12 months - each has been a major concern, a moderate concern, or not a concern for your household.

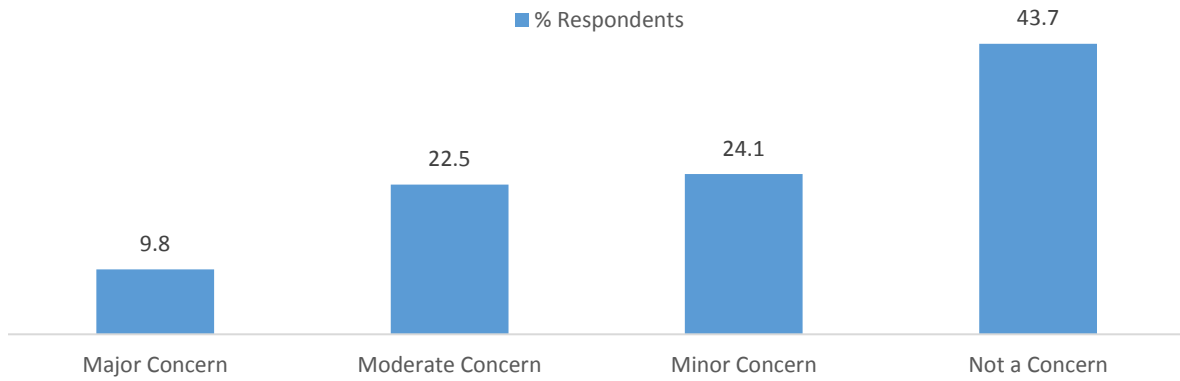




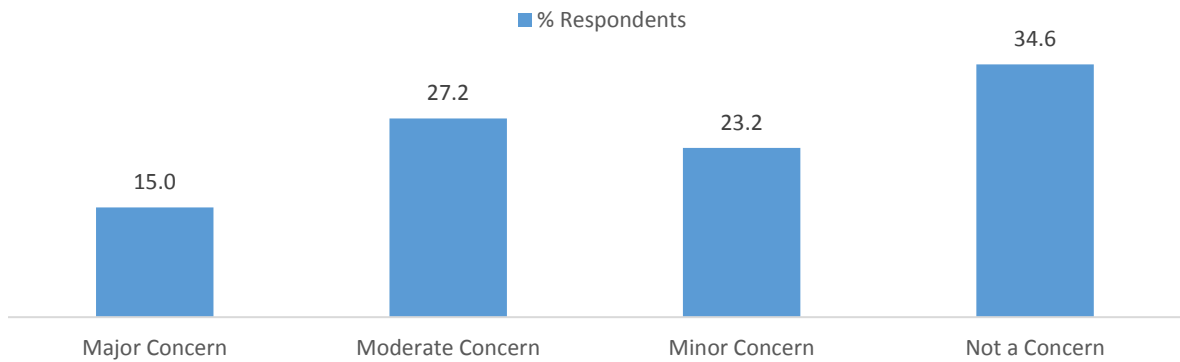
Immunizations for adults (e.g. tetanus, seasonal flu)

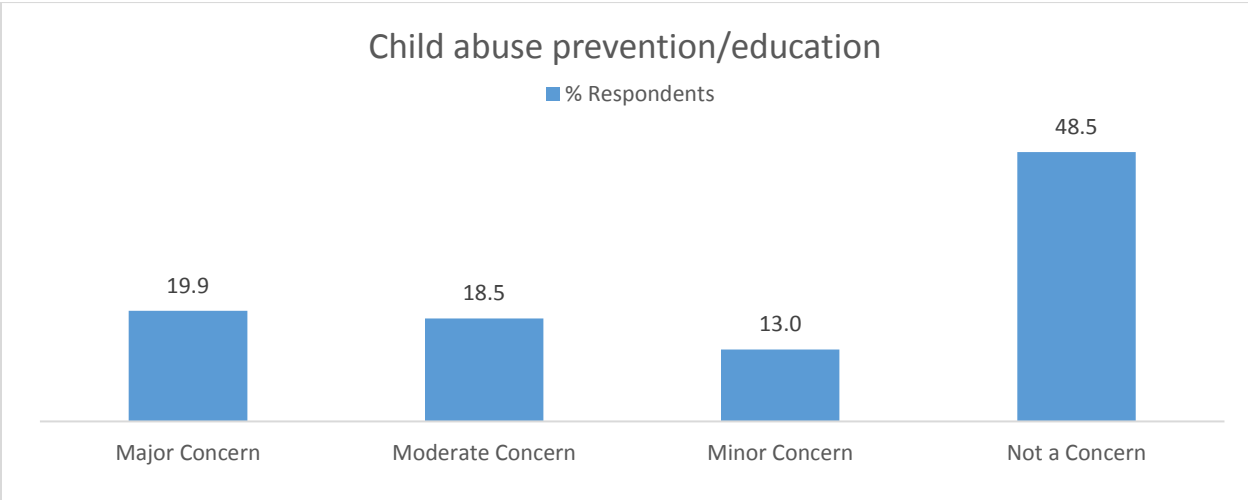
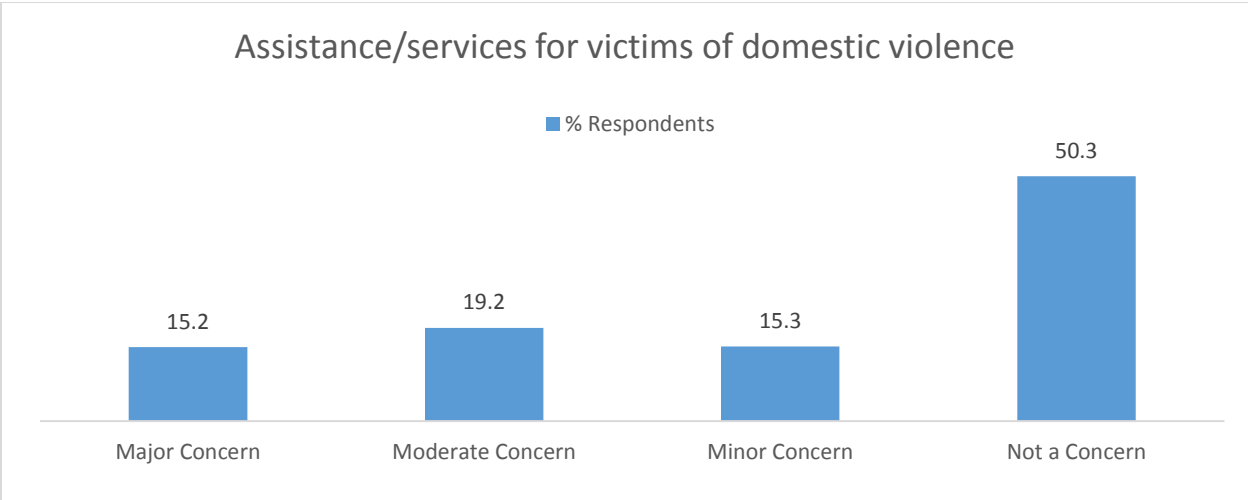
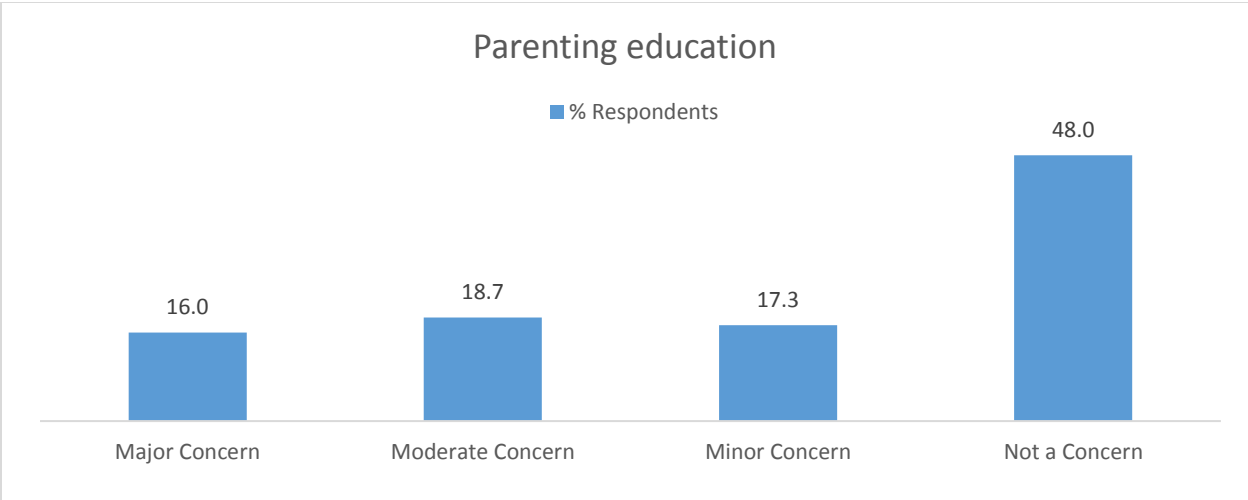


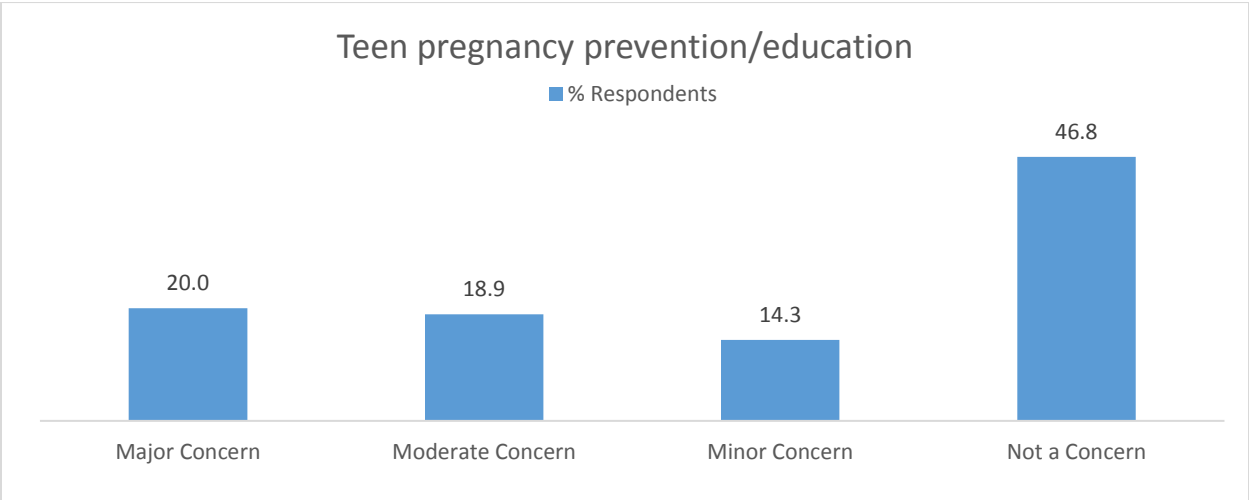
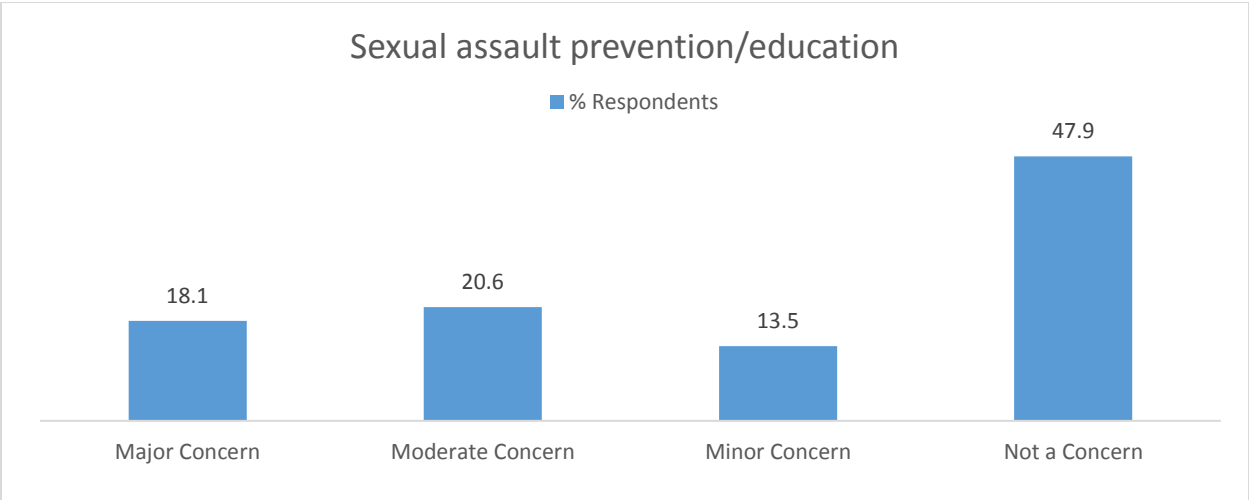
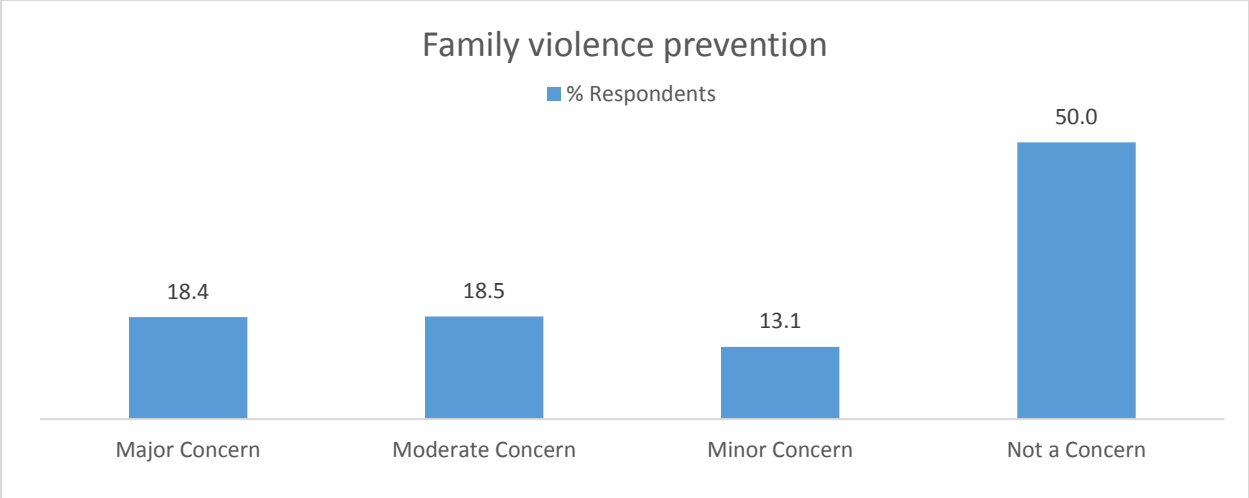
Health education programs



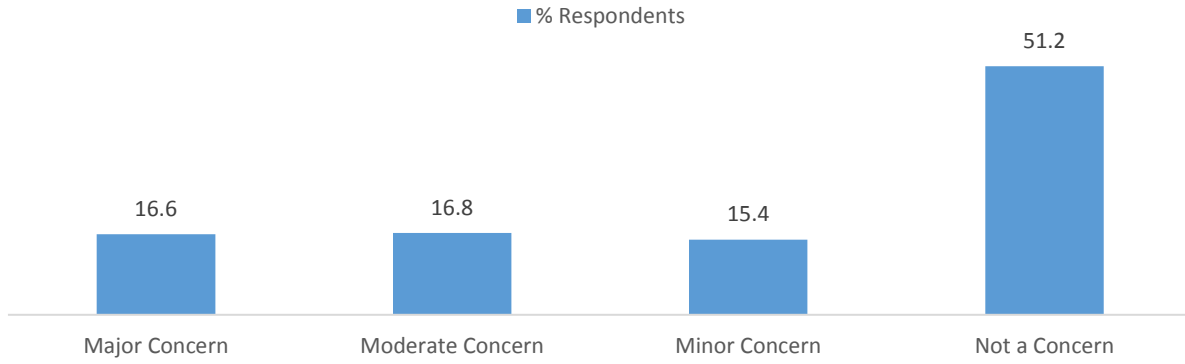
Physical activity programs (for children, youth, or adults)



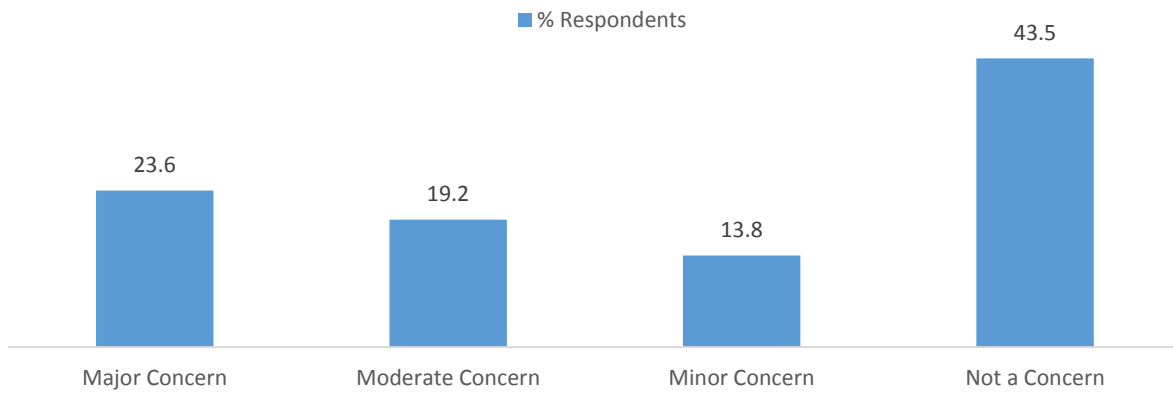




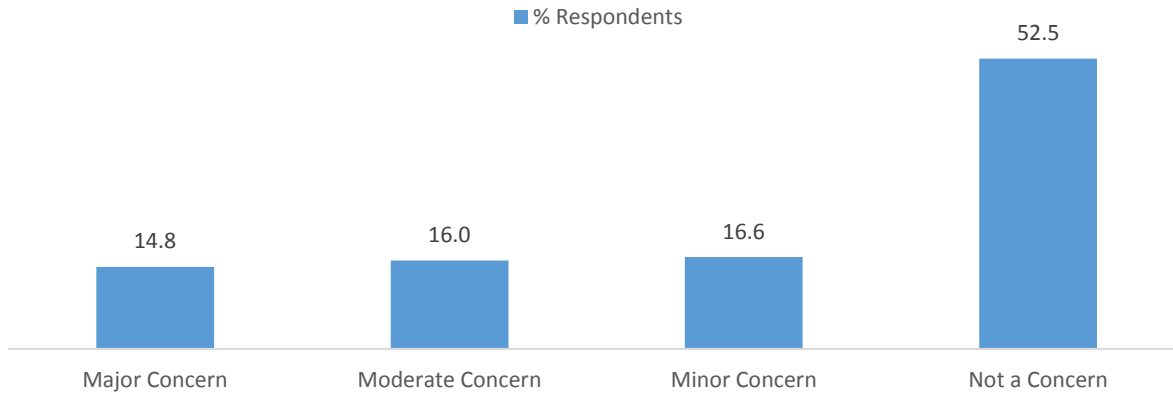
Human/sex trafficking prevention/ education (forced labor)



