2022

SPRINGFIELD COMMUNITY SUMMARY

Regional Health Assessment

OZARKS HEALTHCOMMISSION

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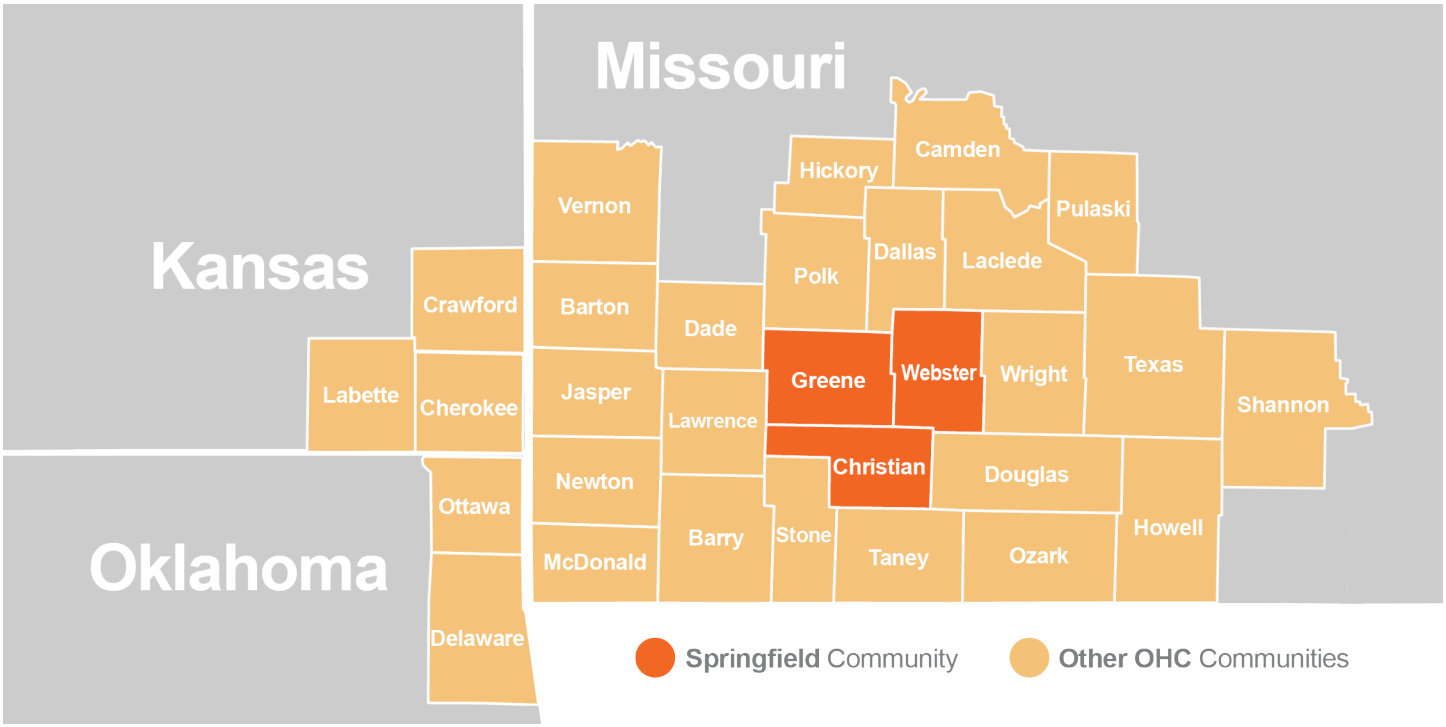
INTRODUCTION

Recognizing the value of assessing and acting together on local health issues, a variety of organizations have collaborated under the umbrella of the Ozarks Health Commission (OHC) to publish regional health assessments every three years since 2016. One of the goals of this report is to recognize an optimal state of health for everyone as a shared value within our community.

Building upon the success of the 2016 and 2019 regional health assessments, in 2021 partners again sought to better understand the health status, behaviors and needs of the populations served. The resulting 2022 Regional Health Assessment (RHA) combines more than 200 hospital and community indicators, including feedback from stakeholders and citizens, across a 30-county region that includes southwest Missouri, southeast Kansas and northeast Oklahoma. The full Ozarks Health Commission RHA can be found at http://ozarkshealthcommission.org/.

Within the OHC Region, seven multi-county Communities were defined based on hospital service areas. Using the data from the RHA, each Community identified priority health issues and published a Community Summary. The Springfield Community consists of 3 counties: Greene, Christian and Webster. Participating hospitals in the Springfield Community include CoxHealth Medical Center South, CoxHealth North Hospital and Mercy Hospital Springfield.

The Springfield Community Summary serves to provide data analysis on the prioritized health needs identified through the assessment process. Furthermore, the assessment was conducted to comply with requirements set forth in the Affordable Care Act, public health accreditation and to further the commitment of the OHC to improve the health of the community and its citizens.



SERVICE AREA

The Springfield Community is made up of 3 Missouri counties: Christian, Greene and Webster Counties. On the Ozarks Health Commission, CoxHealth System, Mercy Hospital System, Burrell Behavioral Health, Jordan Valley Community Health Center, Christian County Health Department, Springfield-Greene County Health Department and Webster County Health Department represent the Springfield Community.

CoxHealth System is the largest employer in the Springfield region, offering high-quality medical services to populations in Southwest Missouri and Northwest Arkansas. The not-for-profit health system, headquartered locally, has two large campuses and a total of 31 CoxHealth facilities in Springfield, ranging from walk-in clinics to the Cox Medical Center South Emergency and Trauma Center and from the Meyer Orthopedic and Rehabilitation Hospital to the CoxHealth Surgery Center.

Mercy Hospital system serves millions each year. Mercy is a cutting-edge healthcare provider that is charged with “providing the region with high-quality care and an experience that is easier and more personal.” Mercy Hospital Springfield houses 886 beds that serve people throughout Southwest Missouri and Northwest Arkansas.

Burrell Behavioral Health is the third largest Certified Community Behavioral Health Center in the nation with multiple locations throughout Springfield and surrounding areas. Burrell has more than 400 licensed providers offering a full continuum of care through their integrated network. Burrell has continued to expand their reach and partnerships in the community through offering community-based services in coordination with schools and other organizations, such as Boys & Girls Clubs Springfield to meet the behavioral health needs of the community.

Jordan Valley Community Health Center is Missouri’s largest Federally Qualified Health Center serving 75,000 patients in the Ozarks each year. Founded in 2003, their mission to improve the community’s health through access and relationships has driven their growth from their first medical clinic located in a strip mall to nine clinics, three school-based clinics and a fleet of mobile units that visit schools and organizations providing medical, dental, vision and behavioral health care services in southwest Missouri. Jordan Valley Community Health Center provides an integrated model of care, simplifying healthcare by giving access to a multitude of services in each clinic.

In 1968 a public health office was established in Ozark, Missouri, under the auspices of the Ozarks Area Community Action Agency Corporation, with funding shared by the federal government and the Missouri Department of Health. Two years later the Christian County Health Department (CCHD) was created by a vote of the residents of the county. CCHD's mission is to serve and protect the county citizens by promoting healthy behaviors, increasing understanding of health issues and improving the quality of the environment. The department offers a variety of programs to serve the needs of Christian County residents.

The Webster County Health Department (WCHD) was established in 1957 in order to preserve and protect public health of the community. WCHD's focus is on teaching, protecting and empowering people so that they don't get sick. By providing vaccinations, offering nutrition education, ensuring clean water and safe food, and providing screening and testing services, WCHD protects individual and community health.

Springfield-Greene County Health (SGCHD) was established by the City of Springfield in 1873 as the Springfield Department of Health. The name was changed, and services were expanded to the entire county in 1976. The mission of SCGHD is to protect and improve community health through education, collaboration and prevention. Through chronic disease prevention, community health & epidemiology, environmental health and other programs, SGCHD can help the citizens of Greene County live longer, happier and healthier lives.

POPULATION OVERVIEW

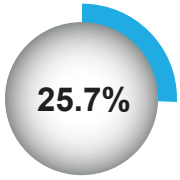
More than 414,000 residents call the Springfield Community home, and it only continues to grow. Between 2000 and 2010, there was nearly a 20% increase in total population followed by a smaller, but still significant, increase of 10% in the years between 2010 and 2020. Roughly evenly split among men and women, almost 15% of those who call the Springfield Community home describe living with a disability and about 6% claim veteran status.

Those that live in this community overwhelmingly identify as Non-Hispanic White persons who were born in the United States. These citizens, however, are not the only people shaping the vibrant Springfield Community. Self-identified persons of color compose more than 10% of the Springfield Community's population. Many more have come to live in this community after being naturalized, born abroad, or born in a US Territory. Close to 5,700 people (slightly more than 1% of all residents) are not US citizens but have chosen to bring their talents and perspective to the Community.

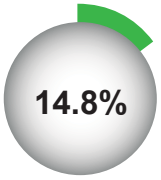
Three in four community residents live in a census tract designated as 'urban'. Amongst rural and urban residents, about 28% of families have children under the age of 18 living at home. In fact, more than 20% of the community is comprised of individuals younger than 18 years old. Seniors, those age 65 and older, make up about 16% of the total population.

Understanding community-wide disparities and challenges while also ensuring that each of the individuals that comprise the Springfield Community have the opportunity to live meaningful, healthy, and long lives is the purpose of this assessment.

SPRINGFIELD DEMOGRAPHICS



RURAL POPULATION



DISABILITY STATUS

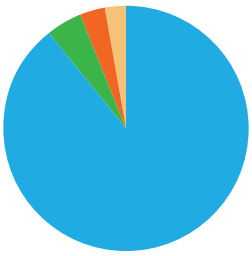
FAMILIES

Families with children make up **28%** of the Springfield Community population.

POPULATION

The Springfield Community population has **increased** by **9.8%** since 2010.

RACE & ETHNICITY



- Non-Hispanic White (89.3%)
- Non-Hispanic Non-White (4.7%)
- Hispanic (3.4%)
- Black (2.6%)

POPULATIONS OF INTEREST

While understanding the health of each person living in the Springfield Community is imperative, some subsets of the population have disparate needs and challenges. Historically disenfranchised populations - such as people in poverty, minorities and the elderly- often experience higher rates of chronic illness and worse health outcomes, due to a multitude of structural and environmental factors. This can lead to health disparities between various socioeconomic classes and/or demographic groups.

Using the Centers for Disease Control and Prevention (CDC) Social Vulnerability Index[1], the OHC identified key factors, or populations, to consider when developing actions to improve prioritized health needs. The table below includes percentile rankings (values range from 0 – 1), with higher values indicative of greater vulnerability for each population. It also highlights populations that are 80%, 85%, and 90% more vulnerable than the same population in other counties in its respective state. For example, Webster County has more youth than 99% of counties in Missouri- Christian County has more than 95% of Missouri counties. For more information about the methodology used in the CDC's Social Vulnerability Index can be found on their website.

Those living in the Springfield Community are nearly 80% more likely than other Missourians to live in multi-unit structures and are 77% more at-risk of living in a crowded home. Though a relatively small percentage of community residents are not native US citizens, residents report speaking English 'less than well' at a rate higher than 74% of Missouri counties. These examples indicate known barriers to health and healthcare, which is why populations experiencing these issues are of special interest in this assessment. The needs of children aged 18 years and younger, those living in crowded or multi-unit housing, and those who may have health literacy challenges should be considered when developing Community Health Improvement Plan (CHIP) strategies for this area.

WHAT MAKES A POPULATION VULNERABLE?

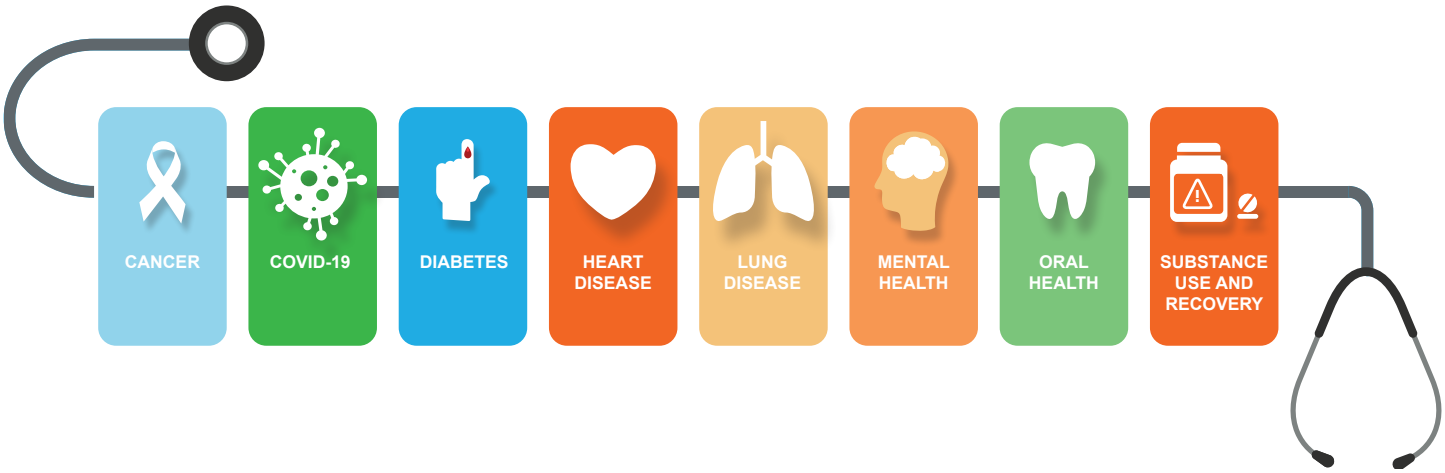
		Christian County	Greene County	Webster County	Springfield Community
SOCIO-ECONOMIC STATUS	Below Poverty	0.08	0.67	0.54	0.43
	Unemployed	0.33	0.38	0.46	0.39
	Income	0.20	0.24	0.74	0.39
	No High School Diploma	0.08	0.10	0.52	0.23
HOUSEHOLD COMPOSITION & DISABILITY	Aged 65+	0.12	0.18	0.13	0.15
	Under Age 18	**0.95**	0.16	**0.99**	0.70
	Disability Status	0.14	0.27	0.27	0.23
	Single-Parent Households	0.51	0.36	0.23	0.37
MINORITY STATUS & LANGUAGE	Minority	0.55	0.77	0.38	0.57
	Speaks English "Less than Well"	0.61	0.73	**0.89**	0.74
HOUSING TYPE & TRANSPORTATION	Multi-Unit Structures	0.75	**0.97**	0.65	0.79
	Mobile Homes	0.12	0.05	0.54	0.24
	Crowding	0.69	0.67	**0.96**	0.77
	No Vehicle	0.00	0.70	0.75	0.48
	Group Quarters	0.01	0.76	0.61	0.46

Unless otherwise noted, all numbers are percentile rankings with values ranging from 0 to 1, with higher values indicative of greater vulnerability. Percentiles are from the CDC's SVI data.

Orange highlight: The population in this county is more vulnerable than 90% of all other counties in its respective state.

Blue highlight: The population in this county is more vulnerable than 85% of all other counties in its respective state.

ASSESSED HEALTH ISSUES



OHC Region stakeholders began the RHA process with analysis of publicly available health data and participating health systems' emergency department utilization data to identify health issues of greatest concern across the region. The result was a ranked list of eight Ozarks Health Commission Region health issues. A full description of the health issues and indicators used can be found in the OHC Regional Health Assessment.

To represent diverse views from across the region and population, qualitative data was collected between July and October 2021. Across the OHC Region these viewpoints were solicited via 75 individual interviews, 10 focus groups and 2,638 surveys. Specifically in the Springfield Community, 20 individual interviews were held with stakeholders and 3 virtual focus groups were held with local health system leaders, community outreach organizations, and a local drug task force as well as other sectors of the Springfield Community to allow voices to highlight challenges that they see as the biggest health related needs. Further, approximately 31% of regional survey respondents were from the Springfield Community.

Methodologies used for the initial scoring/ranking of the health issues and the full report of the qualitative work can be found in the OHC Regional Health Assessment. This prioritization information can be used by organizations to develop community health improvement plans, guide decision making, foster collaboration across initiatives for collective community impact and increase funding by using evidence to describe issues and propose solutions.

SPRINGFIELD COMMUNITY HEALTH PRIORITIES

Each OHC Community convened stakeholders to assess the feasibility and readiness to address the health issues identified through emergency department and public health data sources, and further evaluate the qualitative feedback that was garnered through community input (interviews, focus groups and survey responses). In the Springfield Community, Springfield-Greene County Health convened a series of virtual community stakeholders' meetings in December 2021 and January 2022. Efforts were made to engage all public health agencies in the Community (Christian, Greene and Webster Counties), healthcare partners (CoxHealth and Mercy Springfield), mental healthcare partners (Burrell Behavioral Health), Federally Qualified Health Centers (Jordan Valley Community Health Center) and organizations engaged by Crescendo Consulting.

Based on the eight health issues identified by OHC using publicly available and participating health systems' data, stakeholders from the Springfield Community were convened to further consider and identify the top priorities for the community to focus efforts over the next 3 years. During the meetings background data information was given to all participants along with context data gathered through community input. The participants used this information along with their own assessment of feasibility and readiness to change the health issues to answer a survey that was deployed and open for one week. The stakeholders further met to discuss the results of the survey and further rank the issues according to feasibility and readiness to change discussion.

Feasibility of changing each issue and readiness to address each issue was assessed through survey and stakeholder discussion and further ranking. Feasibility rankings were influenced by stakeholders' perceptions of the readiness of the community to address an issue, existing initiatives or momentum, whether leadership was established around the condition, perceived feasibility to change, complexity of the issue and the time frame to improve the issue (within 2-3 years or more than 2-3 years).

The table shows Springfield Community health issue rankings based on emergency department and public health data (left) and the change after feasibility rankings were included (right). The higher the score, the more significant the impact of the condition on the community, and the less difficult the condition is to address. It should be noted that feasibility was assessed using a 4-point scale, and the difference between the highest and lowest scores did not shift dramatically when the feasibility and readiness scores were included.

SPRINGFIELD COMMUNITY PRIORITIZATION

Rank	Initial Ranking Emergency Department and Public Health Data		Final Ranking Emergency Department, Public Health and Feasibility Data		Rank Change
1	Mental Health	3.25	Mental Health	2.94	no change
2	Substance Use & Recovery	2.69	COVID-19	2.78	+1
3	COVID-19	2.58	Substance Use & Recovery	2.66	-1
4	Lung Disease	2.52	Lung Disease	2.58	no change
5	Heart Disease	2.31	Diabetes	2.52	+1
6	Diabetes	2.30	Oral Health	2.47	+1
7	Oral Health	2.22	Heart Disease	2.42	-2
8	Cancer	2.17	Cancer	2.15	no change

MENTAL HEALTH

Mental health includes a person's emotional, psychological and social well-being. It affects how individuals think, feel and act. A person's mental health status also contributes to how they handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. Many factors contribute to mental health problems, including biology (factors such as genes or brain chemistry), life experiences (such as trauma or abuse) and family history. Within the broad category of mental health, mental illness specifically refers to all diagnosable mental disorders. Mental illness can be chronic or acute. An acute mental health crisis will require different intervention than managing a chronic mental illness[2].

Community-level data used to analyze and prioritize mental health is limited, but what local data is available is convincing and of great concern among care providers, public health and healthcare partners, media and the community. Poor mental health, the number of self-reported poor mental health days in a 30-day period, and the rate of depression in the Springfield Community is higher than in Missouri and the U.S. Moreover, the Springfield Community has a suicide mortality rate 60% worse than the national average. Unfortunately, the rate of suicide mortality is worsening since the last assessment, with the 2015-2019 aggregate rate increasing 30% since the 2011-2015 assessment.

Twenty-eight percent of all emergency department visits associated with an assessed health issue were due to mental health or substance use in the Springfield Community.

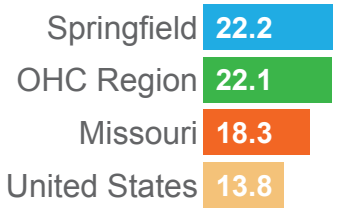
The rate of diagnosis for those 18-64 receiving care in the Springfield Community is **double** that of younger residents and **more than quadruple** that of older residents.

African Americans in the Springfield Community visit the emergency department with a mental illness diagnosis at **double** the rate of any other well-defined race group.

The rate of mental health providers in the Springfield Community is one of the highest in the OHC Region at 85.3 providers per 100,000 residents. In fact, the Springfield Community's rate of mental health providers is in the top 10% in the United States. However, this is still not meeting the demands for mental health care, as evidenced by long waits to access care in the Community. Additionally, more than 15% of adults and 7% of children are completely uninsured in the Community. In hospital emergency departments, one in three patients self-paid for services. Concerningly, the most common method of payment for mental health related visits was Medicaid, indicating a financial or lifestyle hardship for these patients.

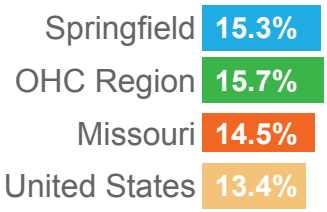
The COVID-19 pandemic will have meaningful health consequences beyond the acute phase of the pandemic. In the OHC Region, two in 3 residents report that their social isolation has 'worsened' over the course of the pandemic. More than half report that COVID-19 has affected their mental health or the mental health of someone who lives with them. Of those with children at home, 70% say that children have been affected by the COVID-19 pandemic. Community stakeholders recount that the COVID-19 pandemic has made mental health more relevant. They are seeing "…very little treatment options and very few therapists who work with children". Anecdotally, providers and community members say they feel that mental health conditions worsened during the COVID-19 pandemic. However, analysis of emergency department utilization data show that diagnoses of mental health conditions declined 10% between 2018 and 2020.

SUICIDE MORTALITY RATE

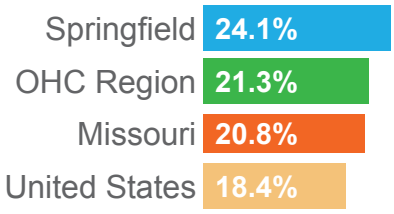


Rate per 100,000 population

POOR MENTAL HEALTH



DEPRESSION PREVALENCE



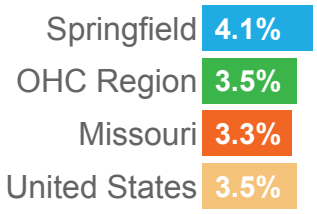
Medicare population only

SUBSTANCE USE & RECOVERY

Substance use as a behavioral health disorder, known as a substance use disorder (SUD), encompasses the use of intoxicating substances in a manner which negatively effects the persons global wellness. For the purposes of this report, substances abused include, but are not limited to, alcohol, opiates, stimulants, narcotics, benzodiazepines, and other prescribed or illicit substances that could cause poisoning. (Not included are things like carbon monoxide poisoning, pesticides, or venomous animals or plants.)

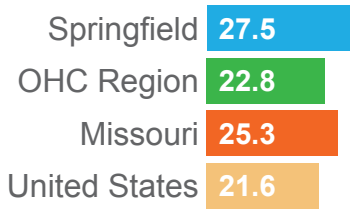
Recovery from substance use disorder is a process through which the individual improves their health and wellness, starts living a self-directed life and striving to reach a more fulfilling purpose. This comes in a variety of pathways, from public health and behavioral health providers, social supports, community resources and mutual aid. There are currently 22.75 million individuals openly in recovery in the US. Only 1 in 4 people needing substance use support and assistance will receive services[3].

SUBSTANCE USE DISORDER PREVALENCE



Medicare population only

DRUG POISONING MORTALITY



Rate per 100,000 population

In the Springfield Community, substance use and recovery ranked second among the assessed health issues when considering public health and hospital data. The prevalence of substance use disorder (among Medicare patients) is greater than the entire OHC Region, Missouri, and the U.S. at 4.1%. This translates to a higher rate of drug poisoning mortality than the region, state, and nation, with 27.5 deaths per 100,000 being from drug poisoning. This is 25% higher than the national average and has increased by 28% since the 2019 community health needs assessment.

One in three emergency hospital visits for substance use or mental health are paid through Medicaid which indicates a financial or lifestyle hardship for the patient. Concerningly, the second most common way of paying for an emergency department visit associated with a substance use or mental health diagnosis is through self-pay. This indicates that the patient will be required to pay for the visit out-of-pocket or that the hospital will use safety net funding.

As with Mental Health, further prioritization could build on momentum of previous community health improvement plans. Newer efforts like the Burrell Behavioral Crisis Center, mental health first aid, Jordan Valley Community Health Center's substance use services, criminal justice community health advocates and other treatment programs will continue to provide service to the Community.

The perceived feasibility of future solutions is high. Half of the community leaders surveyed felt that the Springfield Community had some or total local control necessary to impact policy change related to SUD and that there was a path of what is needed to positively impact this health issue. Seventy-five percent noted that leadership is in place for efforts and all respondents were able to point to a community partnership already in place.

In the community input process, substance use treatment and rehabilitation services, including detox was the fourth most important health issue among community input survey respondents, and substance use education, prevention and early intervention ranked fifth. When the issue was addressed in more detail through interviews and focus groups, support for more strategies was voiced, such as more and higher quality medical detox facilities. This demonstrates an understanding among the community of the importance of addressing this health issue.

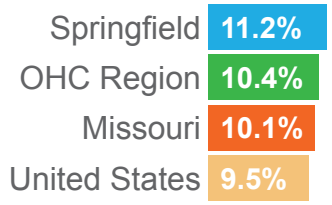
> Slow progress on stigma, but it's still progress. Awareness at Olympics helps, but it's very stigmatized. I keep hearing things like, "I thought I was alone in this." Still siloed for co-occurring treatment – most treatments still pay attention to one side or the other, not looking at whole package.
>
> **-Springfield Community member**

DIABETES

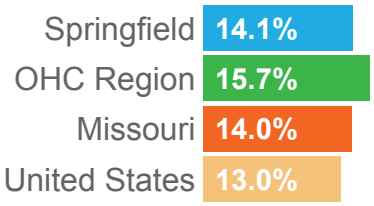
Diabetes is a chronic health condition that affects how your body turns food into energy. If you have diabetes, your body either doesn't make enough insulin or is resistant to the effects of insulin, leading to high blood sugar levels in the bloodstream. Over time, this can cause damage to multiple organs in the body, including the eyes, nerves, blood vessels and kidneys. It can also increase the risk of cardiovascular disease, decrease the body's immunity and lead to decreased life expectancy.

One in five adults in the U.S. have diabetes and do not know it. Diabetes was the seventh leading cause of death in the U.S. in 2019, accounting for 87,647 deaths annually. Direct medical costs and lost productivity attributed to diabetes was estimated to be $327 billion in 2017[4]. The Springfield Community has a higher rate of diabetes than the OHC Region, Missouri and the U.S., and this issue continues to grow, with the prevalence of diabetes increasing 30% since the 2019 assessment. Women are more likely to require an emergency department visit due to diabetes, making it the only assessed health issue besides lung disease to affect women more than men.

DIABETES PREVALENCE



POOR PHYSICAL HEALTH



Some people can control their blood sugar levels with healthy eating and exercise, practices that will also improve cardiovascular and mental health. However, as diabetes progresses, multiple oral and injectable treatments (e.g., insulin) may be needed to control blood sugar levels. Diabetic complications may develop in other organ systems (i.e., the cardiovascular system, kidneys, eyes and nervous system), and more extensive care and treatment may be needed.

Eight percent of emergency department visits were due to diabetes or diabetes-related complications

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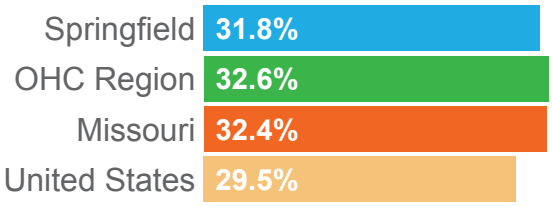
Type 2 diabetes is the most common form of diabetes, accounting for 90-95% of diabetes cases nationwide. It develops over many years and is usually diagnosed in adults. More than one in three adults in the U.S. have prediabetes, but more than 80% are not aware they are prediabetic. In prediabetes, blood sugar levels are higher than normal, but not high enough to be diagnosed as type 2 diabetes.

The progression to diabetes can be prevented or delayed with dietary changes and an active lifestyle. However, the rates of obesity and poor physical health in the Springfield Community are higher than the national average. Obesity is caused by a number of overlapping factors. A person's home or workplace can promote gaining weight, this is referred to as an obesogenic environment. Modifying these environments at community and policy levels can decrease the risk of developing obesity and diabetes. For instance, workplaces can adopt wellness policies that promote or incentivize healthy eating and physical activity.

OBESITY PREVALENCE



Change the culture of how we live. This starts with children and their families: cooking classes with healthy food, have the right support for their needs. Healthy culture and lifestyle, including mental health support. Education for disease states, how to avoid diabetes, obesity.

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Community stakeholders surveyed overwhelmingly believe this is a health issue that can be improved within 2-3 years. Leaders point out that 'changing the culture of how we live' could be a solution for better health. Working with children and families, providing education and demonstrations for eating healthier, reducing obesity and avoiding diabetes will help.

Through community input and survey, diabetes was recognized as needing the most focus for improvement over all other health issues, except mental health and substance use. A recent survey of residents in the OHC Region suggests that health behaviors most impacted by the COVID-19 pandemic include diet (43% of respondents say this behavior has 'worsened') and exercise (40% say behavior has 'worsened'.) Results from the same survey indicate that 45% of residents believe that programs for diabetes prevention, awareness, and care are 'very needed'.

SPECIAL HEALTH ISSUE: COVID-19

Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus. Most people infected with the virus experience mild to moderate respiratory illness and recover without requiring special treatment. However, some become seriously ill and require more advanced medical care. People over the age of 64 and those with underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease or cancer are more likely to develop serious illness. Even after recovery, some people may have post-COVID conditions. These conditions can present as different types and combinations of health problems for different lengths of time. Multiorgan effects can affect many body systems, including heart, lung, kidney, skin and neurologic functions.

The first case of COVID-19 in Greene County was confirmed on March 12, 2020. Five days later, on March 17, the City and County placed a limit on gatherings of more than 10 people, followed by a county-wide stay at home order on March 24. This order stayed in place until May 4, 2020. In Christian County, the cities of Nixa and Ozark implemented stay-at-home orders on March 18, 2020, both lasting until May 3, 2020. Missouri implemented a statewide stay-at-home order on March 24, expanding prevention measures to Webster County and the remainder of Christian County.

Near the conclusion of the stay-at-home order, the City of Springfield and Greene County implemented a joint Road to Recovery plan, which included the passing of a city-wide masking ordinance beginning July 16, 2020. In Christian County, the cities of Nixa and Ozark implemented masking requirements within city limits on October 21, 2020.

COVID exacerbated childcare issues in the community with facilities being closed due to outbreaks or staffing capacity demands. "Some childcare programs closed during COVID and have not reopened. The need outpaces the capacity even without COVID. Quality is also an issue.

-Springfield Community member

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As hospitalizations due to COVID-19 increased, shortages in staff and supplies resulted in elective and preventative procedures and health visits being postponed or cancelled. On July 15, 2020, when there were 39 people admitted in Greene County hospitals with COVID-19, CoxHealth opened the first COVID-19 intensive care unit in the Springfield Community in response to rising severe illness and hospitalizations.

By the end of 2020, the vaccination effort was in its infancy as the Community continued with preventative measures like masking and occupancy restrictions. The Pfizer-BioNTech COVID-19 vaccine received Emergency Use Authorization (EUA) from the FDA Dec. 11, followed by the Moderna vaccine Dec. 18. Nurses at Mercy Springfield received the first COVID-19 vaccines in the Springfield Community on Dec 13, 2020.

At the start of 2021, Springfield and Greene County prioritized the vaccination effort. Distribution of the vaccine in the county followed the recommended phases outlined by the state. All Missouri residents over the age of 18 were eligible for vaccination by April 9, 2021.

Throughout the spring of 2021 cases began to slow. The average weekly case count in Greene County was under 20 per day when City of Springfield repealed the last masking mandate in the state on May 17.

Cases increased with the emergence of the Delta variant, which brought national attention to Southwest Missouri in summer 2021. At the height of Delta near the end of July, over 250 people were admitted to Greene County hospitals, and more than a third of patients were in critical care. Most of these patients were unvaccinated.

Pfizer received EUA for pediatric vaccine doses in late October, and the health departments and healthcare providers began vaccinating children ages 5-11 on Nov. 4, 2021. The end of 2021 saw the emergence of another new variant: Omicron. Cases began to spike in the Springfield Community near the end of November and rose quickly through the end of the year into January 2022. Vaccination and testing remained at the forefront of the pandemic response in the Community as Omicron spread. Throughout the pandemic, the community pulled together for multiple testing and immunization events.

The onset of the COVID-19 pandemic greatly impacted all aspects of health care and public health, which is evident through its inclusion as an assessed health issue.

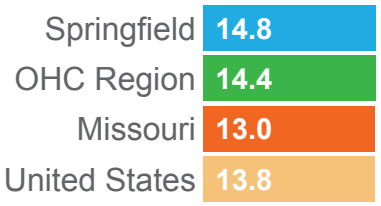
The Springfield Community had a COVID-19 case rate that was slightly higher than the national average and about 15% higher than the state. Mortality rates were similarly distributed, slightly higher than the national rate and 15% higher than the state mortality rate, as of Oct. 29, 2021. Rates between communities are extremely variable, with Christian County showing a rate that was 21% lower than that of Webster County. Of course, COVID-19 data for the community is limited due to testing availability in some areas, the increased use of at-home tests and undercounting asymptomatic cases if the patient does not seek testing.

In 2020, hospitals in the Springfield Community treated more than 3,800 emergency department admissions due to COVID-19. Those over the age of 65 were 3.4 times more likely to present for treatment than those age 18-64 and 34 times more likely than those under the age of 18. Nearly half of these visits were paid using Medicare, aligned with the patient population most impacted by COVID-19.

• • •

The Springfield Community was more aligned with the Missouri average on vaccinations, with roughly 5 in 10 persons over 18 vaccinated, as of October 29, 2021. National vaccination rates saw closer to 6 in 10 persons. These rates were consistent throughout the Community with only a 2-percentage point difference between the least vaccinated (Webster) and most vaccinated (Greene) counties.

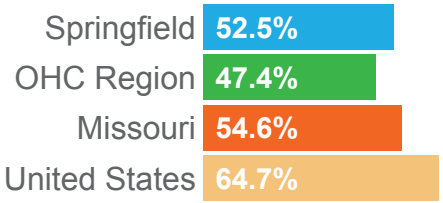
COVID-19 CASE RATE



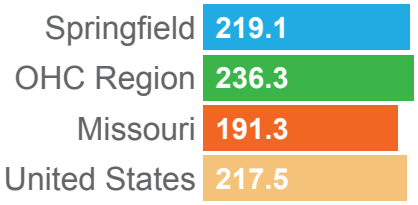
Rate per 100,000 population

COVID-19, per community and stakeholder feedback, is virtually impossible to separate from the other assessed health issues in the Springfield Community. Therefore, the committee deemed its inclusion as a special health issue appropriate.

COVID-19 VACCINATION RATE



COVID-19 MORTALITY RATE



Rate per 100,000 population

Based on survey results in the Ozarks Health Region, 56% of respondents report that COVID-19 affected their mental health or that of someone who lives with them. Community members also reported a change in everyday health behaviors, due to COVID-19. Respondents noted a negative change in social isolation (66%), diet (43%), and exercise (40%).

The full impacts of the virus will be seen in the months and years to come, so it will be prudent to continue evaluation of its impact.

COVID-19 has helped bring mental health and substance misuse into the 21st century and make it relevant. We've discovered new ways to provide services virtually, but we just need better internet access. This is an opportunity. Virtual treatment had a bit of a negative effect since people didn't have the connections and interactions. There are more acute mental health issues due to COVID, more suicidal ideations, more depression, and lots of anxiety. Social interactions were disrupted and people in recovery for years have had reoccurrences of use.

-Springfield Community member

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SOCIAL DETERMINANTS OF HEALTH

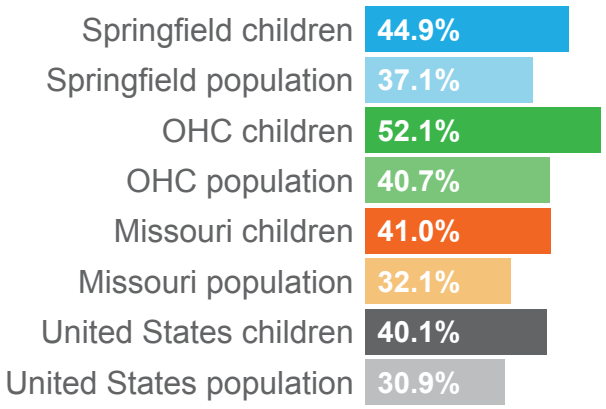
Additional data critical to understanding the health of the population and the vulnerability of the Community was discerned by examining six groupings classified as Social Determinants of Health: Economic Stability, Education Access and Quality, Healthcare Access and Quality, Neighborhood and Built Environment, Social and Community Context and Health Behaviors. The social determinants of health have a major impact on people's healåth, well-being and quality of life while also contributing widely to health disparities and inequities. Therefore, examination of these factors is important as they play a significant role in the impact the assessed health issues have on the Springfield Community.

ECONOMIC STABILITY

In the United States, 3 in 10 people live in poverty, and many people can't afford things like healthy foods, health care, and housing. People with steady employment are less likely to live in poverty and more likely to be healthy, but many people have trouble finding and keeping a job. People with disabilities, injuries, or conditions like arthritis may be especially limited in their ability to work. In addition, many people with steady work still don't earn enough to afford the things they need to stay healthy.

In the Springfield Community, more than 1 in 3 people (37.1%) live at or below 200% of the Federal Poverty Level (FPL), meaning a family of four cannot earn more than $25,750 annually. The poverty rate among children is even higher in the Community, with nearly 45% of children living in poverty. In Webster County, this rate is more than 1 in 2, with 53.9% of children living in poverty.

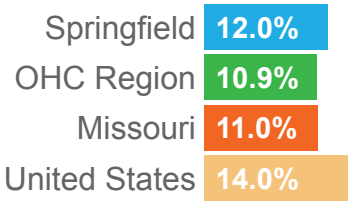
POVERTY RATE



Below 200% Federal Poverty Level

In addition to living in poverty, affordable housing is a challenge for many. In the Springfield Community, 28% of residents live in substandard housing and 12% report a severe housing cost burden. Less than 1 in 3 people in the Community currently have affordable housing, meaning that most residents make at least 60% of the area's median income. This in turn affects the resources that families must pay for other necessities, such as health care or nutritious food, leading to worse health outcomes.

SEVERE HOUSING COST BURDEN



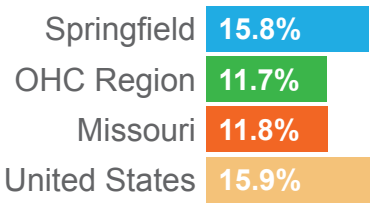
EDUCATION ACCESS & QUALITY

Education can be an indicator of health, with persons with higher levels of education often living healthier and longer lives. The rate of high school completion, or equivalent, in the Springfield Community is 14% higher than Missouri's rate and 28% higher than the U.S.

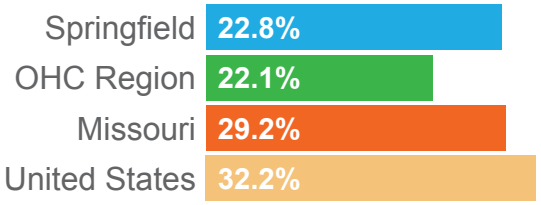
However, the chronic absence rate for children under the age of 18 in the Community is 30% higher than the state average. Greene County accounts for much of this disparity with a rate of chronic absence, at 19.6%, more than double the rates in Christian and Webster Counties.

Moreover, the Springfield Community has a lower rate of higher education completion than both Missouri and the U.S., with roughly 10% fewer people completing an Associate's or bachelor's degree or higher than the rest of the nation.

CHRONIC ABSENCE RATE



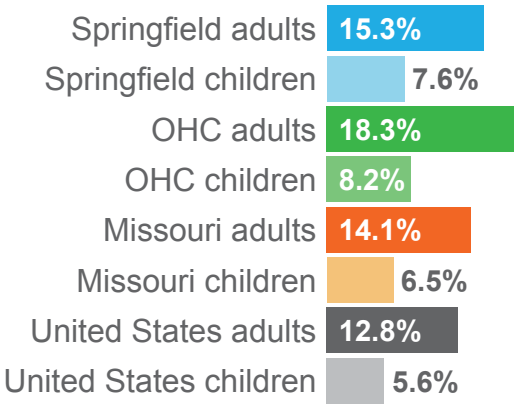
BACHELOR'S DEGREE OR HIGHER



HEALTHCARE ACCESS & QUALITY

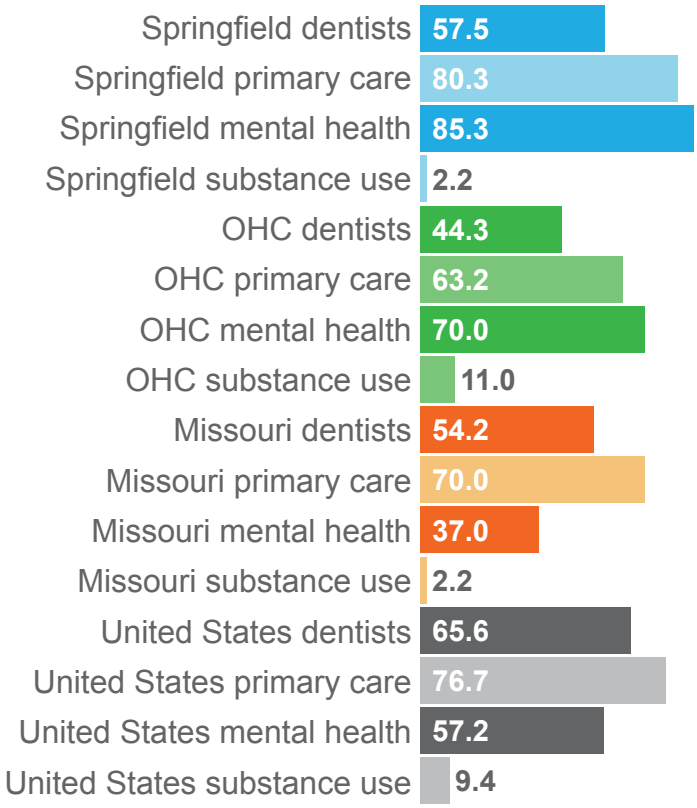
Many people in the United States don't get the health care services they need. About 1 in 10 people don't have health insurance. In the Springfield Community, the rate of uninsured is even higher, with more than 15% adults and more than 7% of children not having health insurance. People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. In addition, people may not trust the healthcare system. Some reasons for this may include lack of cultural awareness by providers, feeling unwelcome or uncomfortable in traditional clinical settings, previous negative experiences with healthcare providers, insufficient accommodations for the disabled, language barriers or clinics not having convenient times or locations[5].

UNINSURED



Those with the financial means to access healthcare in the Springfield Community have more primary care, mental health and dental providers to seek services with than the rest of Missouri and the U.S. However, the Community has less than a quarter of average rate of substance use providers than the rest of the country. And while there are more providers for many health areas, Community members have identified that "Providers are overburdened and understaffed and don't have time to provide individual care. It's hard to get people to work in healthcare in rural areas, physicians, community health workers, admin staff, dentists, psychiatrists." Moreover, Community members commented, "There is a lack of public transportation in rural areas and people may have to leave hours early for an appointment and there are delays. Medicaid supported transportation is not always reliable. The transportation options can be difficult to coordinate."

HEALTHCARE PROVIDER RATES

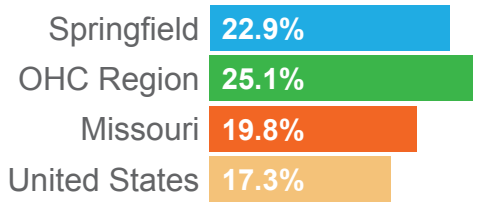


NEIGHBORHOOD & BUILT ENVIRONMENT

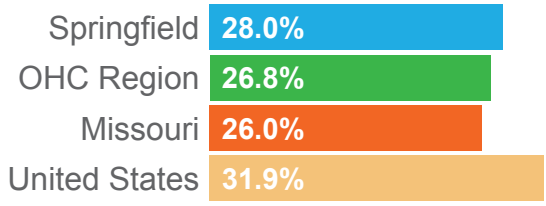
The neighborhoods people live in have a major impact on their health and well-being. Where we live affects the basics of our daily lives and health. When affordable housing is lacking it impacts families and where they can afford to live. In the Springfield Community, 28% of residents reside in substandard housing, with most of the impact being in Greene County at 29.5%. Twenty-three percent of households in the Springfield Community have low or slow internet access. In Webster County, 30% of households have internet that is low or slow. Community members have commented, "We've discovered new ways to provide services virtually, but we just need better internet access."

Additionally, many people in the United States live in neighborhoods with high rates of violence, unsafe air or water, and other health and safety risks. Racial/ethnic minorities and people with low incomes are more likely to live in places with these risks.

HOUSEHOLDS WITH LOW OR SLOW INTERNET ACCESS



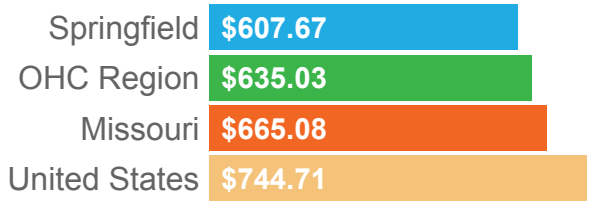
SUBSTANDARD HOUSING



HEALTH BEHAVIORS

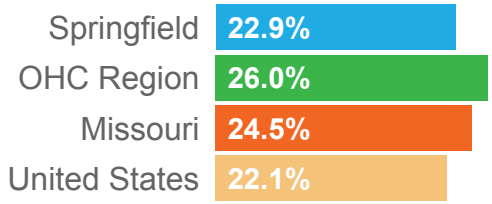
Health behaviors include individual-level behaviors, often influenced by access or quality of services, that can impact the overall health of an individual or community. Measured health behaviors include physical activity, fruit and vegetable expenditures, smoking, alcohol binge drinking, sexually transmitted infection (STI) rates and the prevalence of HIV. These behaviors can affect a wide range of health, functioning, and quality-of-life outcomes and risks.

FRUIT & VEGETABLE EXPENDITURE



In the Springfield Community, physical inactivity rates have remained stagnant since the publication of the prior Community Health Needs Assessment (2019). More than one in five (22.9) residents report no leisure time physical activity, though the state average is slightly less than one in four.

PHYSICAL INACTIVITY



Collected quarterly, via survey of randomly selected households, Nielsen's Consumer Buying Power Site Reports allow analysis of fruit and vegetable expenditures which are a way of determining how many citizens have the inclination and ability to enjoy healthy foods. In the Springfield Community, a household spends just over $600 on fruits and vegetables (fresh, frozen, or canned), which is nearly $150 less than the national average. Healthy eating habits may be a choice, but barriers such as the cost of fresh fruit and vegetables, the inability to find transportation to purchase healthy food, the time to prepare healthy meals, cultural considerations, and others make this a more complex situation.

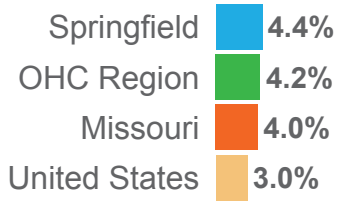
One in five members of the Springfield Community is currently a smoker. This is a rate 18% higher than the national average. Both Christian and Greene Counties have smoking rates lower than the state average, but at 25%, the Webster County rate is nearly five percentage points higher.

Missouri has higher incidence rates of STI than the United States for both chlamydia and gonorrhea. The Springfield Community has higher rates still, with 641.2 persons per 100,000 newly diagnosed with chlamydia and 277.8 with gonorrhea. Untreated, these conditions can cause serious and permanent health problems in both women and men.

SOCIAL & COMMUNITY CONTEXT

Health begins where we live, learn and play. Community connections and social relationships can have a major impact on their health and well-being. Many people face challenges and dangers they can't control, like unsafe neighborhoods, discrimination or trouble affording the things they need. A prime example of this is homelessness. In the Springfield Community, 4.4% of elementary and secondary students have been identified as homeless, which is greater than the State and Nation. Homelessness is closely connected to declines in physical and mental health. Persons without homes often lack access to health care and resources for treatment.

HOMELESS STUDENTS



CONCLUSION

The issues and trends discussed in the Springfield Community summary have their limitations and cannot tell the full story of the health of these counties. Other factors, such as environmental, social and economic, impact individual and community health and provide context necessary to understanding the Community. Therefore, it is important to consider the Social Determinants of Health outlined in this summary when creating plans to address mental health, substance use & recovery, diabetes or any of the other assessed health issues. The results of this assessment will be utilized to prioritize public health issues and develop community health implementation plans (CHIPs) focused on meeting community needs through collective impact.

ENDNOTES

1 Centers for Disease Control and Prevention, At A Glance: CDC?ATSDR Social Vulnerability Index. (2021) https://www.atsdr.cdc.gov/placeandhealth/svi/at-a-glance_svi.html

2 Mental Health.gov, What Is Mental Health. (2021) https://www.mentalhealth.gov/basics/what-is-mental-health

3 Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration.

4 https://www.cdc.gov/chronicdisease/resources/publications/factsheets/diabetes-prediabetes.htm

5 Martha Hostetter and Sarah Klein, “Understanding and Ameliorating Medical Mistrust Among Black Americans,” Transforming Care (newsletter), Commonwealth Fund, Jan. 14, 2021. https://doi.org/10.26099/9grt-2b21

DISSEMINATION

The Ozarks Health Commission Regional Health Assessment and related community reports are resources designed for public dissemination, and multiple dissemination methods listed below will reach a wide variety of audiences.

WEBSITES

Please visit the following websites to access the full RHA, Community Summaries, and related resources:

Ozarks Health Commission
www.ozarkshealthcommission.org

CoxHealth
www.coxhealth.com

Mercy Hospital Springfield
mercy.net

PRINTED COPIES

Printed copies will be available by request through hospital and public health partners. Please refer to the websites above or contact a participating organization directly.

SOCIAL MEDIA

Announcements of the availability of the regional health assessment, as well as community health improvement plans by each organization will be made via social media channels, including Facebook and Twitter.

Christian County Health Department
www.facebook.com/christiancountyhealth

CoxHealth
www.facebook.com/coxhealth/
twitter.com/coxhealth

Mercy Hospital Springfield
www.facebook.com/MercyHospitalSpringfield/
twitter.com/MercySpringfield

Springfield-Greene County Health
www.facebook.com/sgchd
twitter.com/sgchd

Webster County Health Unit
www.facebook.com/WebsterCountyHealth

HEALTH SERVICES AVAILABLE

In addition to the websites of participating health systems and public health agencies, there are several robust resource directories available to assist consumers in locating care. These include:

Burrell Behavioral Health
burrellcenter.com/get-help/

Christian County Health Department
christiancountyhealth.com/

COVID-19 Vaccines
vaccine417.com

CoxHealth
doctors.coxhealth.com/
coxhealth.com/services/

Jordan Valley Community Health Center
jordanvalley.org/request-an-appointment/

Mercy Hospital Springfield
mercy.net/search/service/
mercy.net/search/doctor/

Springfield-Greene County Health
health.springfieldmo.gov

The Arc of the Ozarks
thearcoftheozarks.org/about/springfield-division/

Webster County Health Unit
http://webstercohealth.com/

ACKNOWLEDGMENTS

The Ozark Health Commission Steering Committee expresses appreciation to the many organizations and stakeholders that contributed to this report. To see a complete list, please visit ozarkshealthcommission.org.

APPENDIX A

COMMUNITY DATA

HOW TO READ THESE TABLES

	Measure is better than Missouri average.
	Measure is up to 9.9% worse than Missouri average.
	Measure is 10-25% worse than Missouri average.
	Measure is more than 25% worse than Missouri average.
Normal	Measure is better than United States average.
Italics	Measure is up to 9.9% worse than United States average.
Bold Italics	Measure is 10-25% worse than United States average.
Bold	Measure is more than 25% worse than United States average.

COVID-19 MORTALITY RATE

	COVID-19 Mortality Rate	COVID-19 Case Rate	COVID-19 Fully Vaccinated Adults
Bolivar Community	178.6	*14369.2*	**45.0%**
Branson Community	***268.3***	*14809.2*	**42.5%**
Joplin Community	**287.2**	***17041.8***	***53.9%***
Lebanon Community	***240.4***	12705.1	**46.3%**
Monett Community	*223.6*	12817.0	**46.6%**
Mountain View Community	***243.4***	13401.7	**33.1%**
Springfield Community	*219.1*	*14848.3*	***52.5%***
OHC Region	*236.3*	*14423.4*	**47.4%**
Missouri	191.3	12973.0	54.6%
United States	217.5	13846.0	64.7%

*Crude rate per 100,000 population
COVID-19 data through 10/29/2021

HEART DISEASE

	Stroke Mortality Rate	Heart Disease Mortality Rate	High Blood Pressure Prevelance	High Cholesterol Prevelance	Coronary Heart Disease Prevalance	Obesity Prevalance	Poor Physical Health
Bolivar Community	**48.4**	***199.4***	***37.4%***	***40.0%***	**9.6%**	***35.2%***	**16.7%**
Branson Community	35.4	**264.7**	***38.1%***	***40.7%***	**10.1%**	29.3%	**16.6%**
Joplin Community	***42.4***	**236.7**	***36.8%***	***37.7%***	**8.8%**	***34.3%***	***16.0%***
Lebanon Community	36.9	***201.3***	*35.4%*	***37.9%***	**8.7%**	*31.1%*	***15.9%***
Monett Community	*39.6*	**230.2**	***36.8%***	***39.8%***	**9.7%**	***35.6%***	**17.4%**
Mountain View Community	***44.8***	***201.4***	***40.4%***	***41.6%***	**11.0%**	***32.8%***	**19.0%**
Springfield Community	*38.7*	***183.8***	31.2%	*35.8%*	*7.2%*	*31.8%*	*14.1%*
OHC Region	*40.1*	**212.3**	*35.1%*	***37.7%***	***8.6%***	***32.6%***	***15.7%***
Missouri	39.6	191.2	33.2%	36.0%	7.5%	32.4%	14.0%
United States	37.3	164.8	32.9%	34.2%	6.9%	29.5%	13.0%

Age adjusted rate per 100,000 population

ORAL HEALTH

	Recent Dental Visit	Public Water Service Fluoridation*	Early Childhood Caries Referrals**
Bolivar Community	***55.5%***	0.0%	26.6%
Branson Community	***55.8%***	17.3%	25.1%
Joplin Community	***55.1%***	56.7%	4.0%
Lebanon Community	***54.1%***	41.2%	8.5%
Monett Community	***52.9%***	24.7%	no data
Mountain View Community	***49.7%***	0.0%	13.8%
Springfield Community	*60.5%*	73.2%	2.3%
OHC Region	***56.4%***	50.4%	7.0%
Missouri	61.4%	71.8%	4.5%
United States	64.4%		

*Missouri counties only
**PSP participants age five and under only

LUNG DISEASE

	Lung Disease Mortality Rate	Poor Physical Health	Asthma Prevalence	COPD Prevalence
Bolivar Community	**57.9**	**16.7%**	*10.1%*	**11.1%**
Branson Community	*40.7*	**16.6%**	*10.0%*	**11.2%**
Joplin Community	**68.3**	***16.0%***	*10.4%*	**10.0%**
Lebanon Community	**72.3**	***15.9%***	*10.0%*	**10.3%**
Monett Community	**63.5**	**17.4%**	*10.2%*	**11.4%**
Mountain View Community	**62.6**	**19.0%**	***10.5%***	**12.9%**
Springfield Community	**51.7**	*14.1%*	*9.7%*	***8.6%***
OHC Region	**60.7**	***15.7%***	*10.1%*	**10.0%**
Missouri	50.4	14.0%	9.7%	8.5%
United States	40.2	13.0%	9.5%	7.2%

*Age adjusted rate per 100,000 population

DIABETES

	Annual Hemoglobin A1c Test*	Diabetes Prevalence	Poor Physical Health	Obesity Prevalence
Bolivar Community	88.0%	8.7%	**16.7%**	***35.2%***
Branson Community	*84.0%*	*9.9%*	**16.6%**	29.3%
Joplin Community	*81.6%*	*10.1%*	***16.0%***	***34.3%***
Lebanon Community	*85.2%*	8.9%	***15.9%***	31.1%
Monett Community	86.2%	**12.5%**	**17.4%**	***35.6%***
Mountain View Community	86.1%	***11.5%***	**19.0%**	***32.8%***
Springfield Community	89.3%	***11.2%***	*14.1%*	*31.8%*
OHC Region	*84.8%*	*10.4%*	***15.7%***	***32.6%***
Missouri	86.3%	10.1%	14.0%	32.4%
United States	85.7%	9.5%	13.0%	29.5%

*Medicare enrollees

CANCER

	Cancer Incidence Rate*	Cancer Mortality Rate**	Recent Mammogram***	Recent Pap Smear****	Adequate Colorectal Cancer Screening
Bolivar Community	371.5	*163.1*	*66.4*	*81.3%*	*63.8%*
Branson Community	399.1	151.6	*66.8*	*82.5%*	*65.6%*
Joplin Community	440.2	***187.1***	*67.4*	*81.6%*	*61.6%*
Lebanon Community	437.0	***173.9***	*67.8*	*82.3%*	*64.3%*
Monett Community	413.5	***172.1***	*65.3*	*81.7%*	*62.7%*
Mountain View Community	368.9	***180.6***	*63.2*	*80.7%*	*60.9%*
Springfield Community	420.1	*158.6*	*69.2*	*82.7%*	*65.9%*
OHC Region	419.9	***171.3***	*67.6*	*82.1%*	*63.8%*
Missouri	454.9	166.4	70.8	84.1%	67.0%
United States	448.7	152.3	73.7	83.9%	65.5%

*rate per 100,000 population
**Age adjusted rate per 100,000 population
***Females, age 50-74
****Females, 21-65

MENTAL HEALTH

	Suicide Mortality Rate*	Poor Mental Health	Depression Prevalence**
Bolivar Community	**20.4**	***15.7%***	***23.0%***
Branson Community	**24.5**	***14.9%***	18.1%
Joplin Community	**22.7**	***16.0%***	***20.8%***
Lebanon Community	**20.4**	***15.6%***	*18.6%*
Monett Community	**19.4**	***16.1%***	*18.9%*
Mountain View Community	**25.4**	***16.6%***	*18.4%*
Springfield Community	**22.2**	***15.3%***	**24.1%**
OHC Region	**22.1**	***15.7%***	***20.8%***
Missouri	18.3	14.5%	21.3%
United States	13.8	13.4%	18.4%

*Age adjusted rate per 100,000
**Medicare beneficiaries only

SUBSTANCE USE AND RECOVERY

	Drug Poisoning Mortality Rate*	Alcohol Use Disorder Prevalence**	Substance Use Disorder Prevalence**
Bolivar Community	***25.0***	2.0%	*3.5%*
Branson Community	***24.0***	1.5%	3.3%
Joplin Community	16.6	1.6%	3.3%
Lebanon Community	***26.1***	1.6%	3.0%
Monett Community	14.9	1.8%	3.2%
Mountain View Community	11.2	1.5%	3.8%
Springfield Community	**27.5**	1.9%	***4.1%***
OHC Region	***22.8***	1.7%	3.5%
Missouri	25.3	1.9%	3.3%
United States	21.6	2.1%	3.5%

*Age adjusted rate per 100,000
**Medicare beneficiaries only

ECONOMIC STABILITY

	Population Below 200% FPL	Children Below 200% FPL	Per Capita Income ($)	Unemployment Rate	Cost Burden, Severe (50%)	Affordable Housing (60% AMI)
Bolivar Community	**43.3%**	**52.5%**	**$22,444.00**	3.6%	10.5%	38.9%
Branson Community	**38.6%**	**54.4%**	***$25,689.00***	**8.3%**	10.2%	31.1%
Joplin Community	**42.2%**	**54.2%**	**$24,304.00**	3.7%	10.0%	43.8%
Lebanon Community	**40.6%**	**54.4%**	**$23,782.00**	4.5%	10.9%	35.0%
Monett Community	**44.9%**	**61.2%**	**$23,974.00**	4.0%	10.1%	41.0%
Mountain View Community	**49.9%**	**62.2%**	**$20,330.00**	4.9%	11.3%	33.7%
Springfield Community	***37.1%***	***44.9%***	***$27,241.00***	3.5%	12.0%	31.7%
OHC Region	**40.7%**	**52.1%**	**$24,962.00**	4.0%	10.9%	36.6%
Missouri	32.1%	41.0%	$30,810.00	4.7%	11.0%	38.8%
United States	30.9%	40.1%	$34,102.00	5.5%	14.0%	29.9%

EDUCATION ACCESS AND QUALITY

	No High School Diploma*	Associate's Level Degree or Higher*	Bachelor's Degree or Higher*	Chronic Absence Rate
Bolivar Community	*12.7%*	**23.1%**	**16.3%**	8.7%
Branson Community	11.8%	**27.3%**	**19.4%**	*15.9%*
Joplin Community	*13.2%*	**28.8%**	**20.7%**	9.5%
Lebanon Community	*12.5%*	**26.9%**	**18.6%**	9.3%
Monett Community	**15.9%**	**22.5%**	**15.3%**	11.1%
Mountain View Community	**15.4%**	**22.7%**	**15.3%**	6.7%
Springfield Community	8.7%	*36.9%*	***28.8%***	15.8%
OHC Region	11.8%	**30.0%**	**22.1%**	11.7%
Missouri	10.1%	37.1%	29.2%	11.8%
United States	12.0%	40.6%	32.2%	15.9%

*Age 25+

HEALTHCARE ACCESS AND QUALITY

	Uninsured Adults	Uninsured Children	Population Receiving Medicaid	Population Living in HPSA	Primary Care Physician Provider Rate*	Mental Health Provider Rate*
Bolivar Community	**19.2%**	**9.0%**	*23.2%*	**56.7%**	***65.7***	**39.0**
Branson Community	**20.6%**	**9.1%**	19.8%	**42.0%**	***62.3***	**16.1**
Joplin Community	**20.2%**	**8.1%**	*22.5%*	**42.9%**	**54.3**	103.0
Lebanon Community	**18.3%**	**8.2%**	21.0%	**41.1%**	**45.5**	**36.7**
Monett Community	**21.7%**	**10.0%**	*24.1%*	**45.0%**	***59.6***	**14.9**
Mountain View Community	**20.6%**	**8.3%**	**29.3%**	**50.0%**	***63.5***	**35.3**
Springfield Community	***15.3%***	**7.6%**	16.9%	**36.7%**	80.3	85.3
OHC Region	**18.3%**	**8.2%**	20.7%	**41.6%**	***63.2***	70.0
Missouri	14.1%	6.5%	16.3%	27.6%	70.0	37.0
United States	12.8%	5.6%	22.2%	22.6%	76.7	57.2

*per 100,000 population

HEALTHCARE ACCESS AND QUALITY CONTINUED

	Addiction/ Substance Abuse Provider Rate*	Dentists Provider Rate*	Core Preventative Services for Men**	Core Preventative Services for Women**	Lack of Prenatal Care*	Households with No Motor Vehicle
Bolivar Community	**19.2%**	**9.0%**	*23.2%*	**56.7%**	***65.7***	**39.0**
Branson Community	**20.6%**	**9.1%**	19.8%	**42.0%**	***62.3***	**16.1**
Joplin Community	**20.2%**	**8.1%**	*22.5%*	**42.9%**	**54.3**	103.0
Lebanon Community	**18.3%**	**8.2%**	21.0%	**41.1%**	**45.5**	**36.7**
Monett Community	**21.7%**	**10.0%**	*24.1%*	**45.0%**	***59.6***	**14.9**
Mountain View Community	**20.6%**	**8.3%**	**29.3%**	**50.0%**	***63.5***	**35.3**
Springfield Community	***15.3%***	**7.6%**	16.9%	**36.7%**	80.3	85.3
OHC Region	**18.3%**	**8.2%**	20.7%	**41.6%**	***63.2***	70.0
Missouri	14.1%	6.5%	16.3%	27.6%	70.0	37.0
United States	12.8%	5.6%	22.2%	22.6%	76.7	57.2

*per 100,000 population, **age 65+

NEIGHBORHOOD AND BUILT ENVIRONMENT

	Substandard Housing	Violent Crime Rate*	Households with No or Slow Internet	Low Food Access	Respiratory Hazard Index Score
Bolivar Community	25.2%	307.1	26.0%	4.7%	1.1
Branson Community	27.7%	387.7	***19.6%***	**31.1%**	1.5
Joplin Community	26.1%	367.1	**26.6%**	***24.7%***	1.4
Lebanon Community	26.3%	251.5	**26.0%**	**35.5%**	1.3
Monett Community	26.0%	324.5	**27.8%**	19.1%	1.3
Mountain View Community	25.9%	259.2	**31.4%**	***24.7%***	1.4
Springfield Community	28.0%	**634.8**	**22.9%**	21.8%	1.7
OHC Region	26.8%	426.4	**25.1%**	***24.8%***	1.5
Missouri	26.0%	524.3	19.8%	24.9%	1.7
United States	31.9%	416.0	17.3%	22.2%	1.8

*per 100,000 population

SOCIAL & COMMUNITY CONTEXT

	Social Vulnerability Index (SVI)*	SVI-Household Composition*	SVI-Housing & Transportation*	SVI-Minority Status*	SVI-Socioeconomic*	Homeless Students
Bolivar Community	**0.6**	**0.7**	*0.6*	0.2	**0.7**	*3.0%*
Branson Community	**0.7**	**0.7**	***0.8***	0.3	**0.6**	**4.0%**
Joplin Community	**0.7**	**0.7**	0.6	0.5	**0.6**	**4.1%**
Lebanon Community	**0.6**	**0.6**	0.6	0.3	**0.7**	**4.7%**
Monett Community	**0.8**	**0.8**	0.4	0.6	**0.7**	**4.3%**
Mountain View Community	**0.6**	**0.8**	0.5	0.1	**0.8**	***3.7%***
Springfield Community	*0.4*	0.2	*0.7*	0.4	**0.4**	**4.4%**
OHC Region	**0.6**	**0.5**	*0.6*	0.4	**0.6**	**4.2%**
Missouri	0.4	0.4	0.5	0.5	0.4	4.0%
United States	0.4	0.3	0.6	0.8	0.3	3.0%

*1 indicates highest vulnerability

HEALTH BEHAVIORS

	Adult Binge Drinking*	Physical Inactivity	Current Smokers	Chlamydia Incidence**	Fruit/Vegetable Expenditures ($)	Gonorrhea Incidence**	HIV Prevalence**
Bolivar Community	15.7%	*23.0%*	**22.4%**	331.6	***$643.48***	98.2	76.4
Branson Community	14.6%	**29.7%**	**21.3%**	350.4	***$615.50***	155.1	80.6
Joplin Community	15.3%	***27.2%***	**22.8%**	472.6	***$640.72***	183.0	99.4
Lebanon Community	16.6%	26.2%	**22.6%**	417.8	***$665.26***	156.3	86.6
Monett Community	15.7%	**30.0%**	**23.8%**	278.0	*$681.10*	102.6	112.0
Mountain View Community	14.2%	**29.2%**	**25.2%**	261.2	***$654.18***	53.6	89.9
Springfield Community	*17.4%*	*22.9%*	***20.1%***	***641.2***	***$607.67***	**277.8**	196.2
OHC Region	16.1%	***26.0%***	**21.9%**	482.2	***$635.03***	*192.7*	129.0
Missouri	17.5%	24.5%	20.3%	568.1	$665.08	246.8	245.6
United States	16.9%	22.1%	17.0%	539.9	$744.71	179.1	372.8

*in the past 30 days
**per 100,000 population

APPENDIX B

COUNTY DATA

HOW TO READ THESE TABLES:

	Measure is better than state average.
	Measure is worse than state average.
Bold	Measure is worse than national average.

BOLIVAR COMMUNITY- ASSESSED HEALTH ISSUES

	Dade County, MO	Hickory County, MO	Polk County, MO	Bolivar Community	ORC Region	Missouri	United States
Assessed Health Issue: Cancer							
Cancer Incidence Rate*	413.2	353.2	367.5	371.5	419.9	454.9	448.7
Cancer Mortality*	**173.2**	**190.2**	**152.7**	**163.1**	**171.3**	166.4	152.3
Recent Mammogram**	**65.8**	**65.8**	**66.7**	**66.4**	**67.6**	70.8	73.7
Recent Pap Smear***	**81.4%**	**81.6%**	**81.2%**	**81.3%**	**82.1%**	84.1%	83.9%
Adequate Colorectal Cancer Screening	**67.6%**	**64.0%**	**64.2%**	**63.8%**	**63.8%**	67.0%	65.5%
Assessed Health Issue: Diabetes							
Annual Hemoglobin A1c Test+	91.2%	86.8%	87.5%	88.0%	84.8%	86.3%	85.7%
Diabetes Prevalence	9.3%	8.4%	8.7%	8.7%	10.4%	10.1%	9.5%
Poor Physical Health	18.6%	19.4%	15.5%	16.7%	15.7%	14.0%	13.0%
Obesity Prevalence	36.0%	30.4%	36.6%	35.2%	32.6%	32.4%	29.5%
Assessed Health Issue: Lung Disease							
Lung Disease Mortality*	38.5	**57.5**	**62.7**	**57.9**	**60.7**	50.4	40.2
Asthma Prevalence	**10.3%**	**10.2%**	**10.0%**	**10.1%**	**10.1%**	9.7%	9.5%
COPD Prevalence	**12.6%**	**13.8%**	**9.9%**	**11.1%**	**10.0%**	8.5%	7.2%
Assessed Health Issue: Heart Disease							
Stroke Mortality*	**52.6**	**38.1**	**50.4**	**48.4**	**40.1**	39.6	37.3
Heart Disease Mortality*	**223.1**	164.4	**204.1**	**199.4**	**212.3**	191.2	164.8
High Blood Pressure Prevalence	**40.4%**	**46.4%**	**34.0%**	**37.4%**	**35.1%**	33.2%	32.9%
High Cholesterol Prevalence	**42.2%**	**45.9%**	**37.8%**	**40.0%**	**37.7%**	36.0%	34.2%
Coronary Heart Disease Prevalence	**11.0%**	**12.8%**	**8.4%**	**9.6%**	**8.6%**	7.5%	6.9%

* per 100,000 population; ** females age 50-74

*** females age 21-65; +Medicare population

***** no data

\+ Missouri counties only

! Missouri Preventive Services Program (PSP) participants only

BOLIVAR COMMUNITY- ASSESSED HEALTH ISSUES, CONT.

	Dade County, MO	Hickory County, MO	Polk County, MO	Bolivar Community	ORC Region	Missouri	United States
Assessed Health Issue: Mental Health							
Suicide Mortality*	*****	*****	**20.4**	**20.4**	**22.1**	18.3	13.8
Poor Mental Health	**16.0%**	**14.9%**	**15.9%**	**15.7%**	**15.7%**	14.5%	13.4%
Depression Prevalence+	**19.4%**	**20.5%**	**25.5%**	**23.0%**	**20.8%**	21.3%	18.4%
Assessed Health Issue: Substance Use and Recovery							
Drug Poisoning Mortality*	*****	*****	**25.0**	**25.0**	**22.8**	25.3	21.6
Alcohol Use Disorder Prevalence+	1.8%	2.0%	2.1%	2.0%	1.7%	1.9%	2.1%
Substance Use Disorder Prevalence+	**3.6%**	2.5%	**4.0%**	3.5%	3.5%	3.3%	3.5%
Assessed Health Issue: Oral Health							
Recent Dental Visit	**52.4%**	**54.7%**	**56.4%**	**55.5%**	**56.4%**	61.4%	64.4%
PWSD Fluoridation+	0.0%	0.0%	0.0%	0.0%	50.4%	71.8%	*****
Early Childhood Caries Referrals!	15.0%	36.7%	*****	26.6%	7.0%	4.5%	*****
Assessed Health Issue: COVID-19							
COVID-19 Mortality*	**224.6**	**220.8**	155.3	178.6	**236.3**	191.3	217.5
COVID-19 Case Rate*	11454.6	11473.3	**15909.4**	**14369.2**	**14423.4**	12973.0	13846.0
COVID-19 Fully Vaccinated Adults	**49.4%**	**42.0%**	**43.9%**	**45.0%**	**47.4%**	54.7%	64.7%

* per 100,000 population; ** females age 50-74

*** females age 21-65; +Medicare population

***** no data

\+ Missouri counties only

! Missouri Preventive Services Program (PSP) participants only

BOLIVAR COMMUNITY- SOCIAL DETERMINANTS OF HEALTH

	Dade County, MO	Hickory County, MO	Polk County, MO	Bolivar Community	ORC Region	Missouri	United States
CT: Economic Stability							
Population Below 200% FPL	**47.5%**	**43.9%**	**42.1%**	**43.3%**	**40.7%**	32.1%	30.9%
Children Below 200% FPL	**67.1%**	**40.6%**	**52.1%**	**52.5%**	**52.1%**	41.0%	40.1%
Per Capita Income ($)	**$23,186.00**	**$20,735.00**	**$22,773.00**	**$22,444.00**	**$ -**	$30,810.00	$34,102.00
Unemployment Rate	3.2%	3.8%	3.6%	3.6%	4.0%	4.7%	5.5%
Cost Burden, Severe (50%)	8.9%	11.6%	10.6%	10.5%	**10.9%**	11.0%	14.0%
Affordable Housing (60% AMI)	**48.4%**	**40.3%**	**36.0%**	**38.9%**	**36.6%**	38.8%	29.9%

* age 25+; ** per 100,000 population; *** age 65+

\+ 1 indicates highest vulnerability; @in the past 30 days

BOLIVAR COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Dade County, MO	Hickory County, MO	Polk County, MO	Bolivar Community	ORC Region	Missouri	United States
CT: Education Access & Quality							
No High School Diploma*	**12.8%**	**15.7%**	11.6%	**12.7%**	11.8%	10.1%	12.0%
Associate's Level Degree or Higher*	19.1%	15.9%	26.7%	23.1%	30.0%	37.1%	40.6%
Bachelor's Degree or Higher*	**12.7%**	**9.0%**	**19.9%**	**16.3%**	**22.1%**	29.2%	32.2%
Chronic Absence Rate	4.1%	4.4%	11.7%	8.7%	11.7%	11.8%	15.9%
CT: Healthcare Access & Quality							
Uninsured Adults	**19.7%**	**20.0%**	**18.9%**	**19.2%**	**18.3%**	14.1%	12.8%
Uninsured Children	**9.8%**	**10.0%**	**8.6%**	**9.0%**	**8.2%**	6.5%	5.6%
Population Receiving Medicaid	**24.6%**	19.7%	23.8%	23.2%	20.7%	16.3%	22.2%
Population Living in a HPSA	**46.0%**	**98.7%**	46.8%	56.7%	**41.6%**	27.6%	22.6%
Primary Care Physicians Provider Rate**	**65.9**	**21.3**	78.8	**65.7**	**63.2**	70.0	76.7
Mental Health Care Provider Rate**	**66.1**	**62.9**	**189.7**	**146.2**	**200.5**	204.2	261.6
Addiction/Substance Abuse Provider Rate**	**0.0**	**0.0**	**0.0**	**0.0**	11.0	2.2	9.4
Dentists Provider Rate**	**13.2**	**21.7**	**25.6**	**22.9**	**44.3**	54.2	65.6
Core Preventative Services for Men***	31.3%	**30.9%**	33.0%	32.3%	**33.0%**	34.7%	31.0%
Core Preventative Services for Women***	31.5%	32.0%	33.0%	32.6%	33.8%	36.3%	31.1%
Households with No Motor Vehicle	4.7%	4.0%	6.6%	5.7%	6.0%	6.9%	8.6%

* age 25+; ** per 100,000 population; *** age 65+

+ 1 indicates highest vulnerability; @in the past 30 days

BOLIVAR COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Dade County, MO	Hickory County, MO	Polk County, MO	Bolivar Community	ORC Region	Missouri	United States
CT: Neighborhood & Built Environment							
Substandard Housing	24.5%	24.9%	25.5%	25.2%	26.8%	26.0%	31.9%
Violent Crime Rate**	371.2	18.2	374.7	307.1	**426.4**	524.3	416.0
Households with No or Slow Internet	**28.4%**	**36.5%**	**21.8%**	**26.0%**	**25.1%**	19.8%	17.3%
Low Food Access	9.0%	4.4%	3.7%	4.7%	**24.8%**	24.9%	22.2%
Respiratory Hazard Index Score	1.1	1.1	1.2	1.1	1.5	1.7	1.8
CT: Social & Community Context							
Social Vulnerability Index (SVI)+	**0.7**	**0.6**	**0.5**	**0.6**	**0.6**	0.4	0.4
SVI- Household Composition+	**0.8**	**0.8**	**0.5**	**0.7**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.4	**0.8**	0.1	**0.6**	0.6	0.5	0.6
SVI- Minority Status+	0.2	0.1	0.4	0.2	0.4	0.5	0.8
SVI- Socioeconomic+	**0.9**	**0.6**	**0.8**	**0.7**	**0.6**	0.4	0.3
Homeless Students	0.7%	0.0%	**3.6%**	3.0%	**4.2%**	4.0%	3.0%
CT: Health Behaviors							
Adult Binge Drinking@	14.5%	12.7%	16.8%	15.7%	16.1%	17.5%	16.9%
Physical Inactivity	**25.4%**	21.1%	**23.1%**	**23.0%**	**26.0%**	24.5%	22.1%
Current Smokers	**24.1%**	**22.9%**	**21.8%**	**22.4%**	**21.9%**	20.3%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	*****	**$643.48**	**$635.03**	$665.08	$744.71
Chlamydia Incidence**	276.8	179.4	390.0	331.6	482.2	568.1	539.9
Gonorrhea Incidence**	92.3	31.7	119.5	98.2	192.7	246.8	179.1
HIV Prevalence**	107.7	59.8	74.0	76.4	129.0	245.6	372.8

* age 25+; ** per 100,000 population; *** age 65+

\+ 1 indicates highest vulnerability; @in the past 30 days

BRANSON COMMUNITY- ASSESSED HEALTH ISSUES

	Stone County, MO	Taney County, MO	Branson Community	ORC Region	Missouri	United States
Assessed Health Issue: Cancer						
Cancer Incidence Rate*	385.1	410.3	399.1	419.9	454.9	448.7
Cancer Mortality*	**155.0**	**149.7**	**151.6**	**171.3**	166.4	152.3
Recent Mammogram**	**66.5**	**67.0**	**66.8**	**67.6**	70.8	73.7
Recent Pap Smear***	**82.4%**	**82.5%**	**82.5%**	**82.1%**	84.1%	83.9%
Adequate Colorectal Cancer Screening	**67.6%**	**64.5%**	**65.6%**	**63.8%**	67.0%	65.5%
Assessed Health Issue: Diabetes						
Annual Hemoglobin A1c Test+	**85.6%**	**82.9%**	**84.0%**	**84.8%**	86.3%	85.7%
Diabetes Prevalence	8.1%	**11.3%**	**9.9%**	**10.4%**	10.1%	9.5%
Poor Physical Health	**17.4%**	**16.1%**	**16.6%**	**15.7%**	14.0%	13.0%
Obesity Prevalence	28.9%	**29.6%**	29.3%	**32.6%**	32.4%	29.5%
Assessed Health Issue: Lung Disease						
Lung Disease Mortality*	**42.9**	39.4	**40.7**	**60.7**	50.4	40.2
Asthma Prevalence	**9.8%**	**10.1%**	**10.0%**	**10.1%**	9.7%	9.5%
COPD Prevalence	**12.2%**	**10.6%**	**11.2%**	**10.0%**	8.5%	7.2%
Assessed Health Issue: Heart Disease						
Stroke Mortality*	36.6	34.8	35.4	**40.1**	39.6	37.3
Heart Disease Mortality*	**226.0**	**286.7**	**264.7**	**212.3**	191.2	164.8
High Blood Pressure Prevalence	**41.7%**	**36.1%**	**38.1%**	**35.1%**	33.2%	32.9%
High Cholesterol Prevalence	**43.4%**	**39.1%**	**40.7%**	**37.7%**	36.0%	34.2%
Coronary Heart Disease Prevalence	**11.3%**	**9.4%**	**10.1%**	**8.6%**	7.5%	6.9%
Assessed Health Issue: Mental Health						
Suicide Mortality*	**33.9**	**19.2**	**24.5**	**22.1**	18.3	13.8
Poor Mental Health	**14.1%**	**15.4%**	**14.9%**	**15.7%**	14.5%	13.4%
Depression Prevalence+	17.0%	**18.9%**	18.1%	**20.8%**	21.3%	18.4%
Assessed Health Issue: Substance Use and Recovery						
Drug Poisoning Mortality*	**27.7**	**21.9**	**24.0**	**22.8**	25.3	21.6
Alcohol Use Disorder Prevalence+	1.5%	1.5%	1.5%	1.7%	1.9%	2.1%
Substance Use Disorder Prevalence+	2.6%	**3.8%**	3.3%	3.5%	3.3%	3.5%
Assessed Health Issue: Oral Health						
Recent Dental Visit	**56.8%**	**55.2%**	**55.8%**	**56.4%**	61.4%	64.4%
PWSD Fluoridation+	7.2%	21.0%	17.3%	50.4%	71.8%	*****
Early Childhood Caries Referrals!	25.1%	*****	25.1%	7.0%	4.5%	*****
Assessed Health Issue: COVID-19						
COVID-19 Mortality*	**264.6**	**270.4**	**268.3**	**236.3**	191.3	217.5
COVID-19 Case Rate*	12491.7	**16126.6**	**14809.2**	**14423.4**	12973.0	13846.0
COVID-19 Fully Vaccinated Adults	**40.6%**	**44.3%**	**42.5%**	**47.4%**	54.7%	64.7%

* per 100,000 population; ** females age 50-74

*** females age 21-65; +Medicare population

***** no data

\+ Missouri counties only

! Missouri Preventive Services Program (PSP) participants only

BRANSON COMMUNITY- SOCIAL DETERMINANTS OF HEALTH

	Stone County, MO	Taney County, MO	Branson Community	ORC Region	Missouri	United States
CT: Economic Stability						
Population Below 200% FPL	**34.7%**	**40.8%**	**38.6%**	**40.7%**	32.1%	30.9%
Children Below 200% FPL	**52.4%**	**55.4%**	**54.4%**	**52.1%**	41.0%	40.1%
Per Capita Income ($)	**$29,025.00**	**$23,775.00**	**$25,689.00**	**$ -**	$30,810.00	$34,102.00
Unemployment Rate	**7.6%**	**8.7%**	**8.3%**	4.0%	4.7%	5.5%
Cost Burden, Severe (50%)	9.0%	10.9%	10.2%	10.9%	11.0%	14.0%
Affordable Housing (60% AMI)	**32.7%**	**30.2%**	**31.1%**	**36.6%**	38.8%	29.9%
CT: Education Access & Quality						
No High School Diploma*	**12.8%**	11.1%	11.8%	11.8%	10.1%	12.0%
Associate's Level Degree or Higher*	26.5%	27.9%	27.3%	30.0%	37.1%	40.6%
Bachelor's Degree or Higher*	**18.6%**	**19.9%**	**19.4%**	**22.1%**	29.2%	32.2%
Chronic Absence Rate	13.1%	**17.4%**	**15.9%**	11.7%	11.8%	15.9%
CT: Healthcare Access & Quality						
Uninsured Adults	**18.7%**	**21.6%**	**20.6%**	**18.3%**	14.1%	12.8%
Uninsured Children	**10.1%**	**8.6%**	**9.1%**	**8.2%**	6.5%	5.6%
Population Receiving Medicaid	16.2%	22.1%	19.8%	20.7%	16.3%	22.2%
Population Living in a HPSA	**39.1%**	**43.7%**	**42.0%**	**41.6%**	27.6%	22.6%
Primary Care Physicians Provider Rate**	**34.8**	78.0	**62.3**	63.2	70.0	76.7
Mental Health Care Provider Rate**	**40.7**	**76.9**	**63.7**	**200.5**	204.2	261.6
Addiction/Substance Abuse Provider Rate**	**0.0**	**5.4**	**3.5**	**11.0**	2.2	9.4
Dentists Provider Rate**	**12.9**	**29.3**	**23.4**	**44.3**	54.2	65.6
Core Preventative Services for Men***	31.9%	32.3%	32.2%	33.0%	34.7%	31.0%
Core Preventative Services for Women***	34.6%	33.6%	34.0%	33.8%	36.3%	31.1%
Households with No Motor Vehicle	4.0%	5.9%	5.2%	6.0%	6.9%	8.6%
CT: Neighborhood & Built Environment						
Substandard Housing	24.6%	29.5%	27.7%	26.8%	26.0%	31.9%
Violent Crime Rate**	404.1	378.4	387.7	**426.4**	524.3	416.0
Households with No or Slow Internet	**19.4%**	**19.7%**	**19.6%**	**25.1%**	19.8%	17.3%
Low Food Access	14.7%	**41.4%**	**31.1%**	24.8%	24.9%	22.2%
Respiratory Hazard Index Score	1.3	1.6	1.5	1.5	1.7	1.8

* age 25+; ** per 100,000 population; *** age 65+

+ 1 indicates highest vulnerability; @in the past 30 days

BRANSON COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Stone County, MO	Taney County, MO	Branson Community	ORC Region	Missouri	United States
CT: Social & Community Context						
Social Vulnerability Index (SVI)+	0.4	**0.8**	**0.7**	**0.6**	0.4	0.4
SVI- Household Composition+	**0.4**	**0.8**	**0.7**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.4	**1.0**	**0.8**	0.6	0.5	0.6
SVI- Minority Status+	0.1	0.4	0.3	0.4	0.5	0.8
SVI- Socioeconomic+	**0.5**	**0.7**	**0.6**	**0.6**	0.4	0.3
Homeless Students	**5.0%**	**3.6%**	**4.0%**	**4.2%**	4.0%	3.0%
CT: Health Behaviors						
Adult Binge Drinking@	13.9%	15.0%	14.6%	16.1%	17.5%	16.9%
Physical Inactivity	**26.2%**	**32.0%**	**29.7%**	**26.0%**	24.5%	22.1%
Current Smokers	**20.6%**	**21.7%**	**21.3%**	**21.9%**	20.3%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	**$615.50**	**$635.03**	$665.08	$744.71
Chlamydia Incidence**	246.1	410.1	350.4	482.2	568.1	539.9
Gonorrhea Incidence**	69.4	**204.1**	155.1	**192.7**	246.8	179.1
HIV Prevalence**	95.8	71.6	80.6	129.0	245.6	372.8
* age 25+; ** per 100,000 population; *** age 65+						
+ 1 indicates highest vulnerability; @in the past 30 days						

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Community	ORC Region	Missouri	United States
Assessed Health Issue: Cancer									
Cancer Incidence Rate*	**466.5**	478.0	429.4	391.3	435.0	440.2	419.9	454.9	448.7
Cancer Mortality*	**179.1**	**184.1**	**201.7**	**184.4**	**167.6**	**187.1**	**171.3**	166.4	152.3
Recent Mammogram**	**65.9**	**69.3**	**65.3**	**65.8**	**67.7**	**67.4**	**67.6**	70.8	73.7
Recent Pap Smear***	**81.4%**	**82.7%**	**79.8%**	**82.8%**	**82.4%**	**81.6%**	**82.1%**	84.1%	83.9%
Adequate Colorectal Cancer Screening	**63.6%**	**64.9%**	**59.5%**	**63.0%**	**63.7%**	**61.6%**	**63.8%**	67.0%	65.5%
* per 100,000 population; ** females age 50-74									
*** females age 21-65; +Medicare population									
***** no data									
+ Missouri counties only									
! Missouri Preventive Services Program (PSP) participants only									

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
Assessed Health Issue: Cancer							
Cancer Incidence Rate*	*****	*****	*****	440.2	419.9	452.4	448.7
Cancer Mortality*	**187.1**	**199.7**	**179.7**	**187.1**	**171.3**	**158.1**	152.3
Recent Mammogram**	**65.6**	**67.0**	**65.6**	**67.4**	**67.6**	**71.2**	73.7
Recent Pap Smear***	**81.6%**	**79.7%**	**82.2%**	**81.6%**	**82.1%**	**83.4%**	83.9%
Adequate Colorectal Cancer Screening	**58.2%**	**55.5%**	**58.1%**	**61.6%**	**63.8%**	**63.4%**	65.5%
* per 100,000 population; ** females age 50-74							
*** females age 21-65; +Medicare population							
***** no data							

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
Assessed Health Issue: Cancer						
Cancer Incidence Rate*	395.1	**478.9**	440.2	419.9	449.8	448.7
Cancer Mortality*	**172.0**	**218.2**	**187.1**	**171.3**	**178.0**	152.3
Recent Mammogram**	**66.9**	**68.9**	**67.4**	**67.6**	**71.6**	73.7
Recent Pap Smear***	**80.3%**	**79.7%**	**81.6%**	**82.1%**	**81.8%**	83.9%
Adequate Colorectal Cancer Screening	**62.1%**	**57.5%**	**61.6%**	**63.8%**	**60.3%**	65.5%
* per 100,000 population; ** females age 50-74						
*** females age 21-65; +Medicare population						
***** no data						

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Community	ORC Region	Missouri	United States
Assessed Health Issue: Diabetes									
Annual Hemoglobin A1c Test+	90.5%	**85.6%**	**81.1%**	**82.9%**	**85.1%**	**81.6%**	**84.8%**	86.3%	85.7%
Diabetes Prevalence	**10.8%**	9.5%	8.0%	**9.2%**	7.2%	**10.1%**	**10.4%**	10.1%	9.5%
Poor Physical Health	**17.2%**	**15.0%**	**18.4%**	**15.7%**	**16.3%**	**16.0%**	**15.7%**	14.0%	13.0%
Obesity Prevalence	28.6%	**37.0%**	**33.9%**	**30.0%**	**29.9%**	**34.3%**	32.6%	32.4%	29.5%
Assessed Health Issue: Lung Disease									
Lung Disease Mortality*	**55.8**	**69.4**	**105.7**	**58.5**	**64.1**	**68.3**	**60.7**	50.4	40.2
Asthma Prevalence	**10.2%**	**9.9%**	**10.7%**	**9.9%**	**10.1%**	**10.4%**	10.1%	9.7%	9.5%
COPD Prevalence	**11.5%**	**9.3%**	**11.8%**	**9.8%**	**10.7%**	**10.0%**	**10.0%**	8.5%	7.2%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data
\+ Missouri counties only
! Missouri Preventive Services Program (PSP) participants only

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
Assessed Health Issue: Diabetes							
Annual Hemoglobin A1c Test+	**80.5%**	**86.0%**	**81.3%**	**81.6%**	**84.8%**	86.8%	85.7%
Diabetes Prevalence	**12.3%**	**10.3%**	**11.0%**	**10.1%**	**10.4%**	9.5%	9.5%
Poor Physical Health	**15.0%**	12.5%	**14.9%**	**16.0%**	**15.7%**	11.9%	13.0%
Obesity Prevalence	**40.3%**	**31.4%**	**37.8%**	**34.3%**	32.6%	32.9%	29.5%
Assessed Health Issue: Lung Disease							
Lung Disease Mortality*	**74.4**	**68.8**	**57.5**	**68.3**	**60.7**	49.6	40.2
Asthma Prevalence	**10.5%**	**10.2%**	**10.4%**	**10.4%**	10.1%	9.6%	9.5%
COPD Prevalence	**9.6%**	**7.5%**	**9.4%**	**10.0%**	**10.0%**	6.9%	7.2%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
Assessed Health Issue: Diabetes						
Annual Hemoglobin A1c Test+	**72.5%**	**77.4%**	**81.6%**	**84.8%**	79.5%	85.7%
Diabetes Prevalence	**11.7%**	**12.5%**	**10.1%**	**10.4%**	11.3%	9.5%
Poor Physical Health	**19.8%**	**18.6%**	**16.0%**	**15.7%**	14.9%	13.0%
Obesity Prevalence	**32.3%**	**37.3%**	**34.3%**	32.6%	34.4%	29.5%
Assessed Health Issue: Lung Disease						
Lung Disease Mortality*	**64.3**	**70.9**	**68.3**	**60.7**	63.8	40.2
Asthma Prevalence	**11.5%**	**11.6%**	**10.4%**	10.1%	10.5%	9.5%
COPD Prevalence	**12.4%**	**11.5%**	**10.0%**	**10.0%**	8.6%	7.2%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Community	ORC Region	Missouri	United States
Assessed Health Issue: Heart Disease									
Stroke Mortality*	**56.8**	**41.2**	34.6	**44.0**	**48.4**	**42.4**	40.1	39.6	37.3
Heart Disease Mortality*	**183.0**	**239.4**	**224.2**	**230.7**	**243.0**	**236.7**	**212.3**	191.2	164.8
High Blood Pressure Prevalence	**37.4%**	**33.4%**	**36.0%**	**34.9%**	**36.4%**	**36.8%**	35.1%	33.2%	32.9%
High Cholesterol Prevalence	**39.8%**	**34.6%**	**38.9%**	**38.2%**	**39.5%**	**37.7%**	**37.7%**	36.0%	34.2%
Coronary Heart Disease Prevalence	**9.9%**	**7.6%**	**9.5%**	**8.5%**	**9.2%**	**8.8%**	**8.6%**	7.5%	6.9%
* per 100,000 population; ** females age 50-74									
*** females age 21-65; +Medicare population									
***** no data									
+ Missouri counties only									
! Missouri Preventive Services Program (PSP) participants only									

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
Assessed Health Issue: Heart Disease							
Stroke Mortality*	**39.5**	34.7	**44.1**	**42.4**	40.1	37.1	37.3
Heart Disease Mortality*	**262.7**	**196.4**	**206.9**	**236.7**	**212.3**	160.2	164.8
High Blood Pressure Prevalence	**40.2%**	**33.7%**	**41.9%**	**36.8%**	35.1%	33.4%	32.9%
High Cholesterol Prevalence	**38.6%**	**34.5%**	**39.1%**	**37.7%**	**37.7%**	34.8%	34.2%
Coronary Heart Disease Prevalence	**9.0%**	**7.2%**	**8.9%**	**8.8%**	**8.6%**	6.9%	6.9%
* per 100,000 population; ** females age 50-74							
*** females age 21-65; +Medicare population							
***** no data							