Drug/alcohol abuse prevention/education

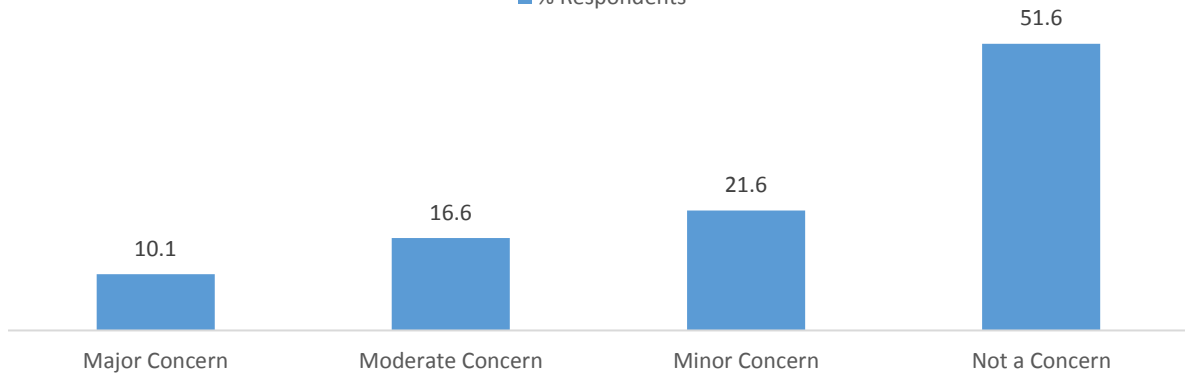


Gambling addiction prevention/education



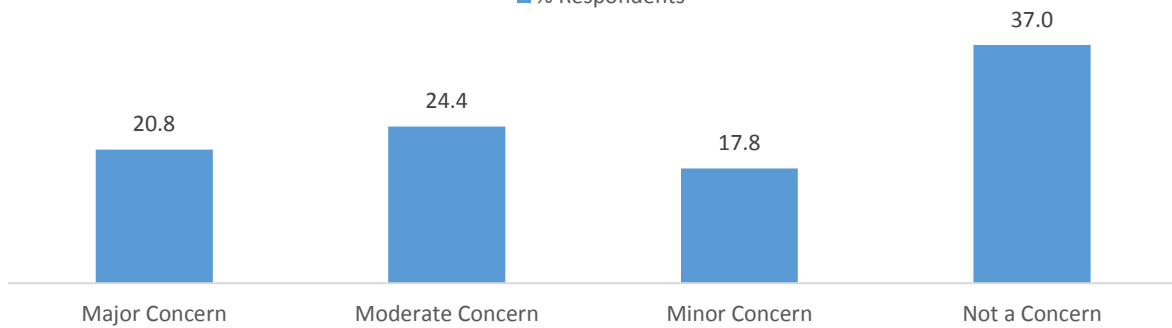
Unintentional injury prevention/education

■ % Respondents



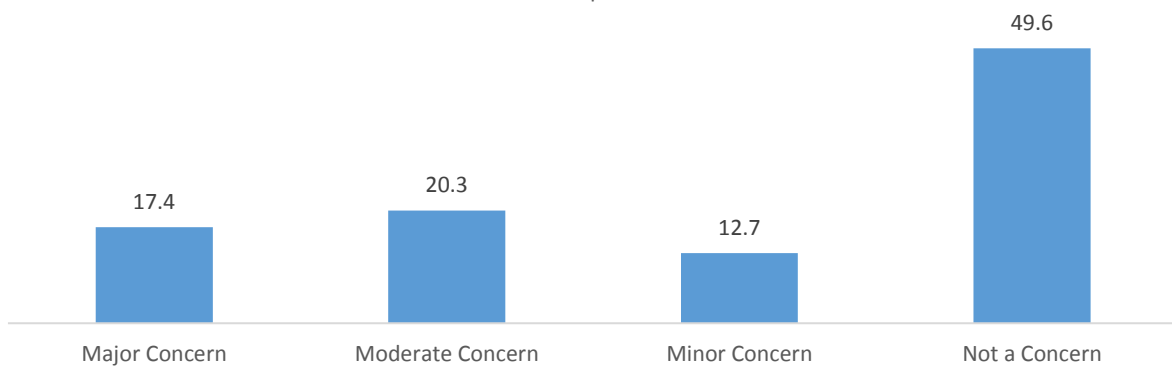
Counseling/mental health services (for children, youth, adults, families, or seniors)

■ % Respondents

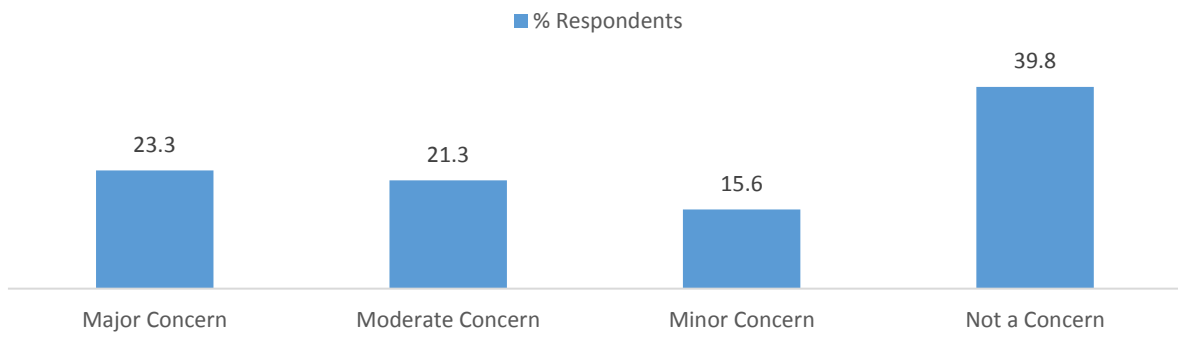


Counseling for victims of sexual assault

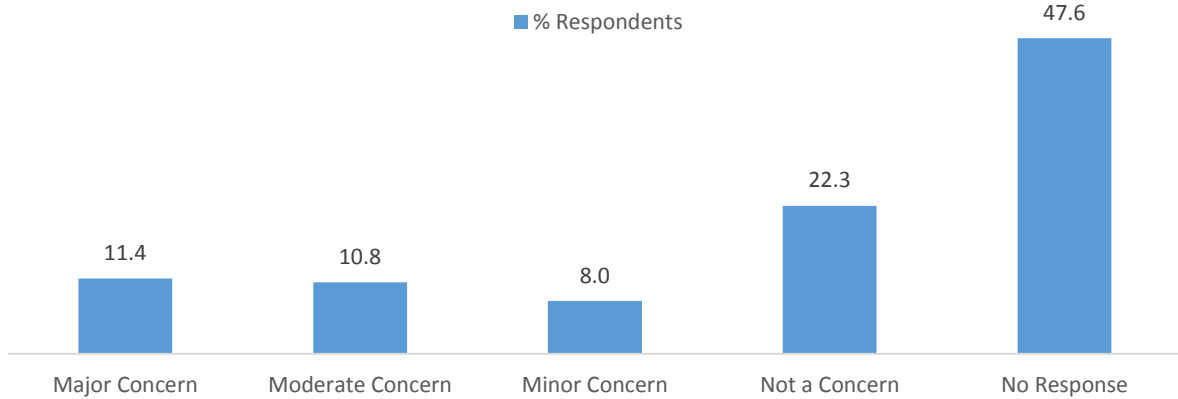
■ % Respondents



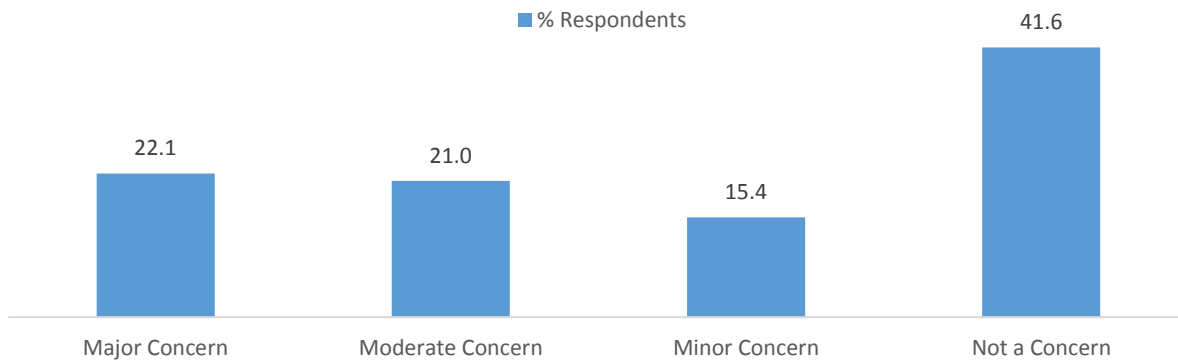
Treatment for life-threatening diseases (e.g. cancer, congestive heart failure, other organ failure)

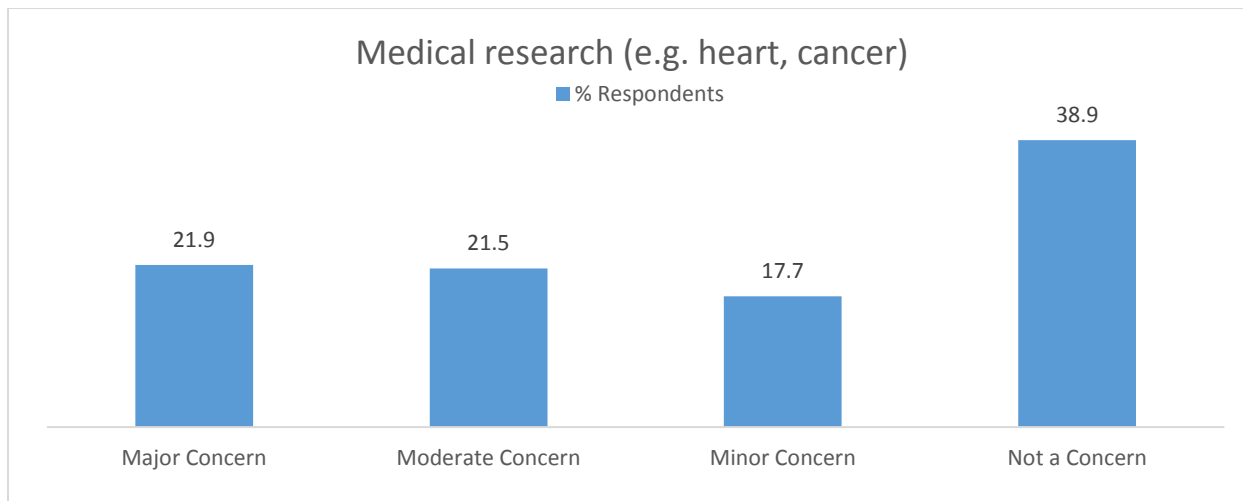


Treatment for drug/alcohol abuse



Support for medical programs at the national level

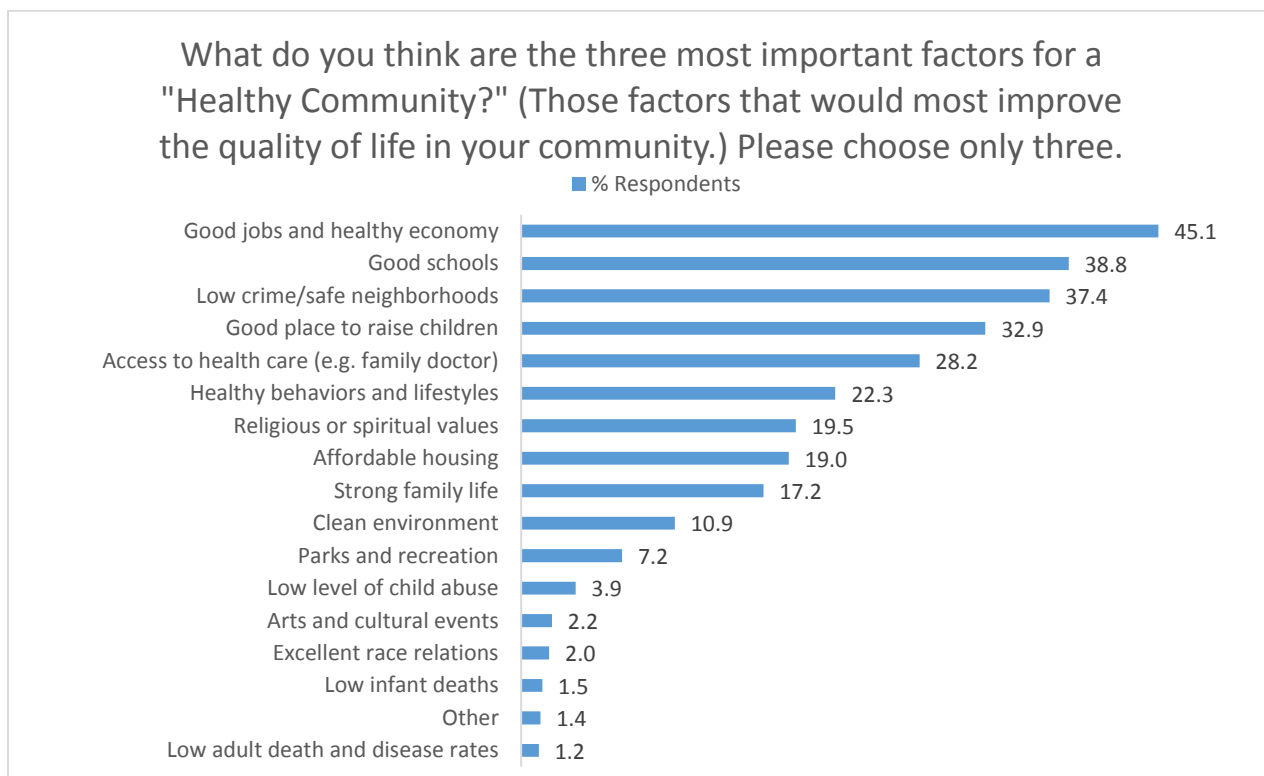




Most important factors for a healthy community

Data highlights

- “Good jobs and healthy economy” was the most popular response option, chosen by nearly half of all respondents (45.1%). “Good schools” and “Low crime/safe neighborhoods” followed at 38.8% and 37.4%, respectively.
- The least popular choice was “Low adult death and disease rates” at 1.2%.
- Several of the write-in “Other” responses related to access to healthy foods, quality housing, and health care.

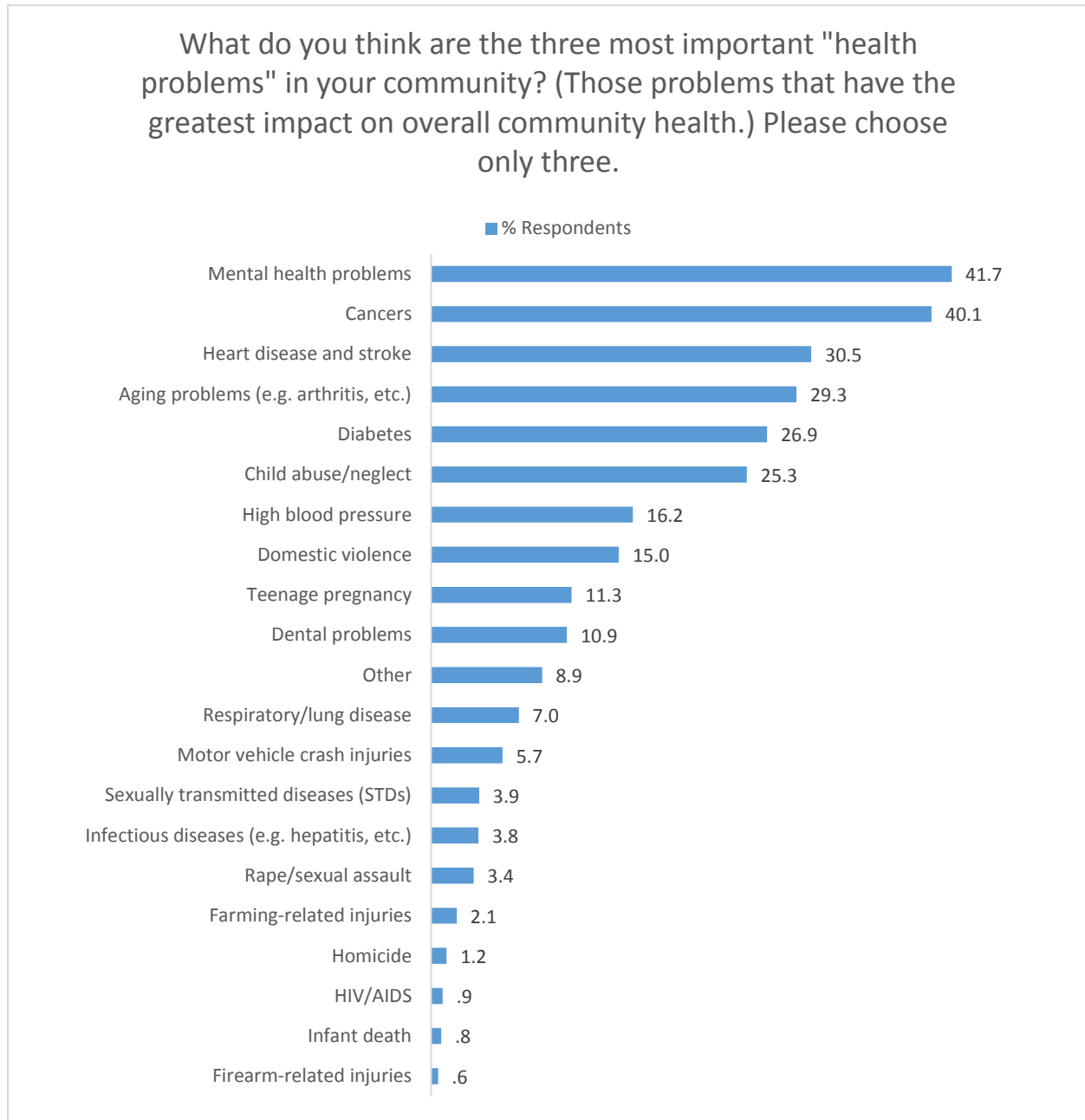


Most important health problems

Data highlights

- “Mental health problems” and “Cancers” were the top choices among respondents, selected by 41.7% and 40.1%, respectively.

- Few respondents indicated that “HIV/AIDS” (0.9%), “Infant death” (0.8%), or “Firearm-related injuries” (0.6%) were among their highest concerns.
- A substantial portion of respondents chose the “Other” option (8.9%). Most of these write-in responses referenced drug and/or alcohol use, with several others referencing obesity and poor eating habits. These topics were included in the next question, which deals with risky behaviors.

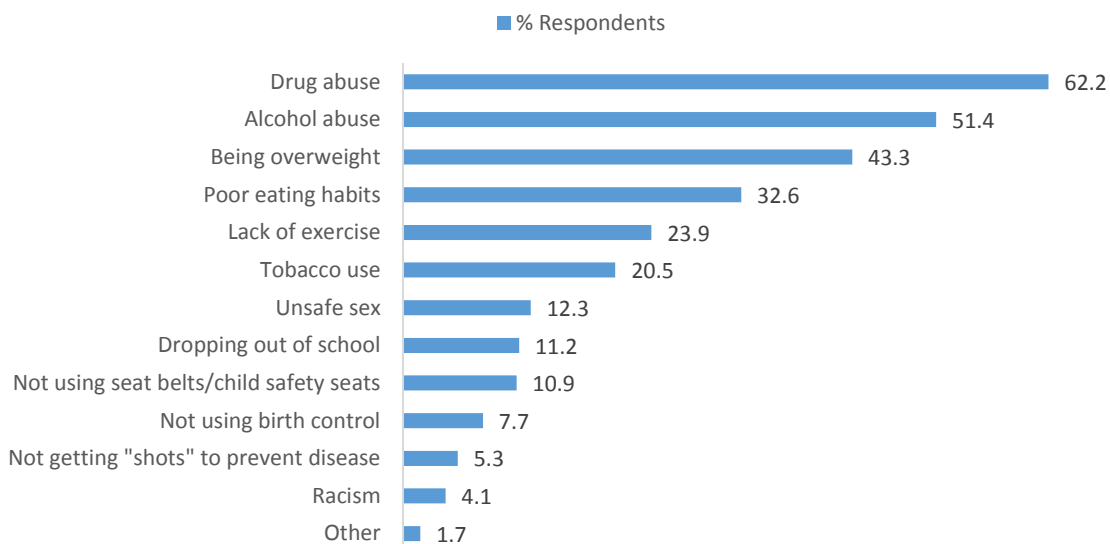


Most important risky behaviors

Data highlights

- “Drug abuse” and “Alcohol abuse” were each chosen by more than half of all respondents (62.2% and 51.4%, respectively).
- “Being overweight” was the third-most-common choice at 43.3%, with two behaviors associated with obesity – “Poor eating habits” and “Lack of exercise” – following directly behind.
- Several write-in responses in the “Other” category referred to the use of alcohol, tobacco, and other drugs. A few respondents mentioned texting and other cell phone use while driving.

What do you think are the three most important "risky behaviors" in your community? (Those behaviors that have the greatest impact on overall community health.) Please choose only three.