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
Assessed Health Issue: Heart Disease						
Stroke Mortality*	**39.1**	**55.0**	**42.4**	40.1	41.3	37.3
Heart Disease Mortality*	**231.0**	**322.5**	**236.7**	**212.3**	231.9	164.8
High Blood Pressure Prevalence	**45.5%**	**40.9%**	**36.8%**	35.1%	38.0%	32.9%
High Cholesterol Prevalence	**43.6%**	**39.7%**	**37.7%**	**37.7%**	37.8%	34.2%
Coronary Heart Disease Prevalence	**12.1%**	**10.6%**	**8.8%**	**8.6%**	8.3%	6.9%
* per 100,000 population; ** females age 50-74						
*** females age 21-65; +Medicare population						
***** no data						

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Community	ORC Region	Missouri	United States
Assessed Health Issue: Mental Health									
Suicide Mortality*	*****	**23.8**	*****	**22.4**	**20.7**	**22.7**	**22.1**	18.3	13.8
Poor Mental Health	**16.0%**	**15.9%**	**17.5%**	**15.3%**	**15.8%**	**16.0%**	**15.7%**	14.5%	13.4%
Depression Prevalence+	15.1%	**23.0%**	**21.3%**	**18.9%**	18.2%	**20.8%**	**20.8%**	21.3%	18.4%
Assessed Health Issue: Substance Use and Recovery									
Drug Poisoning Mortality*	*****	13.8	*****	17.3	*****	16.6	**22.8**	25.3	21.6
Alcohol Use Disorder Prevalence+	1.3%	1.9%	1.5%	1.5%	1.5%	1.6%	1.7%	1.9%	2.1%
Substance Use Disorder Prevalence+	2.1%	3.1%	**3.9%**	2.6%	2.9%	3.3%	3.5%	3.3%	3.5%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data
+ Missouri counties only
! Missouri Preventive Services Program (PSP) participants only

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
Assessed Health Issue: Mental Health							
Suicide Mortality*	**20.3**	**19.3**	**24.0**	**22.7**	**22.1**	18.2	13.8
Poor Mental Health	**14.8%**	**15.2%**	**14.7%**	**16.0%**	**15.7%**	12.9%	13.4%
Depression Prevalence+	**21.3%**	**20.9%**	**17.3%**	**20.8%**	**20.8%**	19.8%	18.4%
Assessed Health Issue: Substance Use and Recovery							
Drug Poisoning Mortality*	*****	*****	*****	16.6	**22.8**	14.2	21.6
Alcohol Use Disorder Prevalence+	1.5%	1.6%	1.4%	1.6%	1.7%	1.6%	2.1%
Substance Use Disorder Prevalence+	3.3%	3.1%	2.6%	3.3%	3.5%	2.5%	3.5%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
Assessed Health Issue: Mental Health						
Suicide Mortality*	**23.4**	**23.9**	**22.7**	**22.1**	20.2	13.8
Poor Mental Health	**16.8%**	**18.0%**	**16.0%**	**15.7%**	15.6%	13.4%
Depression Prevalence+	**20.4%**	**23.8%**	**20.8%**	**20.8%**	21.1%	18.4%
Assessed Health Issue: Substance Use and Recovery						
Drug Poisoning Mortality*	19.8	**21.7**	16.6	**22.8**	21.4	21.6
Alcohol Use Disorder Prevalence+	1.7%	1.6%	1.6%	1.7%	1.6%	2.1%
Substance Use Disorder Prevalence+	**4.4%**	**4.2%**	3.3%	3.5%	5.4%	3.5%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Community	ORC Region	Missouri	United States
Assessed Health Issue: Oral Health									
Recent Dental Visit	**52.8%**	**53.4%**	**50.1%**	54.9%	**55.8%**	**55.1%**	**56.4%**	61.4%	64.4%
PWSD Fluoridation+	**90.3%**	**69.0%**	**75.0%**	0.0%	**17.6%**	**56.7%**	**50.4%**	71.8%	*****
Early Childhood Caries Referrals!	*****	2.7%	*****	6.8%	4.2%	4.0%	7.0%	4.5%	*****
Assessed Health Issue: COVID-19									
COVID-19 Mortality*	**228.9**	**289.3**	195.0	214.5	**316.6**	**287.2**	**236.3**	191.3	217.5
COVID-19 Case Rate*	**15265.3**	**18626.3**	**15542.9**	13338.8	**14950.3**	**17041.8**	**14423.4**	12973.0	13846.0
COVID-19 Fully Vaccinated Adults	**38.8%**	**53.9%**	**36.1%**	**28.9%**	**39.6%**	**53.9%**	**47.4%**	54.7%	64.7%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data
+ Missouri counties only
! Missouri Preventive Services Program (PSP) participants only

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
Assessed Health Issue: Oral Health							
Recent Dental Visit	**58.7%**	65.0%	**58.0%**	**55.1%**	**56.4%**	66.7%	64.4%
PWSD Fluoridation+	*****	*****	*****	**56.7%**	**50.4%**	*****	*****
Early Childhood Caries Referrals!	*****	*****	*****	4.0%	7.0%	*****	*****
Assessed Health Issue: COVID-19							
COVID-19 Mortality*	**384.7**	**374.4**	**300.5**	**287.2**	**236.3**	218.0	217.5
COVID-19 Case Rate*	**18246.3**	**17146.0**	**17621.7**	**17041.8**	**14423.4**	14423.4	13846.0
COVID-19 Fully Vaccinated Adults	**50.3%**	**39.4%**	**55.1%**	**53.9%**	**47.4%**	47.4%	64.7%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data

JOPLIN COMMUNITY- ASSESSED HEALTH ISSUES, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
Assessed Health Issue: Oral Health						
Recent Dental Visit	**54.0%**	**51.6%**	**55.1%**	**56.4%**	59.3%	64.4%
PWSD Fluoridation+	*****	*****	**56.7%**	**50.4%**	*****	*****
Early Childhood Caries Referrals!	*****	*****	4.0%	7.0%	*****	*****
Assessed Health Issue: COVID-19						
COVID-19 Mortality*	**374.4**	**324.0**	**287.2**	**236.3**	271.6	217.5
COVID-19 Case Rate*	**17146.0**	**19467.5**	**17041.8**	**14423.4**	14894.0	13846.0
COVID-19 Fully Vaccinated Adults	**39.4%**	**43.5%**	**53.9%**	**47.4%**	60.8%	64.7%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Commu-nity	ORC Region	Missouri	United States
CT: Economic Stability									
Population Below 200% FPL	**43.6%**	**39.8%**	**50.5%**	**39.2%**	**42.9%**	**38.6%**	**40.7%**	32.1%	30.9%
Children Below 200% FPL	**52.2%**	**51.5%**	**69.7%**	**51.0%**	**56.0%**	**54.4%**	**52.1%**	41.0%	40.1%
Per Capita In-come ($)	**$26,509.00**	**$24,483.00**	**$20,467.00**	**$28,352.00**	**$24,312.00**	**$25,689.00**	**$ -**	$30,810.00	$34,102.00
Unemployment Rate	3.6%	4.0%	3.8%	4.0%	3.3%	8.3%	4.0%	4.7%	5.5%
Cost Burden, Severe (50%)	11.2%	10.0%	5.8%	8.6%	9.3%	10.2%	10.9%	11.0%	14.0%
Affordable Hous-ing (60% AMI)	50.6%	40.9%	40.3%	44.4%	46.6%	31.1%	36.6%	38.8%	29.9%
* age 25+; ** per 100,000 population; *** age 65+									
+ 1 indicates highest vulnerability; @in the past 30 days									

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
CT: Economic Stability							
Population Below 200% FPL	**42.0%**	**42.5%**	**39.7%**	**38.6%**	**40.7%**	29.8%	30.9%
Children Below 200% FPL	**51.2%**	**48.6%**	**55.7%**	**54.4%**	**52.1%**	38.0%	40.1%
Per Capita Income ($)	**$22,615.00**	**$23,091.00**	**$24,572.00**	**$25,689.00**	**$ -**	$31,814.00	$34,102.00
Unemployment Rate	3.4%	3.6%	3.9%	8.3%	4.0%	3.7%	5.5%
Cost Burden, Severe (50%)	7.2%	**14.7%**	8.2%	10.2%	10.9%	10.3%	14.0%
Affordable Housing (60% AMI)	54.3%	39.9%	61.6%	31.1%	36.6%	45.3%	29.9%
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
CT: Economic Stability						
Population Below 200% FPL	**44.4%**	**48.0%**	**38.6%**	**40.7%**	36.5%	30.9%
Children Below 200% FPL	**58.8%**	**60.4%**	**54.4%**	**52.1%**	47.1%	40.1%
Per Capita Income ($)	**$24,070.00**	**$20,814.00**	**$25,689.00**	**$ -**	$28,421.00	$34,102.00
Unemployment Rate	3.1%	3.2%	8.3%	4.0%	3.7%	5.5%
Cost Burden, Severe (50%)	11.3%	10.4%	10.2%	10.9%	10.7%	14.0%
Affordable Housing (60% AMI)	38.8%	43.7%	31.1%	36.6%	41.4%	29.9%
* age 25+; ** per 100,000 population; *** age 65+						
+ 1 indicates highest vulnerability; @in the past 30 days						

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Commu-nity	ORC Region	Missouri	United States
CT: Education Access & Quality									
No High School Diploma*	**12.9%**	**13.3%**	**22.5%**	**12.9%**	11.7%	**13.2%**	11.8%	10.1%	12.0%
Associate's Level Degree or High-er*	**25.4%**	**30.5%**	**17.8%**	**29.0%**	**27.2%**	**28.8%**	**30.0%**	37.1%	40.6%
Bachelor's De-gree or Higher*	**19.9%**	**23.6%**	**11.5%**	**20.0%**	**18.9%**	**20.7%**	**22.1%**	29.2%	32.2%
Chronic Absence Rate	**8.1%**	9.2%	**13.2%**	9.5%	7.1%	9.5%	11.7%	11.8%	15.9%
* age 25+; ** per 100,000 population; *** age 65+									
+ 1 indicates highest vulnerability; @in the past 30 days									

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, MISSOURI

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
CT: Education Access & Quality							
No High School Diploma*	**10.1%**	7.9%	10.2%	**13.2%**	11.8%	9.1%	12.0%
Associate's Level Degree or Higher*	**29.6%**	**38.2%**	**30.0%**	**28.8%**	**30.0%**	42.1%	40.6%
Bachelor's Degree or Higher*	**19.6%**	**29.9%**	**18.7%**	**20.7%**	**22.1%**	33.4%	32.2%
Chronic Absence Rate	11.2%	5.0%	7.6%	9.5%	11.7%	12.3%	15.9%
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, MISSOURI

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
CT: Education Access & Quality						
No High School Diploma*	**15.1%**	**14.7%**	**13.2%**	11.8%	12.0%	12.0%
Associate's Level Degree or Higher*	**25.2%**	**25.2%**	**28.8%**	**30.0%**	33.4%	40.6%
Bachelor's Degree or Higher*	**18.1%**	**14.5%**	**20.7%**	**22.1%**	25.5%	32.2%
Chronic Absence Rate	14.5%	9.1%	9.5%	11.7%	11.9%	15.9%
* age 25+; ** per 100,000 population; *** age 65+						
+ 1 indicates highest vulnerability; @in the past 30 days						

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Commu-nity	ORC Region	Missouri	United States
CT: Healthcare Access & Quality									
Uninsured Adults	**19.3%**	**20.4%**	**27.3%**	**19.1%**	**17.6%**	**20.2%**	**18.3%**	14.1%	12.8%
Uninsured Children	**9.0%**	**8.1%**	**12.0%**	**7.6%**	**10.1%**	**8.1%**	8.2%	6.5%	5.6%
Population Receiving Medicaid	**22.8%**	21.5%	**29.0%**	18.7%	20.8%	**22.5%**	20.7%	16.3%	22.2%
Population Living in a HPSA	**43.7%**	**40.2%**	**50.8%**	**39.8%**	**43.3%**	**42.9%**	**41.6%**	27.6%	22.6%
Primary Care Physicians Provider Rate**	**33.9**	83.3	**13.2**	**13.8**	**39.0**	**54.3**	**63.2**	70.0	76.7
Mental Health Care Provider Rate**	**68.1**	**235.7**	**13.1**	**34.3**	408.5	**196.8**	**200.5**	204.2	261.6
Addiction/Substance Abuse Provider Rate**	**0.0**	**5.8**	**0.0**	**1.7**	**0.0**	28.2	11.0	2.2	9.4
Dentists Provider Rate**	**8.4**	**55.7**	**26.5**	**17.1**	**28.8**	**38.3**	**44.3**	54.2	65.6
Core Preventative Services for Men***	33.6%	34.8%	**29.7%**	32.7%	**32.2%**	32.8%	**33.0%**	34.7%	31.0%
Core Preventative Services for Women***	32.2%	**36.1%**	32.8%	33.9%	**32.9%**	33.4%	33.8%	36.3%	31.1%
Households with No Motor Vehicle	8.6%	6.3%	5.1%	5.1%	7.3%	6.4%	6.0%	6.9%	8.6%

* age 25+; ** per 100,000 population; *** age 65+

\+ 1 indicates highest vulnerability; @in the past 30 days

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
CT: Healthcare Access & Quality							
Uninsured Adults	**13.3%**	**14.3%**	**15.2%**	**20.2%**	**18.3%**	12.8%	12.8%
Uninsured Children	**5.7%**	4.6%	**6.6%**	**8.1%**	8.2%	5.7%	5.6%
Population Receiving Medicaid	**23.8%**	19.7%	**23.4%**	**22.5%**	20.7%	15.0%	22.2%
Population Living in a HPSA	**38.8%**	**44.0%**	**41.8%**	**42.9%**	**41.6%**	34.0%	22.6%
Primary Care Physicians Provider Rate**	**24.8**	82.2	**69.6**	**54.3**	**63.2**	77.4	76.7
Mental Health Care Provider Rate**	**145.4**	**216.4**	**86.7**	**196.8**	**200.5**	207.0	261.6
Addiction/Substance Abuse Provider Rate**	**24.8**	43.7	9.9	28.2	11.0	7.6	9.4
Dentists Provider Rate**	**34.1**	**51.0**	**28.8**	**38.3**	**44.3**	55.4	65.6
Core Preventative Services for Men***	**29.6%**	**30.5%**	**28.6%**	32.8%	**33.0%**	33.7%	31.0%
Core Preventative Services for Women***	**28.6%**	31.3%	**28.3%**	33.4%	33.8%	33.7%	31.1%
Households with No Motor Vehicle	8.2%	**9.0%**	5.9%	6.4%	6.0%	5.4%	8.6%

* age 25+; ** per 100,000 population; *** age 65+

\+ 1 indicates highest vulnerability; @in the past 30 days

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
CT: Healthcare Access & Quality						
Uninsured Adults	**27.0%**	**24.8%**	**20.2%**	**18.3%**	20.3%	12.8%
Uninsured Children	**10.1%**	**8.5%**	**8.1%**	8.2%	8.6%	5.6%
Population Receiving Medicaid	**24.7%**	**29.8%**	**22.5%**	20.7%	20.5%	22.2%
Population Living in a HPSA	**46.8%**	**48.8%**	**42.9%**	**41.6%**	31.6%	22.6%
Primary Care Physicians Provider Rate**	**46.9**	**51.0**	**54.3**	**63.2**	61.9	76.7
Mental Health Care Provider Rate**	**181.4**	491.5	**196.8**	**200.5**	411	261.6
Addiction/Substance Abuse Provider Rate**	51.6	175.3	28.2	11.0	26.3	9.4
Dentists Provider Rate**	**41.0**	**28.1**	**38.3**	**44.3**	57.5	65.6
Core Preventative Services for Men***	34.4%	33.3%	32.8%	**33.0%**	35.4%	31.0%
Core Preventative Services for Women***	32.7%	32.8%	33.4%	33.8%	37.7%	31.1%
Households with No Motor Vehicle	4.7%	6.3%	6.4%	6.0%	5.5%	8.6%

* age 25+; ** per 100,000 population; *** age 65+

+ 1 indicates highest vulnerability; @in the past 30 days

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Commu-nity	ORC Region	Missouri	United States
CT: Neighborhood & Built Environment									
Substandard Housing	**25.5%**	25.0%	28.8%	23.4%	24.1%	26.1%	26.8%	26.0%	31.9%
Violent Crime Rate**	**312.3**	427.0	**514.5**	249.3	**714.3**	367.1	**426.4**	524.3	416.0
Households with No or Slow In-ternet	**31.6%**	**22.3%**	**45.5%**	**25.0%**	**21.7%**	**26.6%**	**25.1%**	19.8%	17.3%
Low Food Ac-cess	**56.5%**	**26.1%**	3.8%	16.5%	**32.9%**	**24.7%**	**24.8%**	24.9%	22.2%
Respiratory Haz-ard Index Score	1.2	1.5	1.4	1.4	1.3	1.4	1.5	1.7	1.8
* age 25+; ** per 100,000 population; *** age 65+									
+ 1 indicates highest vulnerability; @in the past 30 days									

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
CT: Neighborhood & Built Environment							
Substandard Housing	21.7%	30.4%	26.4%	26.1%	26.8%	25.4%	31.9%
Violent Crime Rate**	303.3	345.6	**437.5**	367.1	**426.4**	368.8	416.0
Households with No or Slow Internet	**27.7%**	**23.0%**	**25.2%**	**26.6%**	**25.1%**	18.2%	17.3%
Low Food Access	**46.4%**	**30.1%**	24.2%	**24.7%**	**24.8%**	26.4%	22.2%
Respiratory Hazard Index Score	1.2	1.2	1.4	1.4	1.5	1.6	1.8
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
CT: Neighborhood & Built Environment						
Substandard Housing	29.7%	26.7%	26.1%	26.8%	26.3%	31.9%
Violent Crime Rate**	208.8	243.1	367.1	**426.4**	443.5	416.0
Households with No or Slow Internet	**31.0%**	**32.5%**	**26.6%**	**25.1%**	21.4%	17.3%
Low Food Access	21.2%	15.9%	**24.7%**	**24.8%**	25.2%	22.2%
Respiratory Hazard Index Score	1.6	1.5	1.4	1.5	1.9	1.8
* age 25+; ** per 100,000 population; *** age 65+						
+ 1 indicates highest vulnerability; @in the past 30 days						

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Commu-nity	ORC Region	Missouri	United States
CT: Social & Community Context									
Social Vulner-ability Index (SVI)+	**0.7**	0.4	**0.5**	0.4	**0.8**	**0.7**	**0.6**	0.4	0.4
SVI- Household Composition+	**0.6**	**0.4**	**0.8**	**0.8**	**0.8**	**0.7**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.6	0.4	0.6	0.2	0.4	0.6	0.6	0.5	0.6
SVI- Minority Status+	0.6	0.5	0.1	0.2	0.7	0.5	0.4	0.5	0.8
SVI- Socioeco-nomic+	**0.6**	**0.4**	**0.4**	**0.5**	**0.8**	**0.6**	**0.6**	0.4	0.3
Homeless Stu-dents	**3.1%**	**3.7%**	**5.4%**	**5.4%**	**4.5%**	**4.1%**	**4.2%**	4.0%	3.0%
* age 25+; ** per 100,000 population; *** age 65+									
+ 1 indicates highest vulnerability; @in the past 30 days									

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
CT: Social & Community Context							
Social Vulnerability Index (SVI)+	**0.7**	**0.6**	**0.6**	**0.7**	**0.6**	0.4	0.4
SVI- Household Composition+	0.3	**0.9**	**1.0**	**0.7**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	**1.0**	0.6	0.5	0.6	0.6	0.4	0.6
SVI- Minority Status+	0.5	0.3	0.1	0.5	0.4	0.6	0.8
SVI- Socioeconomic+	**0.6**	**0.6**	**0.7**	**0.6**	**0.6**	0.3	0.3
Homeless Students	2.2%	**4.0%**	0.4%	**4.1%**	**4.2%**	2.1%	3.0%
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
CT: Social & Community Context						
Social Vulnerability Index (SVI)+	**1.0**	**0.9**	**0.7**	**0.6**	0.6	0.4
SVI- Household Composition+	**1.0**	**0.8**	**0.7**	**0.5**	0.6	0.3
SVI- Housing & Transportation+	**0.9**	**0.7**	0.6	0.6	0.6	0.6
SVI- Minority Status+	0.7	0.8	0.5	0.4	0.7	0.8
SVI- Socioeconomic+	**0.8**	**0.8**	**0.6**	**0.6**	0.5	0.3
Homeless Students	**6.4%**	**4.9%**	**4.1%**	**4.2%**	4.5%	3.0%
* age 25+; ** per 100,000 population; *** age 65+						
+ 1 indicates highest vulnerability; @in the past 30 days						

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, MISSOURI

	Barton County, MO	Jasper County, MO	McDonald County, MO	Newton County, MO	Vernon County, MO	Joplin Commu-nity	ORC Region	Missouri	United States
CT: Health Behaviors									
Adult Binge Drinking@	15.5%	16.4%	16.7%	16.2%	15.7%	14.6%	16.1%	17.5%	16.9%
Physical Inac-tivity	**27.1%**	**25.7%**	20.7%	**29.1%**	**26.6%**	**27.2%**	**26.0%**	24.5%	22.1%
Current Smokers	**23.3%**	**22.7%**	**27.0%**	**22.2%**	**22.6%**	**22.8%**	**21.9%**	20.3%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	*****	*****	*****	**$640.72**	**$635.03**	$665.08	$744.71
Chlamydia Inci-dence**	379.7	**579.0**	501.4	399.7	264.2	472.6	482.2	568.1	539.9
Gonorrhea Inci-dence**	135.0	**253.7**	135.8	118.4	97.9	**183.0**	**192.7**	246.8	179.1
HIV Prevalence**	90.8	177.9	132.8	18.5	104.9	99.4	129.0	245.6	372.8
* age 25+; ** per 100,000 population; *** age 65+									
+ 1 indicates highest vulnerability; @in the past 30 days									

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, KANSAS

	Cherokee County, KS	Crawford County, KS	Labette County, KS	Joplin Community	ORC Region	Kansas	United States
CT: Health Behaviors							
Adult Binge Drinking@	14.7%	16.0%	14.7%	14.6%	16.1%	16.0%	16.9%
Physical Inactivity	**30.5%**	**25.9%**	**30.4%**	**27.2%**	**26.0%**	23.3%	22.1%
Current Smokers	**21.5%**	**19.7%**	**21.4%**	**22.8%**	**21.9%**	17.5%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	*****	**$640.72**	**$635.03**	$677.50	$744.71
Chlamydia Incidence**	333.1	**566.2**	501.4	472.6	482.2	488.5	539.9
Gonorrhea Incidence**	**223.7**	**238.3**	144.0	**183.0**	**192.7**	180.4	179.1
HIV Prevalence**	71.4	45.6	109.1	99.4	129.0	128.1	372.8
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

JOPLIN COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, OKLAHOMA

	Delaware County, OK	Ottawa County, OK	Joplin Community	ORC Region	Oklahoma	United States
CT: Health Behaviors						
Adult Binge Drinking@	11.5%	12.6%	14.6%	16.1%	13.6%	16.9%
Physical Inactivity	**30.5%**	**26.9%**	**27.2%**	**26.0%**	27.1%	22.1%
Current Smokers	**22.9%**	**26.1%**	**22.8%**	**21.9%**	20.6%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	**$640.72**	**$635.03**	$657.14	$744.71
Chlamydia Incidence**	363.8	**558.9**	472.6	482.2	559.0	539.9
Gonorrhea Incidence**	100.9	**182.0**	**183.0**	**192.7**	228.9	179.1
HIV Prevalence**	73.4	42.8	99.4	129.0	192	372.8
* age 25+; ** per 100,000 population; *** age 65+						
+ 1 indicates highest vulnerability; @in the past 30 days						

LEBANON COMMUNITY- ASSESSED HEALTH ISSUES

	Camden County, MO	Dallas County, MO	Laclede County, MO	Pulaski County, MO	Texas County, MO	Wright County, MO	Lebanon Community	ORC Region	Missouri	United States
Assessed Health Issue: Cancer										
Cancer Incidence Rate*	410.8	**462.0**	**453.9**	**484.5**	387.8	**464.8**	**437.0**	**419.9**	454.9	448.7
Cancer Mortality*	152.2	**183.7**	**192.3**	**177.3**	**172.6**	**175.5**	**173.9**	**171.3**	166.4	152.3
Recent Mammogram**	**68.3**	**67.5**	**68.1**	**71.0**	**63.6**	**62.9**	**67.8**	**67.6**	70.8	73.7
Recent Pap Smear***	**83.4%**	**81.6%**	**82.1%**	**83.7%**	**79.9%**	**79.6%**	**82.3%**	**82.1%**	84.1%	83.9%
Adequate Colorectal Cancer Screening	66.6%	**62.4%**	**65.2%**	**64.7%**	**62.4%**	**59.5%**	**64.3%**	**63.8%**	67.0%	65.5%
Assessed Health Issue: Diabetes										
Annual Hemoglobin A1c Test+	87.6%	89.9%	87.6%	**80.3%**	**81.0%**	87.3%	**85.2%**	**84.8%**	86.3%	85.7%
Diabetes Prevalence	8.0%	4.5%	**10.3%**	**10.0%**	**11.7%**	8.3%	8.9%	**10.4%**	10.1%	9.5%
Poor Physical Health	**16.2%**	**17.9%**	**16.7%**	11.4%	**18.7%**	**20.3%**	**15.9%**	**15.7%**	14.0%	13.0%
Obesity Prevalence	23.6%	**31.1%**	**33.9%**	**33.5%**	**38.1%**	29.3%	**31.1%**	**32.6%**	32.4%	29.5%
Assessed Health Issue: Lung Disease										
Lung Disease Mortality*	**54.3**	**60.1**	**102.5**	**76.7**	**59.8**	**74.5**	**72.3**	**60.7**	50.4	40.2
Asthma Prevalence	**9.6%**	**10.3%**	**10.4%**	9.2%	**10.6%**	**10.9%**	**10.0%**	**10.1%**	9.7%	9.5%
COPD Prevalence	**11.1%**	**12.0%**	**11.0%**	6.1%	**12.4%**	**13.8%**	**10.3%**	**10.0%**	8.5%	7.2%
Assessed Health Issue: Heart Disease										
Stroke Mortality*	30.6	36.5	**43.4**	31.2	**46.7**	**42.8**	36.9	**40.1**	39.6	37.3
Heart Disease Mortality*	151.4	**190.5**	**209.3**	**207.0**	**209.7**	**291.2**	**201.3**	**212.3**	191.2	164.8
High Blood Pressure Prevalence	**40.0%**	**38.1%**	**36.7%**	25.4%	**40.7%**	**39.8%**	**35.4%**	**35.1%**	33.2%	32.9%
High Cholesterol Prevalence	**42.7%**	**40.9%**	**39.5%**	28.6%	**41.2%**	**41.7%**	**37.9%**	**37.7%**	36.0%	34.2%
Coronary Heart Disease Prevalence	**10.2%**	**10.0%**	**9.0%**	4.8%	**10.7%**	**11.3%**	**8.7%**	**8.6%**	7.5%	6.9%

* per 100,000 population; ** females age 50-74

*** females age 21-65; +Medicare population

***** no data

\+ Missouri counties only

! Missouri Preventive Services Program (PSP) participants only

LEBANON COMMUNITY- ASSESSED HEALTH ISSUES, CONT.

	Camden County, MO	Dallas County, MO	Laclede County, MO	Pulaski County, MO	Texas County, MO	Wright County, MO	Lebanon Community	ORC Region	Missouri	United States
Assessed Health Issue: Mental Health										
Suicide Mortality*	**18.7**	*****	**24.4**	**20.0**	**15.9**	**23.9**	**20.4**	**22.1**	18.3	13.8
Poor Mental Health	**13.5%**	**16.2%**	**16.2%**	**15.5%**	**16.6%**	**17.9%**	**15.6%**	**15.7%**	14.5%	13.4%
Depression Prevalence+	16.1%	**20.8%**	**22.1%**	**19.2%**	18.0%	**20.1%**	**18.6%**	**20.8%**	21.3%	18.4%
Assessed Health Issue: Substance Use and Recovery										
Drug Poisoning Mortality*	**26.5**	*****	19.1	34.4	17.9	*****	**26.1**	**22.8**	25.3	21.6
Alcohol Use Disorder Prevalence+	1.6%	2.0%	1.7%	1.6%	1.5%	1.2%	1.6%	1.7%	1.9%	2.1%
Substance Use Disorder Prevalence+	2.2%	**4.5%**	**4.5%**	3.2%	2.6%	3.4%	3.0%	3.5%	3.3%	3.5%
Assessed Health Issue: Oral Health										
Recent Dental Visit	**58.4%**	**52.6%**	**52.8%**	**56.2%**	**49.0%**	**48.0%**	**54.1%**	**56.4%**	61.4%	64.4%
PWSD Fluoridation+	39.2%	0.0%	45.9%	54.9%	13.5%	0.0%	41.2%	50.4%	71.8%	*****
Early Childhood Caries Referrals!	7.5%	*****	7.8%	2.9%	19.1%	14.2%	8.5%	7.0%	4.5%	*****
Assessed Health Issue: COVID-19										
COVID-19 Mortality*	**272.8**	**250.6**	**358.4**	151.9	164.3	**277.5**	**240.4**	**236.3**	191.3	217.5
COVID-19 Case Rate*	13809.9	13542.5	**14759.3**	10133.8	11661.7	**13924.3**	12705.1	**14423.4**	12973.0	13846.0
COVID-19 Fully Vaccinated Adults	**48.3%**	**40.8%**	**42.9%**	66.4%	**36.2%**	**42.9%**	**46.3%**	**47.4%**	54.7%	64.7%

* per 100,000 population; ** females age 50-74

*** females age 21-65; +Medicare population

***** no data

+ Missouri counties only

! Missouri Preventive Services Program (PSP) participants only

LEBANON COMMUNITY- SOCIAL DETERMINANTS OF HEALTH

	Camden County, MO	Dallas County, MO	Laclede County, MO	Lebanon Community	ORC Region	Missouri	United States
CT: Economic Stability							
Population Below 200% FPL	**31.5%**	**41.7%**	**42.0%**	**40.6%**	**40.7%**	32.1%	30.9%
Children Below 200% FPL	**52.2%**	**47.7%**	**54.2%**	**54.4%**	**52.1%**	41.0%	40.1%
Per Capita Income ($)	**$28,274.00**	**$23,646.00**	**$23,050.00**	**$23,782.00**	**$ -**	$30,810.00	$34,102.00
Unemployment Rate	**4.9%**	4.6%	4.2%	4.5%	4.0%	4.7%	5.5%
Cost Burden, Severe (50%)	11.2%	8.9%	8.5%	10.9%	10.9%	11.0%	14.0%
Affordable Housing (60% AMI)	27.8%	**38.1%**	**47.0%**	**35.0%**	**36.6%**	38.8%	29.9%
CT: Education Access & Quality							
No High School Diploma*	9.6%	**16.6%**	**14.8%**	**12.5%**	11.8%	10.1%	12.0%
Associate's Level Degree or Higher*	**29.6%**	**17.6%**	**22.6%**	**26.9%**	**30.0%**	37.1%	40.6%
Bachelor's Degree or Higher*	**21.1%**	**12.9%**	**14.6%**	**18.6%**	**22.1%**	29.2%	32.2%
Chronic Absence Rate	13.7%	**16.2%**	8.2%	9.3%	11.7%	11.8%	15.9%

	Pulaski County, MO	Texas County, MO	Wright County, MO	Lebanon Community	ORC Region	Missouri	United States
CT: Economic Stability							
Population Below 200% FPL	**35.7%**	**52.8%**	**55.1%**	**40.6%**	**40.7%**	32.1%	30.9%
Children Below 200% FPL	**45.8%**	**68.3%**	**68.5%**	**54.4%**	**52.1%**	41.0%	40.1%
Per Capita Income ($)	**$23,650.00**	**$19,972.00**	**$19,849.00**	**$23,782.00**	**$ -**	$30,810.00	$34,102.00
Unemployment Rate	**4.7%**	4.4%	4.2%	4.5%	4.0%	4.7%	5.5%
Cost Burden, Severe (50%)	12.7%	12.8%	10.4%	10.9%	10.9%	11.0%	14.0%
Affordable Housing (60% AMI)	**32.1%**	**31.5%**	**35.5%**	**35.0%**	**36.6%**	38.8%	29.9%
CT: Education Access & Quality							
No High School Diploma*	7.2%	**16.4%**	**19.6%**	**12.5%**	11.8%	10.1%	12.0%
Associate's Level Degree or Higher*	**38.7%**	**21.0%**	**17.1%**	**26.9%**	**30.0%**	37.1%	40.6%
Bachelor's Degree or Higher*	**28.3%**	**13.5%**	**10.2%**	**18.6%**	**22.1%**	29.2%	32.2%
Chronic Absence Rate	5.7%	10.9%	9.8%	9.3%	11.7%	11.8%	15.9%

* age 25+; ** per 100,000 population; *** age 65+

+ 1 indicates highest vulnerability; @in the past 30 days

LEBANON COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Camden County, MO	Dallas County, MO	Laclede County,MO	Lebanon Community	ORC Region	Missouri	United States
CT: Healthcare Access & Quality							
Uninsured Adults	**18.1%**	**20.3%**	**17.0%**	**18.3%**	**18.3%**	14.1%	12.8%
Uninsured Children	**8.6%**	**9.8%**	**7.8%**	**8.2%**	**8.2%**	6.5%	5.6%
Population Receiving Medicaid	16.2%	**26.1%**	20.2%	21.0%	20.7%	16.3%	22.2%
Population Living in a HPSA	**37.4%**	**46.9%**	**47.0%**	**41.1%**	**41.6%**	27.6%	22.6%
Primary Care Physicians Provider Rate**	77.0	**6.0**	**53.7**	**45.5**	**63.2**	70.0	76.7
Mental Health Care Provider Rate**	**142.5**	**23.7**	**151.2**	**137.3**	**200.5**	204.2	261.6
Addiction/Substance Abuse Provider Rate**	**2.2**	**0.0**	**0.0**	**1.6**	11.0	2.2	9.4
Dentists Provider Rate**	**45.2**	**30.5**	**25.4**	**51.7**	**44.3**	54.2	65.6
Core Preventative Services for Men***	37.0%	31.2%	**34.0%**	33.8%	33.0%	34.7%	31.0%
Core Preventative Services for Women***	**35.7%**	32.1%	**35.2%**	34.0%	33.8%	36.3%	31.1%
Households with No Motor Vehicle	3.2%	6.6%	5.5%	5.5%	6.0%	6.9%	8.6%
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

	Pulaski County, MO	Texas County, MO	Wright County, MO	Lebanon Community	ORC Region	Missouri	United States
CT: Healthcare Access & Quality							
Uninsured Adults	**14.8%**	**23.1%**	**22.6%**	**18.3%**	**18.3%**	14.1%	12.8%
Uninsured Children	**5.7%**	**10.3%**	**11.0%**	**8.2%**	**8.2%**	6.5%	5.6%
Population Receiving Medicaid	17.3%	**26.2%**	**32.7%**	21.0%	20.7%	16.3%	22.2%
Population Living in a HPSA	**31.3%**	**43.6%**	**58.2%**	**41.1%**	**41.6%**	27.6%	22.6%
Primary Care Physicians Provider Rate**	**40.5**	**35.1**	**16.5**	**45.5**	**63.2**	70.0	76.7
Mental Health Care Provider Rate**	**216.7**	**35.4**	**114.8**	**137.3**	**200.5**	204.2	261.6
Addiction/Substance Abuse Provider Rate**	**1.9**	**0.0**	**5.5**	**1.6**	11.0	2.2	9.4
Dentists Provider Rate**	103.3	**15.6**	**38.3**	**51.7**	**44.3**	54.2	65.6
Core Preventative Services for Men***	**34.2%**	**31.4%**	**29.8%**	33.8%	33.0%	34.7%	31.0%
Core Preventative Services for Women***	**35.4%**	**30.8%**	**29.2%**	34.0%	33.8%	36.3%	31.1%
Households with No Motor Vehicle	4.9%	7.1%	**9.2%**	5.5%	6.0%	6.9%	8.6%
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

LEBANON COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Camden County, MO	Dallas County, MO	Laclede County, MO	Lebanon Community	ORC Region	Missouri	United States
CT: Neighborhood & Built Environment							
Substandard Housing	27.0%	24.1%	22.5%	26.3%	26.8%	26.0%	31.9%
Violent Crime Rate**	335.2	197.8	263.5	251.5	**426.4**	524.3	416.0
Households with No or Slow Internet	**21.9%**	**32.8%**	**27.1%**	**26.0%**	**25.1%**	19.8%	17.3%
Low Food Access	20.5%	**26.0%**	**43.7%**	**35.5%**	**24.8%**	24.9%	22.2%
Respiratory Hazard Index Score	1.2	1.2	1.5	1.3	1.5	1.7	1.8
CT: Social & Community Context							
Social Vulnerability Index (SVI)+	**0.7**	**0.6**	**0.7**	**0.6**	**0.6**	0.4	0.4
SVI- Household Composition+	**1.0**	**0.7**	0.3	**0.6**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.5	**0.6**	**0.7**	0.6	0.6	0.5	0.6
SVI- Minority Status+	0.2	0.1	0.6	0.3	0.4	0.5	0.8
SVI- Socioeconomic+	**0.7**	**0.8**	**0.6**	**0.7**	**0.6**	0.4	0.3
Homeless Students	**12.9%**	2.8%	**3.8%**	**4.7%**	**4.2%**	4.0%	3.0%
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

	Pulaski County, MO	Texas County, MO	Wright County, MO	Lebanon Community	ORC Region	Missouri	United States
CT: Neighborhood & Built Environment							
Substandard Housing	28.0%	29.2%	26.3%	26.3%	26.8%	26.0%	31.9%
Violent Crime Rate**	224.0	172.4	261.5	251.5	**426.4**	524.3	416.0
Households with No or Slow Internet	**18.1%**	**34.3%**	**32.3%**	**26.0%**	**25.1%**	19.8%	17.3%
Low Food Access	**63.3%**	**12.6%**	**18.0%**	**35.5%**	**24.8%**	24.9%	22.2%
Respiratory Hazard Index Score	1.4	1.2	1.2	1.3	1.5	1.7	1.8
CT: Social & Community Context							
Social Vulnerability Index (SVI)+	0.3	**0.9**	**0.8**	**0.6**	**0.6**	0.4	0.4
SVI- Household Composition+	**0.4**	**1.0**	**0.9**	**0.6**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.3	**0.7**	**0.7**	0.6	0.6	0.5	0.6
SVI- Minority Status+	0.2	0.3	0.3	0.3	0.4	0.5	0.8
SVI- Socioeconomic+	**0.5**	**0.9**	**0.9**	**0.7**	**0.6**	0.4	0.3
Homeless Students	1.5%	2.4%	2.8%	**4.7%**	**4.2%**	4.0%	3.0%
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

LEBANON COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Camden County, MO	Dallas County, MO	Laclede County, MO	Lebanon Community	ORC Region	Missouri	United States
CT: Social & Community Context							
Social Vulnerability Index (SVI)+	**0.7**	**0.6**	**0.7**	**0.6**	**0.6**	0.4	0.4
SVI- Household Composition+	**1.0**	**0.7**	0.3	**0.6**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.5	**0.6**	**0.7**	0.6	0.6	0.5	0.6
SVI- Minority Status+	0.2	0.1	0.6	0.3	0.4	0.5	0.8
SVI- Socioeconomic+	**0.7**	**0.8**	**0.6**	**0.7**	**0.6**	0.4	0.3
Homeless Students	**12.9%**	2.8%	**3.8%**	**4.7%**	**4.2%**	4.0%	3.0%
CT: Health Behaviors							
Adult Binge Drinking@	14.3%	15.7%	15.8%	16.6%	16.1%	17.5%	16.9%
Physical Inactivity	**23.0%**	**23.1%**	**28.3%**	**26.2%**	**26.0%**	24.5%	22.1%
Current Smokers	**20.0%**	**24.7%**	**24.2%**	**22.6%**	**21.9%**	20.3%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	*****	**$665.26**	**$635.03**	$665.08	$744.71
Chlamydia Incidence**	302.4	311.9	414.8	417.8	482.2	568.1	539.9
Gonorrhea Incidence**	122.7	90.0	**251.1**	156.3	**192.7**	246.8	179.1
HIV Prevalence**	99.5	136.3	40.9	86.6	129.0	245.6	372.8
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

	Pulaski County, MO	Texas County, MO	Wright County, MO	Lebanon Community	ORC Region	Missouri	United States
CT: Social & Community Context							
Social Vulnerability Index (SVI)+	0.3	**0.9**	**0.8**	**0.6**	**0.6**	0.4	0.4
SVI- Household Composition+	**0.4**	**1.0**	**0.9**	**0.6**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.3	**0.7**	**0.7**	0.6	0.6	0.5	0.6
SVI- Minority Status+	0.2	0.3	0.3	0.3	0.4	0.5	0.8
SVI- Socioeconomic+	**0.5**	**0.9**	**0.9**	**0.7**	**0.6**	0.4	0.3
Homeless Students	1.5%	2.4%	2.8%	**4.7%**	**4.2%**	4.0%	3.0%
CT: Health Behaviors							
Adult Binge Drinking@	**21.1%**	14.8%	14.7%	16.6%	16.1%	17.5%	16.9%
Physical Inactivity	**26.1%**	**33.4%**	**24.9%**	**26.2%**	**26.0%**	24.5%	22.1%
Current Smokers	**20.3%**	**24.8%**	**27.0%**	**22.6%**	**21.9%**	20.3%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	*****	**$665.26**	**$635.03**	$665.08	$744.71
Chlamydia Incidence**	**714.6**	182.6	294.6	417.8	482.2	568.1	539.9
Gonorrhea Incidence**	**217.1**	73.8	**60.0**	156.3	**192.7**	246.8	179.1
HIV Prevalence**	89.6	*****	*****	86.6	129.0	245.6	372.8
* age 25+; ** per 100,000 population; *** age 65+							
+ 1 indicates highest vulnerability; @in the past 30 days							

MONETT COMMUNITY- ASSESSED HEALTH ISSUES

	Barry County, MO	Lawrence County, MO	Monett Community	ORC Region	Missouri	United States
Assessed Health Issue: Cancer						
Cancer Incidence Rate*	386.1	441.9	413.5	419.9	454.9	448.7
Cancer Mortality*	**170.0**	**174.1**	**172.1**	**171.3**	166.4	152.3
Recent Mammogram**	**65.7**	**65.0**	**65.3**	**67.6**	70.8	73.7
Recent Pap Smear***	**81.2%**	**82.2%**	**81.7%**	**82.1%**	84.1%	83.9%
Adequate Colorectal Cancer Screening	**62.9%**	**62.5%**	**62.7%**	**63.8%**	67.0%	65.5%
Assessed Health Issue: Diabetes						
Annual Hemoglobin A1c Test+	**83.9%**	88.4%	86.2%	**84.8%**	86.3%	85.7%
Diabetes Prevalence	**11.0%**	**14.2%**	**12.5%**	**10.4%**	10.1%	9.5%
Poor Physical Health	**17.9%**	**17.0%**	**17.4%**	**15.7%**	14.0%	13.0%
Obesity Prevalence	**40.0%**	**31.4%**	**35.6%**	**32.6%**	32.4%	29.5%
Assessed Health Issue: Lung Disease						
Lung Disease Mortality*	**59.4**	**67.4**	**63.5**	**60.7**	50.4	40.2
Asthma Prevalence	**10.1%**	**10.2%**	**10.2%**	**10.1%**	9.7%	9.5%
COPD Prevalence	**11.7%**	**11.1%**	**11.4%**	**10.0%**	8.5%	7.2%
Assessed Health Issue: Heart Disease						
Stroke Mortality*	**41.0**	**38.4**	**39.6**	**40.1**	39.6	37.3
Heart Disease Mortality*	**244.2**	**217.1**	**230.2**	**212.3**	191.2	164.8
High Blood Pressure Prevalence	**37.5%**	**36.2%**	**36.8%**	**35.1%**	33.2%	32.9%
High Cholesterol Prevalence	**40.2%**	**39.4%**	**39.8%**	**37.7%**	36.0%	34.2%
Coronary Heart Disease Prevalence	**10.1%**	**9.3%**	**9.7%**	**8.6%**	7.5%	6.9%
Assessed Health Issue: Mental Health						
Suicide Mortality*	**18.4**	**20.4**	**19.4**	**22.1**	18.3	13.8
Poor Mental Health	**15.9%**	**16.2%**	**16.1%**	**15.7%**	14.5%	13.4%
Depression Prevalence+	**18.9%**	**18.9%**	**18.9%**	**20.8%**	21.3%	18.4%
Assessed Health Issue: Substance Use and Recovery						
Drug Poisoning Mortality*	12.2	17.5	14.9	**22.8**	25.3	21.6
Alcohol Use Disorder Prevalence+	1.8%	1.9%	1.8%	1.7%	1.9%	2.1%
Substance Use Disorder Prevalence+	3.2%	3.2%	3.2%	3.5%	3.3%	3.5%
Assessed Health Issue: Oral Health						
Recent Dental Visit	**53.3%**	**52.6%**	**52.9%**	**56.4%**	61.4%	64.4%
PWSD Fluoridation+	48.7%	0.0%	24.7%	50.4%	71.8%	*****
Early Childhood Caries Referrals!	*****	*****	*****	7.0%	4.5%	*****
Assessed Health Issue: COVID-19						
COVID-19 Mortality*	172.8	**271.1**	**223.6**	**236.3**	191.3	217.5
COVID-19 Case Rate*	12040.9	13543.1	12817.0	**14423.4**	12973.0	13846.0
COVID-19 Fully Vaccinated Adults	**49.4%**	**43.8%**	**46.6%**	**47.4%**	54.7%	64.7%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
+ Missouri counties only
! Missouri Preventive Services Program (PSP) participants only

MONETT COMMUNITY- SOCIAL DETERMINANTS OF HEALTH

	Barry County, MO	Lawrence County, MO	Monett Community	ORC Region	Missouri	United States
CT: Economic Stability						
Population Below 200% FPL	**45.2%**	**44.7%**	**44.9%**	**40.7%**	32.1%	30.9%
Children Below 200% FPL	**61.3%**	**61.2%**	**61.2%**	**52.1%**	41.0%	40.1%
Per Capita Income ($)	**$25,068.00**	**$22,956.00**	**$23,974.00**	**$-**	$30,810.00	$34,102.00
Unemployment Rate	4.2%	3.8%	4.0%	4.0%	4.7%	5.5%
Cost Burden, Severe (50%)	10.9%	9.4%	10.1%	10.9%	11.0%	14.0%
Affordable Housing (60% AMI)	**38.7%**	**43.1%**	**41.0%**	**36.6%**	38.8%	29.9%
CT: Education Access & Quality						
No High School Diploma*	**16.4%**	**15.3%**	**15.9%**	11.8%	10.1%	12.0%
Associate's Level Degree or Higher*	22.0%	23.0%	22.5%	30.0%	37.1%	40.6%
Bachelor's Degree or Higher*	**14.6%**	**16.0%**	**15.3%**	**22.1%**	29.2%	32.2%
Chronic Absence Rate	11.3%	10.8%	11.1%	11.7%	11.8%	15.9%
CT: Healthcare Access & Quality						
Uninsured Adults	**22.3%**	**21.2%**	**21.7%**	**18.3%**	14.1%	12.8%
Uninsured Children	**10.0%**	**10.0%**	**10.0%**	**8.2%**	6.5%	5.6%
Population Receiving Medicaid	**24.1%**	**24.0%**	**24.1%**	**20.7%**	16.3%	22.2%
Population Living in a HPSA	**45.4%**	**44.7%**	**45.0%**	**41.6%**	27.6%	22.6%
Primary Care Physicians Provider Rate**	**64.6**	**54.9**	**59.6**	**63.2**	70	76.7
Mental Health Care Provider Rate**	**72.6**	**133.0**	**103.9**	**200.5**	204.2	261.6
Addiction/Substance Abuse Provider Rate**	**0.0**	**0.0**	**0.0**	**11.0**	2.2	9.4
Dentists Provider Rate**	**27.9**	**39.3**	**33.8**	**44.3**	54.2	65.6
Core Preventative Services for Men***	32.9%	33.1%	33.0%	33.0%	34.7%	31.0%
Core Preventative Services for Women***	33.3%	31.6%	32.4%	33.8%	36.3%	31.1%
Households with No Motor Vehicle	4.5%	5.1%	4.8%	6.0%	6.9%	8.6%
CT: Neighborhood & Built Environment						
Substandard Housing	26.9%	25.2%	26.0%	26.8%	26.0%	31.9%
Violent Crime Rate**	234.1	**425.1**	324.5	**426.4**	524.3	416
Households with No or Slow Internet	**33.2%**	**22.9%**	**27.8%**	**25.1%**	19.8%	17.3%
Low Food Access	19.7%	18.6%	19.1%	**24.8%**	24.9%	22.2%
Respiratory Hazard Index Score	1.3	1.3	1.3	1.5	1.7	1.8

* age 25+; ** per 100,000 population; *** age 65+
+ 1 indicates highest vulnerability; @in the past 30 days

MONETT COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Barry County, MO	Lawrence County, MO	Monett Community	ORC Region	Missouri	United States
CT: Neighborhood & Built Environment						
Substandard Housing	26.9%	25.2%	26.0%	26.8%	26.0%	31.9%
Violent Crime Rate**	234.1	**425.1**	324.5	**426.4**	524.3	416
Households with No or Slow Internet	**33.2%**	**22.9%**	**27.8%**	**25.1%**	19.8%	17.3%
Low Food Access	19.7%	18.6%	19.1%	**24.8%**	24.9%	22.2%
Respiratory Hazard Index Score	1.3	1.3	1.3	1.5	1.7	1.8
CT: Social & Community Context						
Social Vulnerability Index (SVI)+	**0.8**	**0.7**	**0.8**	**0.6**	0.4	0.4
SVI- Household Composition+	**0.9**	**0.8**	**0.8**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.5	0.3	0.4	0.6	0.5	0.6
SVI- Minority Status+	0.6	0.7	0.6	0.4	0.5	0.8
SVI- Socioeconomic+	**0.8**	**0.7**	**0.7**	**0.6**	0.4	0.3
Homeless Students	**5.3%**	**3.4%**	**4.3%**	**4.2%**	4.0%	3.0%
CT: Health Behaviors						
Adult Binge Drinking@	15.0%	16.3%	15.7%	16.1%	17.5%	16.9%
Physical Inactivity	**32.4%**	**27.7%**	**30.0%**	**26.0%**	24.5%	22.1%
Current Smokers	**23.4%**	**24.2%**	**23.8%**	**21.9%**	20.3%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	**$681.10**	**$635.03**	$665.08	$744.71
Chlamydia Incidence**	213.1	338.2	278.0	482.2	568.1	539.9
Gonorrhea Incidence**	81.3	122.3	102.6	**192.7**	246.8	179.1
HIV Prevalence**	156.3	69.8	112.0	129.0	245.6	372.8

* age 25+; ** per 100,000 population; *** age 65+
+ 1 indicates highest vulnerability; @in the past 30 days

MOUNTAIN VIEW COMMUNITY- ASSESSED HEALTH ISSUES

	Douglas County, MO	Howell County, MO	Ozark County, MO	Shannon County, MO	Mountain View Community	ORC Region	Missouri	United States
Assessed Health Issue: Cancer								
Cancer Incidence Rate*	329.5	393.5	366.5	334	368.9	419.9	454.9	448.7
Cancer Mortality*	**154.5**	**195.0**	**159.1**	**177.1**	**180.6**	**171.3**	166.4	152.3
Recent Mammogram**	**62.3**	**63.0**	**64.4**	**64.4**	**63.2**	**67.6**	70.8	73.7
Recent Pap Smear***	**80.3%**	**81.2%**	**80.4%**	**79.6%**	**80.7%**	**82.1%**	84.1%	83.9%
Adequate Colorectal Cancer Screening	**60.1%**	**61.4%**	**60.2%**	**60.1%**	**60.9%**	**63.8%**	67.0%	65.5%
Assessed Health Issue: Diabetes								
Annual Hemoglobin A1c Test+	**75.0%**	86.6%	88.6%	**81.9%**	86.1%	**84.8%**	86.3%	85.7%
Diabetes Prevalence	8.9%	**15.6%**	5.7%	6.8%	**11.5%**	**10.4%**	10.1%	9.5%
Poor Physical Health	**20.4%**	**17.8%**	**21.3%**	**20.4%**	**19.0%**	**15.7%**	14.0%	13.0%
Obesity Prevalence	**30.6%**	**35.4%**	28.9%	28.8%	**32.8%**	**32.6%**	32.4%	29.5%
Assessed Health Issue: Lung Disease								
Lung Disease Mortality*	**64.8**	**64.2**	**53.3**	**62.0**	**62.6**	**60.7**	50.4	40.2
Asthma Prevalence	**10.6%**	**10.4%**	**10.6%**	**10.8%**	**10.5%**	**10.1%**	9.7%	9.5%
COPD Prevalence	**14.2%**	**11.7%**	**15.0%**	**14.1%**	**12.9%**	**10.0%**	8.5%	7.2%
Assessed Health Issue: Heart Disease								
Stroke Mortality*	**41.7**	**47.6**	**37.8**	**44.4**	**44.8**	**40.1**	39.6	37.3
Heart Disease Mortality*	**207.4**	**202.8**	**171.6**	**217.7**	**201.4**	**212.3**	191.2	164.8
High Blood Pressure Prevalence	**42.4%**	**38.6%**	**44.1%**	**41.6%**	**40.4%**	**35.1%**	33.2%	32.9%
High Cholesterol Prevalence	**43.2%**	**40.1%**	**45.1%**	**42.5%**	**41.6%**	**37.7%**	36.0%	34.2%
Coronary Heart Disease Prevalence	**12.2%**	**9.8%**	**13.5%**	**11.8%**	**11.0%**	**8.6%**	7.5%	6.9%
Assessed Health Issue: Mental Health								
Suicide Mortality*	**30.0**	**23.9**	*****	*****	**25.4**	**22.1**	18.3	13.8
Poor Mental Health	**16.9%**	**16.4%**	**16.4%**	**17.5%**	**16.6%**	**15.7%**	14.5%	13.4%
Depression Prevalence+	**19.0%**	**19.2%**	15.4%	17.1%	18.4%	**20.8%**	21.3%	18.4%
Assessed Health Issue: Substance Use and Recovery								
Drug Poisoning Mortality*	*****	11.2	*****	*****	11.2	**22.8**	25.3	21.6
Alcohol Use Disorder Prevalence+	1.3%	1.4%	1.8%	1.6%	1.5%	1.7%	1.9%	2.1%
Substance Use Disorder Prevalence+	3.4%	**4.1%**	3.4%	**3.8%**	**3.8%**	3.5%	3.3%	3.5%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data
\+ Missouri counties only
! Missouri Preventive Services Program (PSP) participants only

MOUNTAIN VIEW COMMUNITY- ASSESSED HEALTH ISSUES, CONT.

	Douglas County, MO	Howell County, MO	Ozark County, MO	Shannon County, MO	Mountain View Community	ORC Region	Missouri	United States
Assessed Health Issue: Oral Health								
Recent Dental Visit	**48.7%**	**50.3%**	**49.4%**	**49.0%**	**49.7%**	**56.4%**	61.4%	64.4%
PWSD Fluoridation+	0.0%	0.0%	0.0%	0.0%	0.0%	50.4%	71.8%	*****
Early Childhood Caries Referrals!	25.2%	*****	5.1%	3.3%	13.8%	7.0%	4.5%	*****
Assessed Health Issue: COVID-19								
COVID-19 Mortality*	**344.0**	192.1	**332.7**	158.8	**243.4**	**236.3**	191.3	217.5
COVID-19 Case Rate*	12271.0	**14297.8**	12254.6	12126.0	13401.7	**14423.4**	12973.0	13846.0
COVID-19 Fully Vaccinated Adults	**27.3%**	**36.5%**	**34.0%**	**34.6%**	**33.1%**	**47.4%**	54.7%	64.7%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
***** no data
+ Missouri counties only
! Missouri Preventive Services Program (PSP) participants only

MOUNTAIN VIEW COMMUNITY- SOCIAL DETERMINANTS OF HEALTH

	Douglas County, MO	Howell County, MO	Ozark County, MO	Shannon County, MO	Mountain View Community	ORC Region	Missouri	United States
CT: Economic Stability								
Population Below 200% FPL	**53.2%**	**47.5%**	**53.9%**	**51.4%**	**49.9%**	**40.7%**	32.1%	30.9%
Children Below 200% FPL	**70.3%**	**58.6%**	**71.6%**	**58.8%**	**62.2%**	**52.1%**	41.0%	40.1%
Per Capita Income ($)	**$21,083.00**	**$21,048.00**	**$18,738.00**	**$17,387.00**	**$20,330.00**	**$ -**	$30,810.00	$34,102.00
Unemployment Rate	4.4%	4.9%	4.9%	5.2%	4.9%	4.0%	4.7%	5.5%
Cost Burden, Severe (50%)	10.8%	12.3%	8.7%	10.0%	11.3%	10.9%	11.0%	14.0%
Affordable Housing (60% AMI)	**30.6%**	**35.2%**	**31.5%**	**33.9%**	**33.7%**	**36.6%**	38.8%	29.9%
CT: Education Access & Quality								
No High School Diploma*	**17.9%**	**13.0%**	**17.7%**	**20.0%**	**15.4%**	11.8%	10.1%	12.0%
Associate's Level Degree or Higher*	**18.1%**	**26.5%**	**16.4%**	**19.6%**	**22.7%**	**30.0%**	37.1%	40.6%
Bachelor's Degree or Higher*	**10.8%**	**18.0%**	**11.0%**	**14.9%**	**15.3%**	**22.1%**	29.2%	32.2%
Chronic Absence Rate	12.1%	4.3%	10.6%	6.4%	6.7%	11.7%	11.8%	15.9%

* age 25+; ** per 100,000 population; *** age 65+

+ 1 indicates highest vulnerability; @in the past 30 days

***** no data

MOUNTAIN VIEW COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Douglas County, MO	Howell County, MO	Ozark County, MO	Shannon County, MO	Mountain View Community	ORC Region	Missouri	United States
CT: Neighborhood & Built Environment								
Substandard Housing	25.4%	25.9%	27.0%	25.1%	25.9%	26.8%	26.0%	31.9%
Violent Crime Rate**	166.8	289.4	232.4	295.8	259.2	**426.4**	524.3	416
Households with No or Slow Internet	**37.8%**	**27.8%**	**32.4%**	**37.9%**	**31.4%**	**25.1%**	19.8%	17.3%
Low Food Access	**37.6%**	20.5%	**36.9%**	10.1%	**24.7%**	**24.8%**	24.9%	22.2%
Respiratory Hazard Index Score	1.3	1.5	1.4	1.4	1.4	1.5	1.7	1.8
CT: Social & Community Context								
Social Vulnerability Index (SVI)+	**0.7**	**0.5**	**0.6**	**0.6**	**0.6**	**0.6**	0.4	0.4
SVI- Household Composition+	**0.9**	**0.6**	**0.6**	**0.9**	**0.8**	**0.5**	0.4	0.3
SVI- Housing & Transportation+	**0.7**	0.2	0.4	0.3	0.5	0.6	0.5	0.6
SVI- Minority Status+	0.1	0.2	0.0	0.1	0.1	0.4	0.5	0.8
SVI- Socio-economic+	**0.7**	**0.9**	**0.9**	**0.9**	**0.8**	**0.6**	0.4	0.3
Homeless Students	1.4%	**4.6%**	**3.4%**	**4.1%**	**3.7%**	**4.2%**	4.0%	3.0%

* age 25+; ** per 100,000 population; *** age 65+

\+ 1 indicates highest vulnerability; @in the past 30 days

***** no data

MOUNTAIN VIEW COMMUNITY- SOCIAL DETERMINANTS OF HEALTH, CONT.

	Douglas County, MO	Howell County, MO	Ozark County, MO	Shannon County, MO	Mountain View Community	ORC Region	Missouri	United States
CT: Health Behaviors								
Adult Binge Drinking@	13.7%	14.8%	12.6%	14.2%	14.2%	16.1%	17.5%	16.9%
Physical Inactivity	**26.7%**	**30.6%**	**30.5%**	**25.7%**	**29.2%**	**26.0%**	24.5%	22.1%
Current Smokers	**25.7%**	**24.5%**	**25.6%**	**26.9%**	**25.2%**	**21.9%**	20.3%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	*****	*****	**$654.18**	**$635.03**	$665.08	$744.71
Chlamydia Incidence**	270.7	309.2	130.6	157.6	261.2	482.2	568.1	539.9
Gonorrhea Incidence**	37.6	77.3	21.8	0.0	53.6	**192.7**	246.8	179.1
HIV Prevalence**	221.5	45.1	*****	*****	89.9	129.0	245.6	372.8
* age 25+; ** per 100,000 population; *** age 65+								
+ 1 indicates highest vulnerability; @in the past 30 days								
***** no data								

SPRINGFIELD COMMUNITY- ASSESSED HEALTH ISSUES

	Christian County, MO	Greene County, MO	Webster County, MO	Springfield Community	ORC Region	Missouri	United States
Assessed Health Issue: Cancer							
Cancer Incidence Rate*	418.3	418.1	439.3	420.1	419.9	454.9	448.7
Cancer Mortality*	**153.1**	**157.6**	**178.2**	**158.6**	**171.3**	166.4	152.3
Recent Mammogram**	**72.1**	**68.6**	**67.3**	**69.2**	**67.6**	70.8	73.7
Recent Pap Smear***	85.2%	**82.0%**	**82.4%**	**82.7%**	**82.1%**	84.1%	83.9%
Adequate Colorectal Cancer Screening	68.1%	65.6%	**63.1%**	65.9%	**63.8%**	67.0%	65.5%
Assessed Health Issue: Diabetes							
Annual Hemoglobin A1c Test+	90.9%	89.3%	86.1%	89.3%	**84.8%**	86.3%	85.7%
Diabetes Prevalence	**12.7%**	**10.7%**	**11.4%**	**11.2%**	**10.4%**	10.1%	9.5%
Poor Physical Health	**13.5%**	**14.0%**	**16.6%**	**14.1%**	**15.7%**	14.0%	13.0%
Obesity Prevalence	**33.8%**	**31.0%**	**33.1%**	**31.8%**	**32.6%**	32.4%	29.5%
Assessed Health Issue: Lung Disease							
Lung Disease Mortality*	**41.2**	**55.0**	**49.8**	**51.7**	**60.7**	50.4	40.2
Asthma Prevalence	**9.6%**	**9.7%**	**10.2%**	**9.7%**	**10.1%**	9.7%	9.5%
COPD Prevalence	**8.4%**	**8.4%**	**10.6%**	**8.6%**	**10.0%**	8.5%	7.2%
Assessed Health Issue: Heart Disease							
Stroke Mortality*	**43.3**	36.0	**48.3**	**38.7**	**40.1**	39.6	37.3
Heart Disease Mortality*	158.7	**189.3**	**198.3**	**183.8**	**212.3**	191.2	164.8
High Blood Pressure Prevalence	31.8%	30.6%	**34.8%**	31.2%	**35.1%**	33.2%	32.9%
High Cholesterol Prevalence	**36.2%**	**35.3%**	**38.7%**	**35.8%**	**37.7%**	36.0%	34.2%
Coronary Heart Disease Prevalence	7.0%	**7.1%**	**8.6%**	**7.2%**	**8.6%**	7.5%	6.9%
Assessed Health Issue: Mental Health							
Suicide Mortality*	**20.7**	**22.5**	**22.5**	**22.2**	22.1	18.3	13.8
Poor Mental Health	**14.2%**	**15.5%**	**16.5%**	**15.3%**	**15.7%**	14.5%	13.4%
Depression Prevalence+	**21.7%**	**24.9%**	**22.7%**	**24.1%**	**20.8%**	21.3%	18.4%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
+ Missouri counties only
! Missouri Preventive Services Program (PSP) participants only

SPRINGFIELD COMMUNITY- ASSESSED HEALTH ISSUES, CONT.

	Christian County, MO	Greene County, MO	Webster County, MO	Springfield Community	ORC Region	Missouri	United States
Assessed Health Issue: Substance Use and Recovery							
Drug Poisoning Mortality*	14.3	**31.1**	**29.3**	**27.5**	**22.8**	25.3	21.6
Alcohol Use Disorder Prevalence+	1.4%	2.0%	1.9%	1.9%	1.7%	1.9%	2.1%
Substance Use Disorder Prevalence+	3.3%	**4.4%**	**3.8%**	**4.1%**	3.5%	3.3%	3.5%
Assessed Health Issue: Oral Health							
Recent Dental Visit	**64.0%**	**60.5%**	**53.0%**	**60.5%**	**56.4%**	61.4%	64.4%
PWSD Fluoridation+	40.3%	86.1%	0.0%	73.2%	50.4%	71.8%	*****
Early Childhood Caries Referrals!	2.3%	*****	*****	2.3%	7.0%	4.5%	*****
Assessed Health Issue: COVID-19							
COVID-19 Mortality*	182.8	**228.3**	**230.1**	**219.1**	**236.3**	191.3	217.5
COVID-19 Case Rate*	**14868.4**	**14863.2**	**14692.3**	**14848.3**	**14423.4**	12973.0	13846.0
COVID-19 Fully Vaccinated Adults	**51.9%**	**52.8%**	**50.7%**	**52.5%**	**47.4%**	54.7%	64.7%

* per 100,000 population; ** females age 50-74
*** females age 21-65; +Medicare population
+ Missouri counties only
! Missouri Preventive Services Program (PSP) participants only

SPRINGFIELD COMMUNITY - SOCIAL DETERMINANTS OF HEALTH

	Christian County, MO	Greene County, MO	Webster County, MO	Springfield Community	ORC Region	Missouri	United States
CT: Economic Stability							
Population Below 200% FPL	29.5%	**38.9%**	**40.5%**	**37.1%**	**40.7%**	32.1%	30.9%
Children Below 200% FPL	37.5%	**46.1%**	**53.9%**	**44.9%**	**52.1%**	41.0%	40.1%
Per Capita Income ($)	**$28,215.00**	**$27,524.00**	**$22,960.00**	**$27,241.00**	**$-**	$30,810.00	$34,102.00
Unemployment Rate	3.2%	3.6%	3.5%	3.5%	4.0%	4.7%	5.5%
Cost Burden, Severe (50%)	8.4%	13.5%	6.6%	12.0%	10.9%	11.0%	14.0%
Affordable Housing (60% AMI)	**37.5%**	29.2%	**41.3%**	**31.7%**	**36.6%**	38.8%	29.9%
CT: Education Access & Quality							
No High School Diploma*	8.0%	8.3%	**13.9%**	8.7%	11.8%	10.1%	12.0%
Associate's Level Degree or Higher*	**37.9%**	**38.3%**	**24.2%**	**36.9%**	**30.0%**	37.1%	40.6%
Bachelor's Degree or Higher*	**28.6%**	**30.5%**	**16.8%**	**28.8%**	**22.1%**	29.2%	32.2%
Chronic Absence Rate	8.0%	**19.6%**	8.1%	15.8%	11.7%	11.8%	15.9%
CT: Healthcare Access & Quality							
Uninsured Adults	**14.5%**	**15.1%**	**18.3%**	**15.3%**	**18.3%**	14.1%	12.8%
Uninsured Children	**6.3%**	**8.0%**	**7.7%**	**7.6%**	**8.2%**	6.5%	5.6%
Population Receiving Medicaid	16.2%	16.2%	**24.7%**	16.9%	20.7%	16.3%	22.2%
Population Living in a HPSA	**29.9%**	**38.2%**	**40.0%**	**36.7%**	**41.6%**	27.6%	22.6%
Primary Care Physicians Provider Rate**	**44.5**	98.1	**25.8**	80.3	**63.2**	70	76.7
Mental Health Care Provider Rate**	**106.1**	381.5	**58.1**	293.2	**200.5**	204.2	261.6
Addiction/Substance Abuse Provider Rate**	**1.2**	**2.8**	**0.0**	**2.2**	11.0	2.2	9.4
Dentists Provider Rate**	**30.0**	69.4	**26.7**	**57.5**	**44.3**	54.2	65.6
Core Preventative Services for Men***	33.1%	33.5%	33.1%	33.4%	33.0%	34.7%	31.0%
Core Preventative Services for Women***	37.8%	34.3%	33.5%	35.0%	33.8%	36.3%	31.1%
Households with No Motor Vehicle	2.1%	7.2%	7.1%	6.2%	6.0%	6.9%	8.6%

* age 25+; ** per 100,000 population; *** age 65+
+ 1 indicates highest vulnerability; @in the past 30 days

SPRINGFIELD COMMUNITY - SOCIAL DETERMINANTS OF HEALTH, CONT.

	Christian County, MO	Greene County, MO	Webster County, MO	Springfield Community	ORC Region	Missouri	United States
CT: Neighborhood & Built Environment							
Substandard Housing	24.0%	29.5%	23.7%	28.0%	26.8%	26.0%	31.9%
Violent Crime Rate**	186.2	**825.4**	177.0	**634.8**	**426.4**	524.3	416
Households with No or Slow Internet	17.3%	**23.5%**	**30.3%**	**22.9%**	**25.1%**	19.8%	17.3%
Low Food Access	21.5%	**23.5%**	8.9%	21.8%	**24.8%**	24.9%	22.2%
Respiratory Hazard Index Score	1.5	1.8	1.3	1.7	1.5	1.7	1.8
CT: Social & Community Context							
Social Vulnerability Index (SVI)+	0.2	**0.4**	**0.6**	0.4	**0.6**	0.4	0.4
SVI- Household Composition+	**0.4**	0.1	**0.4**	0.2	**0.5**	0.4	0.3
SVI- Housing & Transportation+	0.1	**0.8**	**0.8**	**0.7**	0.6	0.5	0.6
SVI- Minority Status+	0.2	0.4	0.4	0.4	0.4	0.5	0.8
SVI- Socioeconomic+	0.3	**0.4**	**0.6**	**0.4**	**0.6**	0.4	0.3
Homeless Students	1.4%	**5.5%**	**4.6%**	**4.4%**	**4.2%**	4.0%	3.0%
CT: Health Behaviors							
Adult Binge Drinking@	**17.6%**	**17.4%**	**17.2%**	**17.4%**	16.1%	17.5%	16.9%
Physical Inactivity	**22.9%**	**22.7%**	**24.4%**	**22.9%**	**26.0%**	24.5%	22.1%
Current Smokers	**20.0%**	**19.5%**	**25.0%**	**20.1%**	**21.9%**	20.3%	17.0%
Fruit/Vegetable Expenditures ($)	*****	*****	*****	**$607.67**	**$635.03**	$665.08	$744.71
Chlamydia Incidence**	317.2	**779.1**	323.3	**641.2**	482.2	568.1	539.9
Gonorrhea Incidence**	124.1	**342.3**	134.5	**277.8**	**192.7**	246.8	179.1
HIV Prevalence**	103.7	236.9	85.8	196.2	129.0	245.6	372.8

* age 25+; ** per 100,000 population; *** age 65+
+ 1 indicates highest vulnerability; @in the past 30 days

APPENDIX C

GLOSSARY

DEMOGRAPHICS

TOTAL POPULATION

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.
Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Population density is a measurement of persons per square mile. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. Total population counts are reported in the ACS public use files by combined race and ethnicity; social and economic data are reported by race or ethnicity alone.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

CHANGE IN TOTAL POPULATION

Data Background

The U.S. Census counts every resident in the United States. It is mandated by Article I, Section 2 of the Constitution and takes place every 10 years. The census collects information about the age, sex, race, and ethnicity of every person in the United States. The data collected by the decennial census determine the number of seats each state has in the U.S. House of Representatives and is also used to distribute billions in federal funds to local communities. For more information about this source, refer to the United States Census 2010 website.

Methodology

Population data for years 2000 and 2010 from the U.S. Census Bureau Decennial Census. Mapped data are summarized to 2010 census tract boundaries. Population change is calculated using the following formula:

Total Change = [Total Population 2010] - [Total Population 2000]
Rate Change = (([Total Population 2010] - [Total Population 2000]) / [Total Population 2000]) * 100

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the US Decennial Census based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the 2010 Census are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity.

FAMILIES WITH CHILDREN

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts by household type are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries.

A household includes all the people who occupy a housing unit. (People not living in households are classified as living in group quarters.) Households are classified by type according to the sex of the householder and the presence of relatives. Two types of householders are distinguished: a family householder and a nonfamily householder. A family householder is a householder living with one or more individuals related to him or her by birth, marriage*, or adoption. The householder and all people

in the household related to him or her are family members. A nonfamily householder is a householder living alone or with non-relatives only. Figures for this indicator are measured as a percentage of total population based on the following formula:

Percentage = [Population by Family Type] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

*Note: In Census Bureau tabulations, beginning in 2019, unless otherwise specified, the terms “spouse”, “married couple” and “marriage” include same-sex couples and marriages.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

MEDIAN AGE

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Median age data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. The median divides the income distribution into two equal parts: one-half of the cases falling below the median income and one-half above the median. Due to the nature of medians, report areas based on multiple counties or custom areas will return “no data”.

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

MALE POPULATION
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community

Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

FEMALE POPULATION

Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may

only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 0-4
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This

is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 5-17

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION UNDER AGE 18

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an

annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 18-64
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS

estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 18-24
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 25-34
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are

measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 35-44

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 45-54
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are:

White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 55-64
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION AGE 65+

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

POPULATION WITH ANY DISABILITY

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Counts of population subgroups and total area population data are acquired from the U.S. Census Bureau's American Community Survey (ACS). Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Disability status is classified in the ACS according to yes/no responses to questions (17 - 19) about six types of disability concepts. For children under 5 years old, hearing and vision difficulty are used to determine disability status. For children between the ages of 5 and 14, disability status is determined from hearing, vision, cognitive, ambulatory, and self-care difficulties. For people aged 15 years and older, they are considered to have a disability if they have difficulty with any one of the six difficulty types. Indicator statistics are measured as a percentage of the total universe (non-institutionalized) population using the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

FOREIGN-BORN POPULATION

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

HISPANIC POPULATION

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

NON-HISPANIC WHITE POPULATION
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-

2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

BLACK OR AFRICAN AMERICAN POPULATION

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

CITIZENSHIP STATUS

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau’s American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

VETERAN POPULATION

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time

as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Counts for population subgroups and total area population data are acquired from the U.S. Census Bureau's American Community Survey (ACS). Data represent estimates for the 5 year period 2014-2019. Data are summarized to 2010 census tract boundaries. Veteran status is classified in the ACS according to yes/no responses to questions 26 and 27. ACS data define civilian veteran as a person 18 years old and over who served (even for a short time), but is not now serving on acting duty in the U.S. Army, Navy, Air Force, Marine Corps or Coast Guard, or who served as a Merchant Marine seaman during World War II. Individuals who have training for Reserves or National Guard but no active duty service are not considered veterans in the ACS. Indicator statistics are measured as a percentage of the population aged 18 years and older using the following formula:

Percentage = [Veteran Population] / [Total Population Age 18+] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

Trends Over Time
Trends over time are produced using single-year data from the American Community Survey. Single-year data are only available for geographic regions with 100,000 population or more. Because many counties have less than 100,000 population, data are reported for the total United States, states, and Public Use Microdata Area (PUMA) regions. Starting in 2012, PUMA boundaries for many areas changed. To accommodate this change, single-year data for survey years prior to 2012 are disaggregated to the county level using population weighted proportions, and then re-summarized to current PUMA boundaries. Single-year time trend estimates should not be compared to 5-year aggregate estimates.

URBAN AND RURAL POPULATION

Data Background

The U.S. Census counts every resident in the United States. It is mandated by Article I, Section 2 of the Constitution and takes place every 10 years. The census collects information about the age, sex, race, and ethnicity of every person in the United States. The data collected by the decennial census determine the number of seats each state has in the U.S. House of Representatives and is also used to distribute billions in federal funds to local communities. For more information about this source, refer to the United States Census 2010 website.

Methodology

Data are from the US 2010 Decennial Census, which provides urban and rural attributes for all geographic areas. by the 2010 Census definition, urban areas are comprised of a densely settled core of census tracts and/or census blocks that
meet minimum population density requirements and/or land use requirements. The Census Bureau identifies two types of urban areas:

- Urbanized Areas (UAs) of 50,000 or more people;
- Urban Clusters (UCs) of at least 2,500 and less than 50,000 people.

To qualify as an urban area, the territory identified according to criteria must encompass at least 2,500 people, at least 1,500 of which reside outside institutional group quarters. Areas adjacent to urban areas and cores are also designated as urban when they are non-residential, but contain urban land uses, or when they contain low population, but link outlying densely settled territory with the densely settled core. “Rural” areas consist of all territory, population, and housing units located outside UAs and UCs. Geographic entities, such as metropolitan areas, counties, minor civil divisions, places, and census tracts, often contain both urban and rural territory, population, and housing units. Indicator data tables display the percentage of population in areas designated either urban or rural based on the following formula:

Percentage = [Urban or Rural Population] / [Total Population] * 100

For more information, please visit the US Census Bureau’s 2010 Urban and Rural Classification web page.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the US Decennial Census based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the 2010 Census are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as “Two or More Races”. The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity.

PHYSICAL ENVIRONMENT

FOOD ACCESS - LOW FOOD ACCESS

Data Background

The Food Access Research Atlas (FARA) presents a spatial overview of food access indicators for populations using different measures of supermarket accessibility. The FARA is a compliment to the USDA's Food Environment Atlas, which houses county-level food-related data. The FARA provides census-tract level detail of the food access measures, including food desert census tracts. Estimates in the latest version of the Food Access Research Atlas draw from various sources, including the 2019 STARS (Store Tracking and Redemption System) directory of stores authorized to accept SNAP benefits and the 2019 Trade Dimensions TDLinx directory of stores, the 2010 Decennial Census, and the 2014-18 American Community Survey. FARA estimates are released approximately every 5 years, allowing for comparisons of the food environment for years 2010, 2015, and 2019.

For more information about this source, including the methodology and data definitions please visit the Food Access Research Atlas web page.

Methodology

This indicator reports the percentage of population without access to a supermarket or large grocery store. Census tract- level data was acquired from the USDA Food Access Research Atlas (FARA) and aggregated to generate county and state- level estimates.

The Food Access Research Atlas provides data which is derived from the analysis of multiple datasets. First, a directory of supermarkets and large grocery stores within the United States, including Alaska and Hawaii, was created by merging the 2019 STARS directory of stores authorized to accept SNAP benefits and the Trade Dimensions TDLinx directory of stores. Stores met the definition of a supermarket or large grocery store if they reported at least $2 million in annual sales and contained all the major food departments found in a traditional supermarket, including fresh meat and poultry, dairy, dry and packaged foods, and frozen foods. The combined list of supermarkets and large grocery stores was converted into a GIS-usable format by geocoding the street address into store-point locations. Population data are obtained at the block level from the 2010 Census of Population and Housing, while data on income are drawn at the block group-level from the 2014-18 American Community Survey. Distance to nearest supermarket was determined for population blocks. These numbers and shares are then similarly aerially allocated down to the ½-kilometer-square grid level. For each ½-kilometer- square grid cell, the distance was calculated from its geographic center to the center of the grid cell with the nearest supermarket. Then, the number of households and population living more than 1, 10, and 20 miles from a supermarket or large grocery store was aggregated to the tract level and divided by the underlying population.

Rural or urban status is determined using population size. A census tract is considered rural if the population-weighted centroid of that tract is located in an area with a population of less than 2,500; all other tracts are considered urban tracts. Low-income is defined as annual family income of less than or equal to 200 percent of the Federal poverty threshold given family size.

For more information, please refer to the Food Access Research Atlas Documentation.

Notes

Race and Ethnicity

Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

AIR & WATER QUALITY - RESPIRATORY HAZARD INDEX

Data Background

According to the Environmental Protection Agency (EPA), the National Air Toxic Assessment (NATA): "Assembles information on air toxics, characterizes emissions, and prioritizes air toxics and locations that merit more refined analysis and investigation. This information is used to plan, and assist with the implementation of, national, regional, and local efforts to reduce toxic air pollution. Using general information about sources to develop estimates of risks, NATA provides screening - level estimates of the risk of cancer and other potentially serious health effects as a result of inhaling air toxics. The resulting

risk estimates are purposefully more likely to be overestimates of health impacts than underestimates, and thus they are health protective.

NATA uses emissions data compiled for a single year as inputs for modeling ambient air concentrations and estimating health risks. Results include estimates of ambient concentrations and exposure concentrations (ECs) of air toxics and estimates of cancer risks and potential noncancer health effects associated with chronic inhalation exposure to air toxics. The estimates are generated within each state, at both county and census - tract levels."

The assessment includes four steps:

- Compiling a national emissions inventory of air toxics emissions from outdoor sources
- Estimating ambient concentrations of air toxics across the United States
- Estimating population exposures across the United States
- Characterizing potential public health risk due to inhalation of air toxics including both cancer and non-cancer effects For more information, please see the NATA 2011 website or the NATA Technical Documentation.

Methodology

This indicator reports the modelled non-cancer health risks associated with air toxics exposure. Figures represent the likelihood of hazardous exposure per 1 million population. Data are from the 2011 EPA National Air Toxic Assessment - Modeled Ambient Concentrations, Exposures and Risks data files. EPA combines the census tract level exposure concentration estimates with available unit risk estimates and inhalation reference concentrations to calculate risks and hazard quotients, respectively, for each pollutant.

The toxicity values used for NATA are quantitative expressions used to estimate the likelihood of adverse health effects given an estimated level and duration of exposure. These toxicity values are based on the results of dose - response assessments, which estimate the relationship between the dose and the frequency or prevalence of a response in a population or the probability of a response in any individual. Because NATA is focused on long - term exposures , the toxicity values used in NATA are based on the results of chronic dose - response studies when such data are available.
Chronic dose - response assessments can be used to help evaluate the specific 70 - year - average (i.e., "lifetime") EC s associated with cancer prevalence rates, or, for noncancer effects, the concentrations at which noncancer adverse health effects might occur given exposure over an extended period of time (possibly a lifetime, but the time frame also can be shorter). For more information, please see the Assessment Methods page or in the Technical Support Document.

BUILT ENVIRONMENT - BROADBAND ACCESS

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Counts of households are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. The data on internet access are obtained from Housing Question 9 and 10 in the 2019 American Community Survey (ACS) and used by CARES to calculate the rate of households with no or slow internet access. Both questions are asked at occupied housing units. The data on Question 9 show whether any member of the household has access to the internet, regardless of whether or not they pay for the service. For a response of either "Yes, without paying a cell phone company or Internet service provider" or "No access to the Internet at this house, apartment, or mobile home", they are counted by CARES into "No or SLow Internet". If a responder answers "Yes, by paying a cell phone company or Internet service provider", they are asked to select the type of internet service in Question 10, including cellular data plan for a smartphone, high speed broadband, satellite, dial-up, and other service. For the person who reports dial-up with no other type of Internet subscription, they are also counted as "No or Slow Internet". Therefore, households with no or slow internet are composed of three types of households - using dial-up only, having internet access without a subscription, and with no internet access. For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

INCOME & ECONOMICS

POVERTY - POPULATION BELOW 200% FPL

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Trends Over Time

The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the poverty universe (for example, people living in group homes or those living in agriculture workers' dormitories) is many times more likely to be in poverty than people living in households. Direct comparisons of the data would likely result in erroneous conclusions about changes in the poverty status of all people in the poverty universe.

POVERTY - CHILDREN BELOW 200% FPL

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for demographic groups and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population based on the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Trends Over Time

The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the poverty universe (for example, people living in group homes or those living in agriculture workers' dormitories) is many times more likely to be in poverty than people living in households. Direct comparisons of the data would likely result in erroneous conclusions about changes in the poverty status of all people in the poverty universe.

INCOME - PER CAPITA INCOME

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million
addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Total income and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Per capita income is the mean money income received in the past 12 months computed for every man, woman, and child in a geographic area. It is derived by dividing the total income of all people 15 years old and over in a geographic area by the total population in that area based on the following formula:

Per Capita Income = [Total Income of Population Age 16+] / [Total Population]

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Trends Over Time

The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. The part of the group quarters population in the poverty universe (for example, people living in group homes or those living in agriculture workers' dormitories) is many times more likely to be in poverty than people living in

households. Direct comparisons of the data would likely result in erroneous conclusions about changes in the poverty status of all people in the poverty universe.

Index of Disparity (ID)
The Index of Disparity (ID) used with this indicator was adopted by researchers at the National Center for Health Statistics (NCHS) and the National Institute of Health (NIH) for use with Healthy People 2010 and 2020 guidelines. This index measures the magnitude of variation in indicator percentages across groups - in this case racial and ethnic groups.
Specifically, the index of disparity is defined as "the average of the absolute differences between rates for specific groups within a population and the overall population rate, divided by the rate for the overall population and expressed as a percentage". The ID values for the indicator displayed here are calculated from American Community Survey 2008-12 5-year estimates using the following four population subgroups: Non-Hispanic White; Hispanic or Latino; Black or African American; and Other Race. The Other Race category includes Asian, Native American / Alaskan Native, Native Hawaiian / Pacific Islander, Multiple Race, and Some Other Race populations.
The ID can be expressed using the following formula:

Index of Disparity = 100.0 * ((SUM (|r - R|) / n) / R)

...where r is the sub-group rate and R is the total population rate. Index values range from 0 (where all sub-groups are equal) to infinity. Index values are heavily dependent on the total population value (R), so comparisons should be made across geographic areas (county vs. state vs. nation), and not across indicators.

For more information on the index of disparity, please see the NIH research article A Summary Measure of Health Disparity.

EMPLOYMENT - UNEMPLOYMENT RATE

Data Background
The Bureau of Labor Statistics (BLS) is the principal Federal agency responsible for measuring labor market activity, working conditions, and price changes in the economy. Its mission is to collect, analyze, and disseminate essential economic information to support public and private decision-making. As an independent statistical agency, BLS serves its diverse user communities by providing products and services that are objective, timely, accurate, and relevant.

Methodology
Unemployment statistics are downloaded from the US Bureau of Labor Statistics (BLS) Local Area Unemployment Statistics (LAUS) database. The LAUS is dataset consists of modelled unemployment estimates. It is described by the BLS as follows:

The concepts and definitions underlying LAUS data come from the Current Population Survey (CPS), the household survey that is the official measure of the labor force for the nation. State monthly model estimates are controlled in "real time" to sum to national monthly labor force estimates from the CPS. These models combine current and historical data from the CPS, the Current Employment Statistics (CES) program, and State unemployment insurance (UI) systems. Estimates for seven large areas and their respective balances of State are also model-based. Estimates for the remainder of the sub-state labor market areas are produced through a building-block approach known as the "Handbook method." This procedure also uses data from several sources, including the CPS, the CES program, State UI systems, and the decennial census, to create estimates that are adjusted to the statewide measures of employment and unemployment. Below the labor market area level, estimates are prepared using disaggregation techniques based on inputs from the decennial census, annual population estimates, and current UI data.

From the LAUS estimates, unemployment is recalculated as follows:

Unemployment Rate = [Total Unemployed] / [Total Labor Force] * 100

For more information, please visit the Bureau of Labor Statistics Local Area Unemployment Statistics web page.

Notes

Race and Ethnicity

Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

HOUSING & FAMILIES

HOUSING COST - COST BURDEN, SEVERE (50%)

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Counts of total households and households by monthly housing cost are acquired from the U.S. Census Bureau's American Community Survey (ACS). Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. The data for monthly housing costs as a percentage of household income are developed from a distribution of "Selected Monthly Owner Costs as a Percentage of Household Income" for owner-occupied and "Gross Rent as a Percentage of Household Income" for renter-occupied units. The owner-occupied categories are further separated into those with a mortgage and those without a mortgage. Indicator statistics are measured as a percentage total households using the following formula:

[Households with Costs Exceeding 30% of Income] / [Total Households] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

HOUSING QUALITY - SUBSTANDARD HOUSING

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Counts of housing units by age and condition are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2012-2016. Mapped data are summarized to 2010 census tract boundaries. Area estimates are developed at the U.S. Census Bureau, and given as a value for each geographic area. Raw counts are not provided, inhibiting the ability to produce median ages for report areas.

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2016 Code Lists, Definitions, and Accuracy.

AFFORDABLE HOUSING

Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
This indicator reports the number of housing units available to families with different income levels. Income levels are based on various percentages of Area Median Income (AMI). AMI is acquired for each county using data from the 2015-19 American Community Survey (ACS). AMI is then used to determine affordable monthly housing payments at various income levels relative to AMI. For this assessment, affordability assumes that a family should pay no more than 30% of their income toward mortgage or gross rent. For example, the AMI for Washington, DC is $64,267. In DC, a family earning 40% of AMI earns $22,494 per year, or $1,875 per month. For this family to live in affordable housing, total monthly housing costs should not exceed $562.

Using these assumptions, the number of units affordable at each income level is estimated using ACS data on household value (for owner-occupied households) and gross rent (for renter-occupied households)*. In the ACS, this data are presented in the form of counts of units that fall in certain value ranges. For example, in Washington, DC there are 4,563 units with gross rents between $500 and $600. To determine unit counts affordable at certain income levels, a proportional allocation method is used. Using the example above, the total number of rental units affordable to a family that should spend no more than $562 on housing expenses is calculated as follows:

Units with GR under $562 = [# GR $1.00 - $100] + [# GR $100 - $200] + [# GR $200 - $300] + [# GR $300 - $400] + [# GR $400 - $500] + [# GR $500 -$600] * [(562 – 500) / 100]

Thus all units with gross rent (GR) in the ranges 0-100, 100-200, 200-300, 300-400, and 400-500 are counted, and around 60% of those units in the 500-600 range. Using this method, the data shows that there are approximately 20,024 units available to families earning 40% of AMI in Washington, DC.

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

HOUSEHOLDS - OVERVIEW

Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Counts of households by type and relationship are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. A household includes all the people who occupy a housing unit. (People not living in households are classified as living in group quarters.) Households are classified by type according to the sex of the householder and the presence of relatives. Two types of householders are distinguished: a family householder and a nonfamily householder. A family householder is a householder living with one or more individuals related to him or her by birth, marriage, or adoption. The householder and all people in the household related to him or her are family members. A nonfamily householder is a householder living alone or with non-relatives only. Figures for this indicator are measured as a percentage of total households based on the following formula:

Percentage = [Households by Composition or Type] / [Total Households] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

EDUCATION

ATTAINMENT - NO HIGH SCHOOL DIPLOMA

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Population counts for population by educational attainment and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population aged 25+ based on the following formula:

Percentage = [Subgroup Population] / [Total Population Age 25+] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes

Trends Over Time

The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations may have educational attainment distributions that are different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on the educational attainment distribution. This is particularly true for areas with a substantial GQ population.

ATTAINMENT - HIGH SCHOOL GRADUATION RATE

Data Background

EDFacts is a U. S. Department of Education (ED) initiative to collect, analyze, report on, and promote the use of high-quality, kindergarten through grade 12 (K–12) performance data for use in education planning, policymaking, and management and budget decision-making to improve outcomes for students. EDFacts centralizes data provided by state education agencies, local education agencies, and schools, and provides users with the ability to easily analyze and report on submitted data. ED collects performance data at the school and school-district levels and provides public use files containing data that have been modified to protect against the ability to determine personally identifiable information on students.

Methodology

Graduation rates are acquired for all US school-districts in the United States from US Department of Education (ED) EdFacts 2018-19 data tables. States are required to report graduation data to the US Department of Education under Title I, Part A of the Elementary and Secondary Education Act (ESEA). Specifically, states are required to report rates based on a cohort method, which would provide a more uniform and accurate measure of the high school graduation rate that improved comparability across states. The cohort graduation rate is defined as “the number of students who graduate in four years with a regular high school diploma divided by the number of students who form the adjusted cohort for the graduating class.” From the beginning of 9th grade (or the earliest high school grade), students who are entering that grade for the first time form a cohort that is “adjusted” by adding any students who subsequently transfer into the cohort and subtracting any students who subsequently transfer out, emigrate to another country, or die.

County-level summaries are calculated by CARES using small-area estimation technique based on the proportion of the population aged 15-19 in each school district/county. The population figures for this calculation are based on data from the 2010 US Decennial Census at the census block geographic level.

For more information please consult the original data the original data or download the complete EdFacts Data Documentation.

Notes

Race and Ethnicity

Statistics by race and ethnicity are not provided for this indicator.

Data Limitations

Graduation rates for some school districts are provided by EdFacts as ranges; range mid-points were calculated by CARES to facilitate data manipulation.

ATTAINMENT - ASSOCIATE’S LEVEL DEGREE OR HIGHER

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).

For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for population by educational attainment and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population aged 25+ based on the following formula: Percentage = [Subgroup Population] / [Total Population Age 25+] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Trends Over Time
The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations may have educational attainment distributions that are different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on the educational attainment distribution. This is particularly true for areas with a substantial GQ population.

ATTAINMENT - BACHELOR'S DEGREE OR HIGHER
Data Background
The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

Citation: Citation: U.S. Census Bureau: UNDERSTANDING AND USING AMERICAN COMMUNITY SURVEY DATA: WHAT ALL DATA USERS NEED TO KNOW (2018).
For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Population counts for population by educational attainment and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. Area demographic statistics are measured as a percentage of the total population aged 25+ based on the following formula:

Percentage = [Subgroup Population] / [Total Population Age 25+] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Trends Over Time
The American Community Survey multi-year estimates are based on data collected over 5 years. For any given consecutive release of ACS 5-year estimates, 4 of the 5 years overlap. The Census Bureau discourages direct comparisons between estimates for overlapping periods; use caution when interpreting this data.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations may have educational attainment distributions that are different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on the educational attainment distribution. This is particularly true for areas with a substantial GQ population.

CHRONIC ABSENCE RATE
Data Background
Since 1968, the U.S. Department of Education Civil Rights Data Collection (CRDC), formerly the Elementary and Secondary School Survey, has collected data on key education and civil rights issues in our nation's public schools. The data are used by the U.S. Department of Education's Office for Civil Rights (OCR) in its enforcement and monitoring efforts, by other Department of Education offices and federal agencies, and by policymakers and researchers outside the Department of Education. The CRDC collects information about school characteristics and about programs, services, and outcomes for students. Most student data are disaggregated by race/ethnicity, sex, English-learner status, and disability status.