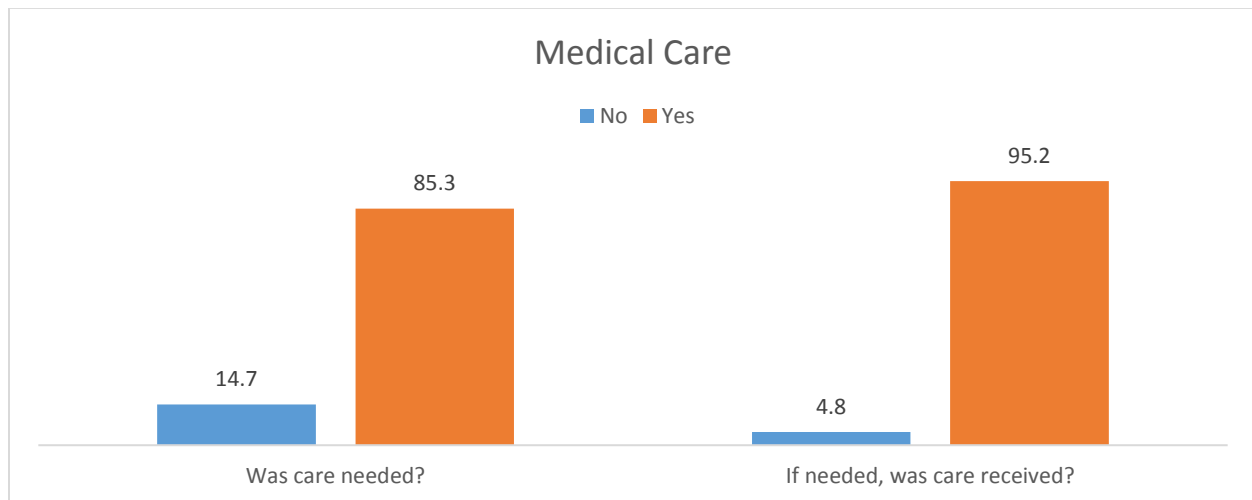


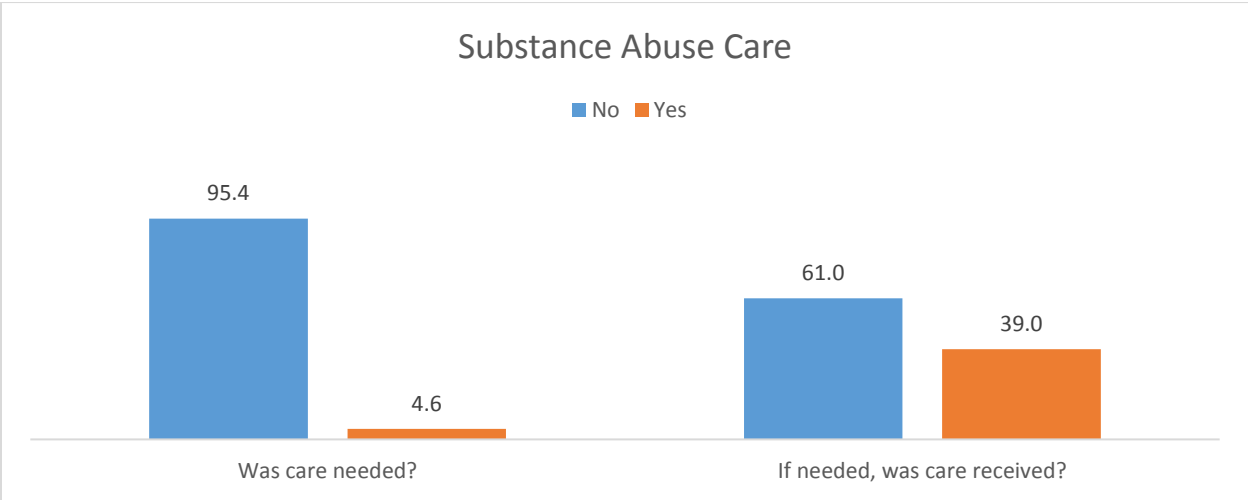
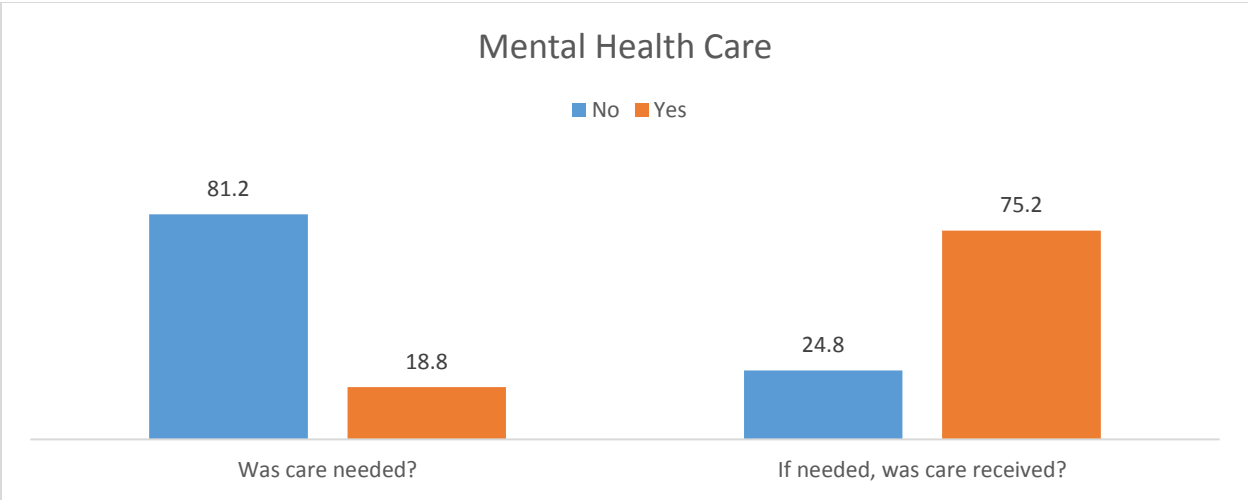
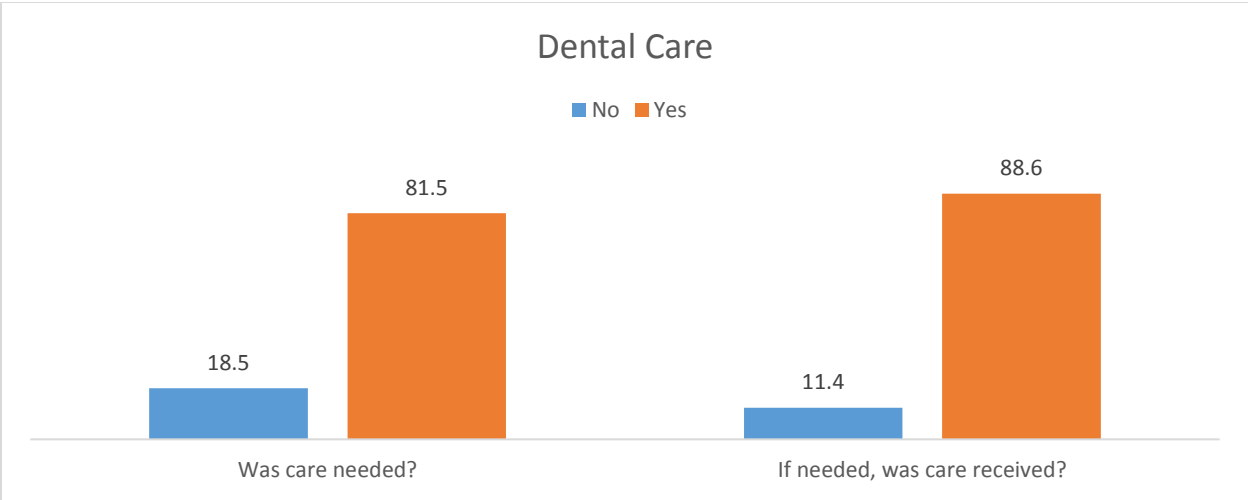
Need for care

Data highlights

- Most respondents indicated they had needed medical care and dental care at some point in 2015 (85.3% and 81.5%, respectively).
- Of those who needed medical care, 4.8% said they did not receive it. Of those who needed dental care, 11.4% said they did not receive it.
- Nearly one in five respondents (18.8%) said they needed mental health care in 2015. Of those, 24.8% said they did not receive it.
- While a relatively small portion of respondents (4.6%) said they needed substance abuse care in 2015, the majority of those who did need substance abuse care said they did not receive it (61.0%).
- Most respondents who needed prenatal care were able to receive it (96.0%).

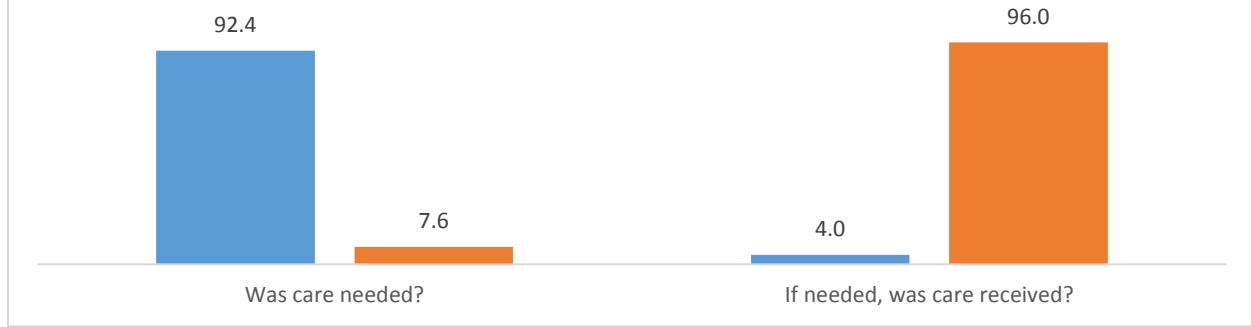
In 2015, did you or anyone in your household need:





Prenatal Care

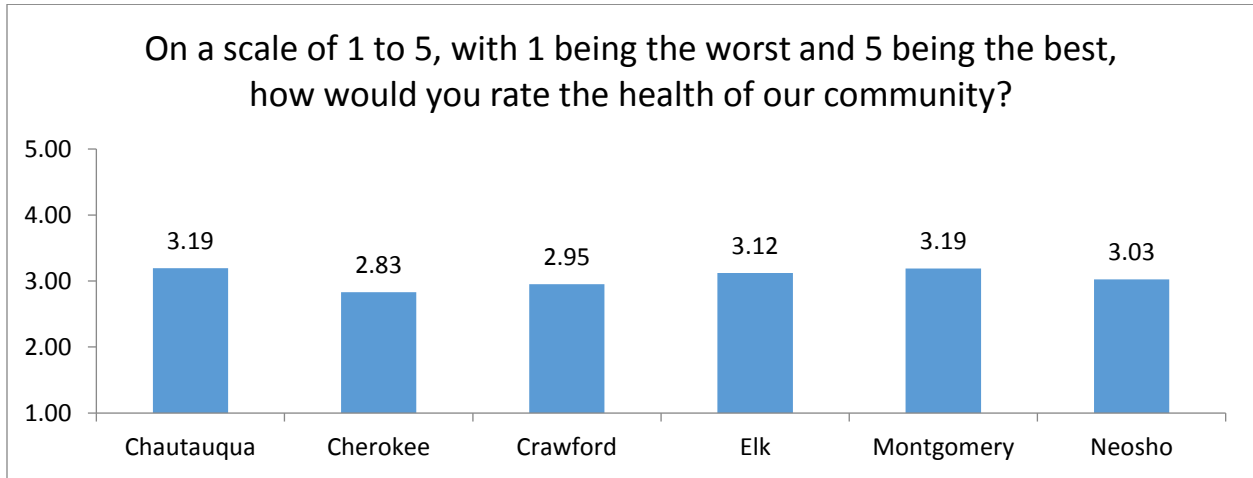
■ No ■ Yes



County comparison

Each answer to each survey question was assigned a numeric score. Examining the mean (average) score across counties can reveal areas of relative strength and weakness, or areas where certain health and well-being services may be more needed than others. Mean scores are compared in the following charts.

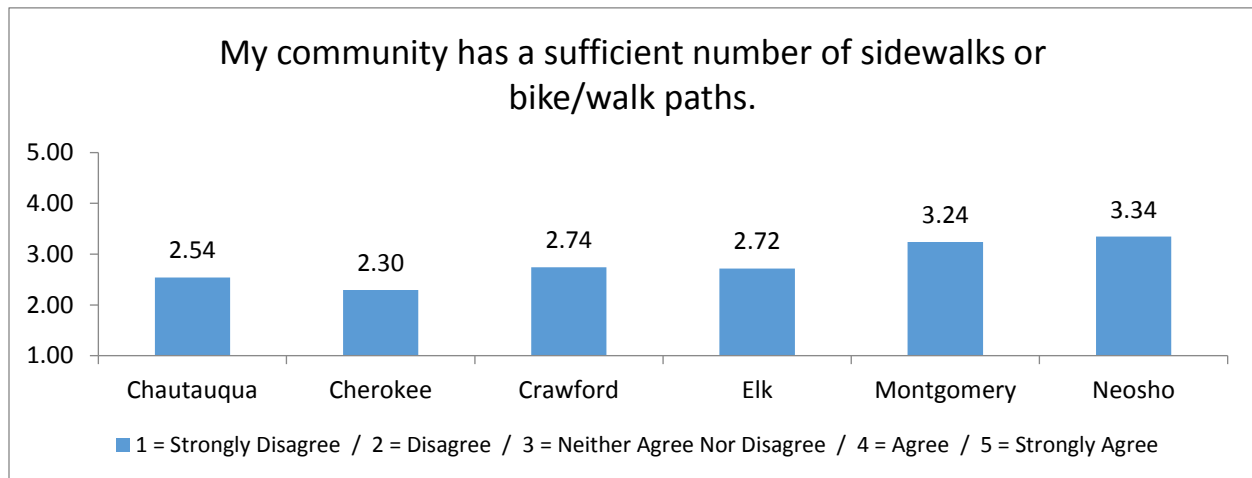
Overall health

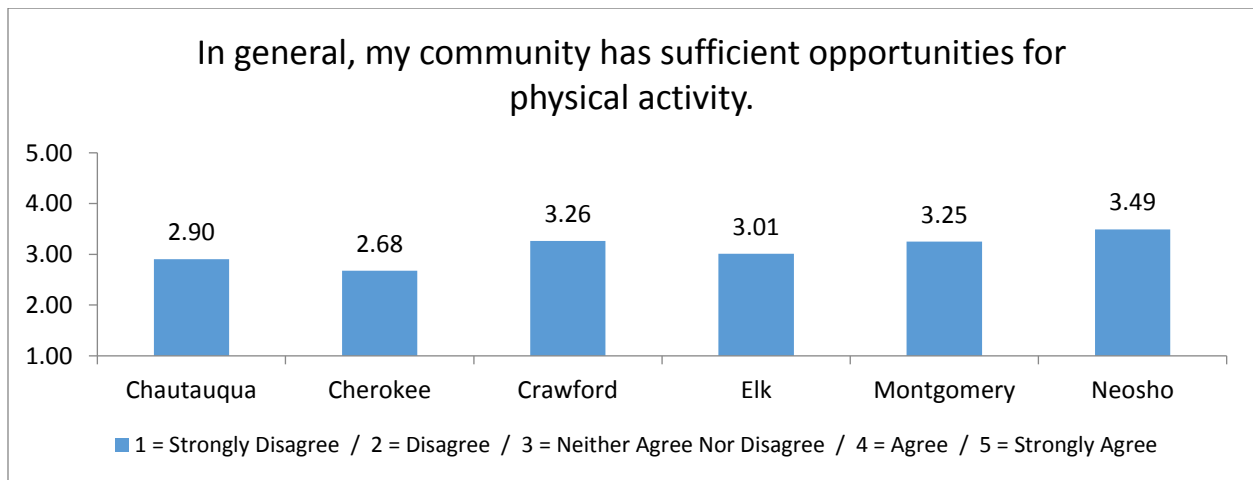
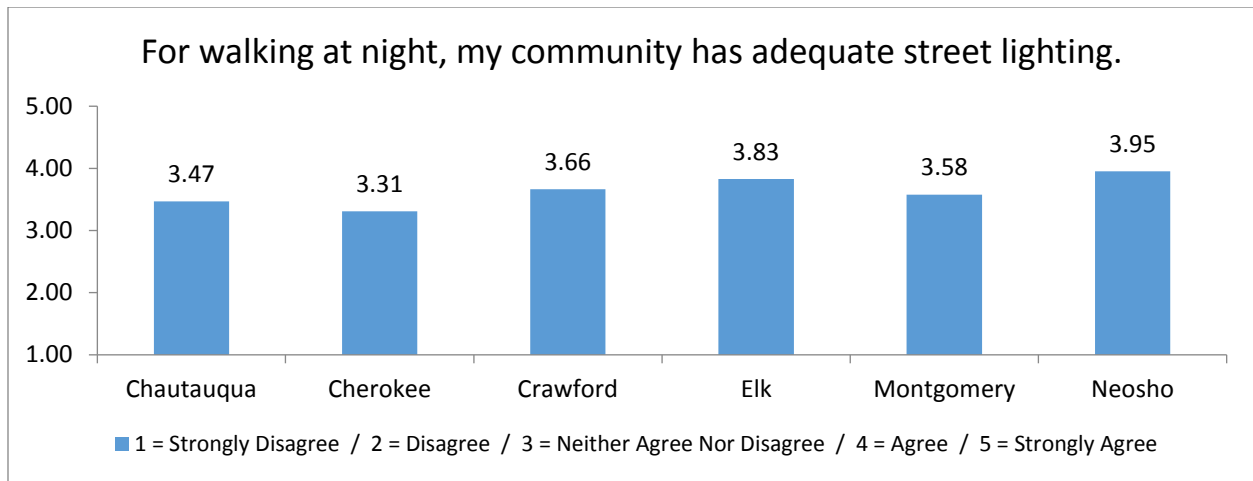
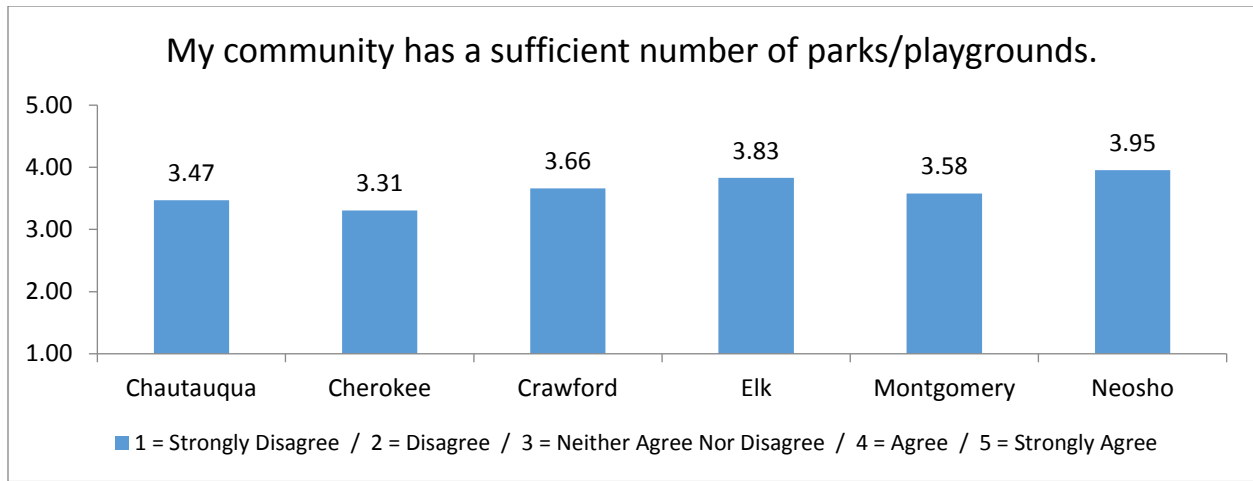