The CRDC is a biennial survey (i.e., it is conducted every other school year), and response to the survey is required by law. The CRDC collects data from the universe of all LEAs and schools, including long-term secure juvenile justice facilities, charter schools, alternative schools, and schools serving students with disabilities.

The CRDC is a longstanding and critical aspect of the overall enforcement and monitoring strategy used by OCR to ensure that recipients of the Department of Education's federal financial assistance do not discriminate on the basis of race, color, national origin, sex, or disability status. Fore more information, please visit the U.S. Department of Education CRDC Data Collection website.

Methodology
Data for this indicator are obtained from the U.S. Department of Education Civil Rights Data Collection

(CRDC). According to the CRDC, a chronically absent student is a student who is absent 15 or more school days during the school year. A student is absent if he or she is not physically on school grounds and is not participating in instruction or instruction-related
activities at an approved off-grounds location for at least half the school day. Each day that a student is absent for 50 percent or more of the school day should be counted. Any day that a student is absent for less than 50 percent of the school day should not be counted. The number of absences is based on the total number of school days absent. Chronically absent students include students who are absent for any reason (e.g., illness, suspension, the need to care for a family member), regardless of whether absences are excused or unexcused.

School-district data are aggregated from school-level records. Calculated percentages only reflect chronic absenteeism among schools within the district with valid (unsuppressed) data. For more information, please see the definitions for Chronic Student Absenteeism from the CRDC Survey.

OTHER SOCIAL & ECONOMIC FACTORS

HOMELESS CHILDREN & YOUTH

Data Background

EDFacts is a U. S. Department of Education (ED) initiative to collect, analyze, report on, and promote the use of high-quality, kindergarten through grade 12 (K–12) performance data for use in education planning, policymaking, and management and budget decision-making to improve outcomes for students. EDFacts centralizes data provided by state education agencies, local education agencies, and schools, and provides users with the ability to easily analyze and report on submitted data. ED collects performance data at the school and school-district levels and provides public use files containing data that have been modified to protect against the ability to determine personally identifiable information on students.

Methodology

This indicator reports the number and percentage of homeless children and youth enrolled in the public school system during the latest report year. According to the data source definitions, homelessness is defined as lacking a fixed, regular, and adequate nighttime residence. Those who are homeless may be sharing the housing of other persons, living in motels, hotels, or camping grounds, in emergency transitional shelters, or may be unsheltered. County-level summaries are calculated by CARES using small-area estimation technique based on the proportion of the population aged 5-17 in each school district/county. The population figures for this calculation are based on data from the 2010 US Decennial Census at the census block geographic level.

Notes:

1. Data is suppressed for school districts when the count of students is less than 3.
2. Data is missing for a number of school districts. The percentage of districts with data, and the percentage of students in
3. districts with data are reported to aid with interpretation.
4. Use caution when comparing data across states due to discrepancies in reporting. For more information please consult the original data or download the complete EdFacts Data Documentation.

HOUSEHOLDS WITH NO MOTOR VEHICLE

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April 1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology

Counts of housing units are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Mapped data are summarized to 2010 census tract boundaries. The data on vehicles available were obtained from Housing Question 11 in the 2019 American Community Survey (ACS) . The question was asked at occupied housing units. These data show the number of passenger cars, vans, and pickup or panel trucks of one-ton capacity or less kept

at home and available for the use of household members. Vehicles rented or leased for one month or more, company vehicles, and police and government vehicles are included if kept at home and used for non-business purposes. Dismantled or immobile vehicles are excluded. Vehicles kept at home but used only for business purposes also are excluded. For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

INSURANCE - UNINSURED ADULTS (SAHIE)

Data Background

The Small Area Health Insurance Estimates (SAHIE) program was created to develop model-based estimates of health insurance coverage for counties and states. It is currently the only dataset providing complete health-insurance coverage estimates. The models predict state and county level insurance estimates for total populations, as well as population groups defined by age, sex, race and income.

The SAHIE program models health insurance coverage by combining survey data with population estimates and administrative records. SAHIE estimates are a product of the US Census Bureau with funding from the Centers for Disease Control and Prevention.

The SAHIE health insurance models use data from the following sources:

- American Community Survey
- Internal Revenue Service: Federal Tax Returns
- Supplemental Nutrition Assistance Program (SNAP): Participation
- Records County Business Patterns
- Medicaid and Children's Health Insurance Program (CHIP): Participation
- Records US Census 2010

Methodology

Counts of the number of persons without medical insurance are modelled for the Small Area Income and Health Insurance Estimates (SAHIE) datasets by the Census Bureau using both survey and census data. In this reporting platform, indicator percentages are summarized from the SAHIE estimates based on the following formula:

Percentage = SUM [Uninsured Population] / SUM [Total Population] * 100

For more information about the data used in these estimates, please visit the Small Area Health Insurance Estimates website and view the provided Data Inputs page.

Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the US Census Bureau's Small Area Health Insurance Estimates (SAHIE) program is available by combined race and ethnicity, and is reported only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available from a local source.

INSURANCE - UNINSURED CHILDREN (SAHIE)

Data Background

The Small Area Health Insurance Estimates (SAHIE) program was created to develop model-based estimates of health insurance coverage for counties and states. It is currently the only dataset providing complete health-insurance coverage estimates. The models predict state and county level insurance estimates for total populations, as well as population groups defined by age, sex, race and income.

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- Records US Census 2010

Methodology

Counts of the number of persons without medical insurance are modelled for the Small Area Income and Health Insurance Estimates (SAHIE) datasets by the Census Bureau using both survey and census data. In this reporting platform, indicator percentages are summarized from the SAHIE estimates based on the following formula:

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Notes

Race and Ethnicity

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SOCIAL VULNERABILITY INDEX

Methodology

About the Social Vulnerability Index (SVI)

The degree to which a community exhibits certain social conditions, including high poverty, low percentage of vehicle access, or crowded households, may affect that community's ability to prevent human suffering and financial loss in the event of disaster. These factors describe a community's social vulnerability.

The Geospatial Research, Analysis & Services Program (GRASP) created the Centers for Disease Control and Prevention Social Vulnerability Index (CDC SVI or simply SVI, hereafter) to help public health officials and emergency response planners identify and map the communities that will most likely need support before, during, and after a hazardous event. SVI indicates the relative vulnerability of every U.S. Census tract. Census tracts are subdivisions of counties for which the Census collects statistical data. SVI ranks the tracts on 15 social factors, including unemployment, minority status, and disability, and further groups them into four related themes. Thus, each tract receives a ranking for each Census variable and for each of the four themes, as well as an overall ranking. In addition to tract-level rankings, SVI 2010, 2014, 2016, and 2018 also have corresponding rankings at the county level. Notes below that describe "tract" methods also refer to county methods. How can CDC SVI help communities be better prepared for hazardous events? SVI provides specific socially and spatially relevant information to help public health officials and local planners better prepare communities to respond to emergency events such as severe weather, floods, disease outbreaks, or chemical exposure.

INSURANCE - POPULATION RECEIVING MEDICAID

Data Background

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely social, economic, housing, and demographic data every year. The ACS has an annual sample size of about 3.5 million addresses, with survey information collected nearly every day of the year. Data are pooled across a calendar year to produce estimates for that year. As a result, ACS estimates reflect data that have been collected over a period of time rather than for a single point in time as in the decennial census, which is conducted every 10 years and provides population counts as of April

1. The Census Bureau combines 5 consecutive years of ACS data to produce estimates for geographic areas with fewer than 65,000 residents. These 5-year estimates represent data collected over a period of 60 months. Because the ACS is based on a sample, rather than all housing units and people, ACS estimates have a degree of uncertainty associated with them, called sampling error. In general, the larger the sample, the smaller the level of sampling error. Data users should be careful in drawing conclusions about small differences between two ACS estimates because they may not be statistically different.

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For more information about this source, including data collection methodology and definitions, refer to the American Community Survey data users website.

Methodology
Counts of the population by health insurance status and total area population data are acquired from the U.S. Census Bureau's American Community Survey. Data represent estimates for the 5 year period 2014-2019. Data are aggregate summaries based on 2010 Census Tract boundaries. Health insurance coverage status is classified in the ACS according to yes/no responses to questions (16a - 16h) representing eight categories of health insurance, including: Employer-based, Directly-purchased, Medicare, Medicaid/Medical Assistance, TRICARE, VA health care, Indian Health Service, and Other. An eligibility edit was applied to give Medicaid, Medicare, and TRICARE coverage to individuals based on program eligibility rules. People were considered insured if they reported at least one "yes" to Questions 16a - 16f. Indicator statistics are measured as a percentage of the universe population using the following formula:

Percentage = [Subgroup Population] / [Total Population] * 100

For more information on the data reported in the American Community Survey, please see the complete American Community Survey 2019 Subject Definitions.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories in the American Community Survey (ACS) based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Indicator race and ethnicity statistics are generated from self-identified survey responses. Using the OMB standard, the available race categories in the ACS are: White, Black, American Indian/Alaskan Native, Asian, and Other. An ACS survey respondent may identify as one race alone, or may choose multiple races. Respondents selecting multiple categories are racially identified as "Two or More Races". The minimum ethnicity categories are: Hispanic or Latino, and Not Hispanic or Latino. Respondents may only choose one ethnicity. All social and economic data are reported in the ACS public use files by race alone, ethnicity alone, and for the white non-Hispanic population.

Data Limitations
The population 'universe' for most health insurance coverage estimates is the civilian noninstitutionalized population, which excludes active-duty military personnel and the population living in correctional facilities and nursing homes. Some noninstitutionalized group quarters (GQ) populations have health insurance coverage distributions that are different from the household population (e.g., the prevalence of private health insurance among residents of college dormitories is higher than the household population). The proportion of the universe that is in the noninstitutionalized GQ populations could therefore have a noticeable impact on estimates of the health insurance coverage. Institutionalized GQ populations may also have health insurance coverage distributions that are different from the civilian noninstitutionalized population, the distributions in the published tables may differ slightly from how they would look if the total population were represented.

VIOLENT CRIME - TOTAL
Data Background
The Federal Bureau of Investigation (FBI) is a governmental agency belonging to the United States Department of Justice that serves to protect and defend the United States against terrorist and foreign

intelligence threats, to uphold and enforce the criminal laws of the United States, and to provide leadership and criminal justice services to federal, state, municipal, and international agencies and partners. The FBI's Uniform Crime Reporting (UCR) Program has been the starting place for law enforcement executives, students of criminal justice, researchers, members of the media, and the public at large seeking information on crime in the nation. The program was conceived in 1929 by the International Association of Chiefs of Police to meet the need for reliable uniform crime statistics for the nation. In 1930, the FBI was tasked with collecting, publishing, and archiving those statistics.

Today, four annual publications, Crime in the United States, National Incident-Based Reporting System, Law Enforcement Officers Killed and Assaulted, and Hate Crime Statistics are produced from data received from over 18,000 city, university/college, county, state, tribal, and federal law enforcement agencies voluntarily participating in the program. The crime data are submitted either through a state UCR Program or directly to the FBI's UCR Program. For more information, please visit the FBI's Uniform Crime Reports website.

Methodology
Crime totals, population figures, and crime rates are multi-year county-level estimates created by the National Archive of Criminal Justice Data (NACJD) based on agency-level* records in a file obtained from the FBI, which also provides aggregated county totals. NACJD imputes missing data and then aggregates the data to the county-level. Violent crimes consist of homicide, forcible rape, robbery, and aggravated assault. Rates are reported as the number of crimes per 100,000 population using the following formula:

Crime Rate = [Number Violent Crimes] / [Total Population] *100,000

*Police jurisdictions may be defined by the boundary of a county, county subdivision, or city. Regional police departments may consist of multiple cities or subdivisions.

Access to the complete methodology is available through the Inter-university Consortium for Political and Social Research (IPSCOR), a repository for the NAJDC Uniform Crime Reporting Program Data Series.

Notes
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.
Data Limitations
1. Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data and maps do not necessarily represent an exhaustive list of crimes due to gaps in reporting.
2. Data for forcible rape was not consistently reported by city and county agencies in the state of Minnesota. Forcible rapes are not included in the violent crime summaries for cities and counties in that state.
3. Some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds. These offenses are not included in the violent crime statistics, but can be obtained from the Uniform Crime Reports Universities and Colleges data tables.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unreliable or unstable. When the FBI determines that an agency's data collection methodology does not comply with national UCR guidelines, the figure(s) for that agency's offense(s) are not be included. For further details please see the original data tables available online through the FBI Crime in the US website.

HEALTH BEHAVIORS

ALCOHOL - BINGE DRINKING

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

In 2015, The Robert Wood Johnson Foundation and CDC Foundation launched the 500 Cities Project in partnership with the Centers for Disease Control and Prevention (CDC). The 500 city project seeks to identify, analyze, and report city and census tract-level data, obtained using small area estimation methods, for 27 chronic disease measures for the 500 largest American cities.

PHYSICAL INACTIVITY

Data Background

The Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces publically available data to promote general health. The division maintains the Diabetes Data and Trends data system, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System. These programs provide resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Methodology

Data for the total adult population and the estimated population with inadequate physical activity are acquired from the County Level Estimates of Diagnosed Diabetes, a service of the Centers for Disease Control and Prevention's National
Diabetes Surveillance Program. Diabetes and other risk factor prevalence is estimated using the following formula:

Percent Prevalence = [Risk Factor Population] / [Total Population] * 100.

All data are estimates modelled by the CDC using the methods described below:

The National Diabetes Surveillance system produces data estimating the prevalence of diagnosed diabetes and population obesity by county using data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) and data from the U.S. Census Bureau's Population Estimates Program. The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. The survey provides state- specific information on behavioral risk factors and preventive health practices. Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. Respondents were considered obese if their body mass index was 30 or greater. Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Respondents were considered to be physically inactive if they answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Three years of data were used to improve the precision of the year-specific county-level estimates of diagnosed diabetes and selected risk factors. For example, 2003, 2004, and 2005 were used for the 2004

estimate and 2004, 2005, and 2006 were used for the 2005 estimate. Estimates were restricted to adults 20 years of age or older to be consistent with population estimates from the U.S. Census Bureau. The U.S. Census Bureau provides year-specific county population estimates by demographic characteristics—age, sex, race, and Hispanic origin.

The county-level estimates were based on indirect model-dependent estimates. The model-dependent approach employs a statistical model that "borrows strength" in making an estimate for one county from BRFSS data collected in other counties. Bayesian multilevel modeling techniques were used to obtain these estimates. Separate models were developed for each of the four census regions: West, Midwest, Northeast and South. Multilevel Poisson regression models with random effects of demographic variables (age 20–44, 45–64, 65+; race; sex) at the county-level were developed. State was included as a county-level covariate.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Methods and References for County-Level Estimates and Ranks. (2012).

Rates are age adjusted by the CDC for the following three age groups: 20-44, 45-64, 65+. Additional information, including the complete methodology and data definitions, can be found at the CDC's Diabetes Data and Statistics website.

Notes
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

STI - CHLAMYDIA INCIDENCE
Data Background
The National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP) is the branch of the Centers for Disease Control and Prevention (CDC) responsible for public health surveillance, prevention research, and programs to prevent and control HIV and AIDS, other STDs, viral hepatitis, and TB. NCHHSTP developed a set of indicators to monitor the prevalence and track its progress toward ending these diseases in each state, and regularly reports its progress. The NCHHSTEP program includes data from new patient case reports from 56 areas (all 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

Methodology
Cases of a given STD refer to confirmed diagnoses during a given time period. For example, the 2010 data on gonorrhea infection would include persons with laboratory-confirmed infection diagnosed between January 1, 2010 and December 31, 2010, and reported to CDC through June 8, 2011. Rates per 100,000 population were calculated for each STD. The population denominators used to compute these rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for the 2000–2010. These estimates are a modification of the U.S. Census Bureau population estimates in which the 31 race categories used by the Census Bureau are bridged into the five race/ethnicity groups that have been historically used to report race data for STD cases. Each rate was calculated by dividing the number of cases for the calendar year by the population for that calendar year and then multiplying the number by 100,000.

For more information, visit the NCHHSTP Atlas and click on the "About these data and footnotes" link.

Notes
Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state departments of health based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) is available by combined race and ethnicity, and is reported only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available from a local source.

STI - GONORRHEA INCIDENCE

Data Background

The National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP) is the branch of the Centers for Disease Control and Prevention (CDC) responsible for public health surveillance, prevention research, and programs to prevent and control HIV and AIDS, other STDs, viral hepatitis, and TB. NCHHSTP developed a set of indicators to monitor the prevalence and track its progress toward ending these diseases in each state, and regularly reports its progress. The NCHHSTEP program includes data from new patient case reports from 56 areas (all 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

Methodology

Cases of a given STD refer to confirmed diagnoses during a given time period. For example, the 2010 data on gonorrhea infection would include persons with laboratory-confirmed infection diagnosed between January 1, 2010 and December 31, 2010, and reported to CDC through June 8, 2011. Rates per 100,000 population were calculated for each STD. The population denominators used to compute these rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for the 2000–2010. These estimates are a modification of the U.S. Census Bureau population estimates in which the 31 race categories used by the Census Bureau are bridged into the five race/ethnicity groups that have been historically used to report race data for STD cases. Each rate was calculated by dividing the number of cases for the calendar year by the population for that calendar year and then multiplying the number by 100,000.

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Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories by state departments of health based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) is available by combined race and ethnicity, and is reported only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available from a local source.

STI - HIV PREVALENCE

Data Background

The National Center for HIV/AIDS, Viral Hepatitis, Sexually Transmitted Disease (STD), and Tuberculosis (TB) Prevention (NCHHSTP) is the branch of the Centers for Disease Control and Prevention (CDC) responsible for public health surveillance, prevention research, and programs to prevent and control HIV and AIDS, other STDs, viral hepatitis, and TB. NCHHSTP developed a set of indicators to monitor the prevalence and track its progress toward ending these diseases in each state, and regularly reports its progress. The NCHHSTEP program includes data from new patient case reports from 56 areas (all 50 states, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands).

Methodology

Cases of a given STD refer to confirmed diagnoses during a given time period. For example, the 2010 data on gonorrhea infection would include persons with laboratory-confirmed infection diagnosed between January 1, 2010 and December 31, 2010, and reported to CDC through June 8, 2011. Rates per 100,000 population were calculated for each STD. The population denominators used to compute these rates for the 50 states and the District of Columbia were based on the National Center for Health Statistics (NCHS) bridged-race population counts for the 2000–2010. These estimates are a modification of the U.S. Census Bureau population estimates in which the 31 race categories used by the Census Bureau are bridged into the five race/ethnicity groups that have been historically used to report race data for STD cases. Each rate was calculated by dividing the number of cases for the calendar year by the population for that calendar year and then multiplying the number by 100,000.

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Notes

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories by state departments of health based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. Data reported from the CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) is available by combined race and ethnicity, and is reported only for state and national data summaries. County level statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available from a local source.

TOBACCO USAGE - CURRENT SMOKERS

Data Background

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FRUIT/VEGETABLE EXPENDITURES

Data Background

Nielsen is a publicly held information company and a primary supplier of consumer spending data around the world, using both statistical analysis and field sampling techniques to produce accurate and timely information. Published annually, SiteReports provide market analysis to Nielsen customers at multiple geographic levels, spanning a wide range of topics including population demographics, household spending, and market potential. The SiteReports Consumer Buying Power (CBP) database is created using statistical models estimated from the Bureau of Labor Statistics' Consumer Expenditure Surveys (CEX). This survey provides information on the buying habits of American consumers, including expenditures, income, and other characteristics of the consumer unit (families and single consumers). The Consumer Expenditure Survey consists of two surveys: the quarterly Interview survey and the weekly Diary Survey. The surveys target the total non- institutionalized population (urban and rural) of the United States. The data is collected from the independent quarterly interview and weekly diary surveys of approximately 7,500 sample households. Each survey has its own independent sample, and each collects data on household income and socioeconomic characteristics. The current Nielsen Consumer Buying Power data uses a rolling five years of data from the Consumer Expenditure Survey, administered from 2005 through 2009. In addition to this data, the Nielsen Consumer Buying Power database also incorporates information from the following sources:

- Nielsen Demographic Update
- Nielsen Cartographics
- U.S. Census Bureau: Census of Retail Trade.

For more information, please visit the Nielsen website.

Methodology

Census tract level average and aggregated total household expenditures and category expenditures were acquired from the 2011 Nielsen Consumer Buying Power (CBP) SiteReports. Tract-level and county-level expenditure estimates are proprietary Nielsen data restricted from public distribution and subject to terms of use agreements. Indicator data tables contain state and national ranks for counties, and percent expenditure estimates based on aggregated tract-level data. The percent expenditure figures calculated for custom geographic areas can be expressed using the following formula:
Percent Expenditures = [Category Expenditures] / [Total Area Expenditures] * 100

To generate acceptable county-level output for indicator report pages, percent expenditures for each food-at-home category were sorted and ranked by county. Each county's within-state rank and that rank's percentile are displayed in the indicator data table. This information is not available for custom geographic areas, for states, or for the total United States. County percentiles are calculated using the following formula:

Percentile = [County Within State Rank] / [Total Number of Counties in State] * 100

To generate acceptable map output in compliance with the Nielsen terms of use agreement, percent expenditures for each tract were sorted and ranked; quintiles were assigned to each tract based on national rank and symbolized within the map. Additional attributes include each tract's within-state rank and quintile. Definitions for food-at-home categories used for consumer spending indicators are based on categories in the BLS Consumer Expenditure Survey (CEX), and are listed below.

- **Soft drinks:** Soft drink expenditures included in this category are any non-alcoholic carbonated beverages purchased for consumption at home. Soft drinks purchased at restaurants and other dining establishments are not included.
- **Alcoholic beverages:** Alcohol expenditures included in this category are any beer, wine, and liquor purchased for consumption at home. Alcohol purchased at restaurants and bars is not included.
- **Fruit and vegetables:** Fruit and vegetables expenditures included in this category are all fresh, frozen and canned fruits and vegetables purchased for consumption at home.
- **Tobacco:** Tobacco expenditures included in this category are cigarettes only; cigars and other tobacco products are not included.

Further details about the analysis used by Nielsen group can be found in the Consumer Buying Power Methodology.

Notes
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

HEALTH OUTCOMES

POOR OR FAIR HEALTH

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is
"... a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. "
Citation: Centers for Disease Control and Prevention, Office of Surveillance, Epidemiology, and Laboratory Services. Overview: BRFSS 2010.

The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC and tabulated into county estimates by the BRFSS analysis team. Beginning with the 2016 County Health Rankings, the CDC produces county estimates using single-year BRFSS data and a multilevel modeling approach based on respondent answers and their age, sex, and race/ethnicity, combined with county-level poverty, as well as county- and state-level contextual effects. To produce estimates for those counties where there were no or limited data, the modeling approach borrowed information from the entire BRFSS sample as well as Census Vintage 2014 population estimates. CDC used a parametric bootstrapping method to produce standard errors and confidence intervals for those point estimates. This estimation methodology was validated for all U.S. counties, including those with no or small (<50 respondents) samples.

Methodology

Indicator percentages are acquired for year 2015 from Behavioral Risk Factor Surveillance System (BRFSS) prevalence data, accessible through the University of Wisconsin's County Health Rankings. Data are based on the percentage of respondents answering the following question: "Would you say that in general your health is— Excellent, Very good, Good, Fair, Or Poor?" Percentages are age-adjusted and only pertain to the non-institutionalized population aged 18 and up. Additional detailed information about the BRFSS, including questionnaires, data collection procedures, and data processing methodologies are available on the BRFSS web site. For additional information about the single-year estimates displayed here, please visit the County Health Rankings website.

POOR MENTAL HEALTH

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

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POOR PHYSICAL HEALTH

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health

behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

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CANCER INCIDENCE - ALL SITES

Data Background

The State Cancer Profiles website provides statistics to help guide and prioritize cancer control activities at the state and local levels. State Cancer Profiles are a collaborative effort of the National Cancer Institute (NCI) and the Centers for Disease Control and Prevention (CDC). The incidence rates tables accessed through the State Cancer Profiles website provide incidence statistics compiled from state and local cancer registries. Statistics are available for those states with cancer registries whose data have met the criteria required for inclusion in the US Cancer Statistics. Data is provided for use in assessing the burden and risk for a major cancer site for the US overall or for a selected state and its counties. State-based cancer registries are data systems that collect, manage, and analyze data about cancer cases and cancer deaths. In each state, medical facilities (including hospitals, physicians' offices, therapeutic radiation facilities, freestanding surgical centers, and pathology laboratories) report these data to a central cancer registry. State cancer registries receive funding and program guidance through the CDC's National Program of Cancer Registries and the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) program.

For more information, please visit the State Cancer Profiles website.

Methodology

Annual incidence rates are acquired for all US states and counties as an average for years 2013-2017 from the State Cancer Profiles Incidence Rates Tables. This source provides the average annual incidence of new cancer cases, as well as incidence rates, age adjusted to the 2010 US standard population. The new case counts (incidence) used to generate the State Cancer Profiles data tables are provided by the National Program of Cancer Registries Cancer Surveillance System (NPCR-CSS), the Centers for Disease Control and Prevention, CDC's National Program of Cancer Registries Cancer Surveillance System (NPCR- CSS), and by the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program.

In order to perform aggregate (multi-county or service area) incidence rate estimates with the data provided, age-adjusted total populations are first back-calculated using the following formula:

Adj. Population = ([Cancer Incidence] / ([Adj. Incidence Rate] / 100,000))

This estimated population figure is then used in the formula to re-calculate age-adjusted cancer rates as follows:

Adj. Incidence Rate = 100,000 * ([Cancer Incidence] / [Adj. Population])

For more information about the State Cancer Profiles data, including age-adjustment and data suppression, please visit the SEER*Stat website.

Notes

Data Limitations

1. County-level data are not available for the states of Kansas and Minnesota because of state legislation and regulations which prohibit the release of county level data to outside entities.
2. Data for the state of Michigan do not include cases diagnosed in other states because data exchange agreements prohibit the release of data to third parties.

Race and Ethnicity
Cancer statistics from the State Cancer Profiles database are reported by race alone (White, Black, Amer. Indian/AK Native, and Asian) or by ethnicity alone (Hispanic), or for the white Hispanic and white non-Hispanic population. NHIA (NAACCR Hispanic Identification Algorithm) was used to determine Hispanic ethnicity. See the Technical Notes section of the 2003 United States Cancer Statistics Report for more information.

Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the number of cases is less than 16 (for each county/cancer/population group combination) over the time period monitored, or when the total population (per race-ethnicity-sex grouping) of the report area is less than 50,000

CHRONIC CONDITIONS - ALZHEIMER'S DISEASE

Data Background
The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS), is the federal agency that runs the Medicare Program and monitors Medicaid programs offered by each state. Medicare is a type of federally-funded health insurance available to disabled persons and the population age 65 and older. The Office of Enterprise Data and Analytics within the Centers for Medicare & Medicaid Services (CMS) developed a public use file to support further analysis of the geographic variation in the amount and quality of the health care services that Medicare beneficiaries receive. For more information, please see the Geographic Variation Public Use File Methodology document.

Methodology
Indicator percentages are acquired for 2007 - 2018 from Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse. The data used in the chronic condition reports are based upon CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. Beneficiaries who died during the year are included up to their date of death if they meet the other inclusion criteria. Chronic condition prevalence estimates are
calculated by CMS by taking the beneficiaries with a particular condition divided by the total number of beneficiaries in our fee-for-service population, expressed as a percentage. For more information and to view the original data, please visit the CMS Chronic Conditions web page.

Enrollment data are acquired for 2007 - 2018 from Centers for Medicare and Medicaid Services (CMS) Medicare Geographic Variation Public Use File. This CMS table has developed data that enables researchers and policy-makers to evaluate geographic variation in the utilization and quality of health care services for the Medicare fee-for-service population. data are aggregated into a Geographic Variation Public Use File that has demographic, spending, utilization, and quality indicators at the state level (including the District of Columbia, Puerto Rico, and the Virgin Islands), hospital referral region (HRR) level, and county level. For more information and to view the original data, please visit the CMS Medicare Geographic Variation web page.

CHRONIC CONDITIONS - ASTHMA PREVALENCE (ADULT)

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

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CHRONIC CONDITIONS - COPD (ADULT)

Data Background

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CHRONIC CONDITIONS - HEART DISEASE (ADULT)

Data Background

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CHRONIC CONDITIONS - HIGH BLOOD PRESSURE (ADULT)

Data Background

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CHRONIC CONDITIONS - HIGH CHOLESTEROL (ADULT)

Data Background

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MORTALITY - CANCER

Data Background

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Methodology

County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2015-2019 based on a selection of codes from the International Classification of Diseases (ICD) 10th revision. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2019) is available from the World Health Organization.
Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

Mortality Rate = 100,000 * SUM [(Total Population) * ((Age-Adjusted Rate)/100,000)] / SUM(Total Population).

The specific codes used for reported mortality indicators are listed below (notice that motor vehicle crash, firearm, and poisoning are listed as part of the injury mechanism for all kinds of deaths and thus are not related with any specific codes).

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary (Ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease (lung disease): J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): U03, X60-X84, Y87.0
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
- Influenza and pneumonia: J09-J18
- Opioid overdose: T40.0-T40.4

Notes

Data Suppression

Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Trends Over Time

Trends over time are produced using single-year mortality data from the CDC WONDER query system. Use caution when comparing single-year mortality rates with 5-year aggregate mortality rates. Trend data are available for states and for the total US; county-level data are not provided due to data suppression / low numerator counts.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data are reported here in combination, and thus may be subject to higher suppression than if reported separately.

MORTALITY - DRUG POISONING
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER , VitalStats, and the Health Indicator Warehouse .

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2015-2019 based on a selection of codes from the International Classification of Diseases (ICD) 10th revision. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2019) is available from the World Health Organization.
Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

Mortality Rate = 100,000 * SUM [(Total Population) * ((Age-Adjusted Rate)/100,000)] / SUM(Total Population).

The specific codes used for reported mortality indicators are listed below (notice that motor vehicle crash, firearm, and poisoning are listed as part of the injury mechanism for all kinds of deaths and thus are not related with any specific codes).

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary (Ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease (lung disease): J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): U03, X60-X84, Y87.0
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
- Influenza and pneumonia: J09-J18
- Opioid overdose: T40.0-T40.4

Notes
Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Trends Over Time
Trends over time are produced using single-year mortality data from the CDC WONDER query system. Use caution when comparing single-year mortality rates with 5-year aggregate mortality rates. Trend data are available for states and for the total US; county-level data are not provided due to data suppression / low numerator counts.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data are reported here in combination, and thus may be subject to higher suppression than if reported separately.

MORTALITY - HEART DISEASE
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER , VitalStats, and the Health Indicator Warehouse .

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2015-2019 based on a selection of codes from the International Classification of Diseases (ICD) 10th revision. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2019) is available from the World Health Organization.
Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

Mortality Rate = 100,000 * SUM [(Total Population) * ((Age-Adjusted Rate)/100,000)] / SUM(Total Population).

The specific codes used for reported mortality indicators are listed below (notice that motor vehicle crash, firearm, and poisoning are listed as part of the injury mechanism for all kinds of deaths and thus are not related with any specific codes).

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary (Ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease (lung disease): J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): U03, X60-X84, Y87.0
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
- Influenza and pneumonia: J09-J18
- Opioid overdose: T40.0-T40.4

Notes
Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Trends Over Time
Trends over time are produced using single-year mortality data from the CDC WONDER query system. Use caution when comparing single-year mortality rates with 5-year aggregate mortality rates. Trend data are available for states and for the total US; county-level data are not provided due to data suppression / low numerator counts.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data are reported here in combination, and thus may be subject to higher suppression than if reported separately.

MORTALITY - HOMICIDE
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER , VitalStats, and the Health Indicator Warehouse .

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2015-2019 based on a selection of codes from the International Classification of Diseases (ICD) 10th revision. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2019) is available from the World Health Organization.
Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

Mortality Rate = 100,000 * SUM [(Total Population) * ((Age-Adjusted Rate)/100,000)] / SUM(Total Population).

The specific codes used for reported mortality indicators are listed below (notice that motor vehicle crash, firearm, and poisoning are listed as part of the injury mechanism for all kinds of deaths and thus are not related with any specific codes).

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary (Ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease (lung disease): J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): U03, X60-X84, Y87.0
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
- Influenza and pneumonia: J09-J18
- Opioid overdose: T40.0-T40.4

Notes
Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Trends Over Time
Trends over time are produced using single-year mortality data from the CDC WONDER query system. Use caution when comparing single-year mortality rates with 5-year aggregate mortality rates. Trend data are available for states and for the total US; county-level data are not provided due to data suppression / low numerator counts.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data are reported here in combination, and thus may be subject to higher suppression than if reported separately.

MORTALITY - CORONARY HEART DISEASE
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER , VitalStats, and the Health Indicator Warehouse .

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2015-2019 based on a selection of codes from the International Classification of Diseases (ICD) 10th revision. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2019) is available from the World Health Organization.
Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

Mortality Rate = 100,000 * SUM [(Total Population) * ((Age-Adjusted Rate)/100,000)] / SUM(Total Population).

The specific codes used for reported mortality indicators are listed below (notice that motor vehicle crash, firearm, and poisoning are listed as part of the injury mechanism for all kinds of deaths and thus are not related with any specific codes).

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary (Ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease (lung disease): J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): U03, X60-X84, Y87.0
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
- Influenza and pneumonia: J09-J18
- Opioid overdose: T40.0-T40.4

Notes
Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Trends Over Time
Trends over time are produced using single-year mortality data from the CDC WONDER query system. Use caution when comparing single-year mortality rates with 5-year aggregate mortality rates. Trend data are available for states and for the total US; county-level data are not provided due to data suppression / low numerator counts.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data are reported here in combination, and thus may be subject to higher suppression than if reported separately.

MORTALITY - LUNG DISEASE
Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER , VitalStats, and the Health Indicator Warehouse .

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2015-2019 based on a selection of codes from the International Classification of Diseases (ICD) 10th revision. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable,
detailed list of current ICD-10 Codes (Version 2019) is available from the World Health Organization. Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

Mortality Rate = 100,000 * SUM [(Total Population) * ((Age-Adjusted Rate)/100,000)] / SUM(Total Population).

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- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): U03, X60-X84, Y87.0
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
- Influenza and pneumonia: J09-J18
- Opioid overdose: T40.0-T40.4

Notes
Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

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Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data are reported here in combination, and thus may be subject to higher suppression than if reported separately.

MORTALITY - STROKE

Data Background
The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER , VitalStats, and the Health Indicator Warehouse .

Methodology
County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2015-2019 based on a selection of codes from the International Classification of Diseases (ICD) 10th revision. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2019) is available from the World Health Organization.
Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

Mortality Rate = 100,000 * SUM [(Total Population) * ((Age-Adjusted Rate)/100,000)] / SUM(Total Population).

The specific codes used for reported mortality indicators are listed below (notice that motor vehicle crash, firearm, and poisoning are listed as part of the injury mechanism for all kinds of deaths and thus are not related with any specific codes).

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- Cerebrovascular disease (stroke): I60-I69
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- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): U03, X60-X84, Y87.0
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
- Influenza and pneumonia: J09-J18
- Opioid overdose: T40.0-T40.4

Notes
Data Suppression
Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Trends Over Time
Trends over time are produced using single-year mortality data from the CDC WONDER query system. Use caution when comparing single-year mortality rates with 5-year aggregate mortality rates. Trend data are available for states and for the
total US; county-level data are not provided due to data suppression / low numerator counts.

Race and Ethnicity
Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics

registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997. All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data are reported here in combination, and thus may be subject to higher suppression than if reported separately.

MORTALITY-SUICIDE

Data Background

The Division of Vital Statistics is a branch of the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) responsible for maintaining birth and death records for the nation. Data are compiled for the National Vital Statistics System (NVSS) through a joint effort between the NCHS and various state and local health agencies, who are responsible for registering vital events – births, deaths, marriages, divorces, and fetal deaths. NVSS statistics are released annually in various data warehouses, including CDC WONDER , VitalStats, and the Health Indicator Warehouse .

Methodology

County population figures and death statistics are acquired using CDC WONDER from the Underlying Cause of Death database. Conditions were queried for years 2015-2019 based on a selection of codes from the International Classification of Diseases (ICD) 10th revision. The ICD-10 is the current global health information standard for mortality and morbidity statistics. The ICD has been maintained by the World Health Organization since its conception in 1948. A searchable, detailed list of current ICD-10 Codes (Version 2019) is available from the World Health Organization.
Mortality rates were acquired from the source age-adjusted to the year 2000 U.S. standard. To recalculate age-adjusted mortality rates for unique service areas and aggregated county groupings, the following formula was used:

Mortality Rate = 100,000 * SUM [(Total Population) * ((Age-Adjusted Rate)/100,000)] / SUM(Total Population).

The specific codes used for reported mortality indicators are listed below (notice that motor vehicle crash, firearm, and poisoning are listed as part of the injury mechanism for all kinds of deaths and thus are not related with any specific codes).

- Assault (homicide): U01-U02, X85-Y09, Y87.1
- Cerebrovascular disease (stroke): I60-I69
- Coronary (Ischaemic) heart disease: I20-I25
- Chronic lower respiratory disease (lung disease): J40-J47
- Heart disease: I00-I09, I11, I13, I20-I51
- Intentional self-harm (suicide): U03, X60-X84, Y87.0
- Malignant neoplasm (cancer): C00-C97
- Unintentional injury (accident): V01-X59, Y85-Y86
- Influenza and pneumonia: J09-J18
- Opioid overdose: T40.0-T40.4

Notes

Data Suppression

Suppression is used to avoid misinterpretation when rates are unstable. Data are suppressed when the total number of cases is less than 10 (for each county/cause of death/population group) over the time period monitored. Rates should be considered unreliable when calculated with a numerator (number of cases) less than 20.

Trends Over Time

Trends over time are produced using single-year mortality data from the CDC WONDER query system. Use caution when comparing single-year mortality rates with 5-year aggregate mortality rates. Trend data are available for states and for the total US; county-level data are not provided due to data suppression / low numerator counts.

Race and Ethnicity

Race and ethnicity (Hispanic origin) are collected as two separate categories by state vital statistics registries based on methods established by the U.S. Office of Management and Budget (OMB) in 1997.

All mortality statistics from the CDC WONDER databases are available by race alone (White, Black, Amer. Indian/AK Native, and Asian) ethnicity alone (Hispanic, Non-Hispanic), or by combined race and ethnicity. Data are reported here in combination, and thus may be subject to higher suppression than if reported separately.

OBESITY

Data Background

The Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces publicly available data to promote general health. The division maintains the Diabetes Data and Trends data system, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System. These programs provide resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Methodology

Data for total population and estimated obese population data are acquired from the County Level Estimates of Diagnosed Diabetes, a service of the Centers for Disease Control and Prevention's National Diabetes Surveillance Program. Diabetes and other risk factor prevalence is estimated using the following formula:

Percent Prevalence = [Risk Factor Population] / [Total Population] * 100.

All data are estimates modelled by the CDC using the methods described below:

The National Diabetes Surveillance system produces data estimating the prevalence of diagnosed diabetes and population obesity by county using data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) and data from the U.S. Census Bureau's Population Estimates Program. The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. The survey provides state- specific information on behavioral risk factors and preventive health practices. Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. Respondents were considered obese if their body mass index was 30 or greater. Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Respondents were considered to be physically inactive if they answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Three years of data were used to improve the precision of the year-specific county-level estimates of diagnosed diabetes and selected risk factors. For example, 2003, 2004, and 2005 were used for the 2004 estimate and 2004, 2005, and 2006 were used for the 2005 estimate. Estimates were restricted to adults 20 years of age or older to be consistent with population estimates from the U.S. Census Bureau. The U.S. Census Bureau provides year-specific county population estimates by demographic characteristics—age, sex, race, and Hispanic origin.

The county-level estimates were based on indirect model-dependent estimates. The model-dependent approach employs a statistical model that "borrows strength" in making an estimate for one county from BRFSS data collected in other counties. Bayesian multilevel modeling techniques were used to obtain these estimates. Separate models were developed for each of the four census regions: West, Midwest, Northeast and South. Multilevel Poisson regression models with random effects of demographic variables (age 20–44, 45–64, 65+; race; sex) at the county-level were developed. State was included as a county-level covariate.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Methods and References for County-Level Estimates and Ranks. (2012).

Rates are age adjusted by the CDC for the following three age groups: 20-44, 45-64, 65+. Additional information, including the complete methodology and data definitions, can be found at the CDC's Diabetes Data and Statistics website.

Notes
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

DEPRESSION (MEDICARE POPULATION)

Data Background
The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS), is the federal agency that runs the Medicare Program and monitors Medicaid programs offered by each state. Medicare is a type of federally-funded health insurance available to disabled persons and the population age 65 and older. The Office of Enterprise Data and Analytics within the Centers for Medicare & Medicaid Services (CMS) developed a public use file to support further analysis of the geographic variation in the amount and quality of the health care services that Medicare beneficiaries receive. For more information, please see the Geographic Variation Public Use File Methodology document.

Methodology
Indicator percentages are acquired for 2007 - 2018 from Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse. The data used in the chronic condition reports are based upon CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. Beneficiaries who died during the year are included up to their date of death if they meet the other inclusion criteria. Chronic condition prevalence estimates are calculated by CMS by taking the beneficiaries with a particular condition divided by the total number of beneficiaries in our fee-for-service population, expressed as a percentage. For more information and to view the original data, please visit the CMS Chronic Conditions web page.

Enrollment data are acquired for 2007 - 2018 from Centers for Medicare and Medicaid Services (CMS) Medicare Geographic Variation Public Use File. This CMS table has developed data that enables researchers and policy-makers to evaluate geographic variation in the utilization and quality of health care services for the Medicare fee-for-service population. data are aggregated into a Geographic Variation Public Use File that has demographic, spending, utilization, and quality indicators at the state level (including the District of Columbia, Puerto Rico, and the Virgin Islands), hospital referral region (HRR) level, and county level. For more information and to view the original data, please visit the CMS Medicare Geographic Variation web page.

DIABETES (ADULT)

Data Background
The Centers for Disease Control and Prevention's National Center for Chronic Disease Prevention and Health Promotion monitors the health of the Nation and produces publicly available data to promote general health. The division maintains the Diabetes Data and Trends data system, which includes the National Diabetes Fact Sheet and the National Diabetes Surveillance System. These programs provide resources documenting the public health burden of diabetes and its complications in the United States. The surveillance system also includes county-level estimates of diagnosed diabetes and selected risk factors for all U.S. counties to help target and optimize the resources for diabetes control and prevention. Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Frequently Asked Questions (FAQ). (2012).

Methodology
Data for total population and estimated obese population data are acquired from the County Level Estimates of Diagnosed Diabetes, a service of the Centers for Disease Control and Prevention's National Diabetes Surveillance Program. Diabetes and other risk factor prevalence is estimated using the following formula:

Percent Prevalence = [Risk Factor Population] / [Total Population] * 100.

All data are estimates modelled by the CDC using the methods described below:

The National Diabetes Surveillance system produces data estimating the prevalence of diagnosed diabetes and population obesity by county using data from CDC's Behavioral Risk Factor Surveillance System (BRFSS) and data from the U.S. Census Bureau's Population Estimates Program. The BRFSS is an ongoing, monthly, state-based telephone survey of the adult population. The survey provides state- specific information on behavioral risk factors and preventive health practices. Respondents were considered to have diabetes if they responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes. Respondents were considered obese if their body mass index was 30 or greater. Body mass index (weight [kg]/height [m]2) was derived from self-report of height and weight. Respondents were considered to be physically inactive if they answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"

Three years of data were used to improve the precision of the year-specific county-level estimates of diagnosed diabetes and selected risk factors. For example, 2003, 2004, and 2005 were used for the 2004 estimate and 2004, 2005, and 2006 were used for the 2005 estimate. Estimates were restricted to adults 20 years of age or older to be consistent with population estimates from the U.S. Census Bureau. The U.S. Census Bureau provides year-specific county population estimates by demographic characteristics—age, sex, race, and Hispanic origin.
The county-level estimates were based on indirect model-dependent estimates. The model-dependent approach employs a statistical model that "borrows strength" in making an estimate for one county from BRFSS data collected in other counties. Bayesian multilevel modeling techniques were used to obtain these estimates. Separate models were developed for each of the four census regions: West, Midwest, Northeast and South. Multilevel Poisson regression models with random effects of demographic variables (age 20–44, 45–64, 65+; race; sex) at the county-level were developed. State was included as a county-level covariate.

Citation: Centers for Disease Control and Prevention, Diabetes Data & Trends: Methods and References for County-Level Estimates and Ranks. (2012).

Rates are age adjusted by the CDC for the following three age groups: 20-44, 45-64, 65+. Additional information, including the complete methodology and data definitions, can be found at the CDC's Diabetes Data and Statistics website.

Notes
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

SUBSTANCE USE DISORDER (MEDICARE POPULATION)
Data Background
The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS), is the federal agency that runs the Medicare Program and monitors Medicaid programs offered by each state. Medicare is a type of federally-funded health insurance available to disabled persons and the population age 65 and older. The Office of Enterprise Data and Analytics within the Centers for Medicare & Medicaid Services (CMS) developed a public use file to support further analysis of the geographic variation in the amount and quality of the health care services that Medicare beneficiaries receive. For more information, please see the Geographic Variation Public Use File Methodology document.

Methodology
Indicator percentages are acquired for 2007 - 2018 from Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse. The data used in the chronic condition reports are based upon CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service

program. Beneficiaries who died during the year are included up to their date of death if they meet the other inclusion criteria. Chronic condition prevalence estimates are calculated by CMS by taking the beneficiaries with a particular condition divided by the total number of beneficiaries in our fee-for-service population, expressed as a percentage. For more information and to view the original data, please visit the CMS Chronic Conditions web page.

Enrollment data are acquired for 2007 - 2018 from Centers for Medicare and Medicaid Services (CMS) Medicare Geographic Variation Public Use File. This CMS table has developed data that enables researchers and policy-makers to evaluate geographic variation in the utilization and quality of health care services for the Medicare fee-for-service population. data are aggregated into a Geographic Variation Public Use File that has demographic, spending, utilization, and quality indicators at the state level (including the District of Columbia, Puerto Rico, and the Virgin Islands), hospital referral region (HRR) level, and county level. For more information and to view the original data, please visit the CMS Medicare Geographic Variation web page.

ALCOHOL USE DISORDER (MEDICARE POPULATION)

Data Background

The Centers for Medicare & Medicaid Services (CMS), a branch of the Department of Health and Human Services (HHS), is the federal agency that runs the Medicare Program and monitors Medicaid programs offered by each state. Medicare is a type of federally-funded health insurance available to disabled persons and the population age 65 and older. The Office of Enterprise Data and Analytics within the Centers for Medicare & Medicaid Services (CMS) developed a public use file to support further analysis of the geographic variation in the amount and quality of the health care services that Medicare beneficiaries receive. For more information, please see the Geographic Variation Public Use File Methodology document.

Methodology

Indicator percentages are acquired for 2007 - 2018 from Centers for Medicare and Medicaid Services (CMS) Chronic Conditions Warehouse. The data used in the chronic condition reports are based upon CMS administrative enrollment and claims data for Medicare beneficiaries enrolled in the fee-for-service program. Beneficiaries who died during the year are included up to their date of death if they meet the other inclusion criteria. Chronic condition prevalence estimates are calculated by CMS by taking the beneficiaries with a particular condition divided by the total number of beneficiaries in our fee-for-service population, expressed as a percentage. For more information and to view the original data, please visit the CMS Chronic Conditions web page.