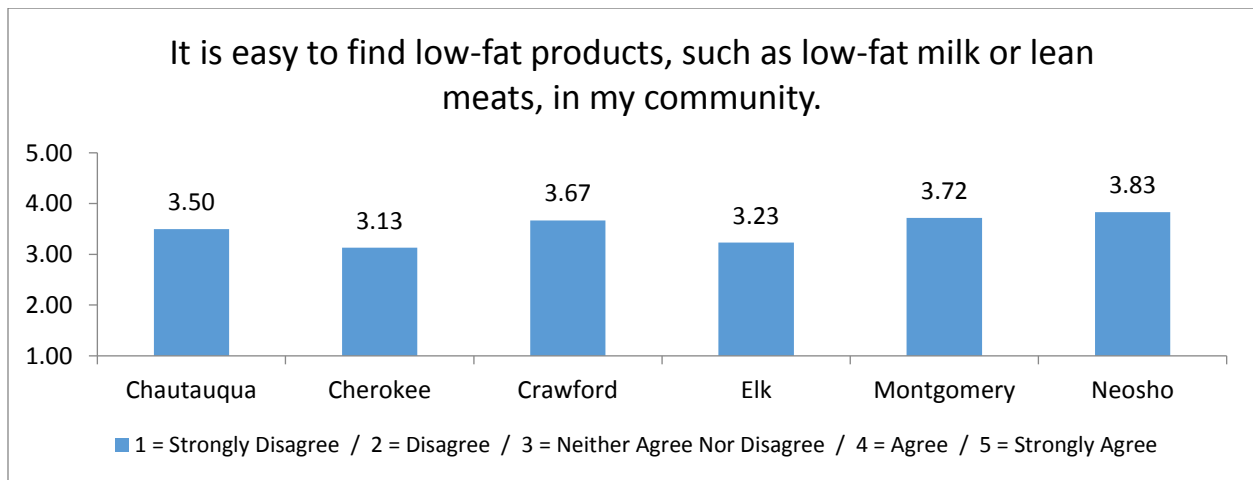
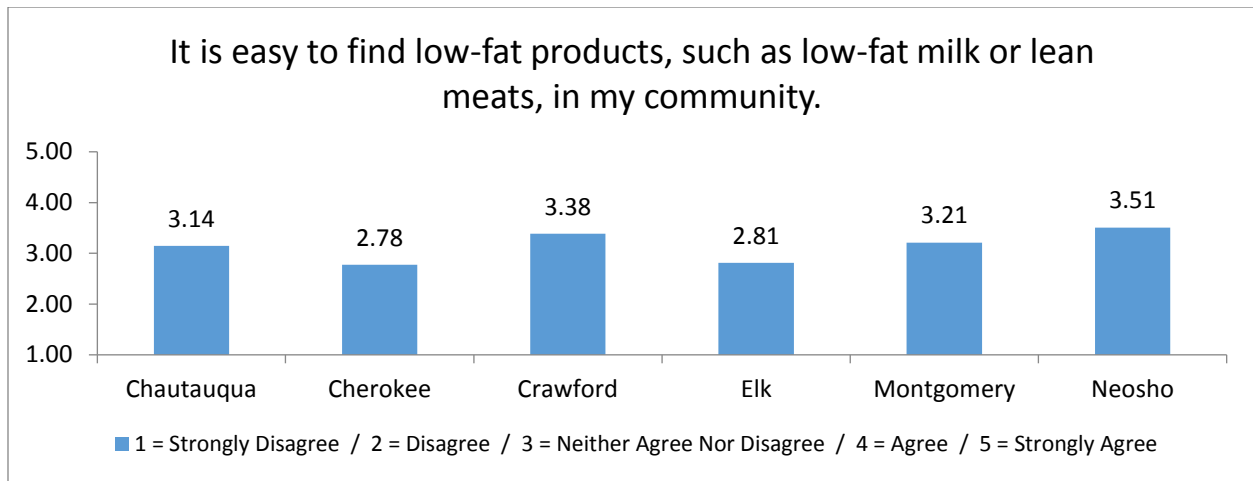
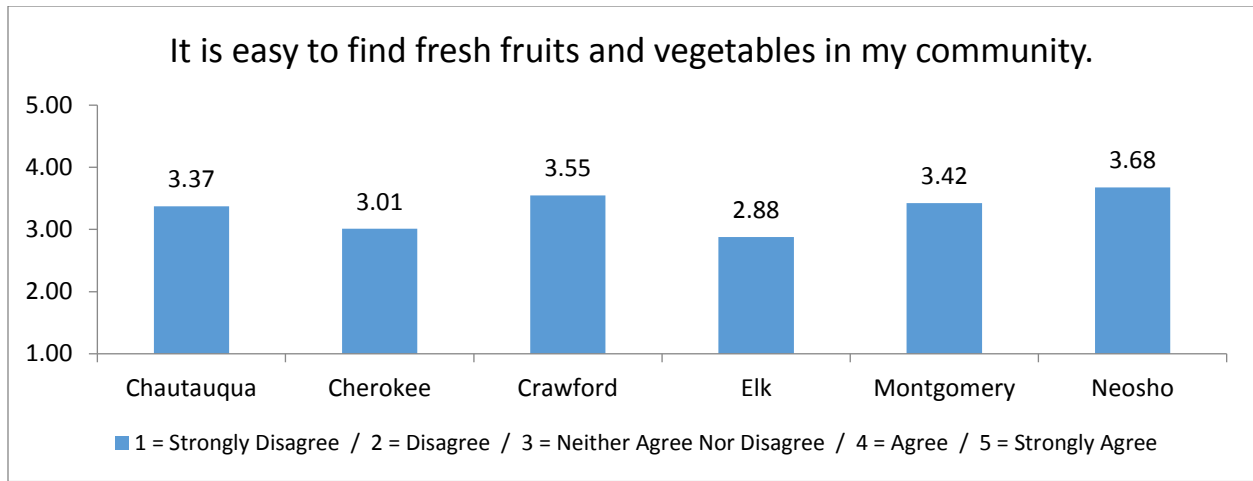
Factors contributing to healthy communities

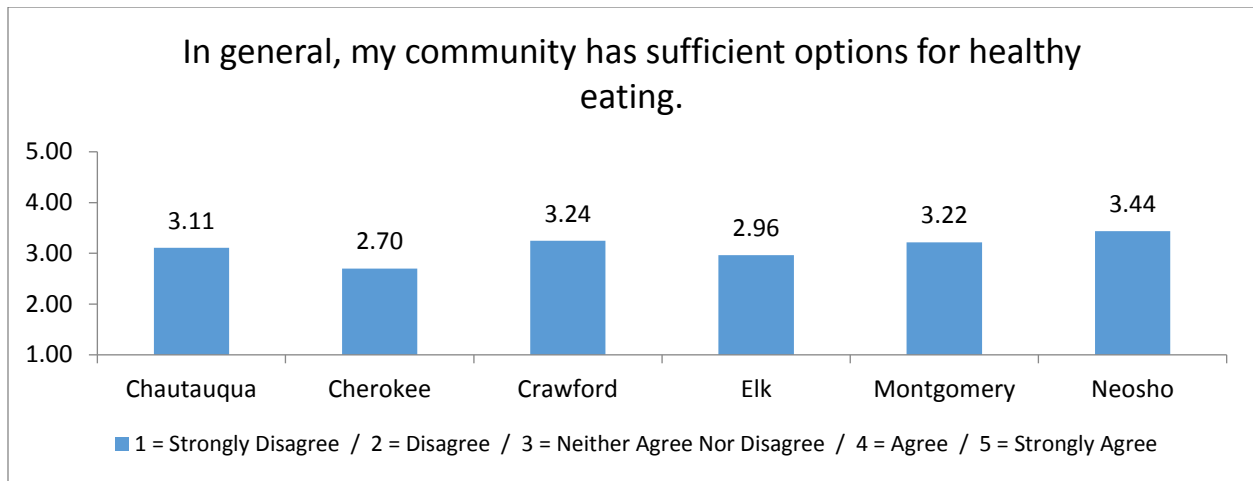
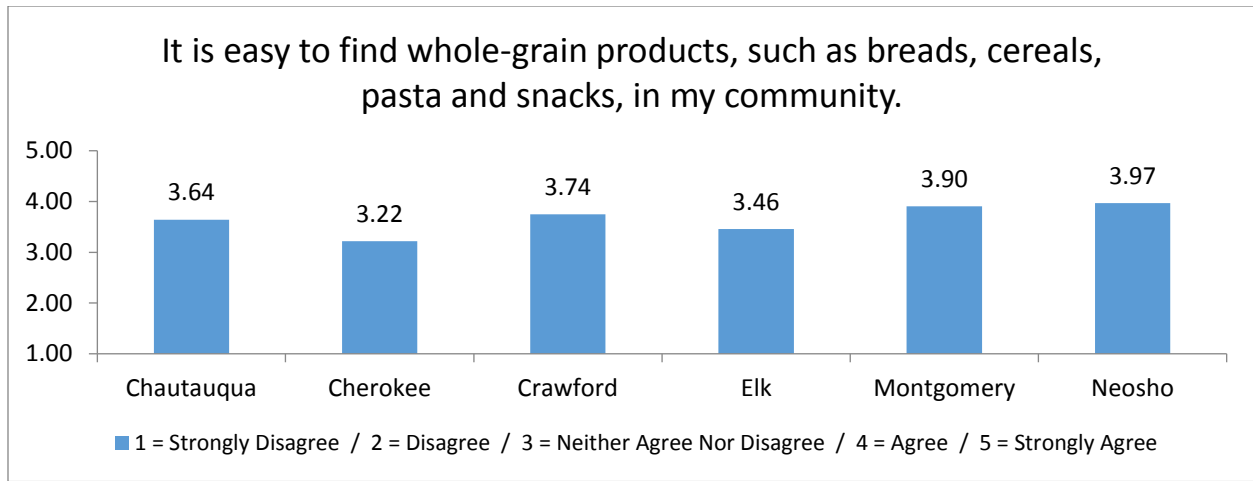
In this section, **higher mean scores indicate greater agreement.** (See key at right.) This means higher mean scores are more desirable.

Key	
1.0	Strongly Disagree
2.0	Disagree
3.0	Neither Agree nor Disagree
4.0	Agree
5.0	Strongly Agree

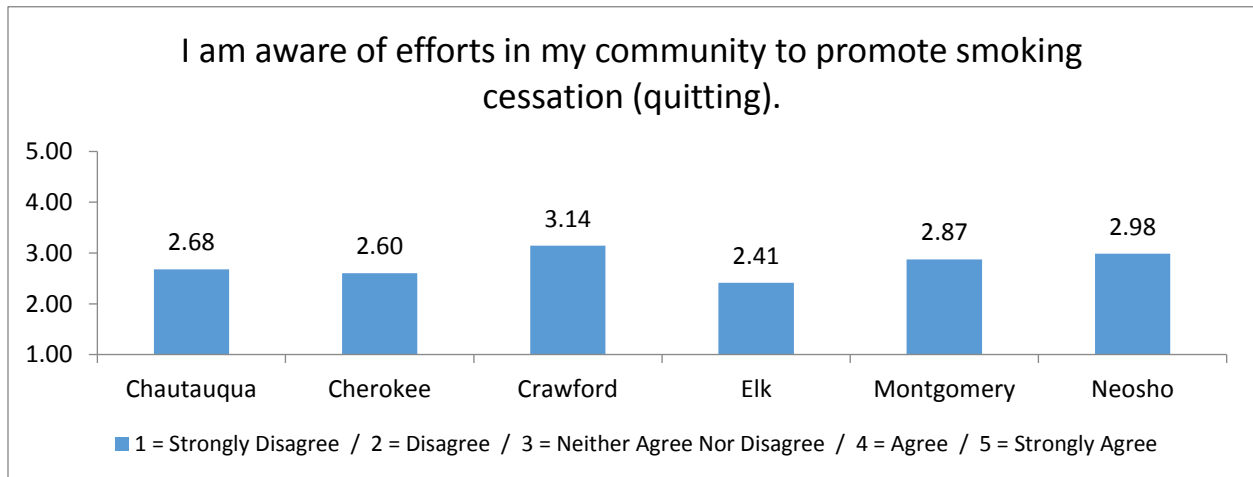


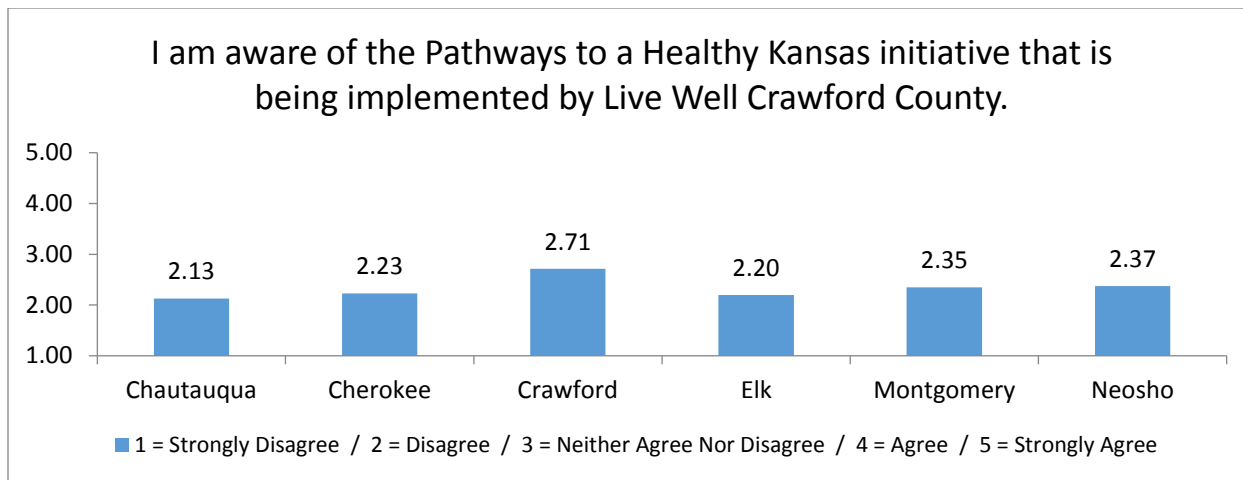






Awareness of health initiatives



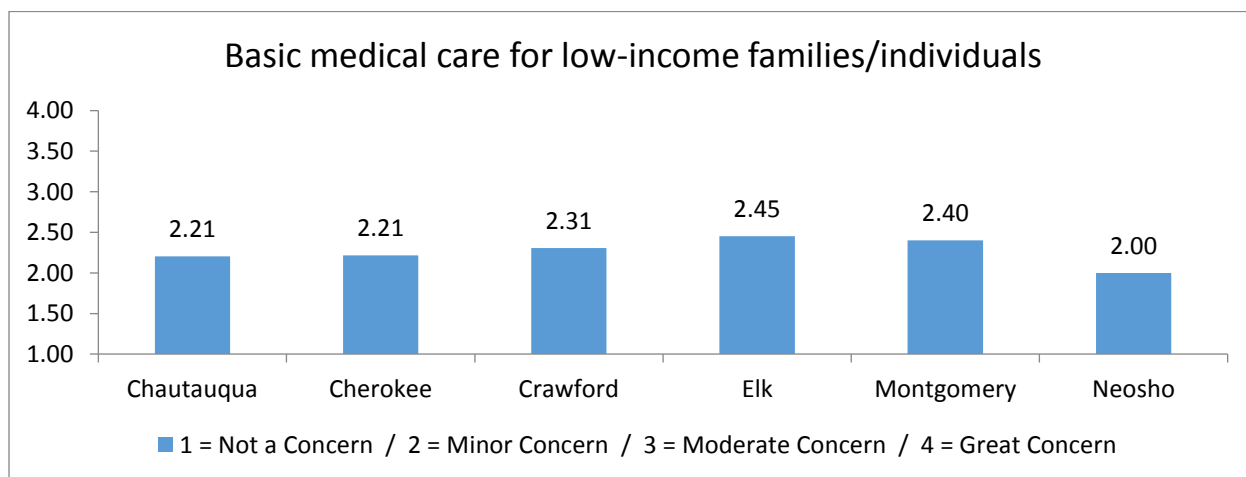
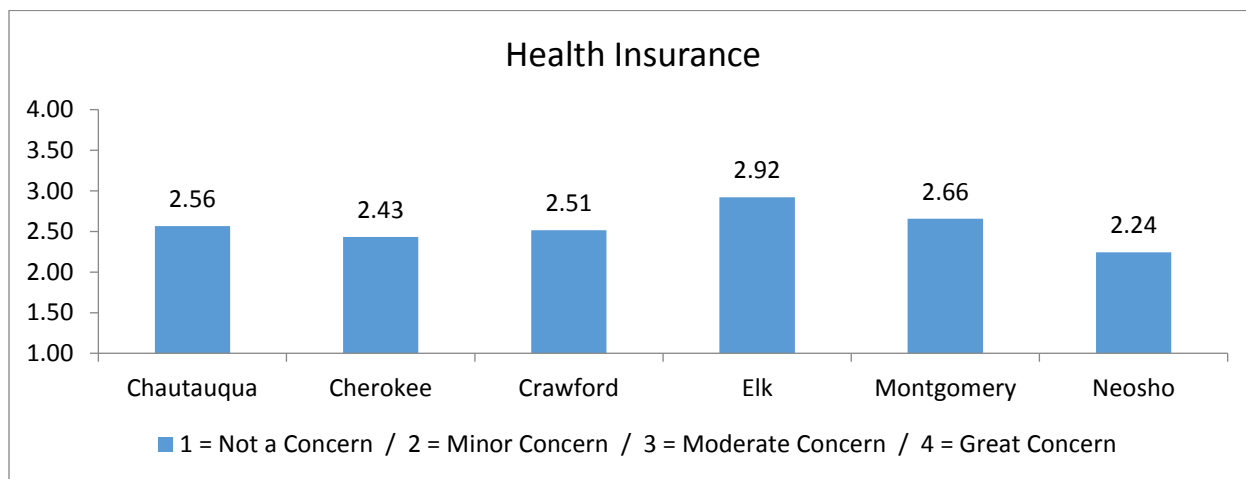


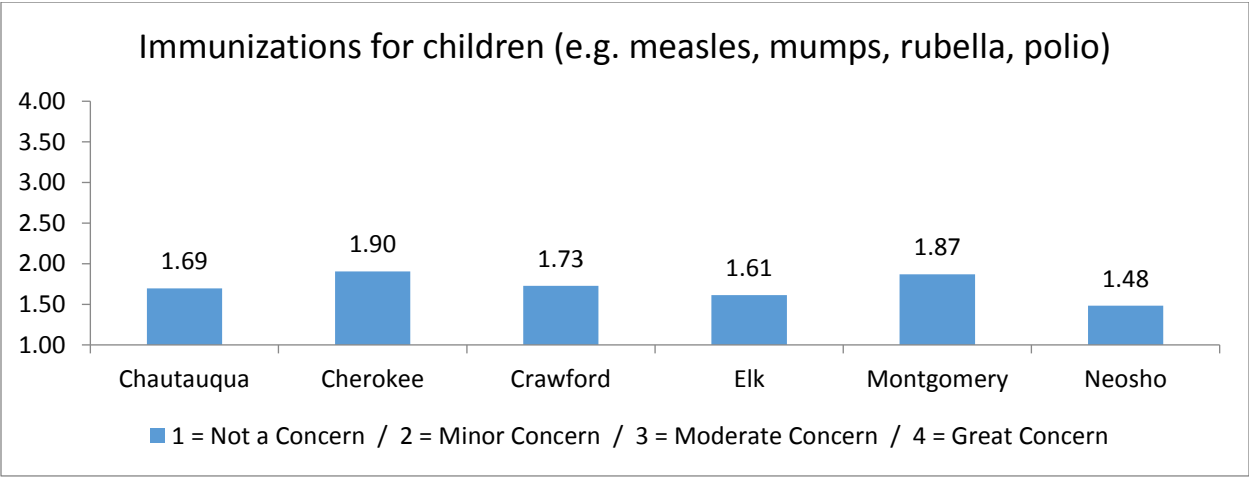
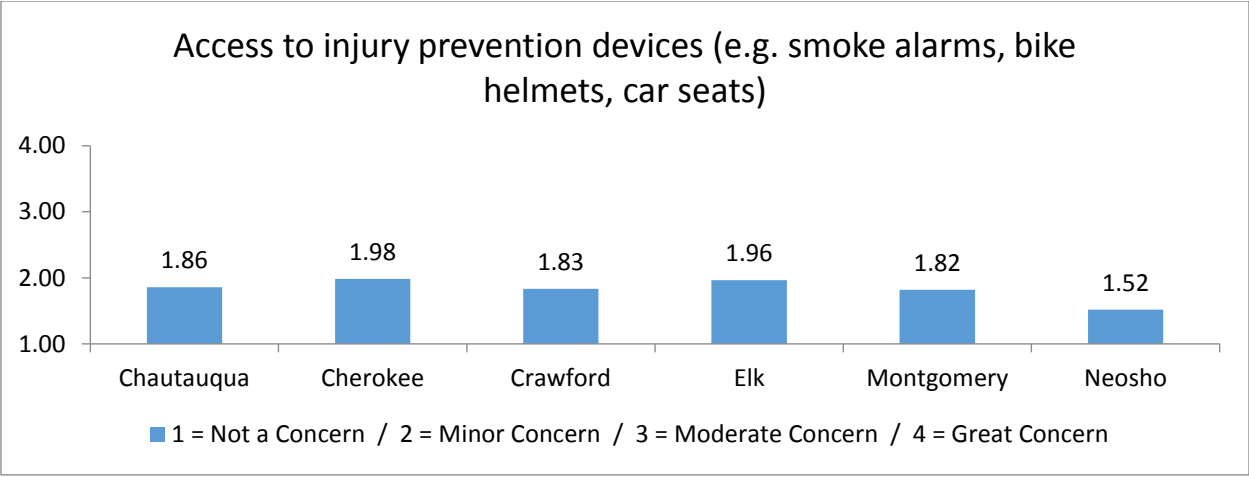
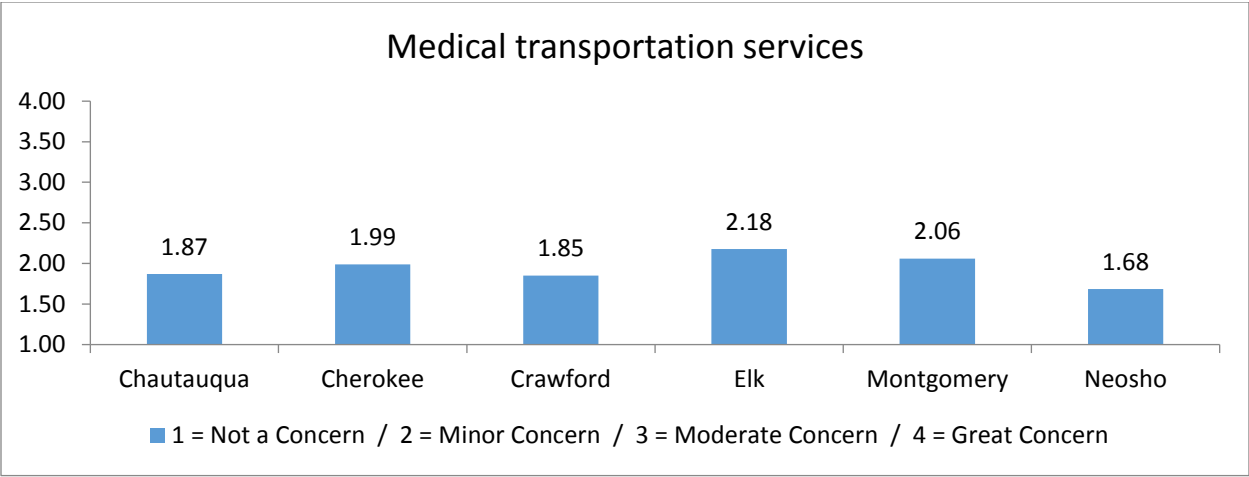
Health and well-being concerns

In this section, **higher mean scores indicate greater concern.** (See key at right.)