Enrollment data are acquired for 2007 - 2018 from Centers for Medicare and Medicaid Services (CMS) Medicare Geographic Variation Public Use File. This CMS table has developed data that enables researchers and policy-makers to evaluate geographic variation in the utilization and quality of health care services for the Medicare fee-for-service population. data are aggregated into a Geographic Variation Public Use File that has demographic, spending, utilization, and quality indicators at the state level (including the District of Columbia, Puerto Rico, and the Virgin Islands), hospital referral region (HRR) level, and county level. For more information and to view the original data, please visit the CMS Medicare Geographic Variation web page.

CLINICAL CARE & PREVENTION

CANCER SCREENING - PAP SMEAR TEST

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

In 2015, The Robert Wood Johnson Foundation and CDC Foundation launched the 500 Cities Project in partnership with the Centers for Disease Control and Prevention (CDC). The 500 city project seeks to identify, analyze, and report city and census tract-level data, obtained using small area estimation methods, for 27 chronic disease measures for the 500 largest American cities.

CANCER SCREENING - SIGMOIDOSCOPY OR COLONOSCOPY

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

In 2015, The Robert Wood Johnson Foundation and CDC Foundation launched the 500 Cities Project in partnership with the Centers for Disease Control and Prevention (CDC). The 500 city project seeks to identify, analyze, and report city and census tract-level data, obtained using small area estimation methods, for 27 chronic disease measures for the 500 largest American cities.

CANCER SCREENING - MAMMOGRAM (ADULT)

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

In 2015, The Robert Wood Johnson Foundation and CDC Foundation launched the 500 Cities Project in partnership with the Centers for Disease Control and Prevention (CDC). The 500 city project seeks to identify, analyze, and report city and census tract-level data, obtained using small area estimation methods, for 27 chronic disease measures for the 500 largest American cities.

DENTAL CARE UTILIZATION

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health

behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.
In 2015, The Robert Wood Johnson Foundation and CDC Foundation launched the 500 Cities Project in partnership with the Centers for Disease Control and Prevention (CDC). The 500 city project seeks to identify, analyze, and report city and census tract-level data, obtained using small area estimation methods, for 27 chronic disease measures for the 500 largest American cities.

DIABETES MANAGEMENT - HEMOGLOBIN A1C TEST

Data Background

The Dartmouth Atlas of Healthcare is an online repository of health data and maps based on information included in the massive Medicare database maintained by the Center for Medicare and Medicaid Services (CMS). The project uses Medicare claims data in conjunction with other demographic data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. The Dartmouth Atlas of Health Care is produced and maintained by The Dartmouth Institute for Health Policy and Clinical Practice.

For more information about this source, including methodologies and definitions, refer to the Dartmouth Atlas of Healthcare website.

Methodology

The Dartmouth Institute analyzes data drawn from enrollment and claims files from the Medicare program. Analysis is restricted to the fee-for-service population over age 65; HMO patients are not included. Indicator data include measures of primary care utilization, quality of care for diabetes, mammography, leg amputation and preventable hospitalizations.
When appropriate, statistical adjustments are carried out to account for differences in age, race and sex.

More information can be found in Regional and Racial Variation in Primary Care and the Quality of Care among Medicare Beneficiaries .

PREVENTION - RECENT PRIMARY CARE VISIT (ADULT)

Data Background

The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

In 2015, The Robert Wood Johnson Foundation and CDC Foundation launched the 500 Cities Project in partnership with the Centers for Disease Control and Prevention (CDC). The 500 city project seeks to identify, analyze, and report city and census tract-level data, obtained using small area estimation methods, for 27 chronic disease measures for the 500 largest American cities.

Methodology

This indicator reports the percentage of respondents age 18 years and older who report having been to a doctor for a routine checkup (e.g., a general physical exam, not an exam for a specific injury, illness, condition) in the previous year. Estimates for this indicator are available only for those cenus tracts within the top 500 most populous cities in the United States. Values are small-area estimates modeled from the Behavioral Risk Factor Surveillance System (BRFSS) annual survey data files. Data are made available by the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics (NCHS) through the 500 Cities: Local Data for Better Health project.

PREVENTION - RECENT PRIMARY CARE VISIT (MEDICARE)

Data Background

The Dartmouth Atlas of Healthcare is an online repository of health data and maps based on information

included in the massive Medicare database maintained by the Center for Medicare and Medicaid Services (CMS). The project uses Medicare claims data in conjunction with other demographic data to provide information and analysis about national, regional, and local markets, as well as hospitals and their affiliated physicians. The Dartmouth Atlas of Health Care is produced and maintained by The Dartmouth Institute for Health Policy and Clinical Practice.

For more information about this source, including methodologies and definitions, refer to the Dartmouth Atlas of Healthcare website.

Methodology
The Dartmouth Institute analyzes data drawn from enrollment and claims files from the Medicare program. Analysis is restricted to the fee-for-service population over age 65; HMO patients are not included. Indicator data include measures of primary care utilization, quality of care for diabetes, mammography, leg amputation and preventable hospitalizations.
When appropriate, statistical adjustments are carried out to account for differences in age, race and sex.

More information can be found in Regional and Racial Variation in Primary Care and the Quality of Care among Medicare Beneficiaries .

PREVENTION - CORE PREVENTATIVE SERVICES FOR MEN

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

In 2015, The Robert Wood Johnson Foundation and CDC Foundation launched the 500 Cities Project in partnership with the Centers for Disease Control and Prevention (CDC). The 500 city project seeks to identify, analyze, and report city and census tract-level data, obtained using small area estimation methods, for 27 chronic disease measures for the 500 largest American cities.

PREVENTION - CORE PREVENTATIVE SERVICES FOR WOMEN

Data Background
The Behavioral Risk Factor Surveillance System (BRFSS) is a collaborative project of the Centers for Disease Control and Prevention (CDC) and U.S. states and territories. The BRFSS, administered and supported by CDC's Behavioral Risk Factor Surveillance Branch, is an ongoing data collection program designed to measure behavioral risk factors for the adult population (18 years of age or older) living in households. The health characteristics estimated from the BRFSS include data pertaining to health behaviors, chronic conditions, access and utilization of healthcare, and general health. Surveys are administered to populations at the state level and then delivered to the CDC. BRFSS annual survey data are publicly available and maintained on the CDC's BRFSS Annual Survey Data web page.

In 2015, The Robert Wood Johnson Foundation and CDC Foundation launched the 500 Cities Project in partnership with the Centers for Disease Control and Prevention (CDC). The 500 city project seeks to identify, analyze, and report city and census tract-level data, obtained using small area estimation methods, for 27 chronic disease measures for the 500 largest American cities.

HEALTHCARE WORKFORCE

ACCESS TO CARE - ADDICTION/SUBSTANCE ABUSE PROVIDERS

Data Background

The Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) provides basic information about all organization and individual providers with a National Provider Identifier (NPI). The National Provider Identifier (NPI) is unique identification number for health care providers, including both organizations and individuals. Each month, CMS provides an updated data file available for download which contains FOIA-disclosable NPPES health care provider information, including name, credential, practice location address, and practice type based on multiple (primary, secondary, tertiary, etc.) taxonomy codes. Additional information about the NPPES downloadable file can be found here.

Methodology

Data for this indicator are acquired from the monthly Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) Downloadable File. This file includes directory information for all Medicare providers that had a valid National Provider Identifier (NPI). Provider information contained in this file includes name, credentials, gender, specialty, and complete address. Indicator counts are tabulations of providers that specialize in addiction or substance abuse treatment, determined based on the "provider type" listed in the data file. Addiction or substance abuse providers include MDs, DOs, and other credentialed professionals specializing in substance abuse treatment, rehabilitation, addiction medicine, or providing methadone. The number of facilities that specialize in addiction and substance abuse treatment are also listed (but are not included in the calculated rate). For more information, please refer to the CMS
National Provider Identifier documentation, available here .

ACCESS TO CARE - DENTISTS

Data Background

The Area Health Resource File (AHRF) is a database of information about the U.S. health care system, maintained and released annually by the U.S. Health and Human Services (HHS) Health Resources and Services Administration (HRSA). The AHRF contains more than 6,000 variables, aggregated for each of the nation's counties. The ARF contains information on health facilities, health professions, health status, economic activity, health training programs, measures of resource scarcity, and socioeconomic and environmental characteristics. In addition, the basic file contains geographic codes and descriptors which enable it to be linked to many other files and to aggregate counties into various geographic groupings.

The ARF integrates data from numerous primary data sources including: the American Hospital Association, the American Medical Association, the American Dental Association, the American Osteopathic Association, the Bureau of the Census, the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration), Bureau of Labor Statistics, National Center for Health Statistics and the Veteran's Administration.
For more information, please visit HRSA's Area Health Resource File website.

Methodology

Data for this indicator are acquired from the 2015-16 Area Health Resource File database. For this indicator, the 2015-16 AHRF reports figures from the Centers from Medicare and Medicaid Services (CMS) National Provider Identification (NPI) File. This resource includes all dentists - qualified as having a doctorate in dental surgery (D.D.S.) or dental medicine (D.M.D.), who are licensed by the state to practice dentistry and who are practicing within the scope of that license. Rates are calculated per 100,000 total population using the following formula:

Provider Rate = [Number of Dentists] / [Total Population] * 100,000

Population figures in the AHRF are from the U.S. Census Bureau's Annual Resident Population Estimates, Estimated

Components of Resident Population Change and Rates of the Components of Resident Population Change for States and Counties: April 1, 2010 to July 1, 2015. For detailed source information, please

view the documentation included in the 2015-2016 AHRF, which can be downloaded here.

Notes
Race and Ethnicity
Statistics by race and ethnicity are not provided for this indicator.

Data Limitations
Reported data represent summaries limited by county boundaries. When comparing rates, consider the following:
1. Rates assume uniform distribution of both establishments and populations throughout the county and may not detect disparities in access for rural or minority populations.
2. Summaries may over-represent or under-represent county rates when populations or establishments are highly concentrated on county border lines.
3. Rates do not describe quality of the establishment or utilization frequency.

ACCESS TO CARE - MENTAL HEALTH PROVIDERS
Data Background
The Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) provides basic information about all organization and individual providers with a National Provider Identifier (NPI). The National Provider Identifier (NPI) is unique identification number for health care providers, including both organizations and individuals. Each month, CMS provides an updated data file available for download which contains FOIA-disclosable NPPES health care provider information, including name, credential, practice location address, and practice type based on multiple (primary, secondary, tertiary, etc.) taxonomy codes. Additional information about the NPPES downloadable file can be found here.

Methodology
Data for this indicator are acquired from the monthly Centers for Medicare and Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES) Downloadable File. This file includes directory information for all Medicare providers
that had a valid National Provider Identifier (NPI). Provider information contained in this file includes name, credentials, gender, specialty, and complete address. Indicator counts are tabulations of providers that deliver mental health care, determined based on the “provider type” listed in the data file. Mental health providers include licensed clinical social workers and other credentialed professionals specializing in psychiatry, psychology, counselling, or child, adolescent, or adult mental health. The number of facilities that specialize in mental health are tabulated, (but are not included in the calculated rate). For more information, please refer to the CMS National Provider Identifier documentation, available here .

ACCESS TO CARE - PRIMARY CARE
Data Background
The Area Health Resource File (AHRF) is a database of information about the U.S. health care system, maintained and released annually by the U.S. Health and Human Services (HHS) Health Resources and Services Administration (HRSA). The AHRF contains more than 6,000 variables, aggregated for each of the nation’s counties. The ARF contains information on health facilities, health professions, health status, economic activity, health training programs, measures of resource scarcity, and socioeconomic and environmental characteristics. In addition, the basic file contains geographic codes and descriptors which enable it to be linked to many other files and to aggregate counties into various geographic groupings.

The ARF integrates data from numerous primary data sources including: the American Hospital Association, the American Medical Association, the American Dental Association, the American Osteopathic Association, the Bureau of the Census, the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration), Bureau of Labor Statistics, National Center for Health Statistics and the Veteran’s Administration.

For more information, please visit HRSA’s Area Health Resource File website.

Methodology
Data for this indicator are acquired from the 2018-19 Area Health Resource File database. For this

indicator, the 2018-19 AHRF reports figures based on the 2010-2017 American Medical Association Physician Masterfiles (Copyright). Doctors classified as "primary care physicians" by the AMA include M.D.s and D.O.s in the fields of: General Family Medicine, General Practice, General Internal Medicine and General Pediatrics. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded. data are tabulated for physicians practicing office-based patient care only. Non-patient care practitioners include administrators, medical teachers, researchers, etc. Rates are calculated per 100,000 total population using the following formula:

Provider Rate = [Number of Primary Care Physicians] / [Total Population] * 100,000

Population figures in the AHRF are from the U.S. Census Bureau's Annual Resident Population Estimates, Estimated Components of Resident Population Change and Rates of the Components of Resident Population Change for States and Counties: April 1, 2010 to July 1, 2017. For detailed source information, please view the documentation included in the 2018-2019 AHRF, which can be downloaded here.

Notes

Race and Ethnicity

Statistics by race and ethnicity are not provided for this indicator.

Data Limitations

Reported data represent summaries limited by county boundaries. When comparing rates, consider the following:

1. Rates assume uniform distribution of both establishments and populations throughout the county and may not detect disparities in access for rural or minority populations.
2. Summaries may over-represent or under-represent county rates when populations or establishments are highly concentrated on county border lines.
3. Rates do not describe quality of the establishment or utilization frequency.

POPULATION LIVING IN A HEALTH PROFESSIONAL SHORTAGE AREA

Data Background

Health Professional Shortage Areas (HPSAs) are designated by the US Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers. HPSAs may refer to an entire geographic area (a county or service area), a demographic group within a geographic area (low income population) or an institution (comprehensive health center, federally qualified health center or other public facility).

HPSAs are designated using several criteria, depending on the type of designation. For example, a HPSA may be designated on the basis that medical professionals in contiguous areas are over-utilized, excessively distant, or inaccessible to the population under consideration. HPSAs are also designated based on population-to-clinician ratios. This ratio is usually 3,500 to 1 for primary care, 5,000 to 1 for dental health care, and 30,000 to 1 for mental health care. All Federally Qualified Health Centers and Rural Health Clinics that provide access to care, regardless of patient ability to pay, receive automatic facility HPSA designation.

HPSAs are updated on a continuous basis through the US Health and Humans Services (HHS) Health Resources and Services Administration (HRSA) GIS data warehouse. For more information about HPSAs, please visit the HRSA Health Professional Shortage Area (HPSA) web page.

Methodology

Health Professional Shortage Area (HPSA) boundary files were acquired from the US Health Resources and Services Administration (HRSA) GIS data warehouse. Data from HRSA contained estimates of the total component population, as well as the degree of shortage. Shortages vary based on HPSA designation, and may refer to the total area's full time equivalency* population, or the population of a specific demographic (income, racial, ethnic) group. This indicator reports the total population in the report area that is living in a Health Professional Shortage Area, regardless of the degree of shortage, or whether the HPSA covers the entire geographic area or a population subgroup. Indicator data are based on the following calculation:

Percentage = [HPSA Population] / [Report Area Population] * 100

The population figures used in this calculation are from the 2017 American Community Survey 5-year Estimates.

* Total equivalency population:

HPSA Designation populations may exceed total census populations in areas with large transient populations as follows:

- Seasonal residents, i.e., those who maintain a residence in the area but inhabit it for only 2 to 8 months per year, may be included but must be weighted in proportion to the fraction of the year they are present in the area.
- Other tourists (non-resident) may be included in an area's population but only with a weight of 0.25, using the following formula: Effective tourist contribution to population = 0.25 x (fraction of year tourists are present in area) x (average daily number of tourists during portion of year that tourists are present).
- Migratory workers and their families may be included in an area's population, using the following formula: Effective migrant contribution to population = (fraction of year migrants are present in area) x (average daily number of migrants during portion of year that migrants are present)

For additional information, including designation procedures and access to the original data, please visit the HRSA Health Professional Shortage Area (HPSA) web page.

Notes

Race and Ethnicity

Statistics by race and ethnicity are not provided for this indicator from the data source. Detailed race/ethnicity data may be available at a broader geographic level, or from a local source.

SPECIAL TOPICS - COVID-19

COVID-19 - CONFIRMED CASES

Data Background

The Center for Systems Science and Engineering (CSSE) is a research collective housed within the Department of Civil and Systems Engineering (CaSE) at Johns Hopkins University (JHU). The Center's faculty, researchers, and students work on a range of complex and interdisciplinary problems, united by the goal to better understand and improve societal, health, and technological systems for everyone. The CSSE is tracking the COVID-19 spread in real-time on our interactive dashboard with data available for download and modeling the spread of the virus.

Methodology

This indicator reports the number of confirmed cases for the novel coronavirus COVID-19 in US counties. Attributes include the total cumulative cases, deaths, case rate (number of cases per 100,000 population) and mortality rate (deaths per 100,000 population).
Note: Rates are used to allow meaningful comparison across geographic areas with different base population sizes.

Case counts data for this layer are updated daily from a feature service provided by the Center for Systems Science and Engineering (CSSE) at the Johns Hopkins University. Rates are calculated by CARES using 2018 population totals. For more information about the data displayed here, please visit the ESRI COVID-19 Overview web page.

COVID-19 - MORTALITY

Data Background

The Center for Systems Science and Engineering (CSSE) is a research collective housed within the Department of Civil and Systems Engineering (CaSE) at Johns Hopkins University (JHU). The Center's faculty, researchers, and students work on a range of complex and interdisciplinary problems, united by the goal to better understand and improve societal, health, and technological systems for everyone. The CSSE is tracking the COVID-19 spread in real-time on our interactive dashboard with data available for download and modeling the spread of the virus.

Methodology

This indicator reports the number of deaths attributed to the novel coronavirus COVID-19 in US counties. Attributes reported with this dataset include the total, cumulative number of deaths and the crude mortality rate (deaths per 100,000 population). Population figures are obtained from the 2018 US Census Population Estimates.
Note: Rates are used to allow meaningful comparison across geographic areas with different base population sizes.

Case counts data for this layer are updated daily from a feature service provided by the Center for Systems Science and Engineering (CSSE) at the Johns Hopkins University. Rates are calculated by CARES using 2018 population totals. For more information about the data displayed here, please visit the ESRI COVID-19 Overview web page.

COVID-19 - FULLY VACCINATED ADULTS

Methodology

Data on vaccine doses administered include data received by CDC as of 6:00 a.m. ET on the day of reporting. Vaccination providers collect data on COVID-19 vaccine doses they administered and report the data to CDC through multiple sources, including jurisdictions, pharmacies, and federal entities. These sources use various reporting methods including immunization information systems, the Vaccine Administration Management System, and direct data submission.

CDC determines county of residence by matching the county Federal Information Processing Standard State code to the state as submitted in the raw data provided to CDC. Vaccine hesitancy rates are estimated in two steps. First, hesitancy rates are estimated at the state level using the HPS for the collection period March 3, 2021 – March 15, 2021, which is referred to as Week 26. Then, the estimated values are used to predict hesitancy rates in more granular areas using the Census Bureau's 2019 American Community Survey (ACS) 1-year Public Use Microdata Sample (PUMS). To create county-

level estimates, a PUMA-to-county crosswalk from the Missouri Census Data Center was used. PUMAs spanning multiple counties had their estimates apportioned across those counties based on overall 2010 Census populations. Population weighted averages are used by CARES to estimate values across multiple states or counties.

The Vaccine Coverage (CVAC) index measures the level of concern about COVID-19 vaccine coverage based on supply and demand-side barriers, including contextual factors, care-seeking behaviors, and historical vaccine coverage data. The CVAC is a modular index where the final score can be broken down into five different themes that reflect barriers to vaccine coverage:

1. Historic undervaccination
2. Sociodemographic barriers
3. Resource-constrained health systems
4. Healthcare accessibility barriers
5. Irregular care-seeking behavior

The overall CVAC composite score and scores per each of the five CVAC themes were calculated at state and county levels, ranking each geographical region on a 0-1 scale of the level of concern about COVID-19 vaccine coverage (0 = least concerning, 1 = most concerning). Population weighted averages are used by CARES to estimate values across multiple states or counties.

APPENDIX D-1

Qualitative Research Overview

The qualitative primary research methodology consisted of stakeholder interviews and focus group discussions with key community stakeholders, policymakers, and residents.

Seventy-five (75) one-on-one interviews that lasted approximately 30 minutes in length were conducted. This provided the opportunity to have in-depth and private conversations about community-wide strengths, barriers to getting care, impacts of the COVID-19 pandemic, and ideas to improve their communities. Although an interview guide (Appendix D-1) was used to help guide the conversation, participants were encouraged to speak about their particular areas of concern, interest, or experience. In addition, ten (10) virtual focus group discussions in many areas across the seven communities allowed regional voices to highlight areas they see as the biggest health-related needs facing the community. Complementary to the individual interviews, the lively conversations in the focus groups added insight and depth to community needs perceptions.

Focus group members were recruited from the regional communities through mass and personal emails, one-on-one conversations, social media, and through word of mouth. Many of their opinions and observations were grounded in both personal and professional experiences. The focus group interview guide (Appendix D-2) mirrored the discussion guide used for the one-on-one interviews. The groups started with introductions, and then participants were asked to think broadly about the topic areas. The discussions then narrowed into what they saw as the biggest concerns facing their community and what possible solutions they envisioned.

The combination of individual interviews and focus group discussions elicited several qualitative themes about areas of need. Each of these themes cuts across and impacts the subsequent Needs and Action Areas, and they are identified below with a short explanation. The Needs and Action Area sections follow the themes, and each includes an overview of the Action Area and utilizes de-identified illustrative observations in italics which are representative of respondents' consensus perspectives. In some cases, the observations highlight examples of potential interventions.

In total, across both qualitative research stages, almost 200 individuals provided input from the following segments. The table below represents a sample of, but not all, sectors of unique communities heavily engaged in the qualitative research processes:

HEALTH SYSTEMS, HEALTHCARE PROVIDERS & LEADERSHIP

- Freeman Hospital System
- Good Samaritan Care Clinic
- HealthTran/Missouri Rural Health Network
- Healthy Nevada
- Mercy Hospital System
- Missouri Ozarks Community Health
- Access Family Care
- Burrell Behavioral Health
- CoxHealth
- Community Health Center of Southeast Kansas
- Cark Community Mental Health Center
- Community Clinic of Southwest Missouri
- Jordan Valley Community Health Center
- Ozark Center
- Aurora Hospital
- Atlantic Coast Dental

NONPROFIT ORGANIZATIONS & COMMUNITY-BASED SERVICES

- Nevada Housing Authority
- Ozark Senior Center
- Texas County Food Pantry
- Grupo Latinoamericano
- Watered Gardens Ministries
- Boys & Girls Club of Southwest Missouri
- Community Foundation of the Ozarks
- Christian County Neighborhood Center
- West Plains Rotary
- Gift of Hope

GOVERNMENTAL ORGANIZATIONS & HEALTH DEPARTMENTS

- Barton County Health Department
- Christian County Health Department
- City of West Plains
- Dallas County Health Department
- Christian County Library
- Neighborhood Adult Literacy Action
- Springfield Greene-County Health Department

SCHOOL SYSTEMS & LIBRARIES

- Joplin R-8 School District
- Nevada R-5 & R-8 School Districts
- Christian County Library
- Franklin Technology Center Adult Education
- Parsons District Schools

TRIBAL COMMUNITIES

- Inter-Tribal Emergency Management Coalition

VULNERABLE POPULATIONS

- Refugee & Immigrant Services & Education

HEALTH EDUCATION ORGANIZATIONS

- Live Well Crawford County
- Eat Well
- Community Partnership of the Ozarks
- Elevate Branson
- Ozarks Wellness Network
- Springfield Drug Taskforce
- McDonald County Coalition

FAITH-BASED ORGANIZATIONS & COMMUNITIES

- Christian Action Ministries
- Connecting Grounds
- First Baptist Church of Ozarks
- Water Gardens Ministries, Homeless Shelter

LGBTQ+ COMMUNITY ADVOCATES

- PROMO

HIGH-LEVEL QUALITATIVE DISCUSSION THEMES

Across the region, many participants shared comments and insights specific to their communities. However, in some rural communities, community engagement was low, such as the Bolivar Community. The following are some key highlights from the qualitative research for the combined seven regions:

- The COVID-19 pandemic, specifically stemming from low vaccination rates in the area, will have long-lasting effects on many health and social aspects of the population.
- Transportation remains a barrier for individuals and families trying to get the healthcare they need, and travel for regular employment.
- Mental health and substance misuse have always plagued the area, but the COVID-19 pandemic has greatly increased the problem and not nearly enough treatment options exist.
- Healthcare has become highly and increasingly politicized, and this has affected both medical and mental health needs of residents across the region.
- The cycle of generational poverty makes it difficult for some residents to envision and build a more positive future for families today and tomorrow.
- Recruiting and retaining the necessary number of and types of providers exacerbates the already challenging health issues, especially of the more rural areas of the region.
- Many shared the hope for children's futures, but isolation due to poverty and COVID-19 risk is creating what they feel are permanent educational and behavioral health challenges for many in our next generation, especially since the true impacts of the pandemic will not be known for years.
- Telehealth is not a viable solution to help solve rural health care needs due to the lack of broadband infrastructure, as well as costs of hardware, consistent internet access, and knowledge gaps.
- The culture of the Ozarks lends itself to how people think, who they trust, and their subsequent actions, many times with long-lasting effects, especially in relation to the pandemic.

In addition to interventions associated with the themes above, there are interventions which flow naturally from the Action Areas below. These are important to include in any planning response. The following High-Level Action Areas are most representative of respondents' consensus in both the qualitative interviews and the focus group discussion. Please note, the Action Areas are not in prioritized order. Items in italics are direct quotes from participants.

THE COVID-19 PANDEMIC

The Ozarks is one area of the United States that was hit particularly hard by the COVID-19 pandemic, especially during the delta variant surge in the summer of 2021. Much of what is reported below and throughout this report includes references to the influence of the pandemic, since it's next to impossible to isolate it from the remainder of the health needs of the communities studied. Yet due to the magnitude of the infection rates in the research target area, as well as the unknowns with respect to the future health of the communities this project included, it warrants its own section.

- *Provider burnout was bad before COVID, but now it's worse. Resources are stressed and things are bad in Oklahoma, hospitals are full, we have COVID tents. COVID funding from the government comes with so many strings attached, i.e., they're having many emergency issues due to COVID and have to reduce emergency room clinic hours and we'd like to build a new clinic but have to refer to another clinic.* (Joplin Community)
- *Testing, vaccinations, vaccination hesitancy – it's very political, and so very challenging.* (Lebanon Community, Douglas County)

- *We've been seeing residual effects of COVID – kidney disease, heart disease, PTSD. Nobody was prepared for that.* (Mountain View Community)
- *Vaccination efforts continue – through working with employees and watching social media. There's lots of misinformation and push back and feelings of distrust from what I perceived as trusted resources, including doctors and school nurses.* (Lebanon & Mountain View Communities)
- *COVID-19 has helped bring mental health and substance misuse into the 21st century and make it relevant. We've discovered new ways to provide services virtually, but we just need better internet access. This is an opportunity. Virtual treatment had a bit of a negative effect since people didn't have the connections and interactions. There are more acute mental health issues due to COVID, more suicidal ideations, more depression, and lots of anxiety. Social interactions were disrupted and people in recovery for years have had reoccurrences of use.* (Springfield Community)
- *Providers were open, but there may have been people who had a yearly checkup and chose not to go.* (Mountain View Community, Howell County)
- *Isolation is hard, especially for the elderly. When the senior center closed, they lost friends either due to COVID or other illnesses. Churches closed. Expect long-term mental health issues for older adults.* (Lebanon Community, Dallas County)
- *My daughter was pregnant and got COVID. She was on a vent for 17 days and received the highest oxygen she could get. COVID ate a hole in her lung. The child was born 2 months early. My daughter has really bad anxiety and my grandchild has separation anxiety. The experience was a nightmare because the only contact you have is with the nurse. Long-term, her lungs look like someone who smoked for 40 years. If she ever gets pneumonia, then she will need to be hospitalized. My son-in-law had heart issues and almost had a heart attack.* (Joplin Community, Vernon County)

MENTAL HEALTH & SUBSTANCE USE DISORDER

Mental health (MH) and substance use disorders (SUD) affect people of all ages, genders, race, and ethnic groups. Prior to Covid-19, out of the 330.1 million people living in America, nearly one in five (61.2 million) were living with a mental illness and/or substance use disorder which is a 5.9% increase from the prior year. Of these people 25.5% (13.1 million) are experiencing a severe mental illness, which can be defined as an individual over 18 having (within the past year) a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities.

People feel that the 'good life' isn't for them.

Branson Community

In the region included in this community health needs assessment, access to mental health and substance use disorder treatment is highly varied with many stating that access is limited in their local area, and this is exacerbated in rural areas of the states. Stigma continues to act as a barrier to getting care, and lack of housing options make matters worse.

- *Our area has high percentage of people on drugs. Meth is big. If you have a record, it's hard to get housing, so people live in extended stay hotels and drugs are prevalent – people can't get out of the cycle.* (Branson Community, Taney County)
- *Addiction is huge. Suicidal ideation of teenagers is growing, and the internet makes an impact, plus not being in school and no face-to-face interactions. Parents' addictions, spousal abuse, food insecurity, housing, jobs – all impact behavioral health.* (Lebanon Community, Douglas County)
- *Need an increase in medical detox beds, i.e., people with high blood pressure, asthma who want to go through detox. They've detoxed people in ways that aren't safe, i.e., putting them in a hotel room and have a doctor check on them every few hours.* (Springfield Community)

- *Meth is a major problem, including with Medicaid moms with no social support. People with substance use and mental health are very stigmatized.* (Joplin Community, Cherokee County)
- *There's a stigma to seeking psych care. People have been suffering from mental health for years and haven't gotten care.* (Mountain View Community, Howell County)
- *We're seeing more kids with lack of direction, diagnoses, or lack of diagnoses when they should have one in our programs. There has been slow growing anxiety behaviors and autism since the pandemic, but our area wasn't affected like east or west coast – they were back in school earlier. We have a huge population of divorced parents and so many mixed families. They need family education and support.* (Joplin Community, Jasper County)
- *Mental health is still taboo and stigmatized. We have residual effects from facility closures a few decades ago.* (Joplin Community, Vernon County)
- *Slow progress on stigma, but it's still progress. Awareness at Olympics helps, but it's very stigmatized. I keep hearing things like, "I thought I was alone in this." Still siloed for co-occurring treatment – most treatments still pay attention to one side or the other, not looking at whole package.* (Springfield Community)

TRANSPORTATION & INTERNET ACCESS

Uniqueness of communities isn't considered when developing solutions for communities.

Mountain View Community

Simply seeing a healthcare provider – whether in person or via telehealth – is a major barrier for many in the region to get the care they need. When asked to name one of the biggest challenges to living in the area, participants regularly cited transportation, even though transportation is a central beneficiary of the 2021 Federal infrastructure bill. Less often offered when asked a general question about challenges in the area, but frequently told was a major issue when specifically asked about telehealth, is the lack of broadband or internet access, especially for more rural areas of the study's geography and for low income or people experiencing homelessness in the community. The following are representative comments from across the areas of study

- *Public transportation in Branson would be life changing.* (Branson Community, Taney County)
- *Access (including transportation) to specialty care is hard, including women's health, endocrinologist, orthopedic surgeons.* (Mountain View Community, Howell County)
- *The low-income community has few resources to travel for healthcare due to unreliable transportation. They need more basic services in community, and to work with others to get more advanced care including appointments, transportation Mission Fund to help patients pay for services or equipment, but there's still a large gap and access to services. 35-45 minutes from Aurora to Springfield, but 1:15-1:25 from Cassville to Springfield.* (Monett Community, Barry County)
- *No real public transportation in this rural area. There is a little bus, but it has limited hours and it's only within city limits. Hard for people to get to the bus station. No taxis, even though they have funding.* (Lebanon Community, Texas County)
- *We need to get all hands-on deck to provide phone lines and return calls to help people complete the really long application forms. Advocacy for changing payment structure, making it easier.* (Lebanon Community, Douglas County)

CHRONIC CONDITIONS, CANCER, DENTAL HEALTH & AGING

Due to the difficulty of accessing healthcare providers, whether due to transportation, insurance or cost considerations, the general avoidance of healthcare unless in case of an emergency, unhealthy lifestyles, and other reasons, leads to a large number of people who indicated that chronic conditions are a major issue in the region. Diabetes, heart disease, obesity, Chronic Obstructive Pulmonary Disease (COPD), and hypertension were consistently cited. People feel that many of the health issues are preventable, and that people make poor choices about their diet and exercise. Many feel that this can be improved by education, but cultural changes are also needed. The increasing needs of the aging population were also noted by various participants, both for the patients themselves and for their caregivers, including care for patients with Alzheimer's Disease or dementia.

Cancer is gaining ground. Many participants cited cancer as a major and growing problem.
Care for the body, and the mind, is needed. More and more, people are realizing that the body is an entire system and needs to be treated as one, rather than siloed care depending on the body part.
Rural dental care is severely lacking. Many participants shared a need for affordable and accessible dental care, especially for pediatric patients.

What many of these have in common is the need for preventative care, and that was commonly cited as a major need. The belief is a large number of residents – especially those that don't have insurance or are affected by poverty – use the emergency departments for their regular care, or only visit the emergency room, clinic, or doctor when the situation escalates.

- *People think there's something wrong with the water or other system in West Plains that makes them more susceptible to cancers.* (Mountain View Community)
- *90% of our patients are two times under poverty level. Two-thirds of the patients have multiple chronic conditions. People drop out of workforce so they could qualify for healthcare.* (Branson Community, Taney County)
- *Since COVID, we've seen increase in pulmonary issues, and post-COVID issues like needing inhalers, other breathing issues, etc. We desperately need more inhalers.* (Joplin Community, Jasper& Newton Counties)
- *Kids are overweight and unhealthy.* (Springfield Community, Greene County)
- *There's no follow up or preventative care for diabetes. Not enough knowledge about diabetes.* (Mountain View Community)
- *Pediatric dental providers are real need unless you have insurance or pot of gold.* (Lebanon Community, Dallas County)
- *End of life care (emotional and social support) in both home care and in facilities is needed.* (Joplin Community, Crawford County)
- *With the aging population, we need adequate nursing homes or add one or two more. Mental and behavioral health issues (rather than medical health) for aging the population with Alzheimer's or dementia; not enough internal medicine/geriatric providers. Kids are moving away but old people are staying. Men are too proud to ask for help, especially with Alzheimer's or dementia.* (Mountain View Community, Howell County)
- *People who are trying to make an honest living, the working poor, can't afford health insurance and other help. Only excessively poor can get help.* (Lebanon Community, Texas County)
- *Universal healthcare in some form. Healthcare is a right up to a certain point. Our current system doesn't work for all.* (Lebanon Community, Douglas County)
- *We need an umbrella organization or community hub, like Healthy Nevada, that connects each service and has case managers.* (Joplin Community, Vernon County)
- *We need wider availability of all medical and dental services and give all people a means to access those services - make it easy to access re transportation, costs, etc. More affordable medications (i.e., for diabetes).* (Springfield Community, Christian County)

SOCIAL DETERMINANTS OF HEALTH

Maslow's original hierarchy of needs is still relevant today. In addition to shelter, food, clothing, and warmth remain essential for well-being. Just before the COVID-19 pandemic, the Urban Institute found that nearly 40 percent of American families struggled to meet at least one basic need for housing, utilities, or food, and this directly correlates to healthcare needs, both acute and chronic.

Housing. While the housing first model is espoused by many social service providers across the country, even those who are not directly engaged with this delivery feel that if an individual or family does not have a home, then the other social determinants of health are harder, or next to impossible, to attain.

Food. Healthy eating habits may be a choice, but barriers such as the cost of fresh fruit and vegetables, the inability to find transportation to purchase healthy food, the time to prepare healthy meals, cultural considerations, and others make this a more complex situation.

People leaving or not re-entering the workforce. One cannot separate these basic needs from the requirement of employment. The pandemic put a strain on many aspects of employment, and people have been afraid of being infected at work or not returning to the workforce. Among those not in the labor force as of September, 1.6 million people were prevented from looking for work due to the pandemic. Referring to the issues above and other Social Determinants of Health issues, community members had many insightful comments; several are shown below in order to illustrate the granular perspectives.

- *People break into abandoned houses; there is some stigma around vouchers, and many don't want to play by the rules; hard to find landlords right now. Usually twice a year (before school and after Christmas break) people move or relocate – this past year no one relocated; we have had people turn in vouchers because they couldn't find anything. We have a lot of homeless and has it increased.* (Joplin Community, Vernon County)
- *Food insecurity is one of the three main health issues in our area. The YMCA does a grocery grab weekly for kids in school, ages 3-18, but there's a gap through the farm to family food program. We should work with farmer's markets to provide families with a complete meal with fresh produce, recipes, videos how to prepare. Create a healthy mindset and that educate that healthy doesn't have to be expensive.* (Joplin Community, Vernon County)
- *Social determinants of health issues are the biggest that need to be addressed like housing and food. Healthcare is now coming together with public health, whereas before they were siloed.* (Springfield Community, Greene County)
- *Before COVID you could rent a house, but there's none. There's a one year waiting list for Section 8 and public housing with 200 units is about full. The housing market here is very slim; a lot of houses aren't suitable and are owned by slumlords.* (Joplin Community, Vernon County)
- *Homeless have a lot of unmet needs because no homeless shelter, but we do have a daytime shelter to shower, get food, get resources, etc. There's no place for homeless to sleep, so they have to keep walking. If they stop, the cops will tell them to move on. There are two shelters in Joplin where people may go at night, but not enough beds.* (Joplin Community, Cherokee County)

- *Homeless teens and homeless in general are a major problem. We have a lot of couch surfers or multifamily homes, not enough homes for growing community in Durham. The number of people without a permanent address is extremely staggering for kids in schools.* (Lebanon Community, Dallas County)
- *Homelessness is an issue and depends on how you define it – couch surfing is fairly rampant. If you look at the community from the outside, then you don't see it outright. People may be under a bridge, in abandoned houses, couch surfing.* (Joplin Community, Vernon County)
- *Childcare has long waited lists and limited access. It's expensive, especially with low pay. Head Start has a waiting list, at some point it will return to full capacity, but what to do in the meantime? The need outpaces the capacity even without COVID. Quality is also an issue. Some childcare programs closed during COVID and have not reopened. Personally, I do not trust outside of family to watch my youngest.* (Springfield Community)
- *Affordable housing is a problem. This is a poor community in general, but with COVID at the beginning the employers were paying people, but now they're not, including people in quarantine, so now first timers are visiting because they and their spouse are not getting paid. New faces show up to get services.* (Lebanon Community, Texas County)
- *We need double or triple classroom teacher staff. Academically there's not much correlation to student performance and class size, but on the social and emotional side much more needs to be addressed. Teachers need to be able to focus on fewer students. Teachers are feeling beat up due to masking, critical race theory debates, and polarization.* (Joplin Community, Jasper County)

THE CULTURE OF THE OZARKS

Almost every community research participant directly mentioned or alluded to what can generally be described as the culture of the Ozarks. The sense of community resiliency, independence, and caring for one's neighbors reflect the strong fabric of the region. This sense of independence was often given as a reason why some people have a mistrust of government institutions or others from outside of their local area (or not personally known to them). Some suggest that cultural aspects can be a great draw for some healthcare providers interested in the Ozarks lifestyle, yet it can pose challenges to recruiting and retaining healthcare providers in other instances. Due to the rural nature of many of the communities included in this study, the number of physicians and higher-level providers is severely lacking. An unstable healthcare provider base (as seen in many rural areas of the project research) may further foster ongoing trust issues between healthcare system providers and community members. Community members shared some insightful and very direct comments regarding these issues.

- *The culture of the Ozarks has distrust of medicine, even though I have a master's degree. Some of my ancestors were distrustful of doctors. We have a patriarchal view of the world.* (Mountain Community)
- *Send speakers into schools to talk to kids about building self-esteem and that there are ways out of poverty. Showcase local people who have risen above.* (Branson Community)
- *McDonald County has a very high and noticeable teen pregnancy rate, it's part of the culture. Get a hip nurse practitioner to get on social media and encourage education. There's an opportunity to work through churches to reduce teen pregnancy. We can't use term "family planning" because people hear "abortion," and many are against contraceptives. Abstinence and purity are good messages, but it's too late.* (Joplin Community, Newton County)
- *There is no consistency of care. Doctors come after residency for a few years then they leave when their term is done.* (Monett Community, Lawrence County)

- *Early on, about 50% of my staff refused to get vaccinated. Since then, they're at 80% vaccinated, but some employees don't want their friends and co-workers to know they received the vaccine, as they were initially so against it. Our company offered a private room for people who wanted to get vaccinated privately.* (Mountain View Community, Howell County)
- *The history of Joplin is a really rough town. It's a mining community–- lead and zinc mines. I think there is a lack of interest [in community pride, as well as health-related issues]. Not a ton of great industry to attract new people. It's heavily a trucking/transition industry.* (Joplin Community, Jasper & Newton Counties)
- *No industry when poultry company closed over 10 years ago. School system has been the biggest employer.* (Lebanon Community, Dallas County)
- *The Arkansas governor has been going around the state with a pop-up vaccine clinic and having conversations with the community. People can share their stories and help reverse how social media has influenced people in certain circles who won't look for other information. I heard a story about this on NPR. Doing it in person has a huge impact, according to the story.* (Mountain View Community)

HIGH-LEVEL COMMUNITY-FOCUSED ACTION AREAS & OBSERVATIONS

In addition to the community summaries below, there are certainly actions which flow naturally from the themes above. These are important to include in any planning response. The following High Level Action Areas are most representative of respondents' consensus in both the qualitative interviews and the focus group discussion. Comments and community summaries which follow beginning in the next section, include granular insight about each High-Level Action Area. Each community-level summary below includes some similar project level information regarding the total extent of the research so that individual community sections can be easily shared, if desired.

HIGH-LEVEL ACTION AREAS

PLEASE NOTE, THE ACTION AREAS ARE IN ALPHABETICAL NOT PRIORITIZED ORDER. EACH COMMUNITY-LEVEL SUMMARY BELOW INCLUDES SOME SIMILAR PROJECT LEVEL INFORMATION REGARDING THE TOTAL EXTENT OF THE RESEARCH SO THAT INDIVIDUAL COMMUNITY SECTIONS CAN BE EASILY SHARED, IF DESIRED.

REGIONAL INSIGHTS FROM THE BOLIVAR COMMUNITY

The Bolivar Community, consisting of Dade, Hickory, and Polk Counties, was also included in the scope of this process. Over the course of the assessment, engagement with certain communities was a challenge, and nowhere is that more evident than in the Bolivar Community. The timing of the CHNA occurred during the peak of the COVID-19 pandemic's delta variant spread which has had a significant impact on the Ozarks. Understandably, many of the professionals and organizations who may have been tapped to assist with CHNA efforts were overwhelmed and understaffed and focused on pandemic-related tasks. Qualitative analysis was unable to be conducted due to a lack of participants for either one-on-one stakeholder interviews or focus groups with residents living in the Bolivar Community. A small number of people who identified as either living or working in counties in the Bolivar Community participated in the online community survey as well as a one resident from a focus group in the broader area.

BOLIVAR COMMUNITY COMMENTS & IDEAS

Community Positives:

- Strong sense of community, strong school system.
- Giving and caring community with the resources they have. Good police chief.
- Tremendous growth in a lot of areas that seemed to be stagnant for over a decade, and it's encouraging. Downtown revitalization and coffee shops.

Housing & Homelessness:

- There are a lot of couch surfers or multifamily homes, not enough homes for growing community.
- The number of people without a permanent address are extremely staggering for kids in schools.
- Homeless teens and teens in general. Teens are homeless and couch surfing, may not have transportation, don't have transportation. Can give them nutrition education but they're not buying the food.

Behavioral Health Tratment & Services:

- There are more mental health issues. Isolation is hard, especially for the elderly. When the senior center closed, they lost friends either due to COVID or illnesses.
- There is stigma asking for help. Elderly have pride and don't want to ask for help.

Access to Healthcare:

- People need to choose between healthcare and other bills. Not much help for financial assistance and refer people to patient assistance program, but it's more work for primary care physicians.

Magic Wand Highlight:

- Fitness or activity or social place where people can gather in a cost-effective way, and the transportation to get there.

REGIONAL INSIGHTS FROM THE BRANSON COMMUNITY

Seven one-on-one interviews that lasted approximately 30 minutes in length were conducted. This provided the opportunity to have in-depth and private conversations about community-wide strengths, barriers to getting care, impacts of the COVID-19 pandemic, and ideas to improve their communities. Although an interview guide was used to help guide the conversation, participants were encouraged to speak about his or her particular areas of concern, interest, or experience. In addition, virtual focus group discussions were held in Toney and Stone Counties to allow regional voices to highlight challenges that they see as the biggest health-related needs facing the community.

Community members provided input from the following community organizations:

- Christian Action Ministries
- CoxHealth
- Elevate Branson
- Faith Community Health
- Gift of Hope
- MU Extension
- Ozarks Wellness Network
- Table Rock Chamber

BRANSON COMMUNITY COMMENTS & IDEAS

Top Challenges Identified:

- Access to Healthcare
- Housing & Homelessness

Community Positives:

- There is great community support. People are helping people and there are great school districts.
- There is legacy of servant leadership in community, people want to give back.

Housing & Homelessness:

- Housing is expensive, substandard, and unsafe.
- Topographically it's a hard and expensive area to build. The land is expensive, housing is expensive, housing problems, people live in converted extended stay motels that are substandard.
- Women sleep with duct tape around their clothes, so they won't be attacked.
- For homeless individuals, it’s very, very hard to get healthcare and food because they don't have identification.

Transportation & Broadband:

- Public transportation in Branson would be life changing. Everyone struggles with transportation and if this was addressed it would improve housing, food insecurity, jobs, and health.
- There is no public transportation in Branson. There is one taxi in town and it’s $20 a ride.
- Terrible broadband, even near major highways. Many people are older, and they can't use telehealth.
- Everyone struggles with transportation, and if this was addressed it would improve housing, food insecurity, jobs, and health.

Workforce:

- It's hard to "just get a job" especially for people with intellectual disabilities or if people are in fight or flight mode or, if they don't have good relationships with family.

Behavioral Health Tratment & Services:

- There are very little treatment options and very few therapists who work with children.
- Mental health issues for kids on the rise. There are no interactions with peers and few options for childcare and kids are home alone, even young kids.

Substance Use Treatment & Services:

- Our area has high percentage of people on drugs. Meth is big. If you have a record, it's hard to get housing, so people live in ex-tended stay hotels and drugs are prevalent – people can't get out of the cycle.
- There is no free help for substance abuse. Sometimes neighbors try to get clean themselves, they show up to church.

Access to Healthcare:

- Ninety percent of our patients are two times under poverty level. Two-thirds of the patients have multiple chronic conditions. People drop out of workforce so they could qualify for healthcare.
- Generationally poor people don't understand access or need for healthcare.
- Definitely access issues to physicians in county. More doctors are closer to hospital, which is about 45-minute drive. Older popula-tion in county and want physicians closer.
- The clinic operates on a shoestring budget, and they don't have marketing funds. There is constant turnover of people and em-ployees and it's tough to reach certain people. We could see 2 to 3 times the number of patients if people knew the clinic existed.