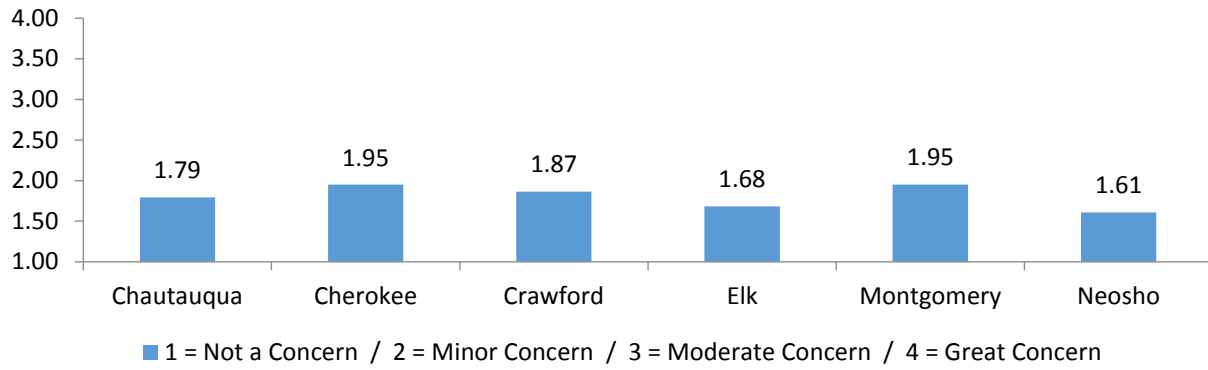
Key	
1.0	Not a concern
2.0	Minor concern
3.0	Moderate concern
4.0	Major concern

For each concern below, please tell whether - in the past 12 months - each has been a major concern, a moderate concern, or not a concern for your household.

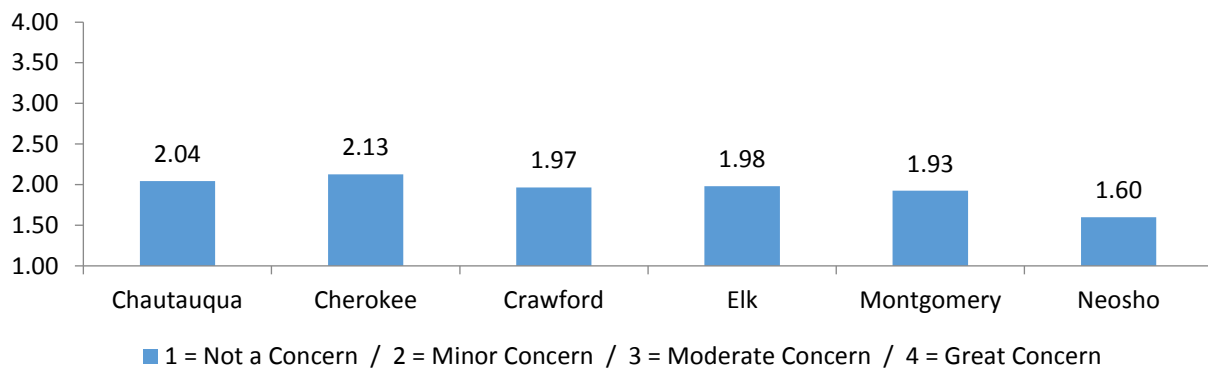




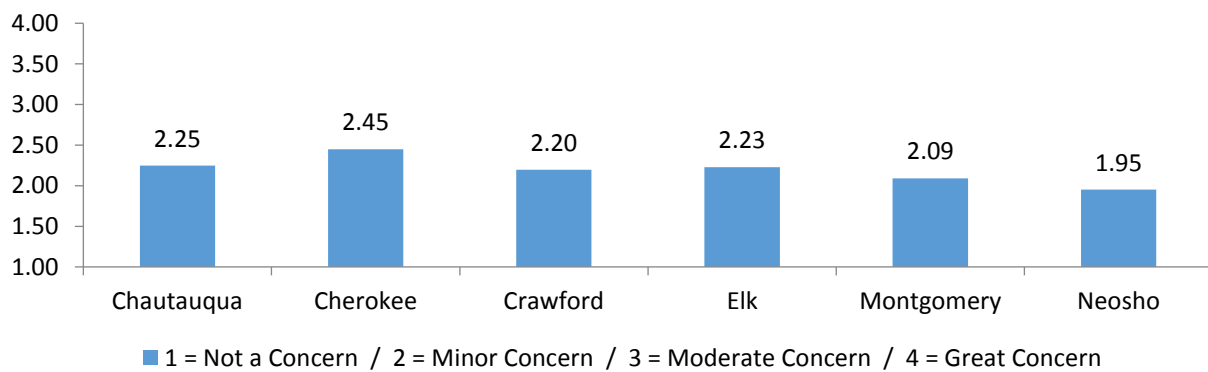
Immunizations for adults (e.g. tetanus, seasonal flu)

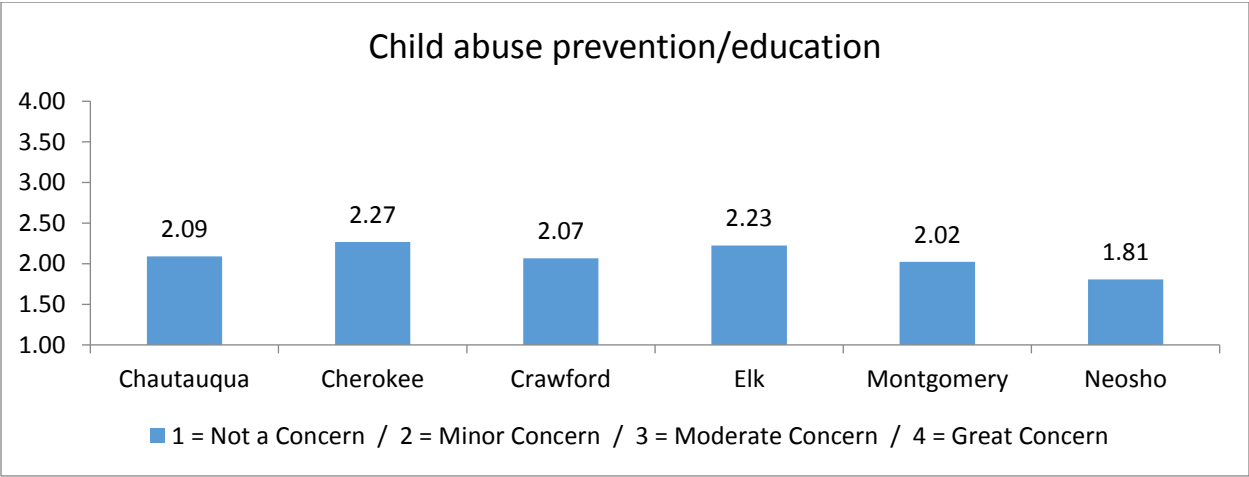
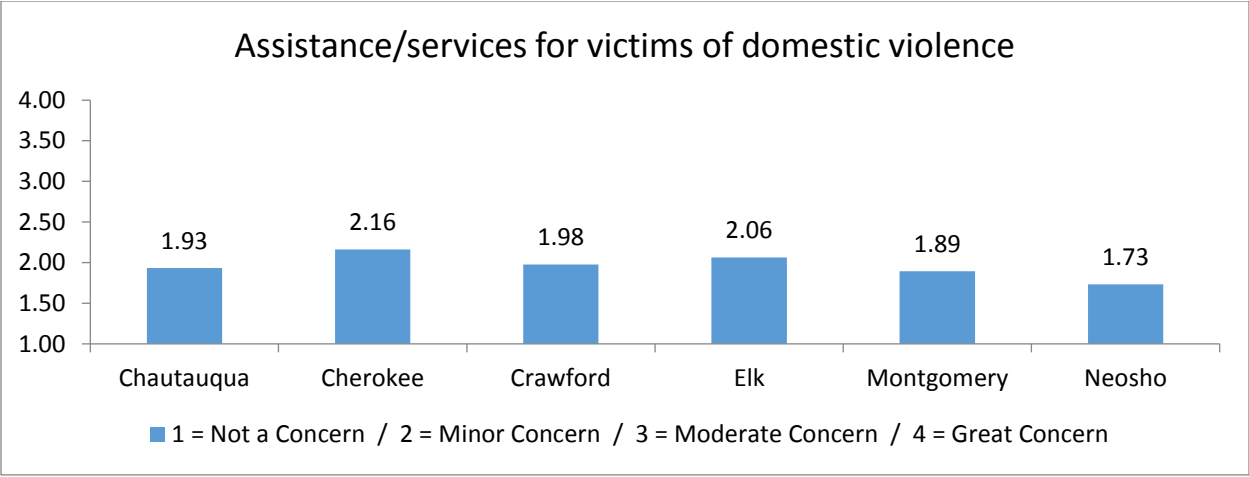
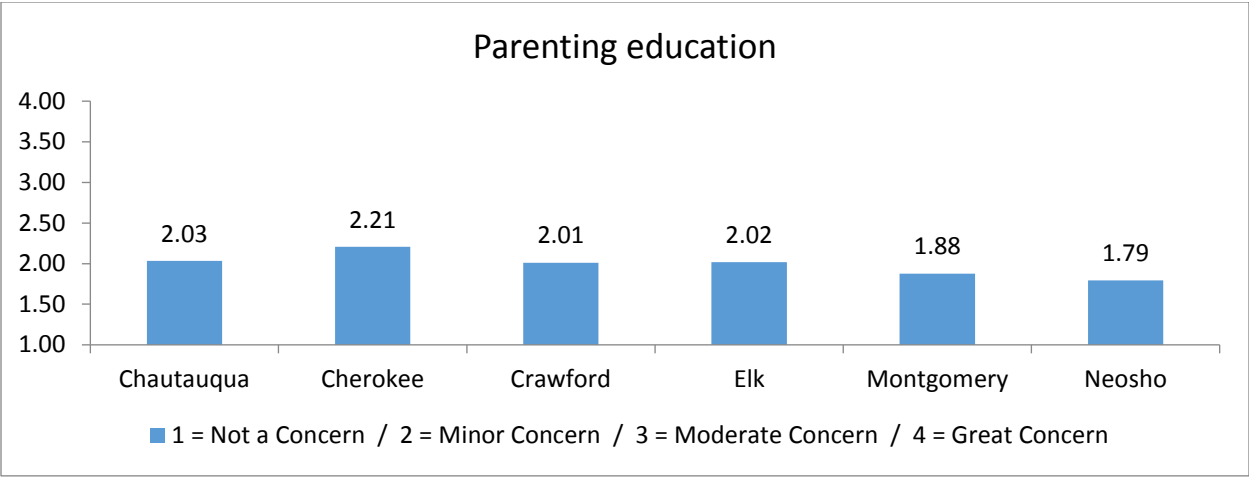


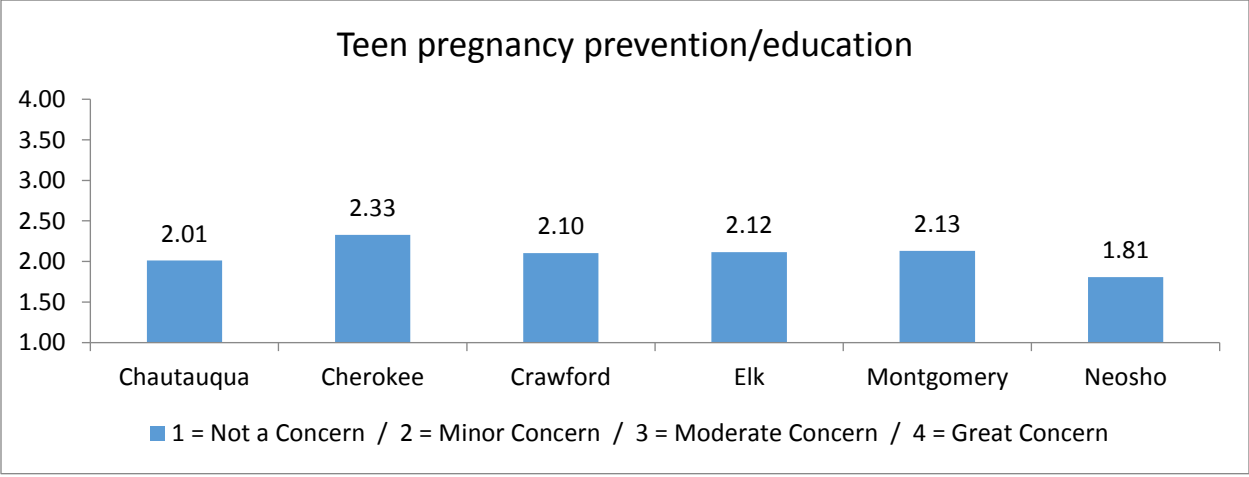
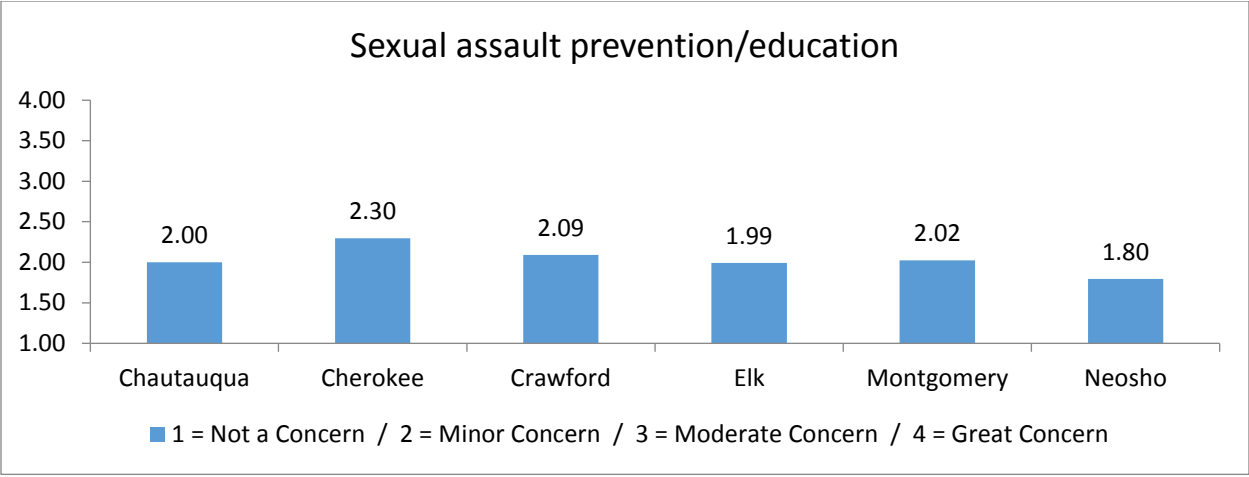
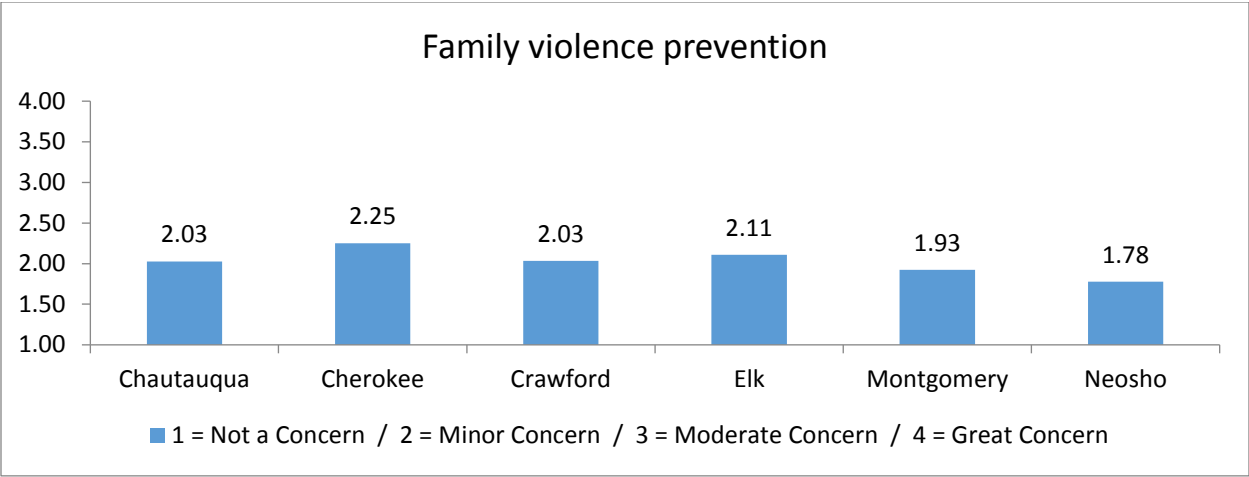
Health education programs



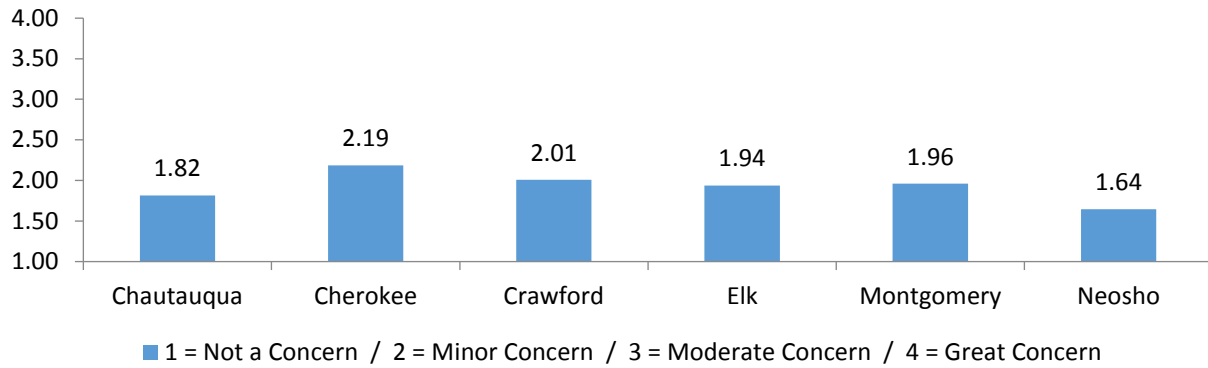
Physical activity programs (for children, youth, or adults)



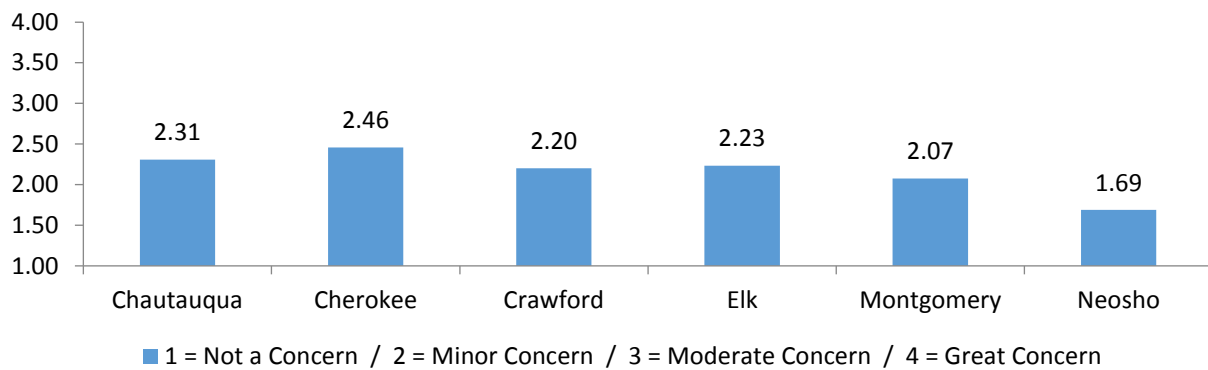




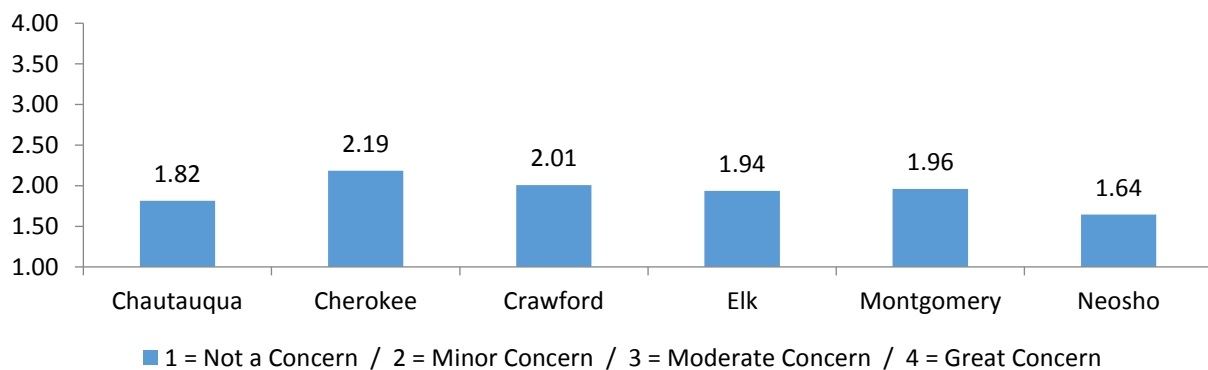
Human/sex trafficking prevention/ education (forced labor)

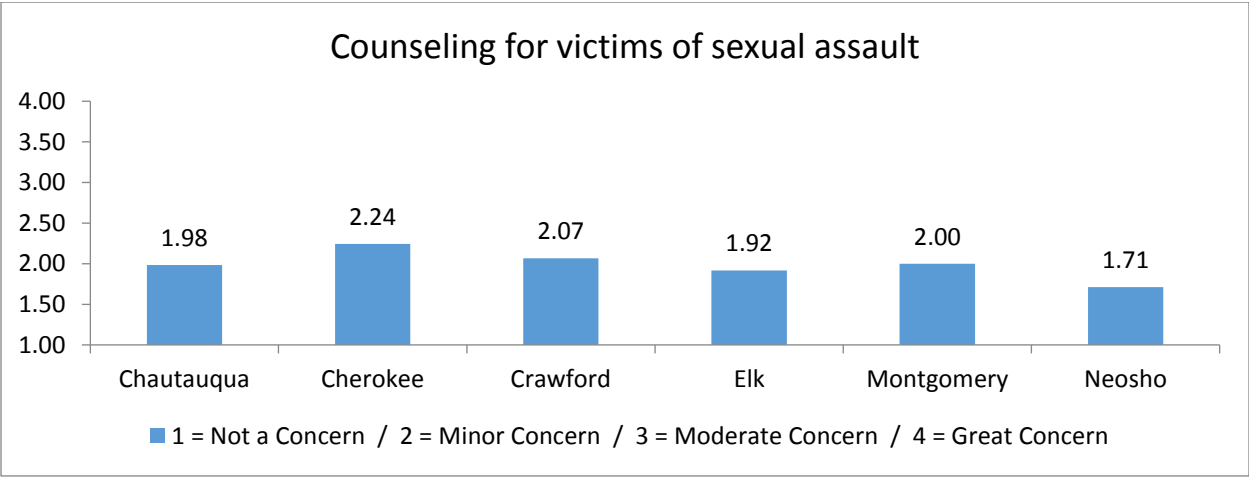
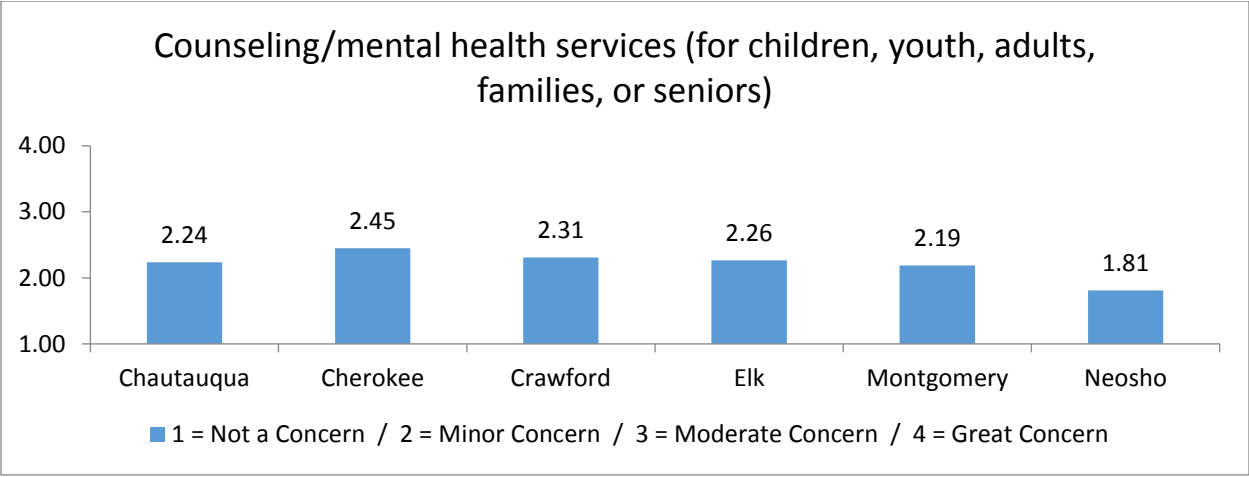
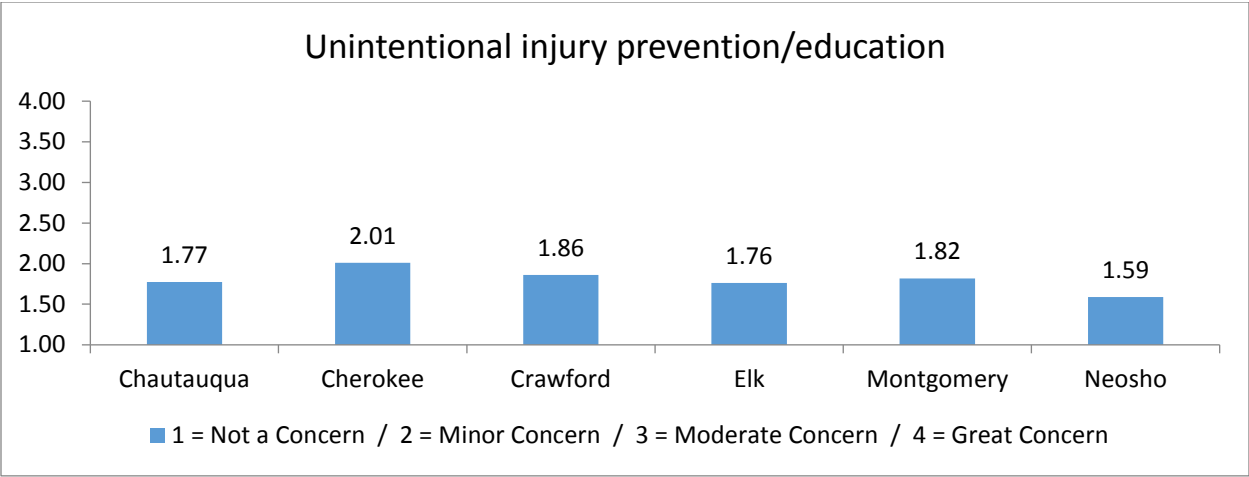


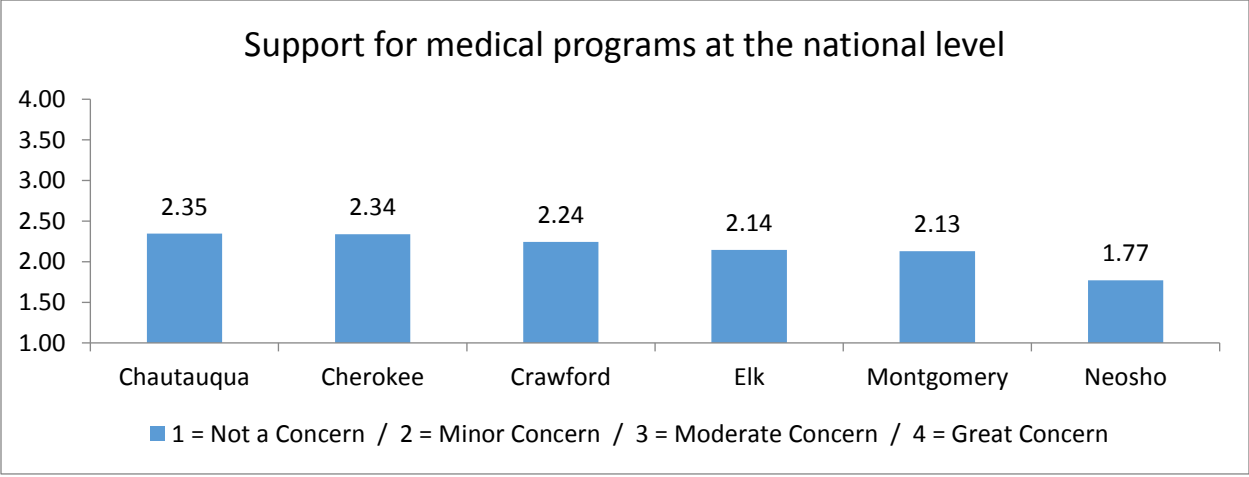
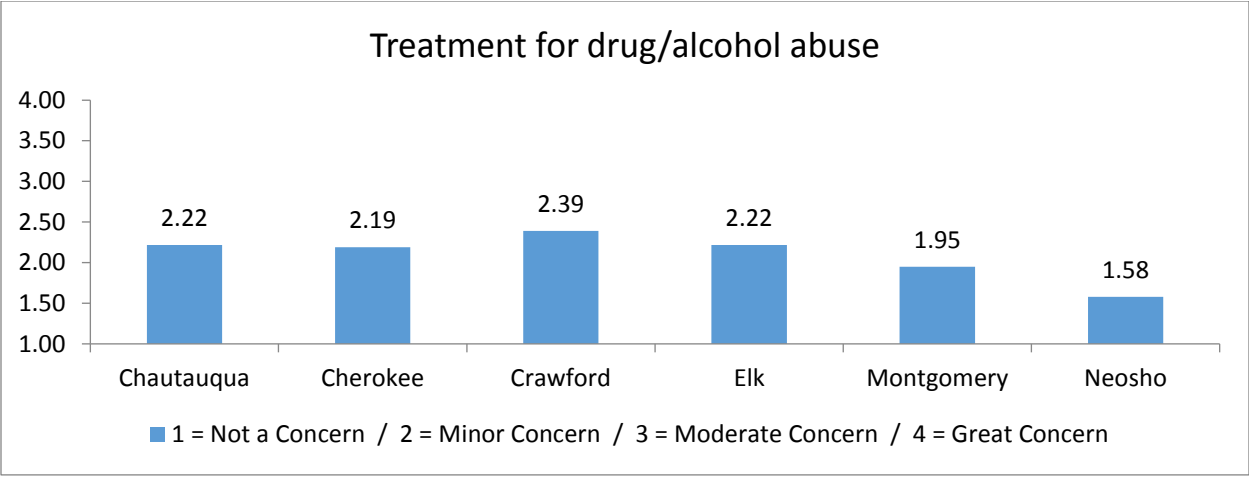
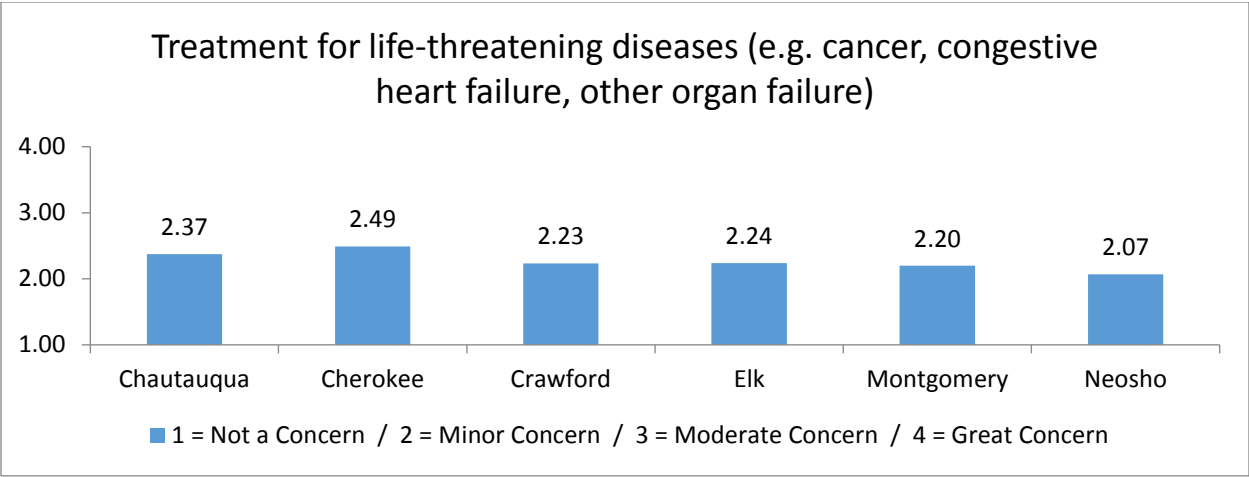
Drug/alcohol abuse prevention/education

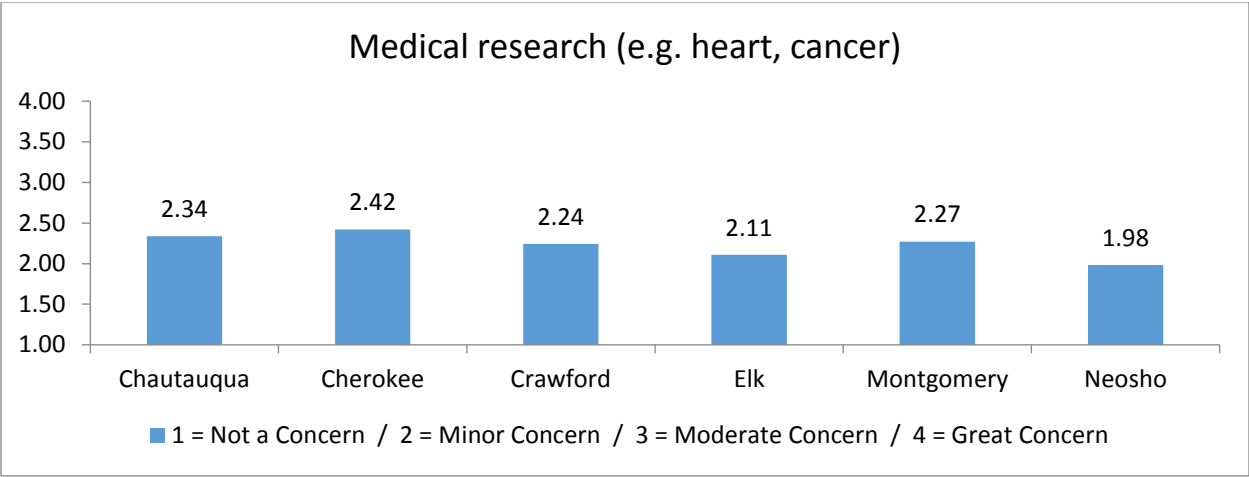


Gambling addiction prevention/education









Appendix F

Forces of Change

Southeast Kansas Health Committee

Forces of Change Assessment

This report summarizes the findings from the Forces of Change assessments conducted by the Lower 8 Region CHA team.

This report contains the following components:

1. Introduction
2. Summary of Findings and Recurrent Themes
3. Forces of Change Summary Table
4. Forces of Change Wall Sheets
5. Forces of Change Brainstorming Worksheet

1. Introduction

As a component of the CHA process outlined by the Mobilizing for Action through Planning and Partnerships (MAPP) tool, the Forces of Change (FOC) assessment is designed to help participants answer two questions: “What is occurring or might occur that affects the health of our community or the local public health system?” and “What specific threats or opportunities are generated by these occurrences?” The exercise is designed to produce a comprehensive but focused list that identifies key forces and describes their effects.

For the purpose of the FOC exercise, forces are defined as broad and all-encompassing, to include trends, events and factors.

- Trends: patterns over time
- Events: one-time occurrences
- Factors: discrete elements or attributes of a community

Participants in the FOC assessment engage in brainstorming sessions to identify forces pertinent to their community. Once they develop comprehensive list of forces, the identified items are reviewed and discussed more fully. An organized list is developed by combining smaller or linked forces and deleting or adding items as needed. Each force on the final list is then evaluated further, and associated threats and opportunities for the community and local public health system are identified.

The Southeast Kansas Health Committee selected this tool as a part of the MAPP process for assessment. The FOC tool is designed to identify outside factors that shape the environment where change for better health will occur. The force categories generated in the Southeast Kansas brainstorming sessions were categorized into eight domains: ethical, social, environmental, political, technological, economic, legal, and scientific. This report includes a summary of the combined results from the sessions and the identified threats and opportunities.

2. Summary of Findings and Recurrent Themes

Results from the FOC assessment are presented in the summary table. They are categorized by domain and assigned as opportunities or threats according to recommendations from the Southeast Kansas Healthcare Committee.

Economic	Opportunity	Threat
Casino	X	X
Jobs	X	
Medicaid Expansion	X	X
Education/Vocational Training	X	
Lack of Workforce		X
Decrease in Physicians/Family Practice		X
Pharmaceutical Costs		X
Drug use		X
Sidewalks	X	
Lack of Priorities		X
Lack of accountability		X
Affordable transportation		X
Environment	Opportunity	Threat
Quality of food	X	X
Increase in Super bugs		X
Water Contamination		X
Aerosol Plant	X	X
Decrease in vaccinations		X
Fires		X
Highways/Expansions	X	
Safe neighborhoods	X	X
Safe Play Area	X	
Regulation Changes	X	X
Walk/Bike ability	X	
Legislative	Opportunity	Threat
Changes to ACA	X	X
Medicaid Expansion	X	X
Rural Health Clinics	X	X
Backlog of KanCare		X
Reduction of Medical Services		X
Hospital/Medical Facilities Closing		X
Decrease in Providers that accept KanCare		X
Legal	Opportunity	Threat
Changes to ACA	X	X

Abortion		X
Treatment limitations		X
Planned Parenthood Funding		X
Power of Attorney's	X	
STD/HIV Testing	X	
Privacy/HIPAA	X	X
Drug Testing/ Consequences	X	X
Osawatomie Hospital limitations		X
Ethical	Opportunity	Threat
Advance Directives	X	
End of Life Care	X	X
Access To Medical Records	X	X
Genetic Testing	X	X
Abortion		X
Assisted Suicide		X
Lack of Ethics/Family Ethics	X	X
Resource Allocation	X	X
Drug Use/Prescription Drug Use		X
Rationing of Care		X
Immunization Opt Out		X
Technology	Opportunity	Threat
TeleMed Not Covered by insurance		X
Lack of High Quality Internet		X
Lack of cell phone reception		X
Social Media/Fake News		X
Robotics	X	
Constant Change	X	X
Double Entry/Duplication		X
Sitting at desk all day		X
Scientific	Opportunity	Threat
New methods to treat/monitor	X	
Genetic Testing	X	X
Government Control		X
New pharmaceuticals	X	
Political	Opportunity	Threat
Governor Change	X	X
Presidential Change	X	X
Health Care Changes	X	X
Politics in everything		X

Appendix G

National Public Health Performance Standards Assessment Results



National Public Health Performance Standards



Southeast Kansas Health Committee Assessment Report



Acknowledgements

The National Public Health Performance Standards (NPHPS) was developed collaboratively by the program's national partner organizations. The NPHPS partner organizations include: Centers for Disease Control and Prevention (CDC); American Public Health Association (APHA); Association of State and Territorial Health Officials (ASTHO); National Association of County and City Health Officials (NACCHO); National Association of Local Boards of Health (NALBOH); National Network of Public Health Institutes (NNPHI); and then Public Health Foundation (PHF). We thank the staff of these organizations for their time and expertise in the support of the NPHPS.