Access to Basic Needs:

- Knowledge of what to do with healthy food is the issue. Many think food is handed through a window. They get raw or canned fruits and veggies and frozen meats and don't know what to do with it when they take it home. They need education about how to cook healthy food.
- Health is a big issue for people living in poverty because they don't understand proper nutrition, do fast food and prepackaged foods. People have access to food, healthy food at farmer's markets, but don't know how to cook healthier foods.
- Many people who were laid off from tourism-related employment showed up for the first time at the food pantry.

Impact of COVID-19:

- Huge impact on people with substance abuse and those in recovery and many relapses due to lack of access, isolation, COVID-19 re-strictions.
- The health department can't be a part of anything besides COVID. They are such a resource but don't have capacity to deal with COVID-19 plus all other health issues.

Magic Wand Highlight:

- It's not a money situation, it's a heart situation. There is a Christian approach to dealing with healthcare. It's going to be a God-ordained solution when it happens. We need to find that right structure when it happens.
- Send speakers into schools to talk to kids about building self-esteem and that there are ways out of poverty. Showcase local people who have risen above.

REGIONAL INSIGHTS FROM THE JOPLIN COMMUNITY

Twenty-five (25) interviews that lasted approximately 30 minutes in length were conducted. This provided the opportunity to have in-depth and private conversations about community-wide strengths, barriers to getting care, impacts of the COVID-19 pandemic, and ideas to improve their communities. Although an interview guide was used to help guide the conversation, participants were encouraged to speak about his or her particular areas of concern, interest, or experience. In addition, three (3) virtual focus group discussions were held with local school districts and housing authorities, as well as other sectors of the Joplin community to allow regional voices to highlight challenges that they see as the biggest health-related needs.

Community members provided input from the following community organizations:

- 3M
- ACCESS Family Care
- Barton County Health Department
- Boys & Girls Club of Southwest Missouri
- Children's Center
- Community Health Center of Southeast Kansas
- Community Support Services of Missouri

- Eat Well
- Freeman Hospital System
- Freeman Technology Center
- Healthy Nevada
- Inter-Tribal Emergency Management
- Joplin R-8 School District
- Live Well, Crawford County
- McDonald County Coalition
- Neighborhood Adult Literacy Action
- Nevada Housing Authority
- Nevada R-5 & R-8 School Districts
- Parsons District Schools
- Refugee and Immigrant Services & Education
- Watered Gardens

JOPLIN COMMUNITY COMMENTS & IDEAS

Top Challenges Identified:

- Access to Healthcare
- Housing & Homelessness

Community Positives:

- Great culture of non-profits working together to avoid duplication.
- They're a shining light in Native healthcare community and they're doing the best they can.

Housing & Homelessness:

- The housing market here is very slim; a lot of houses aren't suitable and are owned by slumlords. People break into abandoned houses; some stigma around vouchers and many don't want to play by the rules; hard to find landlords right now.
- Homelessness is an issue and depends on how you define it – couch surfing is fairly rampant. If you look at the community from the outside, then you don't see it outright. People may be under a bridge, in abandoned houses, couch surfing.
- Crawford County is very poor. Homeless have a lot of unmet needs because no homeless shelter, but we do have a daytime shelter to shower, get food and get resources.
- Homeless, transient kids, and those who sleep on couches are a problem. There is not much housing availability in Pineville, so families move in with friends.
- There are two shelters in Joplin where people may go at night, but not enough beds.
- Major institutions have been closed, and by moving to a community-based model presents a challenge since people are limited to affordable and accessible housing.

Workforce:

- The history of Joplin is that it’s a really rough town. It's a mining community with lead and zinc mines. I think there is a lack of interest in community pride, as well as a health-related issues.
- Not a ton of great industry to attract new people

Behavioral Health Tratment & Services:

- More social and emotional support for kids in schools, preteens, more social workers to strengthen families.
- Mental health was huge issue before the pandemic, and it's still an issue - needs may be higher as pandemic has increased anxiety and depression. This has resulted in more domestic abuse, more drug and alcohol use, etc.

- We are seeing more kids with lack of direction, diagnoses, or lack of diagnoses when they should have one, in our programs.
- Slow growing anxiety, behaviors, autism since pandemic, but their area wasn't affected like east or west coast - they were back in school earlier.
- Social isolation a major problem especially for those with mental health disorders.
- Mental health was huge issue before the pandemic, and it's still an issue. The pandemic has increased anxiety and depression. This has resulted in more domestic abuse, more drug and alcohol use.

Access to Healthcare:

- Holistic health screening needed to understand where people are physically and mentally, then a decision tree afterwards to help them as best as they can.
- There's an opportunity to work through churches to reduce teen pregnancy. Anti-abortion is very high; we can't use term "family planning" because people hear "abortion," and many are against contraceptives. Abstinence and purity are good messages, but it's too late.
- Since COVID, we've seen increase in pulmonary issues and issues like needing inhalers and other breathing issues. We desperately need more inhalers.
- Food insecurity is one of the three main health issues in our area. The YMCA does a grocery grab weekly for kids in school ages 3 to 18, but there's a gap through farm to family food program.
- People want to be seen face to face. Midwestern culture thinks internet is for city people, not for them.
- End of life care, emotional and social support, in both home care and in facilities is needed.

Impact of COVID-19:

- Substance abuse has taken a back burner with COVID. Mental health is still playing its part, people are not receiving appropriate care.
- Physicians question whether they want to continue working. One surgeon who had COVID-19 and never felt like he recovered is quitting next month. Some nurses have walked away from nursing. We will see a major shift.
- Provider burnout was bad before COVID, but now it's worse. Resources are stressed and things are bad in Oklahoma, hospitals are full, we have COVID tents. COVID funding from the government comes with so many strings attached.

Magic Wand Highlight:

- Find a way to get to people who are falling through the cracks, those who have given up on their lives.
- Give everyone free training and education classes to help everyone get jobs and have a better life.
- Clean up homeless population, help them move in a different direction, get life, and work skills.

REGIONAL INSIGHTS FROM THE LEBANON COMMUNITY

Five (5) interviews that lasted approximately 30 minutes in length were conducted. This provided the opportunity to have in-depth and private conversations about community-wide strengths, barriers to getting care, impacts of the COVID-19 pandemic, and ideas to improve their communities. Although an interview guide was used to help guide the conversation, participants were encouraged to speak about his or her particular areas of concern, interest, or experience. In addition, a virtual focus group discussion was held in Dallas County to allow regional voices to highlight challenges that they see as the biggest health-related needs facing the community.

Community members provided input from the following community organizations:

- Dallas County Health Department
- Live Well Alliance, Dallas County
- Dallas County Resource Group
- Missouri Ozarks Community Health
- Texas County Food Pantry

LEBANON COMMUNITY COMMENTS & IDEAS

Top Challenges Identified:

- Access to Healthcare

Housing & Homelessness:

- Homeless teens and homeless in general are a major problem. We have a lot of couch surfers or multifamily homes, not enough homes for growing community in Durham. The number of people without a permanent address is extremely staggering for kids in schools.

Transportation & Broadband:

- No real public transportation in this rural area. There is a little bus, but it has limited hours and it's only within city limits. Hard for people to get to the bus station. No taxis, even though they have funding.

Workforce:

- People who work minimum wage or service jobs who don't make any money or don't have insurance. Parents work different shifts because they can't afford childcare; some people can't afford to work.
- We are losing a lot of public health people due to the stress. People do it for love of their community.

Substance Use Treatment & Services:

- Addiction is huge. Suicidal ideation of teenagers is growing, and the internet makes an impact, plus not being in school and no face-to-face interactions. Parents' addictions, spousal abuse, food inse-curity, housing, jobs – all impact behavioral health.

Access to Healthcare:

- People who are trying to make an honest living, the working poor can't afford health insurance and other help. Only excessively poor can get help.
- Affordable pediatric dental providers are needed unless you have insurance or pot of gold.
- We need to get all hands-on deck to provide phone lines and return calls to help people complete really long application forms as well as advocacy for changing payment structure, making it easier. Improving visibility in schools - being in touch with school leadership about services available.

Impact of COVID-19:

- Leadership in Jefferson City doesn't listen to public health leaders. There is a nonbelief of science, people need to try to have people have faith in programs like tobacco cessation and women's health).We need to work on trust.

Magic Wand Highlight:

- Set up public transportation system that's free and a very large radius beyond downtown.
- Continue partnerships, don't be afraid to reach out to county hospitals and other clinics to include them in discussions on how to improve services, not duplicate, improve access.

REGIONAL INSIGHTS FROM THE MONETT COMMUNITY

Six (6) one-on-one interviews that lasted approximately 30 minutes in length were conducted. This provided the opportunity to have in-depth and private conversations about community-wide strengths, barriers to getting care, impacts of the COVID-19 pandemic, and ideas to improve their communities. Although an interview guide was used to help guide the conversation, participants were encouraged to speak about his or her particular areas of concern, interest, or experience In addition, virtual focus group discussions were held to allow regional voices to highlight challenges that they see as the biggest health-related needs facing the community.

Community members provided input from the following community organizations:

- Cassville Chamber of Commerce
- Clark Community Mental Health Center
- Mercy Hospital, Aurora
- Mercy Hospital, Cassville
- Ozarks Area Community Action Corporation, Lawrence County

MONETT COMMUNITY COMMENTS & IDEAS

Top Challenges Identified:

- Behavioral Health Treatment & Services
- Transportation & Broadband

Housing & Homelessness:

- Lower income rentals simply aren't available anymore, so people get put up in hotels. People have jobs put kids with relatives and the parents work out of their cars.
- Housing costs have outpaced salaries. There are huge wait lists for lower cost rentals, and people are charging more for rent.
- Many people are displaced. There has always had a lot of homeless people, but they were more transitionally homeless. Now more locals are homeless , it’s harder to get healthcare and no homeless shelters.
- People have really good working relationships with service providers, but there are roadblocks like transportation.
- If you don’t have a safe place to live, how can you be healthy?

Transportation & Broadband:

- Small town with low socioeconomic status, limited public transportation and lucky that hospital is in town.
- If people don't have transportation, they don't get healthcare.
- People must reserve transportation to medical appts 24 to 48 hours in advance, and sometimes people can't do that.
- The low-income community has few resources to travel for healthcare due to unreliable transportation. They need more basic services in community, and to work with others to get more advanced care including appointments, transportation Mission Fund to help patients pay for services or equipment, but there's still a large gap and access to services. 35 to 45 minutes from Aurora to Springfield, but 1:15-1:25 from Cassville to Springfield.
- The low-income community has few resources to travel for healthcare due to unreliable transportation.

Workforce:

- Workforce is a problem and was before the pandemic, especially in mental health in rural conservative America due to stigma. Their mantra is that everyone has mental health needs.

- People are getting resourceful but it's tough on bottom line and fearful of future, many paid their employees even when business closed for a week.

Behavioral Health Tratment & Services:

- All roads lead to Wal-Mart, so the mental health centers in communities with Wal-Mart are busier. There is a correlation between rural towns with Wal-Marts and Dollar Stores and busier mental health clinics.
- It's taboo in some older generations to seek help for mental health. Younger generations are more open to getting help.
- Stigma to mental healthcare, and when support went digital, many people lost out.

Substance Use Treatment & Services:

- There are a lot of drugs like meth and prescription drugs, and few treatment options. People must pay cash to go rehab facility and few places for people to detox safely.
- There are no inpatient substance abuse facilities nearby, they're 50-60 miles away.
- We have money for mental health first aid training for adults and youth but having trouble getting people trained.

Access to Healthcare:

- People are frustrated and go without care.
- There is no consistency of care. Doctors come after residency for a few years then they leave when their term is done.

Safe & Affordable Childcare:

- Parents work different shifts because they can't afford childcare some people can't afford to work.
- State harps on unlicensed care, but everyone knows everyone in the community.

Impact of COVID-19:

- COVID-19 has impacted housing - landlords have contracted COVID and died, investors bought homes and kicked renters out and they have nowhere to go.
- Right away people stopped coming to emergency, maybe people realized that not all problems were emergencies, but others died of problems they didn't need to because they didn’t get care.
- People don't trust government, but it's a close-knit community so they don't necessarily mistrust the local healthcare providers who are friends or family members.

Magic Wand Highlight:

- Start a detox clinic; it would keep people out of emergency room, and it's really needed.
- Addressing housing issue, homeless. Keeping seniors stable with the pandemic. Coordination among service providers, under-standing how they function to best serve individuals.

REGIONAL INSIGHTS FROM THE MOUNTAIN VIEW COMMUNITY

Eleven (11) one-on-one interviews that lasted approximately 30 minutes in length were conducted. This provided the opportunity to have in-depth and private conversations about community-wide strengths, barriers to getting care, impacts of the COVID-19 pandemic, and ideas to improve their communities. Although an interview guide was used to help guide the conversation, participants were encouraged to speak about his or her particular areas of concern, interest, or experience. In addition, two (2) virtual focus group discussions were held with local rotary clubs and local health system leaders, as well as other sectors of the Mountain View community to allow regional voices to highlight challenges that they see as the biggest health-related needs.

Community members provided input from the following community organizations:

- Airvac Flight Team
- Atlantic Coast Dental
- Good Samaritan Care Clinic
- City of West Plains
- Mercy Hospital Foundation Board
- Missouri Rural Health Association
- West Plains Rotary
- HealthTran
- Ozarks Healthcare

MOUNTAIN VIEW COMMUNITY COMMENTS & IDEAS

Top Challenges Identified:

- Behavioral Health Treatment & Services
- Access to Healthcare

Community Positives:

- Close knit, unique communities, each with specific barriers and resources. Dedicated volunteers who help people in their community. Communities can adjust quickly to change.
- Great community of people to help others, great friends.
- People are helpful to fellow neighbor, raise money for people in healthcare crisis.

Transportation & Broadband:

- There is no broadband in rural areas, so telehealth is tough. Money came in to improve broadband, but companies decided where to put it.
- Telehealth is tough due to lack of broadband.

Behavioral Health Tratment & Services:

- There are not enough mental health inpatient beds, especially in rural areas. How do we transport them to a rural area which may or may not have beds?
- During lockdowns they had a spike in teen suicides and adults feeling overwhelmed. There is a massive sense of depression and isolation.
- It's natural to be depressed about the pandemic and the situa-tion, but people are now suffering from major depression.
- There’s a stigma to seeking psychiatric care. People have been suffering from mental health for years and haven't gotten care.

Substance Use Treatment & Services:

- Most liquor stores sold out of certain types of beer. The supply chain for alcohol was disrupted yet people were staying home and drinking more than ever.
- The primary drug is meth in lower income, rural areas. The hospital saw increase in drug overdoses.
- When people got a lump sum of money, they could buy more drugs and they overdosed. Overdoses make up a small percent of transport volume, but they still saw a noticeable increase.

Access to Healthcare:

- People tend to put their heads in the sand – don't get care since they don't want to know if something is wrong, or don't want the inconvenience.
- People don't have primary care providers. This is a very rural ar-ea, and the cost of gas is high. People wait until the last minute to get care or end up in the emergency room and let problems go longer than they should.

- Doctors are viewed with suspicion. People didn't go to doctors but used natural remedies. People don't have doctors, but those who have them trust them.
- If people aren't in pain, they don't come to dentist. Gum disease, which causes a lot of health issues, doesn't cause pain unless it's advanced.
- This is a very poor area so people can't afford healthcare. Fear is second biggest reason people don't get dental care.

Impact of COVID-19:

- People tend to put their heads in the sand – don't get care since they don't want to know if something is wrong, or don't want the inconvenience.
- People don't have primary care providers. This is a very rural ar-ea, and the cost of gas is high. People wait until the last minute to get care or end up in the emergency room and let problems go longer than they should.

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- If people aren't in pain, they don't come to dentist. Gum disease, which causes a lot of health issues, doesn't cause pain unless it's advanced.
- This is a very poor area so people can't afford healthcare. Fear is second biggest reason people don't get dental care.

Magic Wand Highlight:

- Spread empathy so people can see the cares and concerns of others. People need to realize not everyone is the same. Get rid of hatred and "foaming at the mouth." Buy social media and control messaging or turn off social media.
- One single source to schedule any type of transportation to anywhere for any reason.

REGIONAL INSIGHTS FROM THE SPRINGFIELD COMMUNITY

Twenty (20) one-on-one interviews that lasted approximately 30 minutes in length were conducted. This provided the opportunity to have in-depth and private conversations about community-wide strengths, barriers to getting care, impacts of the COVID-19 pandemic, and ideas to improve their communities. Although an interview guide was used to help guide the conversation, participants were encouraged to speak about his or her particular areas of concern, interest, or experience. In addition, three (3) virtual focus group discussions were held local health system leaders, community outreach organizations, and a local drug task force as well as other sectors of the Springfield community to allow regional voices to highlight challenges that they see as the biggest health-related needs.

Community members provided input from the following community organizations:

- Burrell Behavioral Health
- Christian County Health Department
- Christian County Library
- Christian County Neighborhood Center
- Community Partnership of the Ozarks
- Connecting Grounds
- CoxHealth
- First Baptist Church of Ozark
- Grupo Latinoamericano
- Jordan Valley Community Health Center
- Mercy Hospital Board
- Missouri State University
- Ozark Senior Center
- Ozarks Area Community Action Corporation
- PROMO
- Springfield Chamber of Commerce
- Southwest Drug Positioning Taskforce
- Springfield-Greene County Health Department

SPRINGFIELD COMMUNITY COMMENTS & IDEAS

Top Challenges Identified:

- Transportation & Broadband
- Access to Healthcare

Community Positives:

- The town and the county have excellent support from the Ozark Police, Sheriff, and Fire Department.
- Friendly people and everyone willing to help others in community.

Housing & Homelessness:

- Homeless or those without a fixed address use the library – it's one of the last spaces they can use and not spend money. Use library as space to hang out but not connect to other resources.
- It is difficult to afford housing if you have a criminal record and there is exploitation by the local motels.

Transportation & Broadband:

- Many rural or lower income residents don't have internet access. Broadband and internet are a problem, even for businesses.
- Electronics have been a disaster for seniors and people over 60, even cell phones. They don't know how to operate phones or computers. People have been trained to be leery of who is reaching out to them over computers, so they're scared to access healthcare over the computer, or even answer the door for people other than their housekeeper or caretaker.
- There is a lack of public transportation in rural areas and people may have to leave hours early for an appointment and there are delays. Medicaid supported transportation is not always reliable. The transportation options can be difficult to coordinate.
- Many people are using telehealth, but many want to see their doctors in person. There is spotty internet in Christian County and rural areas are bad.
- We've discovered new ways to provide services virtually, but we just need better internet access.

Workforce:

- Some businesses in Springfield have decent wages, there is a lack of job skills. Unemployment pays more and there is a lack of living wages.
- Legal histories can be a hinderance.

Behavioral health Tratment & Services:

- Depression and suicide rates are increasing in rural areas where people are isolated anyway. People still need human contact whether you're an introvert or an extrovert. Quarantine didn't help.
- There has been a slow process with reducing the stigma on mental health. The biggest barrier is silos with mental health and sub-stance use.
- COVID-19 has helped bring mental health and substance misuse in-to the 21st century and make it relevant This is an opportunity. Vir-tual treatment had a bit of a negative effect since people didn't have the connections and interactions.

Substance Use Treatment & Services:

- We need an increase in medical detox beds, i.e., people with high blood pressure, asthma who want to go through detox.
- People have detoxed in ways that aren't safe, i.e., being put in a hotel room and have a doctor check on them every few hours.

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Access to Healthcare:

- Providers are overburdened and understaffed and don't have time to provide individual care. It's hard to get people to work in healthcare in rural areas, physicians, community health workers, admin staff, dentists, psychiatrists.
- Medicaid recipients receiving transgender-related care, there are many restrictions and denied services. LGBTQ+ communities don't get preventative care, they are worried about what providers will say, especially for transgender men getting pap smears because they don't want to go into a women's care.
- Same sex couples get denied services. There is no holistic support or health support in Springfield to support transgender kids.
- It's bad and getting worse. There was a lack of healthcare, even before pandemic.

Safe & Affordable Childcare:

- Only wealthy families can access care for their kids in Springfield.
- Childcare has long waiting lists and limited access. It's expensive, especially with low pay. Head Start has a waiting list, at some point it will return to full capacity, but what to do in the meantime?
- Some childcare programs closed during COVID and have not reopened. The need outpaces the capacity even without COVID. Quality is also an issue.

Impact of COVID-19:

- The community has pulled together for shots and testing,
- Long term impacts on kids who have been home, fearful of their social skills. Helping Kids need eyes on them – they may put on a smile for the computer, but abuse may be unseen.

Magic Wand Highlight:

- People have to want to be helped, whether it's drugs, alcohol, etc. How do we do that? We don't have programs for homeless and others who want to be helped, like a halfway house, or freeway ministry.
- Change the culture of how we live. This starts with children and their families: cooking classes with healthy food, have the right support for their needs. Healthy culture and lifestyle, including mental health support. Education for disease states, how to avoid diabetes, obesity.

APPENDIX D-2

Stakeholder Interview Guide

OZARKS HEALTH COMMISSION
COMMUNITY HEALTH NEEDS ASSESSMENT 2022
STAKEHOLDER INTERVIEW GUIDE

INTRODUCTION & OBJECTIVE

Good morning [or afternoon]. My name is Tara Auclair [or Scott Good or Katelyn Michaud or Katelyn Malloy] from Crescendo Consulting Group. We are working with the Ozarks Health Commission and the [Springfield-Green County Health Department or other health department/community leader] to conduct the community health needs assessment.

The purpose of this call is to learn more about community strengths and resources, healthcare-related needs, ways that people generally seek services, ongoing impacts of the COVID-19 pandemic, and to collect your insights regarding service gaps and ways to better meet community needs.

Do you have any questions for me before we start?

To start with, please tell me a little about ways that you interact with the community and the populations your organization (or you) serves, if any.

ACCESS, AVAILABILITY, AND DELIVERY OF SERVICES

1. When you think of the good things about living in this community, what are some of the first things that come to mind? [PROBE: outdoor activities, lifestyle, strong sense of "family," other]

2. Generally, what are some of the challenges to living here?

3. When people have needs – healthcare-related, community services, or otherwise – who do they tend to turn to for assistance? [Prompts: friends and family, Town Hall, local Health Department, their doctor, churches, others]

4. To what degree do people struggle with getting appropriate healthcare, or other related issues? [PROBE: are there certain types of care that are more difficult to find?]

5. What would you say are the two or three most pressing healthcare-related needs?

6. How are people accessing care, for example, virtual, face-to-face?

7. To what degree are healthcare services equally available to all citizens? Are there any disparities in access to services based on economic, race / ethnicity, gender or other factors? If so, describe them.

COVID-19 IMPACTS

8. What impact has COVID-19 had on overall community health and specific issues related to services required to care for heart, lung, diabetes, oral health, cancer or other issues?

9. How has the pandemic affected mental health or substance misuse issues?

10. What impact has COVID-19 had on community well-being, social impacts, education, or the economy? Which of these do you think will be short-term effects (e.g., "After COVID is behind us, so will the effects") or long-term effects (e.g., "The impact will be long-lasting.")?

11. How do you think COVID-19 will impact health behaviors and how people interact with the healthcare system or providers, such as for screenings or routine services, vaccine perceptions, virtual healthcare, or others?

12. How, if at all, has COVID-19 affected trust of healthcare providers or systems and the public health system?

ENHANCING COMMUNICATIONS AND INFORMATION

13. To what degree do you think that the community at large is aware of the breadth of available services – COVID-related or other health-related) – in the area? What are the challenges to greater awareness and understanding of the availability of services and ways to access them? What might help overcome the challenges? What types of activities would best reach communities of color, people experiencing homelessness, people living with disabilities, or other diverse or hard-to-reach populations?

14. How do consumers generally learn about access to and availability of services in the area (e.g., on-line directory; social media; hotline; word of mouth)? What method tends to work the best or worst?

LOOKING FORWARD

15. What are some of the community-level actions that can be done to more equitably provide for community health and wellbeing? Are there any low hanging fruit that could be addressed quickly? What policies would you change or create to provide more equitable community health and well-being?

16. Health equity is an important consideration. How can you improve current services for marginalized or hard-to-reach populations in your community?

17. What organizations in the area provide services for individuals and families struggling with poverty, employment, addiction, and housing issues? What programs seem to be the most helpful?

18. Magic Wand Question: If money and resources weren't an issue, what is one thing you would do for your community?

ADDITIONAL INFORMATION

- Based on our conversation and your knowledge about the community, are there others that you suggest we speak with?
- We're going to reach out to others, and we'd appreciate your support.
- First, we're going to develop a brief online survey, and we'd like for you to share the link with your constituents.
- Also, we're going to plan some virtual focus groups, and we'd like for you to participate and/or help us invite individuals who you feel would provide value.
- Would you mind if we reach out to you to assist us with these items when the time is right?
- Thank you for your time today and continued support.

RESEARCHER NOTES

- Bring up each of the following topics and include prompts (subcategories) in the dialogue. Note comments and particular areas of emphasis. Include comparisons between topics where helpful, e.g., "So which do you think requires more attention: substance abuse education in schools or opioid abuse intervention among the homeless?"
- Not all topics will be covered with all interviewees. Discussion content will be modified to respond to interviewees' professional background and availability of time during the interview.

Your name is not going to be used and the responses will be aggregated with many more results.
[PROBE: Note discussion about the magnitude and severity of "high focus" needs.]

NEED PROMPTS	NOTES/COMMENTS
Chronic disease Services for adults Services for adolescents / children	
Substance Use Services for adults Services for adolescents / children	
Chronic disease Education / Early intervention Treatment / Access / Stigma Post-treatment support / care	
Chronic disease Education / Early intervention Treatment / Access / Stigma Post-treatment support / care	
Homeless services	
Alcohol Use Education / Early intervention Treatment / Access / Stigma Post-treatment support / care	
Access to care Transportation Insurance / financial Language barriers / cultural issues Wait times to see a provider	
Mental Illness and Trauma Informed Care	
Intellectual Disability	
Access to care (specify type: IP, OP, IOP, PHP)	
SDOH related issues	
Transitional Housing Access / Availability (i.e. Group Homes)	
Emergency Department Care Utilization, Quality, Reliance	
Geriatric Population Behavioral Health Dementia, Alzheimer's Disease Treatment / Access / Stigma	
[OTHER TO BE ADDED, AS NEEDED]	

APPENDIX D-3

Focus Group Moderator's Guide

OZARKS HEALTH COMMISSION
COMMUNITY HEALTH NEEDS ASSESSMENT 2022
FOCUS GROUP MODERATOR'S GUIDE

Beginning in 2006, the population in group quarters (GQ) was included in the ACS. Some types of GQ populations have age and sex distributions that are very different from the household population. The inclusion of the GQ population could therefore have a noticeable impact on demographic distribution. This is particularly true for areas with a substantial GQ population (like areas with military bases, colleges, or jails).

INTRODUCTION

- Welcome participants and introduce yourself. Thank you for taking the time to join us for this important discussion. My name is {NAME} and I work for Crescendo Consulting Group.
- Explain the general purpose of the discussion. As mentioned in your invitation, we are working with the Ozark Health Commission and the City of Springfield to evaluate regional health needs. The purpose of this meeting is to learn more about your insights regarding the community, gaps you've identified, and ways to better meet community needs.
- Explain the necessity for notetaking and recording. We're taking notes and recording the session to assist us in recalling what you say. We will describe our discussion in a written report; however, individual names will not be used. Please consider what you say and hear here to be confidential.
- Describe protocol for those who have not been to a group before. For those of you who have not participated in a focus group before, the basic process is that I will ask questions throughout our session, however, please feel free to speak up at any time. In fact, I encourage you to respond directly to the comments other people make. If you don't understand a question, please let me know. We are here to ask questions, listen, and make sure everyone has a chance to share and feels comfortable. Please be respectful of the opinions of others.
- Seek participants' honest thoughts and opinions. Honest opinions are the key to this process, and there are no right or wrong answers to the questions. I'd like to hear from each of you and learn more about your opinions, both positive and negative.
- Questions? Do you have any questions for me before we start?

ACCESS, AVAILABILITY, AND DELIVERY OF SERVICES

19. When you think of the good things about living in this community, what are some of the first things that come to mind? [PROBE: outdoor activities, lifestyle, strong sense of "family," other]
20. Generally, what are some of the challenges to living here?
21. When people have needs – healthcare-related, community services, or otherwise – who do they tend to turn to for assistance? [Prompts: friends and family, Town Hall, local Health Department, their doctor, churches, others]
22. To what degree do people struggle with getting appropriate healthcare, or other related issues? [PROBE: are there certain types of care that are more difficult to find?]
23. What would you say are the two or three most pressing healthcare-related needs?
24. How are people accessing care, for example, virtual, face-to-face?
25. To what degree are healthcare services equally available to all citizens? Are there any disparities in access to services based on economic, race / ethnicity, gender or other factors? If so, describe them.

COVID-19 IMPACTS

26. What impact has COVID-19 had on overall community health and specific issues related to services required to care for heart, lung, diabetes, oral health, cancer or other issues? How has the pandemic affected mental health or substance misuse issues?
27. What impact has COVID-19 had on community well-being, social impacts, education, or the economy? Which of these do you think will be short-term effects (e.g., "After COVID is behind us, so will the effects") or long-term effects (e.g., "The impact will be long-lasting.")?

28. How do you think COVID-19 will impact health behaviors and how people interact with the healthcare system or providers, such as for screenings or routine services, vaccine perceptions, virtual healthcare, or others?
29. How, if at all, has COVID-19 affected trust of healthcare providers or systems and the public health system?

ENHANCING COMMUNICATIONS AND INFORMATION

30. To what degree do you think that the community at large is aware of the breadth of available services – COVID-related or other health-related) – in the area? What are the challenges to greater awareness and understanding of the availability of services and ways to access them? What might help overcome the challenges? What types of activities would best reach communities of color, people experiencing homelessness, people living with disabilities, or other diverse or hard-to-reach populations?
31. How do consumers generally learn about access to and availability of services in the area (e.g., on-line directory; social media; hotline; word of mouth)? What method tends to work the best or worst?

LOOKING FORWARD

32. What are some of the community-level actions that can be done to more equitably provide for community health and wellbeing? Are there any low hanging fruit that could be addressed quickly? What policies would you change or create to provide more equitable community health and well-being?
33. Health equity is an important consideration. How can you improve current services for marginalized or hard-to-reach populations in your community?
34. What organizations in the area provide services for individuals and families struggling with poverty, employment, addiction and housing issues? What programs seem to be the most helpful?
35. Magic Wand Question: If money and resources weren't an issue, what is one thing you would do for your community?

Thank you for your time today and continued support!

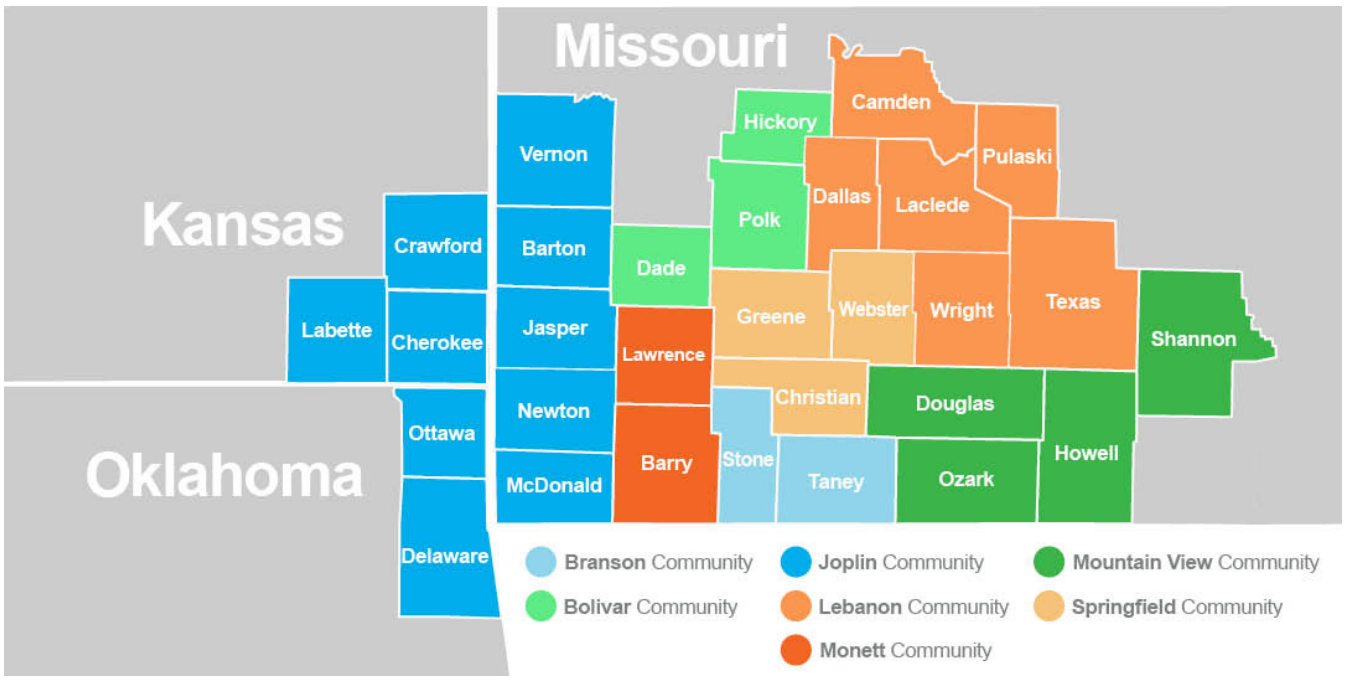
APPENDIX D-4

Community Survey Results & Highlights

OZARKS HEALTH COMMISSION
COMMUNITY HEALTH NEEDS ASSESSMENT 2022

The community survey was broadly disseminated by Ozarks Health Commission and other project leaders throughout the approximately 30 county (seven "community") region. In total, 2,638 individuals participated in the survey. The purpose of the survey was to garner quantifiable insights from each community regarding prioritized health-related needs, the impact of COVID-19, and other communications and service use issues. The community survey summary below includes highlights and insights of survey results.

OHC COMMUNITIES

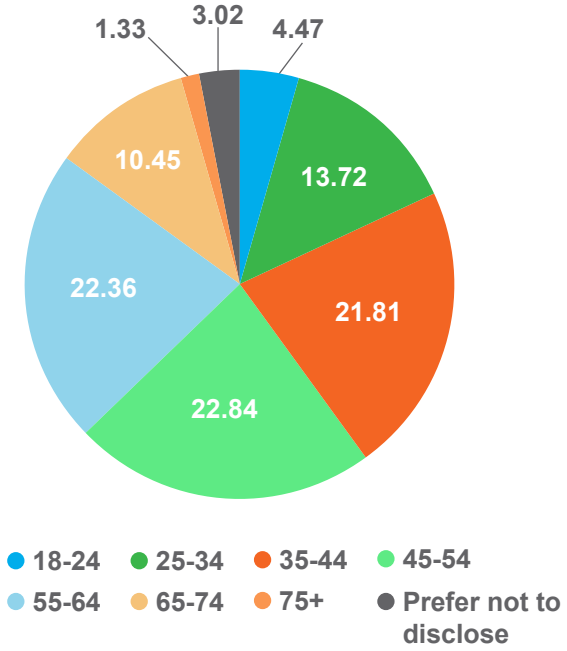


SURVEY RESPONDENT PROFILE & DEMOGRAPHICS

DEMOGRAPHIC BREAKDOWN

The community survey was available electronically through an online platform, as well as paper -based in both English and Spanish. Most survey respondents, (99.7%) chose to take the survey in English and most respondents (89.20%) were Caucasian / White. The majority of the respondents were females (79.32%), and two-thirds (67.01%) were within the three 35 to 64 age groups – though, there was notable representation of younger and older community members.

AGE GROUPS



DEMOGRAPHIC BREAKDOWN

	Percent of respondents
Gender	
Male	17.11
Female	79.32
Non-binary	0.67
Other	0.06
Prefer not to disclose	2.84
Age Groups	
18 to 24	4.47
25 to 34	13.72
35 to 44	21.81
45 to 54	22.84
55 to 64	22.36
65 to 74	10.45
75 or older	1.33
Prefer not to disclose	3.02

The survey included responses from a well-disperse array of community members based on educational attainment and annual household income.

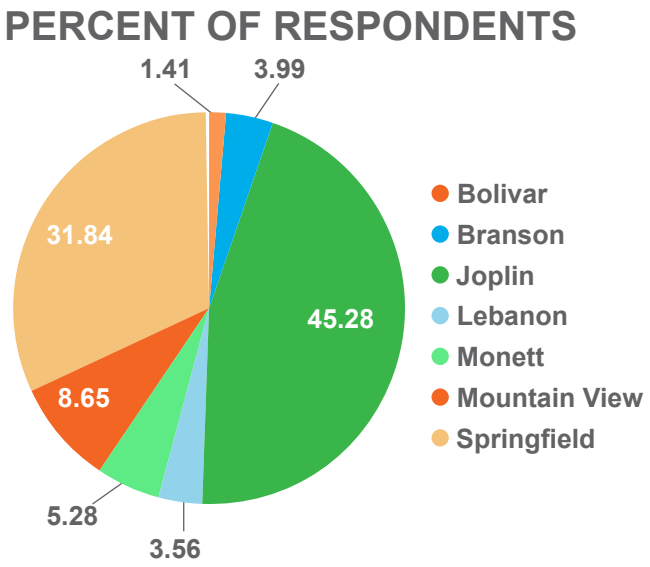
	Percent of Respondents
Educational Attainment	
Less than high school	0.30
Graduated high school	6.89
Some college or vocational training	18.32
Completed a 2-year college degree or a vocational training program	14.09
Graduated college (4-year bachelor's degree)	28.11
Completed Graduate or Professional school (Masters, PhD, etc.)	29.32
Prefer not to disclose	2.96
Annual Household Income	
Less than $25,000	7.52
$25,001 to $50,000	24.61
$50,001 to $75,000	18.18
$75,001 to $100,000	17.27
More than $100,000	21.27
Prefer not to disclose	11.15
Housing Status	
Rent	17.65
Own	78.35
Staying with friends	3.75
Unhoused	0.25

- Approximately one in four (25.51%) respondents indicate that they have less than a 2-year college degree or vocational training. Over half of the respondents say that they have a bachelor's degree or more education.
- Similarly, approximately half have annual household income under $75,000 (with approximately one-third, 32.13%, under $50,000); one half earn over $75,000. Most (78.35%) own their own home. The median income of survey participants is slightly higher than the regional averages, yet it reflects similar variations within income categories.

There was survey representation from each of the seven communities, yet Joplin and Springfield respondents comprised more than three-fourths (77.12%) of the survey total.

	Percent of Respondents
Community	
Bolivar	1.41
Branson	3.99
Joplin	45.28
Lebanon	3.56
Monett	5.28
Mountain View	8.65
Springfield	31.84

- Given the varying numbers / percentages of respondents by community, needs analyses and other information in these report sections are broken out by community, where helpful, and community-level insights are noted.
- Even though many participants are from the Joplin or Springfield communities, several of the more rural communities are well represented in the survey responses



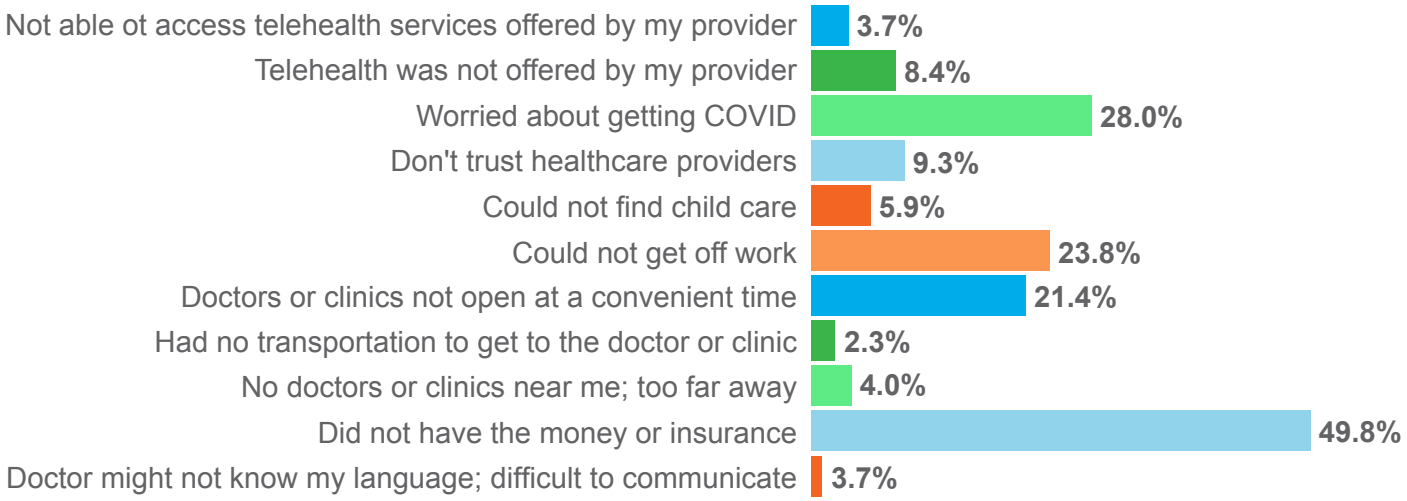
USE OF HEALTH-RELATED SERVICES

ROUTINE MEDICAL CARE

A very high percentage (91.45%) of respondents have a family doctor, family dentist, family health center, or clinic for regular or annual medical or dental care. However, nearly one-third (30.61%) of people who needed care in the past year chose NOT to receive care.

REASON FOR NOT GETTING NEEDED CARE

Percent of respondents



- The most common reasons were financial issues (half of those who chose not to seek needed care) and COVID-19-related issues (identified by approximately 28 percent of those who chose not to seek needed care).
- Timing and access to care issues (i.e., “Could not get off work” and “Doctors or clinics not open at a convenient time”) were each noted by approximately one-fourth of those who chose not to seek needed care.

HEALTH BEHAVIORS DURING COVID-19

Specifically, respondents note that exercise and dietary habits have worsened during the pandemic. Two-thirds say that social isolation has worsened. Social isolation – as demonstrated in nationally reviewed research – leads to increased behavioral health issues, more acute chronic disease, and other factors. High priority communities (e.g., Hispanic communities, LGBTQ+, seniors, and others) are more widely impacted.

Do you think that the COVID-19 pandemic has changed any of your following health behaviors?				
Behaviors	**Improved**	**Worsened**	**No change**	**Not sure**
Exercise	15.8	40.0	41.8	2.4
Diet	14.5	42.7	40.7	2.1
Tobacco use	1.4	11.6	82.9	4.2
Alcohol use	2.1	16.7	78.0	3.2
Social isolation	2.1	66.0	29.1	2.8
Use of illicit drugs, such as marijuana, meth, heroin, etc.	.3	7.8	87.4	4.5

PRIORITIZED RANKED NEEDS
Based on the community survey responses, basic needs (i.e., affordable, quality childcare; affordable housing), behavioral health (e.g., mental health, crisis care, substance use care), and the process of care (e.g., care coordination and integrated care) are the most highly prioritized needs.

GENDER COMPARISON
Males and females similarly rank the leading community needs. However, females tend to rate each need (i.e., the “P Percent saying "Very Needed”) more highly than males.

Prioritized Community Survey Needs				
Percent saying "Very Needed"				
Needs	**Total**		**Male**	**Female**
Affordable, quality childcare	70.37		57.46	73.34
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adolescents and children	70.30		55.34	73.55
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adults	66.73		52.24	69.80
Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking or actions, self-harm, or harm to others	64.93		50.38	68.20
Affordable housing	64.14		53.79	66.72
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97		51.34	65.65
Integrated care, or where people can get medical care and counseling at the same time	60.86		45.25	64.47
Drug and other substance abuse education, prevention, and early intervention services	60.54		51.72	62.76
Social services (other than healthcare) for people experiencing homelessness	57.58		48.66	59.80
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15		45.38	59.87

AGE GROUP COMPARISONS

The overall ranking of high priority needs is fairly consistent across age groups. However, young and middle age adults tend to rate each community need more highly than younger or older respondents.

Prioritized Community Survey Needs Percent saying "Very Needed"										
			What is your age?							
Needs	**Total**		**18 - 24**	**25 - 34**	**35 - 44**	**45 - 54**	**55 - 64**	**65 - 74**	**75 or older**	**Prefer not to dis-close**
Affordable, quality childcare	70.37		67.61	79.17	76.74	68.61	65.34	66.05	57.14	60.00
Counseling services for mental health issues such as depression, anxiety, trauma, or others for ad-olescents and children	70.30		69.01	75.00	80.34	71.03	65.61	59.49	36.84	53.49
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adults	66.73		69.12	70.75	75.99	67.40	61.47	56.79	36.84	53.49
Emergency mental health services for issues such as suicidal thinking or actions, hom-icidal thinking or actions, self-harm, or harm to others	64.93		72.46	66.19	73.28	67.42	59.38	56.69	36.84	48.84
Affordable housing	64.14		68.06	69.90	64.88	60.81	68.31	58.39	45.00	46.51

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"										
			What is your age?							
Needs	**Total**		**18 - 24**	**25 - 34**	**35 - 44**	**45 - 54**	**55 - 64**	**65 - 74**	**75 or older**	**Prefer not to dis-close**
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97		63.38	68.08	70.38	64.07	59.89	54.49	28.57	44.19
Integrated care, or where people can get medical care and counseling at the same time	60.86		61.76	65.71	66.76	61.14	56.29	55.41	33.33	48.78
Drug and other substance abuse education, prevention, and early intervention services	60.54		63.38	65.09	66.09	61.33	58.52	55.13	21.05	40.91
Social services (other than healthcare) for people experiencing homelessness	57.58		66.18	62.38	60.60	55.52	56.93	51.27	56.25	39.02
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15		65.22	60.10	59.54	56.23	56.13	55.63	36.84	41.03

- Young respondents (ages 18-24) rate “Emergency mental health services” (i.e., Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking) as their highest priority need. Among older seniors (ages 75 and older) affordable housing is an especially important issue, as they rank it as the second most needed community issue.

RACE COMPARISONS

The prioritized list of community needs is very similar among Whites / Caucasians and Black / African Americans. However, Black / African Americans tend to rank “Healthcare services for people experiencing homelessness” and “Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking” more highly than Whites / Caucasians.

Needs	Total	Black / African American	White / Caucasian
Affordable, quality childcare	70.37	72.22	70.34
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adolescents and children	70.30	77.78	70.29
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adults	66.73	77.78	66.67
Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking or actions, self-harm, or harm to others	64.93	88.89	64.71
Affordable housing	64.14	77.78	65.18
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97	72.22	63.11
Integrated care, or where people can get medical care and counseling at the same time	60.86	72.22	61.27
Drug and other substance abuse education, prevention, and early intervention services	60.54	72.22	60.54
Social services (other than healthcare) for people experiencing homelessness	57.58	58.82	57.84
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15	66.67	57.71

ANNUAL HOUSEHOLD INCOME COMPARISONS

The ranked list of community needs is similar across all income levels with a few exceptions. Affordability issues are critically important among people making less than $50,000 while they are important, but less so, among higher income groups. Note that ranking based on educational attainment largely mirror the income-related rankings.