Background

The NPHPS is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPS assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards. Through these assessments, responding sites can consider the activities of all public health system partners, thus addressing the activities of all public, private and voluntary entities that contribute to public health within the community.

The NPHPS assessments are intended to help users answer questions such as "What are the components, activities, competencies, and capacities of our public health system?" and "How well are the ten Essential Public Health Services being provided in our system?" The dialogue that occurs in the process of answering the questions in the assessment instrument can help to identify strengths and weaknesses, determine opportunities for immediate improvements, and establish priorities for long term investments for improving the public health system.

Three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health. These instruments are the:

- State Public Health System Performance Assessment Instrument,
- Local Public Health System Performance Assessment Instrument, and
- Public Health Governing Entity Performance Assessment Instrument.

The information obtained from assessments may then be used to improve and better coordinate public health activities at state and local levels. In addition, the results gathered provide an understanding of how state and local public health systems and governing entities are performing. This information helps local, state and national partners make better and more effective policy and resource decisions to improve the nation's public health as a whole.

Introduction

The NPHPS Local Public Health System Assessment Report is designed to help health departments and public health system partners create a snapshot of where they are relative to the National Public Health Performance Standards and to progressively move toward refining and improving outcomes for performance across the public health system.

The NPHPS state, local, and governance instruments also offer opportunity and robust data to link to health departments, public health system partners and/or community-wide strategic planning processes, as well as to Public Health Accreditation Board (PHAB) standards. For example, assessment of the environment external to the public health organization is a key component of all strategic planning, and the NPHPS assessment readily provides a structured process and an evidence-base upon which key organizational decisions may be made and priorities established. The assessment may also be used as a component of community health improvement planning processes, such as Mobilizing for Action through Planning and Partnerships (MAPP) or other community-wide strategic planning efforts, including state health improvement planning and community health improvement planning. The NPHPS process also drives assessment and improvement activities that may be used to support a Health Department in meeting PHAB standards. Regardless of whether using MAPP or another health improvement process, partners should use the NPHPS results to support quality improvement.

The self-assessment is structured around the Model Standards for each of the ten Essential Public Health Services, (EPHS), hereafter referred to as the Essential Services, which were developed through a comprehensive, collaborative process involving input from national, state and local experts in public health. Altogether, for the local assessment, 30 Model Standards serve as quality indicators that are organized into the ten essential public health service areas in the instrument and address the three core functions of public health. Figure 1 below shows how the ten Essential Services align with the three Core Functions of Public Health.

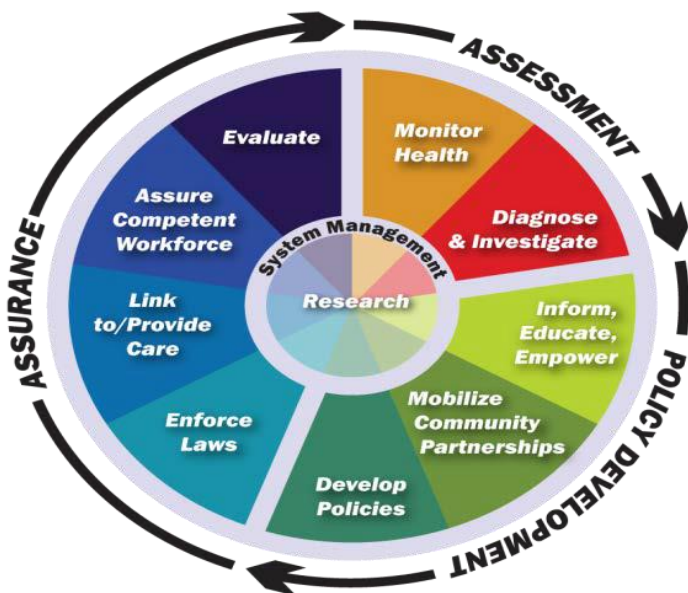


Figure 1. The ten Essential Public Health Services and how they relate to the three Core Functions of Public Health.

Purpose

The primary purpose of the NPHPS Local Public Health System Assessment Report is to promote continuous improvement that will result in positive outcomes for system performance. Local health departments and their public health system partners can use the Assessment Report as a working tool to:

- Better understand current system functioning and performance;
- Identify and prioritize areas of strengths, weaknesses, and opportunities for improvement;
- Articulate the value that quality improvement initiatives will bring to the public health system;
- Develop an initial work plan with specific quality improvement strategies to achieve goals;
- Begin taking action for achieving performance and quality improvement in one or more targeted areas; and
- Re-assess the progress of improvement efforts at regular intervals.

This report is designed to facilitate communication and sharing among and within programs, partners, and organizations, based on a common understanding of how a high performing and effective public health system can operate. This shared frame of reference will help build commitment and focus for setting priorities and improving public health system performance. Outcomes for performance include delivery of all ten essential public health services at optimal levels.

About the Report

Calculating the Scores

The NPHPS assessment instruments are constructed using the ten Essential Services as a framework. Within the Local Instrument, each Essential Service includes between 2-4 Model Standards that describe the key aspects of an optimally performing public health system. Each Model Standard is followed by assessment questions that serve as measures of performance. Responses to these questions indicate how well the Model Standard - which portrays the highest level of performance or "gold standard" - is being met.

Table 1 below characterizes levels of activity for Essential Services and Model Standards. Using the responses to all of the assessment questions, a scoring process generates score for each Model Standard, Essential Service, and one overall assessment score.

Table 1. Summary of Assessment Response Options

Optimal Activity (76-100%)	Greater than 75% of the activity described within the question is met.
Significant Activity (51-75%)	Greater than 50%, but no more than 75% of the activity described within the question is met.
Moderate Activity (26-50%)	Greater than 25%, but no more than 50% of the activity described within the question is met.
Minimal Activity (1-25%)	Greater than zero, but no more than 25% of the activity described within the question is met.
No Activity (0%)	0% or absolutely no activity.

Understanding Data Limitations

There are a number of limitations to the NPHPS assessment data due to self-report, wide variations in the breadth and knowledge of participants, the variety of assessment methods used, and differences in interpretation of assessment questions. Data and resultant information should not be interpreted to reflect the capacity or performance of any single agency or organization within the public health system or used for comparisons between jurisdictions or organizations. Use of NPHPS generated data and associated recommendations are limited to guiding an overall public health infrastructure and performance improvement process for the public health system as determined by organizations involved in the assessment.

All performance scores are an average; Model Standard scores are an average of the question scores within that Model Standard, Essential Service scores are an average of the Model Standard scores within that Essential Service and the overall assessment score is the average of the Essential Service scores. The responses to the questions within the assessment are based upon processes that utilize input from diverse system participants with different experiences and perspectives. The gathering of these inputs and the development of a response for each question incorporates an element of subjectivity, which may be minimized through the use of particular assessment methods. Additionally, while certain assessment methods are recommended, processes differ among sites. The assessment methods are not fully standardized and these differences in administration of the self-assessment may introduce an element of measurement error. In addition, there are differences in knowledge about the public health system among assessment participants. This may lead to some interpretation differences and issues for some questions, potentially introducing a degree of random non-sampling error.

Presentation of results

The NPHPS has attempted to present results - through a variety of figures and tables - in a user-friendly and clear manner. For ease of use, many figures and tables use short titles to refer to Essential Services, Model Standards, and questions. If you are in doubt of these definitions, please refer to the full text in the assessment instruments.

Sites may have chosen to complete two additional questionnaires, the Priority of Model Standards Questionnaire assesses how performance of each Model Standard compares with the priority rating and the Agency Contribution Questionnaire assesses the local health department's contribution to achieving the Model Standard. Sites that submitted responses for these questionnaires will see the results included as additional components of their report.

Results

Now that your assessment is completed, one of the most exciting, yet challenging opportunities is to begin to review and analyze the findings. As you recall from your assessment, the data you created now establishes the foundation upon which you may set priorities for performance improvement and identify specific quality improvement (QI) projects to support your priorities.

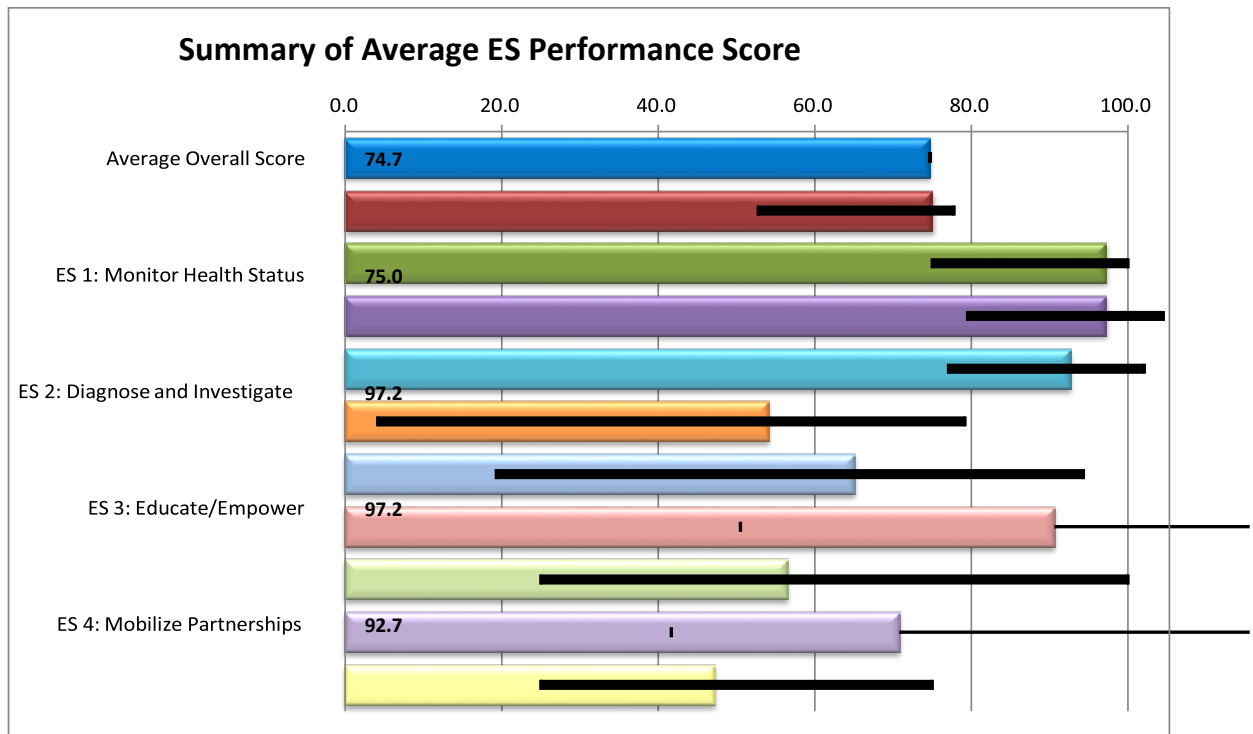
Based upon the responses you provided during your assessment, an average was calculated for each of the ten Essential Services. Each Essential Service score can be interpreted as the overall degree to which your public health system meets the performance standards (quality indicators) for each Essential Service. Scores can range from a minimum value of 0% (no activity is performed pursuant to the standards) to a maximum value of 100% (all activities associated with the standards are performed at optimal levels).

Figure 2 displays the average score for each Essential Service, along with an overall average assessment score across all ten Essential Services. Take a look at the overall performance scores for each Essential Service.

Examination of these scores can immediately give a sense of the local public health system's greatest strengths and weaknesses. Note the black bars that identify the range of reported performance score responses within each Essential Service.

Overall Scores for Each Essential Public Health Service

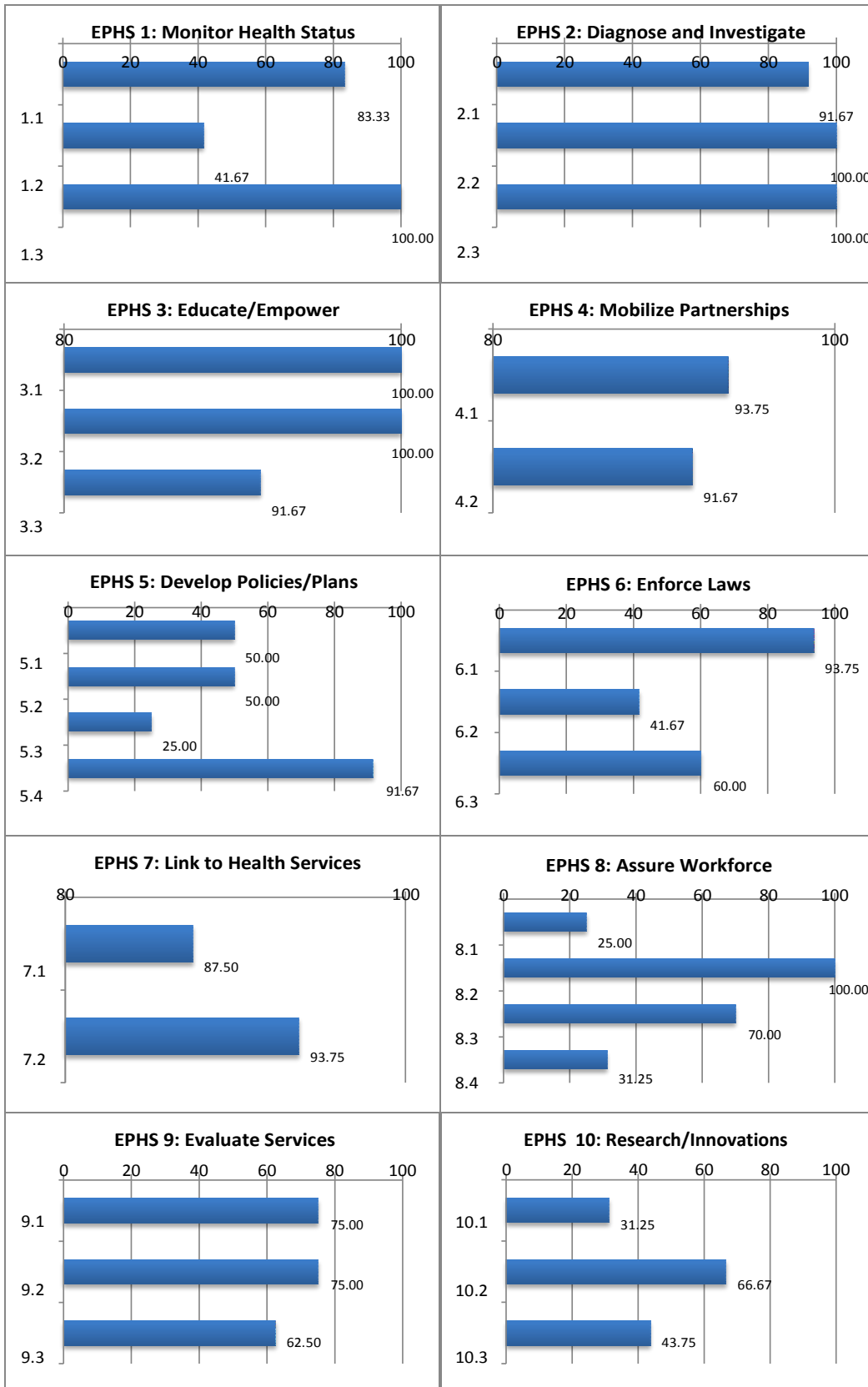
Figure 2. Summary of Average Essential Public Health Service Performance Scores



Performance Scores by Essential Public Health Service for Each Model Standard

Figure 3 and Table 2 on the following pages display the average performance score for each of the Model Standards within each Essential Service. This level of analysis enables you to identify specific activities that contributed to high or low performance within each Essential Service.

Figure 3. Performance Scores by Essential Public Health Service for Each Model Standard



Performance Relative to Optimal Activity

Figures 4 and 5 display the proportion of performance measures that met specified thresholds of achievement for performance standards. The five threshold levels of achievement used in scoring these measures are shown in the legend below. For example, measures receiving a composite score of 76-100% were classified as meeting performance standards at the optimal level.

Figure 4. Percentage of the system's Essential Services scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 2, summarizing the composite performance measures for all 10 Essential Services.

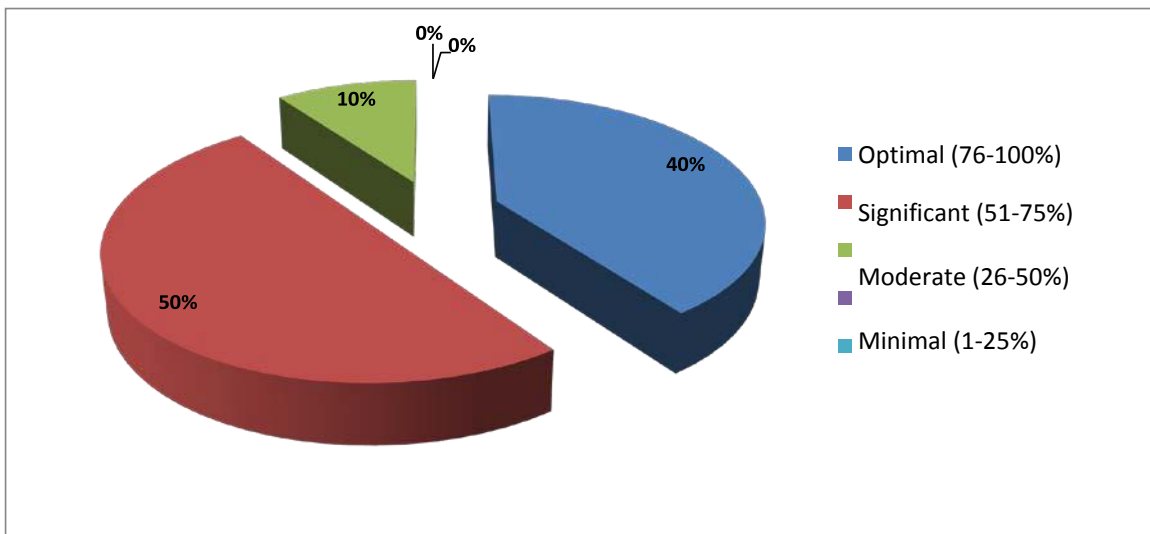
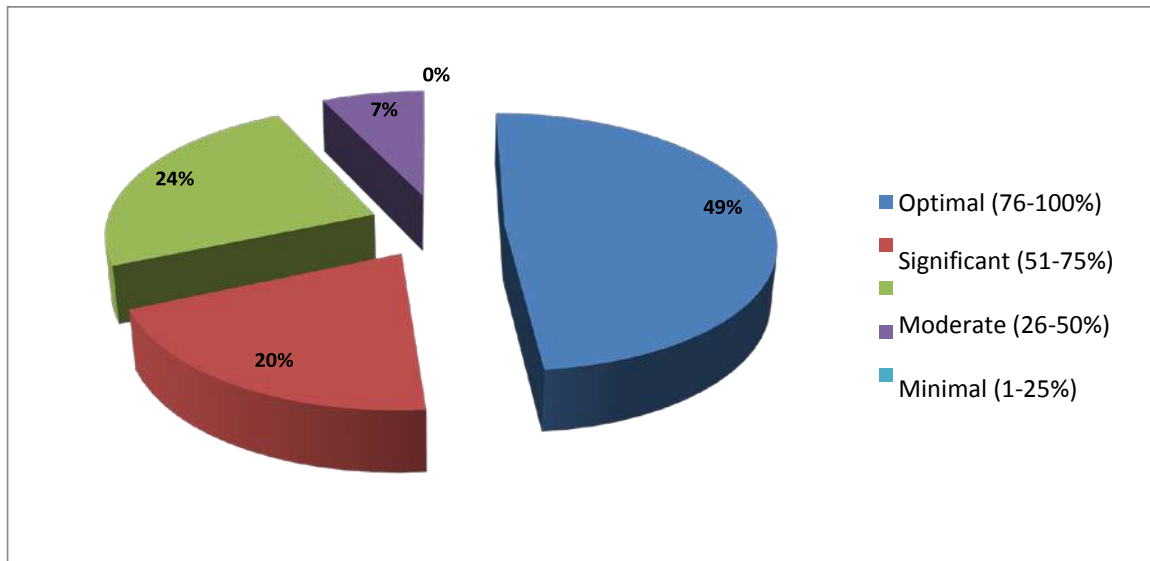


Figure 5. Percentage of the system's Model Standard scores that fall within the five activity categories. This chart provides a high level snapshot of the information found in Figure 3, summarizing the composite measures for all 30 Model Standards.



APPENDIX A: Individual Questions and Responses

Performance Scores

ESSENTIAL SERVICE 1: Monitor Health Status to Identify Community Health Problems		
1.1	Model Standard: Population-Based Community Health Assessment (CHA) <i>At what level does the local public health system:</i>	
1.1.1	Conduct regular community health assessments?	100
1.1.2	Continuously update the community health assessment with current information?	50
1.1.3	Promote the use of the community health assessment among community members and partners?	100
1.2	Model Standard: Current Technology to Manage and Communicate Population Health Data <i>At what level does the local public health system:</i>	
1.2.1	Use the best available technology and methods to display data on the public's health?	50
1.2.2	Analyze health data, including geographic information, to see where health problems exist?	50
1.2.3	Use computer software to create charts, graphs, and maps to display complex public health data (trends over time, sub-population analyses, etc.)?	25
1.3	Model Standard: Maintenance of Population Health Registries <i>At what level does the local public health system:</i>	
1.3.1	Collect data on specific health concerns to provide the data to population health registries in a timely manner, consistent with current standards?	100
1.3.2	Use information from population health registries in community health assessments or other analyses?	100

ESSENTIAL SERVICE 2: Diagnose and Investigate Health Problems and Health Hazards		
2.1	Model Standard: Identification and Surveillance of Health Threats <i>At what level does the local public health system:</i>	
2.1.1	Participate in a comprehensive surveillance system with national, state and local partners to identify, monitor, share information, and understand emerging health problems and threats?	100
2.1.2	Provide and collect timely and complete information on reportable diseases and potential disasters, emergencies and emerging threats (natural and manmade)?	100
2.1.3	Assure that the best available resources are used to support surveillance systems and activities, including information technology, communication systems, and professional expertise?	75
2.2	Model Standard: Investigation and Response to Public Health Threats and Emergencies <i>At what level does the local public health system:</i>	

2.2.1	Maintain written instructions on how to handle communicable disease outbreaks and toxic exposure incidents, including details about case finding, contact tracing, and source identification and containment?	100
2.2.2	Develop written rules to follow in the immediate investigation of public health threats and emergencies, including natural and intentional disasters?	100
2.2.3	Designate a jurisdictional Emergency Response Coordinator?	100
2.2.4	Prepare to rapidly respond to public health emergencies according to emergency operations coordination guidelines?	100
2.2.5	Identify personnel with the technical expertise to rapidly respond to possible biological, chemical, or and nuclear public health emergencies?	100
2.2.6	Evaluate incidents for effectiveness and opportunities for improvement?	100
2.3	Model Standard: Laboratory Support for Investigation of Health Threats <i>At what level does the local public health system:</i>	
2.3.1	Have ready access to laboratories that can meet routine public health needs for finding out what health problems are occurring?	100
2.3.2	Maintain constant (24/7) access to laboratories that can meet public health needs during emergencies, threats, and other hazards?	100
2.3.3	Use only licensed or credentialed laboratories?	100
2.3.4	Maintain a written list of rules related to laboratories, for handling samples (collecting, labeling, storing, transporting, and delivering), for determining who is in charge of the samples at what point, and for reporting the results?	100

ESSENTIAL SERVICE 3: Inform, Educate, and Empower People about Health Issues

3.1	Model Standard: Health Education and Promotion <i>At what level does the local public health system:</i>	
3.1.1	Provide policymakers, stakeholders, and the public with ongoing analyses of community health status and related recommendations for health promotion policies?	100
3.1.2	Coordinate health promotion and health education activities to reach individual, interpersonal, community, and societal levels?	100
3.1.3	Engage the community throughout the process of setting priorities, developing plans and implementing health education and health promotion activities?	100
3.2	Model Standard: Health Communication <i>At what level does the local public health system:</i>	
3.2.1	Develop health communication plans for relating to media and the public and for sharing information among LPHS organizations?	100
3.2.2	Use relationships with different media providers (e.g. print, radio, television, and the internet) to share health information, matching the message with the target audience?	100

3.2.3	Identify and train spokespersons on public health issues?	100
3.3	Model Standard: Risk Communication <i>At what level does the local public health system:</i>	
3.3.1	Develop an emergency communications plan for each stage of an emergency to allow for the effective dissemination of information?	100
3.3.2	Make sure resources are available for a rapid emergency communication response?	100
3.3.3	Provide risk communication training for employees and volunteers?	75

ESSENTIAL SERVICE 4: Mobilize Community Partnerships to Identify and Solve Health Problems

4.1	Model Standard: Constituency Development <i>At what level does the local public health system:</i>	
4.1.1	Maintain a complete and current directory of community organizations?	75
4.1.2	Follow an established process for identifying key constituents related to overall public health interests and particular health concerns?	100
4.1.3	Encourage constituents to participate in activities to improve community health?	100
4.1.4	Create forums for communication of public health issues?	100
4.2	Model Standard: Community Partnerships <i>At what level does the local public health system:</i>	
4.2.1	Establish community partnerships and strategic alliances to provide a comprehensive approach to improving health in the community?	100
4.2.2	Establish a broad-based community health improvement committee?	75
4.2.3	Assess how well community partnerships and strategic alliances are working to improve community health?	100

ESSENTIAL SERVICE 5: Develop Policies and Plans that Support Individual and Community Health Efforts

5.1	Model Standard: Governmental Presence at the Local Level <i>At what level does the local public health system:</i>	
5.1.1	Support the work of a local health department dedicated to the public health to make sure the essential public health services are provided?	75
5.1.2	See that the local health department is accredited through the national voluntary accreditation program?	25
5.1.3	Assure that the local health department has enough resources to do its part in providing essential public health services?	50
5.2	Model Standard: Public Health Policy Development <i>At what level does the local public health system:</i>	
5.2.1	Contribute to public health policies by engaging in activities that inform the policy development process?	25

5.2.2	Alert policymakers and the community of the possible public health impacts (both intended and unintended) from current and/or proposed policies?	25
5.2.3	Review existing policies at least every three to five years?	25
5.3	Model Standard: Community Health Improvement Process and Strategic Planning <i>At what level does the local public health system:</i>	
5.3.1	Establish a community health improvement process, with broad-based diverse participation, that uses information from both the community health assessment and the perceptions of community members?	25
5.3.2	Develop strategies to achieve community health improvement objectives, including a description of organizations accountable for specific steps?	25
5.3.3	Connect organizational strategic plans with the Community Health Improvement Plan?	25
5.4	Model Standard: Plan for Public Health Emergencies <i>At what level does the local public health system:</i>	
5.4.1	Support a workgroup to develop and maintain preparedness and response plans?	75
5.4.2	Develop a plan that defines when it would be used, who would do what tasks, what standard operating procedures would be put in place, and what alert and evacuation protocols would be followed?	100
5.4.3	Test the plan through regular drills and revise the plan as needed, at least every two years?	100

ESSENTIAL SERVICE 6: Enforce Laws and Regulations that Protect Health and Ensure Safety

6.1	Model Standard: Review and Evaluation of Laws, Regulations, and Ordinances <i>At what level does the local public health system:</i>	
6.1.1	Identify public health issues that can be addressed through laws, regulations, or ordinances?	75
6.1.2	Stay up-to-date with current laws, regulations, and ordinances that prevent, promote, or protect public health on the federal, state, and local levels?	100
6.1.3	Review existing public health laws, regulations, and ordinances at least once every five years?	100
6.1.4	Have access to legal counsel for technical assistance when reviewing laws, regulations, or ordinances?	100
6.2	Model Standard: Involvement in the Improvement of Laws, Regulations, and Ordinances <i>At what level does the local public health system:</i>	
6.2.1	Identify local public health issues that are inadequately addressed in existing laws, regulations, and ordinances?	50

6.2.2	Participate in changing existing laws, regulations, and ordinances, and/or creating new laws, regulations, and ordinances to protect and promote the public health?	50
6.2.3	Provide technical assistance in drafting the language for proposed changes or new laws, regulations, and ordinances?	25
6.3	Model Standard: Enforcement of Laws, Regulations, and Ordinances <i>At what level does the local public health system:</i>	
6.3.1	Identify organizations that have the authority to enforce public health laws, regulations, and ordinances?	50
6.3.2	Assure that a local health department (or other governmental public health entity) has the authority to act in public health emergencies?	50
6.3.3	Assure that all enforcement activities related to public health codes are done within the law?	75
6.3.4	Educate individuals and organizations about relevant laws, regulations, and ordinances?	50
6.3.5	Evaluate how well local organizations comply with public health laws?	75

ESSENTIAL SERVICE 7: Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable

7.1	Model Standard: Identification of Personal Health Service Needs of Populations <i>At what level does the local public health system:</i>	
7.1.1	Identify groups of people in the community who have trouble accessing or connecting to personal health services?	100
7.1.2	Identify all personal health service needs and unmet needs throughout the community?	75
7.1.3	Defines partner roles and responsibilities to respond to the unmet needs of the community?	100
7.1.4	Understand the reasons that people do not get the care they need?	75
7.2	Model Standard: Assuring the Linkage of People to Personal Health Services <i>At what level does the local public health system:</i>	
7.2.1	Connect (or link) people to organizations that can provide the personal health services they may need?	100
7.2.2	Help people access personal health services, in a way that takes into account the unique needs of different populations?	100
7.2.3	Help people sign up for public benefits that are available to them (e.g., Medicaid or medical and prescription assistance programs)?	100
7.2.4	Coordinate the delivery of personal health and social services so that everyone has access to the care they need?	75

ESSENTIAL SERVICE 8: Assure a Competent Public and Personal Health Care Workforce

8.1	Model Standard: Workforce Assessment, Planning, and Development <i>At what level does the local public health system:</i>	
8.1.1	Set up a process and a schedule to track the numbers and types of LPHS jobs and the knowledge, skills, and abilities that they require whether those jobs are in the public or private sector?	25
8.1.2	Review the information from the workforce assessment and use it to find and address gaps in the local public health workforce?	25
8.1.3	Provide information from the workforce assessment to other community organizations and groups, including governing bodies and public and private agencies, for use in their organizational planning?	25
8.2	Model Standard: Public Health Workforce Standards <i>At what level does the local public health system:</i>	
8.2.1	Make sure that all members of the public health workforce have the required certificates, licenses, and education needed to fulfill their job duties and meet the law?	100
8.2.2	Develop and maintain job standards and position descriptions based in the core knowledge, skills, and abilities needed to provide the essential public health services?	100
8.2.3	Base the hiring and performance review of members of the public health workforce in public health competencies?	100
8.3	Model Standard: Life-Long Learning through Continuing Education, Training, and Mentoring <i>At what level does the local public health system:</i>	
8.3.1	Identify education and training needs and encourage the workforce to participate in available education and training?	100
8.3.2	Provide ways for workers to develop core skills related to essential public health services?	75
8.3.3	Develop incentives for workforce training, such as tuition reimbursement, time off for class, and pay increases?	75
8.3.4	Create and support collaborations between organizations within the public health system for training and education?	75
8.3.5	Continually train the public health workforce to deliver services in a cultural competent manner and understand social determinants of health?	25
8.4	Model Standard: Public Health Leadership Development <i>At what level does the local public health system:</i>	
8.4.1	Provide access to formal and informal leadership development opportunities for employees at all organizational levels?	25
8.4.2	Create a shared vision of community health and the public health system, welcoming all leaders and community members to work together?	25
8.4.3	Ensure that organizations and individuals have opportunities to provide leadership in areas where they have knowledge, skills, or access to resources?	50

8.4.4	Provide opportunities for the development of leaders representative of the diversity within the community?	25
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ESSENTIAL SERVICE 9: Evaluate Effectiveness, Accessibility, and Quality of Personal and Population- Based Health Services

9.1	Model Standard: Evaluation of Population-Based Health Services <i>At what level does the local public health system:</i>	
9.1.1	Evaluate how well population-based health services are working, including whether the goals that were set for programs were achieved?	50
9.1.2	Assess whether community members, including those with a higher risk of having a health problem, are satisfied with the approaches to preventing disease, illness, and injury?	100
9.1.3	Identify gaps in the provision of population-based health services?	100
9.1.4	Use evaluation findings to improve plans and services?	50
9.2	Model Standard: Evaluation of Personal Health Services <i>At what level does the local public health system:</i>	
9.2.1	Evaluate the accessibility, quality, and effectiveness of personal health services?	75
9.2.2	Compare the quality of personal health services to established guidelines?	75
9.2.3	Measure satisfaction with personal health services?	75
9.2.4	Use technology, like the internet or electronic health records, to improve quality of care?	75
9.2.5	Use evaluation findings to improve services and program delivery?	75
9.3	Model Standard: Evaluation of the Local Public Health System <i>At what level does the local public health system:</i>	
9.3.1	Identify all public, private, and voluntary organizations that provide essential public health services?	75
9.3.2	Evaluate how well LPHS activities meet the needs of the community at least every five years, using guidelines that describe a model LPHS and involving all entities contributing to essential public health services?	100
9.3.3	Assess how well the organizations in the LPHS are communicating, connecting, and coordinating services?	25
9.3.4	Use results from the evaluation process to improve the LPHS?	50

ESSENTIAL SERVICE 10: Research for New Insights and Innovative Solutions to Health Problems

10.1	Model Standard: Fostering Innovation <i>At what level does the local public health system:</i>	
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10.1.1	Provide staff with the time and resources to pilot test or conduct studies to test new solutions to public health problems and see how well they actually work?	25
10.1.2	Suggest ideas about what currently needs to be studied in public health to organizations that do research?	25
10.1.3	Keep up with information from other agencies and organizations at the local, state, and national levels about current best practices in public health?	50
10.1.4	Encourage community participation in research, including deciding what will be studied, conducting research, and in sharing results?	25
10.2	Model Standard: Linkage with Institutions of Higher Learning and/or Research <i>At what level does the local public health system:</i>	
10.2.1	Develop relationships with colleges, universities, or other research organizations, with a free flow of information, to create formal and informal arrangements to work together?	75
10.2.2	Partner with colleges, universities, or other research organizations to do public health research, including community-based participatory research?	75
10.2.3	Encourage colleges, universities, and other research organizations to work together with LPHS organizations to develop projects, including field training and continuing education?	50
10.3	Model Standard: Capacity to Initiate or Participate in Research <i>At what level does the local public health system:</i>	
10.3.1	Collaborate with researchers who offer the knowledge and skills to design and conduct health-related studies?	75
10.3.2	Support research with the necessary infrastructure and resources, including facilities, equipment, databases, information technology, funding, and other resources?	50
10.3.3	Share findings with public health colleagues and the community broadly, through journals, websites, community meetings, etc?	25
10.3.4	Evaluate public health systems research efforts throughout all stages of work from planning to impact on local public health practice?	25

Appendix H

Mental Health Infographics

Mental Health Facts MULTICULTURAL

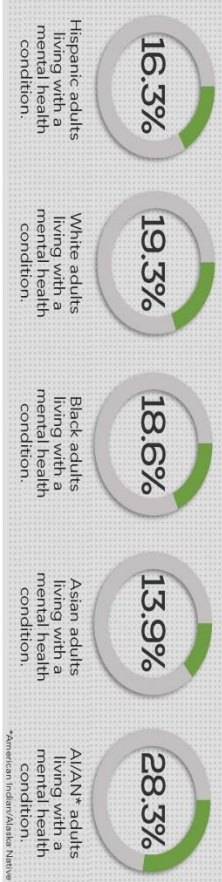
Fact: Mental health affects everyone regardless of culture, race, ethnicity, gender or sexual orientation.

1 in every 5 adults in America experience a mental illness.

Nearly 1 in 25 (10 million) adults in America live with a serious mental illness.

One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.

Prevalence of Adult Mental Illness by Race



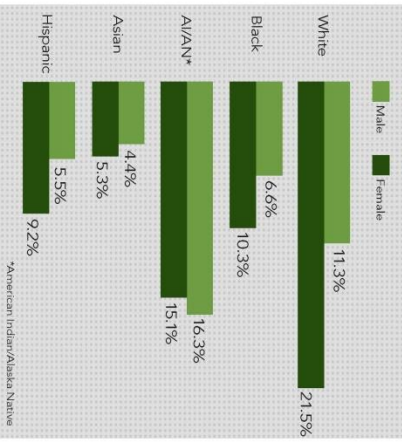
LGBTQ Community

2X LGBTQ individuals are 2 or more times more likely as straight individuals to have a mental health condition.

11% 11% of transgender individuals reported being denied care by mental health clinics due to bias or discrimination.

2-3X Lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth are 2 to 3 times more likely to attempt suicide than straight youth.

Use of Mental Health Services among Adults (2008-2012)



Critical Issues Faced by Multicultural Communities

- ✓ Less access to treatment
- ✓ Less likely to receive treatment
- ✓ Poorer quality of care
- ✓ Higher levels of stigma
- ✓ Culturally insensitive health care system
- ✓ Racism, bias, homophobia or discrimination in treatment settings
- ✓ Language barriers
- ✓ Lower rates of health insurance

Ways to Get Help

Talk with your doctor

Connect with other individuals and families

Learn more about mental illness

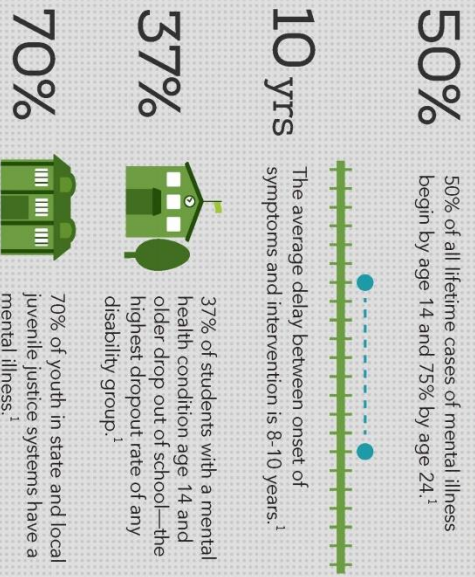
Visit NAMH.org

Mental Health Facts CHILDREN & TEENS

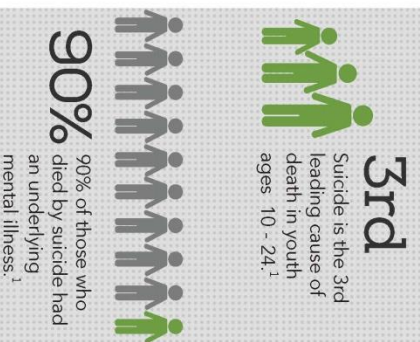
Fact: 1 in 5 children ages 13-18 have, or will have a serious mental illness.¹



Impact



Suicide



Warning Signs

- ⚠ Feeling very sad or withdrawn for more than 2 weeks (e.g., crying regularly, feeling fatigued, feeling unmotivated).
- ⚠ Trying to harm or kill oneself or making plans to do so.
- ⚠ Out-of-control, risk-taking behaviors that can cause harm to self or others.
- ⚠ Sudden overwhelming fear for no reason, sometimes with a racing heart, physical discomfort or fast breathing.
- ⚠ Not eating, throwing up or using laxatives to lose weight; significant weight loss or gain.
- ⚠ Severe mood swings that cause problems in relationships.
- ⚠ Repeated use of drugs or alcohol.
- ⚠ Drastic changes in behavior, personality or sleeping habits (e.g., waking up early and acting agitated).
- ⚠ Extreme difficulty in concentrating or staying still that can lead to failure in school.
- ⚠ Intense worries or fears that get in the way of daily activities like hanging out with friends or going to classes.

4 Things Parents Can Do

- Talk with your pediatrician
- Get a referral to a mental health specialist
- Work with the school
- Connect with other families

¹The document cites statistics provided by the National Institute of Mental Health, www.nimh.nih.gov

Mental Health Facts IN AMERICA

Fact: 43.8 million adults experience mental illness in a given year.



1 in 5 adults in America experience a mental illness.



Nearly 1 in 25 (10 million) adults in America live with a serious mental illness.



One-half of all chronic mental illness begins by the age of 14; three-quarters by the age of 24.

Prevalence of Mental Illness by Diagnosis



Consequences



10.2m
Approximately 10.2 million adults have **co-occurring** mental health and addiction disorders.¹



26%
Approximately 26% of **homeless** adults staying in shelters live with serious mental illness.¹



24%
Approximately 24% of **state prisoners** have "a recent history of a mental health condition."²

Impact



1st
Depression is the leading cause of disability worldwide, and is a major contributor to the global burden of disease.¹



-\$193b
Serious mental illness costs America \$193.2 billion in lost earning every year.³



90%
90% of those who die by suicide have an underlying mental illness. Suicide is the 10th leading cause of death in the U.S.⁴

Treatment in America



Ways to Get Help



Talk with your doctor



Connect with other individuals and families



Learn more about mental illness



Visit NAMI.org

¹ The Department of Health and Human Services, National Institute of Mental Health, www.nimh.nih.gov
² American Journal of Psychiatry and U.S. Sentences Community Report, 1999
³ Substance Abuse and Mental Health Services Administration
⁴ National Institute of Mental Health
⁵ National Institute of Mental Health
⁶ National Institute of Mental Health

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