Prioritized Community Survey Needs Percent saying "Very Needed"							
(Top 12 noted instead of 10)		Which of the following ranges best describes your total annual household income in the last year?					
Needs	**Total**	**Less than $25,000**	**$25,001 to $50,000**	**$50,001 to $75,000**	**$75,001 to $100,000**	**More than $100,000**	**Prefer not to disclose**
Affordable, quality childcare	70.37	64.17	72.44	73.36	68.38	72.37	64.29
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adolescents and children	70.30	65.25	72.63	73.52	69.40	72.40	59.39
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adults	66.73	67.83	69.51	67.47	64.00	68.53	59.04
Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking or actions, self-harm, or harm to others	64.93	65.22	66.49	68.99	61.89	64.90	58.79
Affordable housing	64.14	70.43	75.20	68.61	54.92	59.34	50.31
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97	57.63	66.15	66.90	55.02	69.94	51.83
Integrated care, or where people can get medical care and counseling at the same time	60.86	59.48	64.15	63.41	55.26	63.39	54.27

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"								
(Top 12 noted instead of 10)			Which of the following ranges best describes your total annual household income in the last year?					
Needs	**Total**		**Less than $25,000**	**$25,001 to $50,000**	**$50,001 to $75,000**	**$75,001 to $100,000**	**More than $100,000**	**Prefer not to disclose**
Drug and other substance abuse education, prevention, and early intervention services	60.54		61.02	63.45	66.31	53.33	62.72	51.20
Social services (other than healthcare) for people experiencing homelessness	57.58		62.83	62.67	59.12	55.00	57.36	44.44
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15		54.78	59.73	58.25	53.28	59.52	53.37
Healthcare services for people experiencing homelessness *	56.39		60.36	62.30	58.52	54.79	52.58	47.40
Affordable healthcare services for people or families with low income *	56.25		70.34	64.84	55.79	48.50	50.59	50.00

- Affordable housing is the greatest community need among people in households making less than $50,000 per year. In addition, affordable healthcare services is equally important as affordable housing among people in households making less than $25,000.

COMMUNITY COMPARISONS

There is notable variation between communities regarding prioritized rankings of needs. Across all communities, mental health-related needs are highly ranked. There is greater variation between communities with regard to basic needs (e.g., affordable housing and/or healthcare) and substance use-related issues / needs.

Prioritized Community Survey Needs Percent saying "Very Needed									
			Community						
Needs	**Total**		**Bolivar**	**Branson**	**Joplin**	**Lebanon**	**Monett**	**Mountain View**	**Springfield**
Affordable, quality child-care	70.37		42.86	80.33	69.93	57.89	62.65	67.94	74.75
Counseling services for mental health issues such as depres-sion, anxiety, trauma, or others for ad-olescents and children	70.30		68.18	64.52	68.43	63.79	56.63	66.92	77.71
Counseling services for mental health issues such as depres-sion, anxiety, trauma, or others for adults	66.73		50.00	60.94	64.21	65.52	58.54	62.22	74.80
Emergency mental health services for is-sues such as suicidal think-ing or actions, homicidal thinking or actions, self-harm, or harm to others	64.93		61.90	58.73	62.46	60.71	66.27	54.62	72.58
Affordable housing	64.14		61.90	69.84	63.66	58.93	55.70	54.26	68.96

Prioritized Community Survey Needs, cont. Percent saying "Very Needed									
			Community						
Needs	**Total**		**Bolivar**	**Branson**	**Joplin**	**Lebanon**	**Monett**	**Mountain View**	**Springfield**
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97		70.00	66.67	61.32	61.40	67.47	66.67	63.45
Integrated care, or where people can get medical care and counseling at the same time	60.86		60.00	62.30	60.06	60.34	63.29	57.89	62.96
Drug and other substance abuse education, prevention, and early intervention services	60.54		70.00	68.85	58.31	55.17	60.98	64.44	62.42
Social services (other than healthcare) for people experiencing homelessness	57.58		52.17	60.66	57.92	46.43	53.85	53.23	60.12
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15		57.14	58.73	57.95	55.56	60.49	54.14	57.08

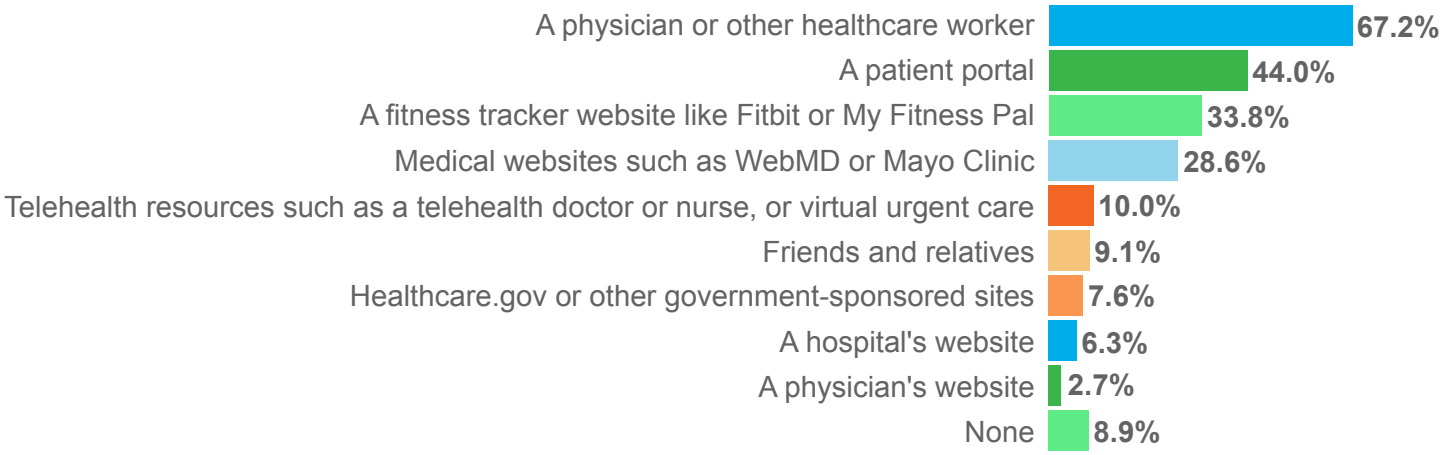
- Joplin and Springfield (the two most populous communities) have nearly identical needs rankings (both similar to the survey totals). Drug / substance misuse issues are more highly ranked in rural counties such as Bolivar, Branson, Monett, and Mountain View compared to other communities.
- Affordable, quality childcare is a leading need in four of seven communities – Joplin, Springfield, Branson, Mountain View. In Bolivar, Lebanon, and Monett, it is “middle of the group” or lower.

SOURCES OF INFORMATION AND DECISION MAKING

HEALTH INFORMATION SOURCES

In order to track or find out about one's personal health, more formal medical provider relations are the most commonly noted – a physician or healthcare worker or patient portal. Medical websites such as WebMD and similar channels are used by approximately one-quarter of respondents.

SOURCES USED TO FIND OUT ABOUT YOUR OWN HEALTH OR TO MONITOR YOUR OWN HEALTH

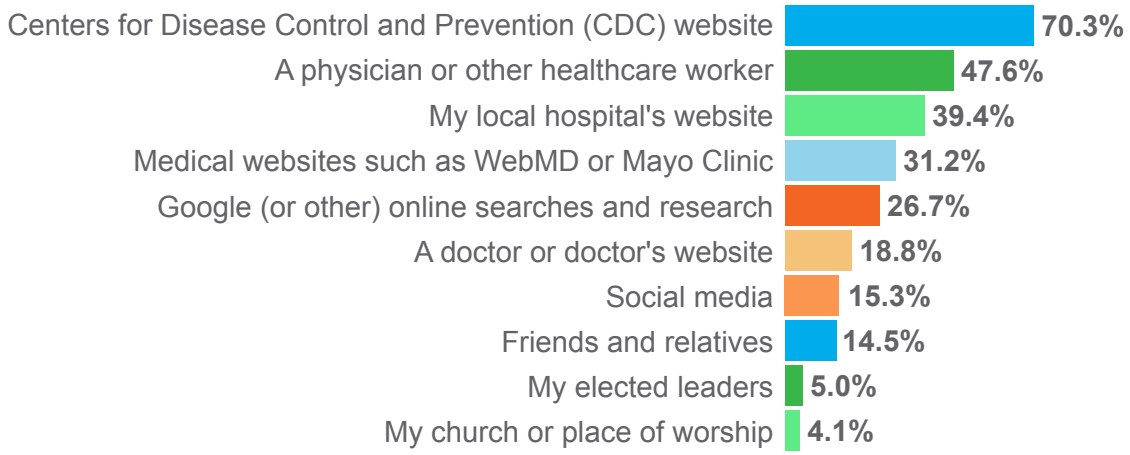


- Two-thirds of respondents name a physician or other healthcare worker as a source used to monitor their own health.
- One-third of respondents indicate that they use a fitness tracker or similar wearable device.
- Very few (e.g., fewer than eight percent each) say that they use websites (other than WebMD or similar sites) – Healthcare.gov, a hospital website, or a physician's website.

SOURCES OF PANDEMIC-RELATED INFORMATION

For COVID-19-related information, the large majority of respondents turn to the U.S. CDC for information. Other sources – including physicians or other healthcare workers – are noted by approximately half as many or fewer respondents.

WHAT SOURCES DO YOU TURN TO OR READ TO LEARN ABOUT THE COVID-19 PANDEMIC OR VACCINES?



- For seven out of ten people seeking COVID-19 or vaccination information, they reference the U.S. CDC.
- A relatively small percentage (14% to 19%) get their information from social media, a doctor's website, or family and friends.
- Though not displayed above, there is little variation between communities.

VACCINATION

There is an apparent sense of altruism or community wellness among people getting vaccinated against the COVID-19 virus, as two of the three most common reasons why they got the vaccine related to concern for others or the greater community. Respondents indicate that politics, religious guidance, and workplace requirements had little impact.

Reason Why People Got Vaccinated	Percent of Respondents
I'm concerned about the health of my family and friends	83.5
I'm concerned about my health	76.1
I care about the health of the greater community, or it seems like the right thing to do	73.6
I want to start enjoying life again	51.5
Healthcare provider's advice	37.2
Workplace requirement	17.6
Politics or elected officials' comments and guidance	3.1
Religious leaders' guidance or comments	3.1

Among those choosing NOT to get vaccinated, one's "personal choice" and "concern about side effects" were the most common reasons for not doing so. There was also a notable percentage who did not get the vaccine because they do not trust the government (42.9% of respondents choosing not to get the vaccine) or do not trust the science (31.4%).

Reason Why People Chose Not to Vaccinated	Percent of Respondents
My personal choice	79.0
I'm concerned about side effects (long-term or short-term) of the vaccine	78.1
I believe there are other, effective ways to avoid getting COVID-19 or to treat it	47.1
I do not trust the government	42.9
I do not trust the science	31.4
Political party or elected officials' comments and guidance	7.1
Religious leaders' guidance or comments	5.7
Family or friends are against it	5.2

Survey Language Preference	
Selection	**Percent of respondents**
English	99.70
Spanish	0.30

Race	Percent of Respondents
Black or African American	**1.1**
American Indian and Alaska Native	**3.3**
Asian	**0.8**
Caucasian/White	**89.2**
Hispanic or Latino	**1.6**
Native Hawaiian and Other Pacific Islander	**0.2**
Two or More Races	**1.0**
Other	**0.5**
Prefer not to disclose	**5.9**

Do you have a place where you go for regular or annual medical or dental care?	
Selection	**Percent of respondents**
Yes, family doctor, family dentist, family health center, or clinic	91.45
Yes, emergency room	0.25
Walk-in urgent care	2.00
No	5.11
I do not get care even when I need it	1.19

SEEKING CARE AND REASONS FOR NOT SEEKING CARE

In the past 12 months, have there been times when you needed medical help but chose NOT to seek it?	
Selection	**Percent of respondents**
Yes	30.61
No	66.79
Not sure	2.60

PRIORITIZED NEEDS – TOTAL LIST BY CATEGORY

Prioritized Community Survey Needs Percent saying "Very Needed"			
Needs	**Total**	**Male**	**Female**
Affordable, quality childcare	70.37	57.46	73.34
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adolescents	70.30	55.34	73.55
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adults	66.73	52.24	69.80
Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking or actions, self-harm, or harm to others	64.93	50.38	68.20
Affordable housing	64.14	53.79	66.72
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97	51.34	65.65
Integrated care, or where people can get medical care and counseling at the same time	60.86	45.25	64.47
Drug and other substance abuse education, prevention, and early intervention services	60.54	51.72	62.76
Social services (other than healthcare) for people experiencing homelessness	57.58	48.66	59.80
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15	45.38	59.87
Healthcare services for people experiencing homelessness	56.39	47.35	58.21
Affordable healthcare services for people or families with low income	56.25	48.87	57.72
Access to dental services	55.08	41.76	57.76
Case workers or navigators to help people with chronic diseases (diabetes, cancer, asthma, etc.) get the needed care	53.39	43.13	55.65
Long-term care or dementia care	53.20	44.84	55.09
Services to help people learn about, and enroll in, programs that help with financial support for people needing healthcare	52.67	47.17	54.00
Regular, convenient places to buy affordable, nutritious food	49.55	36.90	52.41
Services or education to help reduce teen pregnancy, adolescent services, or sex education	48.87	45.56	49.87
Healthcare for seniors	48.06	41.50	49.20

PRIORITIZED NEEDS – TOTAL LIST BY CATEGORY, CONT.

Prioritized Community Survey Needs Percent saying "Very Needed"				
Needs	**Total**		**Male**	**Female**
Parenting classes	47.87		43.97	49.28
Transportation services for patients AFTER receiving services	46.34		40.51	47.98
Transportation services for people needing to go to doctor's appointments or the hospital	46.34		36.82	48.85
Access to your preferred housing situation -- location, size of home, access to services, Americans with Disabilities Act	45.68		35.62	47.47
Programs for diabetes prevention, awareness, and care	44.53		43.30	45.03
Programs for obesity prevention, awareness, and care	43.71		44.11	44.14
Transportation services for people needing to go out of town for healthcare services or appointments	43.66		34.25	45.83
Job training (or, re-training)	43.28		41.54	44.64
Food services such as food pantries, soup kitchens, or a backpack program	42.66		35.21	44.12
Pediatric / child health services	40.72		42.25	40.12
General public transportation	40.46		29.69	42.86
Programs to help people stop smoking	40.07		40.00	40.20
Women's health services (OB/GYN)	38.68		34.31	39.28
Primary healthcare services (such as a family doctor or other provider of routine care)	37.19		35.23	37.69
Urgent care services (that is, walk-in care for immediate health needs not requiring the Emergency Department	36.27		32.95	36.92
Increased neurology, or brain, care	35.60		30.58	36.88
Men's health services	32.94		27.95	33.80
Emergency care and trauma services	31.99		25.95	33.42
Programs for heart health or cardiovascular health	31.43		31.52	31.62
An easy and close place to buy prescription drugs, when needed	30.73		23.19	32.69

AGE GROUP COMPARISONS

Prioritized Community Survey Needs Percent saying "Very Needed"									
		What is your age?							
Needs	**Total**	**18 to 24**	**25 to 34**	**35 to 44**	**45 to 54**	**55 to 64**	**65 to 74**	**75 or older**	**Prefer not to disclose**
Affordable, quality childcare	70.37	67.61	79.17	76.74	68.61	65.34	66.05	57.14	60.00
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adolescents	70.30	69.01	75.00	80.34	71.03	65.61	59.49	36.84	53.49
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adult	66.73	69.12	70.75	75.99	67.40	61.47	56.79	36.84	53.49
Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking or actions, self-harm, or harm to others	64.93	72.46	66.19	73.28	67.42	59.38	56.69	36.84	48.84
Affordable housing	64.14	68.06	69.90	64.88	60.81	68.31	58.39	45.00	46.51
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97	63.38	68.08	70.38	64.07	59.89	54.49	28.57	44.19
Integrated care, or where people can get medical care and counseling at the same time	60.86	61.76	65.71	66.76	61.14	56.29	55.41	33.33	48.78
Drug and other substance abuse education, prevention, and early intervention services	60.54	63.38	65.09	66.09	61.33	58.52	55.13	21.05	40.91
Social services (other than healthcare) for people experiencing homelessness	57.58	66.18	62.38	60.60	55.52	56.93	51.27	56.25	39.02
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15	65.22	60.10	59.54	56.23	56.13	55.63	36.84	41.03
Healthcare services for people experiencing homelessness	56.39	72.06	58.33	58.56	54.57	54.68	54.19	56.25	42.11

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"									
		What is your age?							
Needs	**Total**	**18 to 24**	**25 to 34**	**35 to 44**	**45 to 54**	**55 to 64**	**65 to 74**	**75 or older**	**Prefer not to disclose**
Affordable healthcare services for people or families with low income	56.25	73.61	55.92	60.40	53.65	54.70	53.33	45.00	47.50
Access to dental services	55.08	52.94	47.83	55.87	54.11	60.29	61.88	31.58	40.00
Case workers or navigators to help people with chronic diseases (diabetes, cancer, asthma, etc.) get the needed care	53.39	60.29	57.84	55.56	51.01	54.34	50.94	15.00	40.00
Long-term care or dementia care	53.20	50.77	54.59	51.71	55.49	56.60	50.63	45.00	32.50
Services to help people learn about, and enroll in, programs that help with financial support for people needing healthcare	52.67	60.56	53.99	56.20	51.56	52.84	45.28	35.00	47.62
Regular, convenient places to buy affordable, nutritious food	49.55	59.72	55.50	56.29	46.39	45.95	42.77	30.00	39.13
Services or education to help reduce teen pregnancy, adolescent services, or sex education	48.87	58.57	57.28	50.75	46.15	45.40	51.30	25.00	34.09
Healthcare for seniors	48.06	65.15	48.73	43.67	44.64	53.73	50.63	25.00	40.91
Parenting classes	47.87	54.55	50.00	45.45	49.70	50.00	45.10	29.41	34.15
Transportation services for patients AFTER receiving services	46.34	37.68	45.55	47.22	45.99	48.17	51.28	47.06	26.19
Transportation services for people needing to go to doctor's appointments or the hospital	46.34	33.82	42.19	48.47	48.17	47.01	51.92	50.00	26.19
Access to your preferred housing situation -- location, size of home, access to services, Americans with Disabilities Act	45.68	51.47	52.38	48.08	41.75	47.27	39.86	14.29	35.90

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"									
		What is your age?							
Needs	**Total**	**18 to 24**	**25 to 34**	**35 to 44**	**45 to 54**	**55 to 64**	**65 to 74**	**75 or older**	**Prefer not to disclose**
Programs for diabetes prevention, awareness, and care	44.53	55.88	41.90	44.77	47.54	45.45	40.00	31.58	28.89
Programs for obesity prevention, awareness, and care	43.71	50.72	44.34	44.31	45.11	43.66	43.14	31.58	28.89
Transportation services for people needing to go out of town for healthcare services or appointments	43.66	40.63	37.36	49.03	44.26	44.59	40.14	31.25	37.84
Job training (or, re-training)	43.28	45.31	40.21	45.18	43.28	47.01	43.87	33.33	33.33
Food services such as food pantries, soup kitchens, or a backpack program	42.66	57.35	43.27	44.15	38.75	44.51	41.40	26.32	32.56
Pediatric / child health services	40.72	58.46	47.52	41.35	35.45	42.30	38.00	12.50	31.71
General public transportation	40.46	44.93	43.37	45.40	40.00	37.76	36.00	23.53	29.55
Programs to help people stop smoking	40.07	55.07	40.58	36.87	41.57	40.72	39.49	26.32	30.23
Women's health services (OB/GYN)	38.68	57.97	49.01	39.70	34.21	36.14	35.33	17.65	30.23
Primary healthcare services (such as a family doctor or other provider of routine care)	37.19	42.03	35.71	34.80	38.92	39.03	38.36	23.81	30.23
Urgent care services (that is, walk-in care for immediate health needs not requiring the Emergency Department	36.27	49.25	30.14	32.65	41.64	36.39	37.89	20.00	36.36
Increased neurology, or brain, care	35.60	46.88	37.70	38.51	34.57	36.34	29.25	5.26	26.32
Men's health services	32.94	52.24	40.31	32.62	31.72	30.03	30.56	11.76	23.26
Emergency care and trauma services	31.99	44.78	29.61	30.54	35.63	31.34	32.28	15.00	16.28
Programs for heart health or cardiovascular health	31.43	46.88	33.33	33.03	29.59	31.64	29.80	5.00	21.95
An easy and close place to buy prescription drugs, when needed	30.73	33.33	29.15	32.15	30.95	33.33	28.21	16.67	16.28

RACE COMPARISONS

Prioritized Community Survey Needs Percent saying "Very Needed"				
Needs	**Total**		**Black / African American**	**White / Caucasian**
Affordable, quality childcare	70.37		72.22	70.34
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adolescents	70.30		77.78	70.29
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adult	66.73		77.78	66.67
Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking or actions, self-harm, or harm to others	64.93		88.89	64.71
Affordable housing	64.14		77.78	65.18
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97		72.22	63.11
Integrated care, or where people can get medical care and counseling at the same time	60.86		72.22	61.27
Drug and other substance abuse education, prevention, and early intervention services	60.54		72.22	60.54
Social services (other than healthcare) for people experiencing homelessness	57.58		58.82	57.84
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15		66.67	57.71
Healthcare services for people experiencing homelessness	56.39		76.47	56.37
Affordable healthcare services for people or families with low income	56.25		66.67	56.25
Access to dental services	55.08		70.59	55.41
Case workers or navigators to help people with chronic diseases (diabetes, cancer, asthma, etc.) get the needed care	53.39		61.11	53.45
Long-term care or dementia care	53.20		66.67	53.34
Services to help people learn about, and enroll in, programs that help with financial support for people needing healthcare	52.67		61.11	52.61
Regular, convenient places to buy affordable, nutritious food	49.55		61.11	49.11
Services or education to help reduce teen pregnancy, adolescent services, or sex education	48.87		61.11	48.81
Healthcare for seniors	48.06		66.67	47.60
Parenting classes	47.87		55.56	47.66
Transportation services for patients AFTER receiving services	46.34		70.59	47.04
Transportation services for people needing to go to doctor's appointments or the hospital	46.34		76.47	47.22

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"				
Needs	**Total**		**Black / African American**	**White / Caucasian**
Access to your preferred housing situation -- location, size of home, access to services, Americans with Disabilities Act	45.68		75.00	45.64
Programs for diabetes prevention, awareness, and care	44.53		61.11	44.27
Programs for obesity prevention, awareness, and care	43.71		55.56	43.61
Transportation services for people needing to go out of town for healthcare services or appointments	43.66		50.00	44.34
Job training (or, re-training)	43.28		50.00	43.37
Food services such as food pantries, soup kitchens, or a backpack program	42.66		44.44	42.99
Pediatric / child health services	40.72		70.59	40.22
General public transportation	40.46		64.71	41.06
Programs to help people stop smoking	40.07		61.11	39.87
Women's health services (OB/GYN)	38.68		61.11	38.76
Primary healthcare services (such as a family doctor or other provider of routine care)	37.19		44.44	37.10
Urgent care services (that is, walk-in care for immediate health needs not requiring the Emergency Department	36.27		41.18	36.37
Increased neurology, or brain, care	35.60		58.82	35.29
Men's health services	32.94		55.56	32.48
Emergency care and trauma services	31.99		41.18	32.03
Programs for heart health or cardiovascular health	31.43		41.18	31.63
An easy and close place to buy prescription drugs, when needed	30.73		38.89	31.25

EDUCATIONAL ATTAINMENT COMPARISONS

Prioritized Community Survey Needs Percent saying "Very Needed"									
		What is the highest grade or year in school you completed?							
Needs	**Total**	**Less than high school**	**Grad-uated high school**	**Some college or vo-cational training**	**Completed a 2-year college degree or a vocation-al training program**	**Grad-uated college (4-year Bach-elor's Degree)**	**Complet-ed Gradu-ate or Pro-fessional school (Masters, PhD, etc.)**	**Prefer not to dis-close**
Affordable, quality child-care	70.37	60.00	70.48	66.78	69.96	73.70	72.11	51.16
Counseling services for mental health issues such as depres-sion, anxiety, trauma, or others for adolescents	70.30	60.00	71.70	66.20	68.64	74.09	71.18	60.00
Counseling services for mental health issues such as depres-sion, anxiety, trauma, or others for adult	66.73	80.00	69.52	61.97	64.25	70.54	67.09	61.36
Emergency mental health services for issues such as suicid-al thinking or actions, homicid-al thinking or actions, self-harm, or harm to others	64.93	40.00	66.36	62.32	65.60	67.80	64.46	57.78

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"									
		What is the highest grade or year in school you completed?							
Needs	**Total**	**Less than high school**	**Graduated high school**	**Some college or vocational training**	**Completed a 2-year college degree or a vocational training program**	**Graduated college (4-year Bachelor's Degree)**	**Completed Graduate or Professional school (Masters, PhD, etc.)**	**Prefer not to disclose**
Affordable housing	64.14	40.00	58.82	66.18	63.38	68.29	62.36	47.73
Drug and other substance abuse treatment and rehabilitation services, including detox	62.97	40.00	63.46	58.19	62.84	63.66	66.15	57.78
Integrated care, or where people can get medical care and counseling at the same time	60.86	80.00	60.00	54.61	57.28	65.07	64.02	47.83
Drug and other substance abuse education, prevention, and early intervention services	60.54	80.00	65.38	57.24	61.19	61.33	61.30	51.11
Social services (other than healthcare) for people experiencing homelessness	57.58	60.00	52.88	54.41	59.13	59.77	59.06	45.45

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"									
		What is the highest grade or year in school you completed?							
Needs	**Total**	**Less than high school**	**Graduated high school**	**Some college or vocational training**	**Completed a 2-year college degree or a vocational training program**	**Graduated college (4-year Bachelor's Degree)**	**Completed Graduate or Professional school (Masters, PhD, etc.)**	**Prefer not to disclose**
Coordination of patient care between the hospital and other clinics, private doctors, or others	57.15	60.00	60.00	51.44	56.68	59.95	58.57	46.67
Healthcare services for people experiencing homelessness	56.39	60.00	57.14	53.56	59.61	56.41	58.01	42.86
Affordable healthcare services for people or families with low income	56.25	40.00	59.26	56.18	60.27	57.63	53.90	45.45
Access to dental services	55.08	40.00	65.74	55.00	55.87	54.00	55.80	33.33
Case workers or navigators to help people with chronic diseases (diabetes, cancer, asthma, etc.) get the needed care	53.39	60.00	61.90	48.23	55.05	53.13	54.91	44.44

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"									
		What is the highest grade or year in school you completed?							
Needs	**Total**	**Less than high school**	**Grad-uated high school**	**Some college or vo-cational training**	**Completed a 2-year college degree or a vocation-al training program**	**Grad-uated college (4-year Bach-elor's Degree)**	**Complet-ed Gradu-ate or Pro-fessional school (Masters, PhD, etc.)**	**Prefer not to dis-close**
Long-term care or de-mentia care	53.20	80.00	61.62	56.99	53.88	52.53	49.77	44.19
Services to help people learn about, and enroll in, programs that help with financial sup-port for peo-ple needing healthcare	52.67	40.00	59.81	51.25	54.95	52.15	52.19	47.83
Regular, convenient places to buy affordable, nutritious food	49.55	40.00	59.26	50.00	54.13	47.85	46.90	48.94
Services or education to help re-duce teen pregnancy, adolescent services, or sex educa-tion	48.87	40.00	62.26	51.45	53.55	49.41	42.99	36.36
Healthcare for seniors	48.06	80.00	61.62	49.82	50.47	48.09	42.79	46.67
Parenting classes	47.87	80.00	54.00	49.43	51.20	49.15	43.89	39.13

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"									
		What is the highest grade or year in school you completed?							
Needs	**Total**	**Less than high school**	**Graduated high school**	**Some college or vocational training**	**Completed a 2-year college degree or a vocational training program**	**Graduated college (4-year Bachelor's Degree)**	**Completed Graduate or Professional school (Masters, PhD, etc.)**	**Prefer not to disclose**
Transportation services for patients AFTER receiving services	46.34	25.00	42.42	44.87	44.02	47.20	50.24	30.95
Transportation services for people needing to go to doctor's appointments or the hospital	46.34	25.00	41.00	47.55	44.98	46.96	49.07	29.55
Access to your preferred housing situation -- location, size of home, access to services, Americans with Disabilities Act	45.68	60.00	41.76	48.43	42.35	49.25	43.10	42.11
Programs for diabetes prevention, awareness, and care	44.53	40.00	50.50	47.08	49.77	39.81	44.64	36.96
Programs for obesity prevention, awareness, and care	43.71	40.00	46.00	43.80	49.06	39.95	46.30	29.79

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"									
		What is the highest grade or year in school you completed?							
Needs	**Total**	**Less than high school**	**Grad-uated high school**	**Some college or vo-cational training**	**Completed a 2-year college degree or a vocation-al training program**	**Grad-uated college (4-year Bach-elor's Degree)**	**Complet-ed Gradu-ate or Pro-fessional school (Masters, PhD, etc.)**	**Prefer not to dis-close**
Transporta-tion services for people needing to go out of town for health-care services or appoint-ments	43.66	50.00	45.36	43.48	44.78	45.60	41.86	35.00
Job training (or, re-train-ing)	43.28	50.00	40.21	42.05	50.25	44.15	43.24	35.71
Food ser-vices such as food pan-tries, soup kitchens, or a backpack program	42.66	50.00	55.24	47.31	48.39	39.07	38.24	32.56
Pediatric / child health services	40.72	40.00	50.98	40.23	40.95	40.87	39.11	39.53
General public trans-portation	40.46	40.00	30.30	33.59	36.45	45.72	45.80	23.26
Programs to help people stop smoking	40.07	80.00	52.48	41.70	45.02	34.12	40.04	33.33
Women's health ser-vices (OB/ GYN)	38.68	40.00	48.04	40.07	40.00	37.86	37.10	30.23

Prioritized Community Survey Needs, cont. Percent saying "Very Needed"									
		What is the highest grade or year in school you completed?							
Needs	**Total**	**Less than high school**	**Graduated high school**	**Some college or vocational training**	**Completed a 2-year college degree or a vocational training program**	**Graduated college (4-year Bachelor's Degree)**	**Completed Graduate or Professional school (Masters, PhD, etc.)**	**Prefer not to disclose**
Primary healthcare services (such as a family doctor or other provider of routine care)	37.19	40.00	46.15	37.46	33.94	37.53	37.14	31.82
Urgent care services (that is, walk-in care for immediate health needs not requiring the Emergency Department	36.27	60.00	53.77	36.79	36.49	36.16	31.63	40.00
Increased neurology, or brain, care	35.60	60.00	45.19	38.55	35.86	34.76	32.21	34.09
Men's health services	32.94	40.00	42.86	35.36	38.16	29.65	30.30	31.11
Emergency care and trauma services	31.99	60.00	48.08	33.70	31.80	31.92	27.17	29.55
Programs for heart health or cardiovascular health	31.43	40.00	45.10	34.09	34.98	29.95	26.73	29.79
An easy and close place to buy prescription drugs, when needed	30.73	40.00	38.53	27.44	37.91	29.15	29.73	24.44

HEALTH INFORMATION SOURCES

Sources of Healthcare Information	Percent of Respondents
A hospital's website	6.3%
A physician's website	2.7%
Medical websites such as WebMD or Mayo Clinic	28.6%
A patient portal	44.0%
Healthcare.gov or other government-sponsored sites	7.6%
A fitness tracker website like Fitbit or My Fitness Pal	33.8%
A physician or other healthcare worker	67.2%
Friends and relatives	9.1%
Telehealth resources such as a telehealth doctor or nurse, or virtual urgent care	10.0%
None	8.9%

APPENDIX D-5

Community Survey Questions

Introduction

Hello and thank you for participating in the Community Health Needs Survey!

We need your feedback! The Ozarks Health Commission, local healthcare and health departments are conducting a local community health needs assessment.

By taking the Community Health Needs Survey, you will help us understand your community's current health status, strengths / resources, needs, and related issues.

The survey will take about 8 to 10 minutes. Your personal information will not be shared or connected with your responses.

Thank you for sharing your thoughts!

About the Ozarks Health Commission
In 2017, a variety of organizations (healthcare and local public health departments) across the Ozarks convened under the umbrella of the Ozarks Health Commission to assess the health needs of our region. These partners sought to better understand the health status, behaviors and needs of the populations they serve to be able to prioritize the actions needed to improve the communities health. The regional assessment covers 29 counties, 4 states and 3 hospital systems. For more information: http://ozarkshealthcommission.org

Accessing Care

1. Do you have a place where you go for regular or annual medical or dental care?

- ◯ Yes, family doctor, family dentist, family health center, or clinic
- ◯ Yes, emergency room
- ◯ Walk-in urgent care
- ◯ No
- ◯ I do not get care even when I need it
- ◯ Other (please specify)

2. In the past 12 months, have there been times when you needed medical help but chose NOT to seek it?

- ◯ Yes
- ◯ No
- ◯ Not sure

3. If YES, why did you NOT get care? (pick all that apply)

- [ ] Doctor might not know my language; difficult to communicate
- [ ] Did not have the money or insurance
- [ ] No doctors or clinics near me; too far away
- [ ] Had no transportation to get to the doctor or clinic
- [ ] Doctors or clinics not open at a convenient time
- [ ] Could not get off work
- [ ] Could not find child care
- [ ] Don't trust healthcare providers
- [ ] Worried about getting COVID
- [ ] Telehealth was not offered by my provider
- [ ] Not able to access telehealth services offered by my provider
- [ ] N/A
- [ ] Other (please specify)

Community and Health-related Issues

A healthy community can include many topics such as the availability of healthcare services (including behavioral/mental health), social services, economic vibrancy and good jobs, environmental factors, lifestyle topics (such as obesity, smoking, substance abuse, and healthy living issues), and others. The next few questions ask about your opinions of these subjects.

4. Which of the following TRANSPORTATION, HOUSING, and WORKFORCE DEVELOPMENT issues do you feel need more focus or attention for improvement?

	Not Needed	Rarely Needed	Needed	Very Needed	Don't Know
Transportation services for people needing to go to doctor's appointments or the hospital	○	○	○	○	○
Transportation services for patients AFTER receiving services	○	○	○	○	○
Transportation services for people needing to go out of town for healthcare services or appointments	○	○	○	○	○
General public transportation	○	○	○	○	○
Affordable housing	○	○	○	○	○
Access to your preferred housing situation -- location, size of home, access to services, Americans with Disabilities Act (ADA) needs, etc.	○	○	○	○	○
Job training (or, re-training)	○	○	○	○	○

5. Which of the following HEALTH and SOCIAL SERVICE issues do you feel need more focus or attention for improvement?

	Not Needed	Rarely Needed	Needed	Very Needed	Don't Know
Affordable healthcare services for people or families with low income					
Services to help people learn about, and enroll in, programs that help with financial support for people needing healthcare					
An easy and close place to buy prescription drugs, when needed					
Healthcare services for people experiencing homelessness					
Social services (other than healthcare) for people experiencing homelessness					
Long-term care or dementia care					
Parenting classes					
Services or education to help reduce teen pregnancy, adolescent services, or sex education					
Affordable, quality child care					
Food services such as food pantries, soup kitchens, or a backpack program					
Regular, convenient places to buy affordable, nutritious food					
Programs for obesity prevention, awareness, and care					
Programs for diabetes prevention, awareness, and care					
Programs to help people stop smoking					

6. Which of the following HEALTH CARE – including MENTAL HEALTH – and CARE COORDINATION issues do you feel need more focus or attention for improvement?

	Not Needed	Rarely Needed	Needed	Very Needed	Don't Know
Primary healthcare services (such as a family doctor or other provider of routine care)					
Emergency care and trauma services					
Urgent care services (that is, walk-in care for immediate health needs not requiring the Emergency Department)					
Counseling services for mental health issues such as depression, anxiety, trauma, or others for adults					
Counseling services for mental health issues such as depression, anxiety, trauma, or others **for adolescents / children**					
Emergency mental health services for issues such as suicidal thinking or actions, homicidal thinking or actions, self-harm, or harm to others					
Drug and other substance abuse education, prevention, and early intervention services					
Drug and other substance abuse treatment and rehabilitation services, including detox					
Integrated care, or where people can get medical care and counseling at the same time					
Coordination of patient care between the hospital and other clinics, private doctors, or other health service providers					
Case workers or navigators to help people with chronic diseases (diabetes, cancer, asthma, etc.) get the right care over time					
Programs for heart health or cardiovascular health					
Increased neurology, or brain, care					
Access to dental services					
Women's health services (OB/GYN)					
Men's health services					
Pediatric / child health services					
Healthcare for seniors					

7. Explain any of your answers, if needed.

8. What are the top THREE greatest health-related issues -- that is, items that need more focus and attention -- in the community?

1

2

3

COVID-19 Pandemic

For this section, please think back since March 2020 when the pandemic began.

9. What sources do you turn to or read to learn about the COVID-19 pandemic or vaccines? (Check all that apply)

- ☐ My local hospital's website
- ☐ A doctor or doctor's website
- ☐ Medical websites such as WebMD or Mayo Clinic
- ☐ Centers for Disease Control and Prevention (CDC) website
- ☐ Google (or other) online searches and research
- ☐ A physician or other healthcare worker
- ☐ Friends and relatives
- ☐ Social media
- ☐ My church or place of worship
- ☐ My elected leaders

Other (please specify)

10. Has COVID affected your mental health or the mental health of someone that lives with you?

- ○ Yes
- ○ No
- ○ Unsure

11. If you have children at home, have they been affected by the COVID-19 pandemic?

- ○ Yes
- ○ No
- ○ No children in the house
- ○ Unsure

12. Do you think that the COVID-19 pandemic has changed any of your following health behaviors?

	Improved	Worsened	No change	Not sure
Exercise	◯	◯	◯	◯
Diet	◯	◯	◯	◯
Tobacco use	◯	◯	◯	◯
Alcohol use	◯	◯	◯	◯
Social isolation	◯	◯	◯	◯
Use of illicit drugs, such as marijuana, meth, heroine, etc.	◯	◯	◯	

Please share any details.

13. Has the COVID-19 pandemic changed your perception of the healthcare system or public health?

- ◯ I think better of the healthcare and/or public health systems
- ◯ I think worse of the healthcare and/or public health system
- ◯ No changes
- ◯ Please share any detailed information.

14. Have you received the COVID-19 vaccination?

- ◯ Yes, I am fully vaccinated (Pfizer, Johnson & Johnson, or Moderna)
- ◯ Yes, I have had one of the two required shots and am scheduled to receive the second
- ◯ Yes, I have had one of the two required shots but do NOT plan to receive the second
- ◯ No, but I plan to receive the COVID-19 vaccine
- ◯ No, and I do not plan get vaccinated

Other.

15. If you received or plan to receive a vaccine to protect against COVID-19, what influenced your decision? (Select all that apply)

- [ ] I'm concerned about my health
- [ ] I'm concerned about the health of my family and friends
- [ ] I care about the health of the greater community, or it seems like the right thing to do
- [ ] I want to start enjoying life again
- [ ] Politics or elected officials' comments and guidance
- [ ] Religious leaders' guidance or comments
- [ ] Healthcare provider's advice
- [ ] Workplace requirement
- [ ] Other (please specify)

16. If you chose not to receive a vaccine to protect against COVID-19, what influenced that decision? (select all that apply)

- [ ] I do not trust the science
- [ ] I believe there are other, effective ways to avoid getting COVID-19 or to treat it
- [ ] I do not trust the government
- [ ] Family or friends are against it
- [ ] Religious leaders guidance or comments
- [ ] Political party or elected officials' comments and guidance
- [ ] I'm concerned about side effects (long-term or short-term) of the vaccine
- [ ] My personal choice
- [ ] Other (please specify)

Communications

17. What sources do you normally use to find out about your own health or to monitor your own health? (Check your top three)

- [ ] A hospital's website
- [ ] A physician's website
- [ ] Medical websites such as WebMD or Mayo Clinic
- [ ] A patient portal
- [ ] Healthcare.gov or other government-sponsored sites
- [ ] A fitness tracker website like Fitbit or My Fitness Pal
- [ ] A physician or other healthcare worker
- [ ] Friends and relatives
- [ ] Telehealth resources such as a telehealth doctor or nurse, or virtual urgent care
- [ ] None

Other (please specify)

18. Do you have any additional comments or questions? If so, please enter them here.

A Little Bit About You!

19. What county and state do you live in?

20. What county and state do you work in?

21. What is your gender?

- Male
- Female
- Non-binary
- Other
- Prefer not to disclose

22. What is your age?

- Under 18 years of age
- 18 to 24
- 25 to 34
- 35 to 44
- 45 to 54
- 55 to 64
- 65 to 74
- 75 or older
- Prefer not to disclose

23. What is your race? [Check all that apply]

- ☐ Black or African American
- ☐ American Indian and Alaska Native
- ☐ Asian
- ☐ Caucasian/White
- ☐ Hispanic or Latino
- ☐ Native Hawaiian and Other Pacific Islander
- ☐ Two or More Races
- ☐ Other
- ☐ Prefer not to disclose

24. What is the highest grade or year in school you completed?

- ◯ Less than high school
- ◯ Graduated high school
- ◯ Some college or vocational training
- ◯ Completed a 2-year college degree or a vocational training program
- ◯ Graduated college (4-year Bachelor Degree)
- ◯ Completed Graduate or Professional school (Masters, PhD, etc.)
- ◯ Prefer not to disclose

25. Which of the following ranges best describes your total annual household income in the last year?

- ◯ Less than $25,000
- ◯ $25,001 to $50,000
- ◯ $50,001 to $75,000
- ◯ $75,001 to $100,000
- ◯ More than $100,000
- ◯ Prefer not to disclose

26. What is your current housing status?

- ◯ Rent
- ◯ Own
- ◯ Staying with family or friends
- ◯ Unhoused
- ◯ Other (please specify)

27. How many people (including you) live in your household?

Introducción

Hola y gracias por participar en la ¡Encuesta sobre necesidades sanitarias de la comunidad!

¡Necesitamos su opinión! La Comisión de Salud de Ozarks, los departamentos de atención sanitaria y de salud locales están llevando a cabo una evaluación de las necesidades sanitarias de la comunidad local.

Al realizar la Encuesta sobre necesidades sanitarias de la comunidad, nos ayudará a conocer el estado de salud actual de su comunidad, las fortalezas/recursos, sus necesidades y los problemas relacionados.

La encuesta le tomará entre 8 y 10 minutos. Sus datos personales no se compartirán ni vincularán a sus respuestas.

¡Gracias por compartir sus opiniones!

Acerca de la Comisión de Salud de Ozarks
En 2017, diversas organizaciones (departamentos de salud pública y de atención sanitaria local) de Ozarks se reunieron bajo el paraguas de la Comisión de Salud de Ozarks para evaluar las necesidades sanitarias de nuestra región. Estos socios intentaron comprender mejor el estado de salud, los comportamientos y las necesidades de las poblaciones a las que atienden para poder priorizar las acciones necesarias y mejorar la salud de las comunidades.
La evaluación regional abarca 29 condados, 4 estados y 3 sistemas hospitalarios. Para obtener más información visite el sitio: http://ozarkshealthcommission.org

Acceso a la atención sanitaria

1. ¿Tiene un lugar al cual acudir para recibir atención médica o dental con regularidad o anualmente?

- ◯ Sí, médico de familia, dentista de familia, centro de salud familiar o clínica
- ◯ Sí, sala de emergencias
- ◯ Atención de urgencia
- ◯ Sin cita previa
- ◯ No
- ◯ No recibo atención ni siquiera cuando la necesito
- ◯ Otra opción (especifique)

2. En los últimos 12 meses, ¿hubo ocasiones en las que necesitó ayuda médica pero decidió NO buscarla?

- ◯ Sí
- ◯ No
- ◯ No estoy seguro

3. En caso afirmativo, ¿por qué NO recibió atención? (elija la respuesta que corresponda)

- ☐ Es posible que el doctor no conozca mi idioma; es difícil comunicarse
- ☐ No tenía dinero ni seguro
- ☐ No hay médicos ni clínicas cercanos a mí; están demasiado lejos
- ☐ No tenía transporte para ir al médico o a la clínica
- ☐ Los médicos o las clínicas no abrían a una hora idónea; no podía salir del trabajo
- ☐ No pude encontrar una guardería
- ☐ No confío en los proveedores de servicios sanitarios
- ☐ Me preocupa contraer la COVID.
- ☐ Mi prestador de servicios de salud no ofrecía telesalud
- ☐ No puedo acceder a los servicios de telesalud ofrecidos por mi prestador de servicios de salud
- ☐ N/A
- ☐ Otra opción (especifique)

Problemas comunitarios y relacionados con la salud

Una comunidad saludable puede incluir muchos temas, como la disponibilidad de servicios sanitarios (incluida la salud mental y del comportamiento), los servicios sociales, la vitalidad económica y los buenos empleos, los factores medioambientales, los temas relacionados con el estilo de vida (como la obesidad, el tabaquismo, el abuso de sustancias y los problemas de vida saludable), y otros. Las siguientes preguntas se refieren a su opinión sobre estos temas.

4. ¿Cuál de los siguientes problemas de TRANSPORTE, VIVIENDA y DESARROLLO PARA LOS TRABAJADORES considera que necesita más atención para mejorar?

	No necesita	Pocas veces necesita	Necesita	Necesita mucho	No sé
Servicios de transporte para las personas que necesitan ir a citas médicas o al hospital.	○	○	○	○	○
Servicios de transporte para pacientes DESPUÉS de recibir los servicios.	○	○	○	○	○
Servicios de transporte para personas que necesitan salir de la ciudad para acudir a servicios de atención médica o a citas médicas.	○	○	○	○	○
Transporte público en general.	○	○	○	○	○
Vivienda asequible.	○	○	○	○	○
Acceso a su condición de vivienda preferida: ubicación, tamaño de la vivienda, acceso a los servicios, requisitos de la Ley de Estadounidenses con Discapacidades (ADA), etc,	○	○	○	○	○
Capacitación en el trabajo (o readiestramiento).	○	○	○	○	○

5. ¿Cuál de los siguientes problemas de SALUD y SERVICIO SOCIAL considera que necesita más atención para mejorar?

	No necesita	Pocas veces necesita	Necesita	Necesita mucho	No sé
Servicios de atención médica asequibles para personas o familias con bajos ingresos.	○	○	○	○	○
Servicios para ayudar a que las personas conozcan y se inscriban en programas de ayuda financiera para personas que necesitan atención médica.	○	○	○	○	○
Un lugar fácil y cercano para comprar medicamentos recetados, cuando sea necesario.	○	○	○	○	○
Servicios de atención médica para personas sin hogar.	○	○	○	○	○
Servicios sociales (distintos a la atención médica) para personas sin hogar.	○	○	○	○	○
Atención a largo plazo o atención para la demencia.	○	○	○	○	○
Clases para padres.	○	○	○	○	○
Servicios o educación para ayudar a reducir los embarazos de las adolescentes, servicios para adolescentes o educación sexual.	○	○	○	○	○
Atención infantil asequible y de calidad.	○	○	○	○	○
Servicios de alimentos como despensas de alimentos, comedores de beneficencia o un programa de mochilas.	○	○	○	○	○
Lugares adecuados y habituales para comprar alimentos nutritivos y asequibles.	○	○	○	○	○
Programas de prevención, sensibilización y atención de la obesidad.	○	○	○	○	○
Programas para la prevención, sensibilización y atención de la diabetes.	○	○	○	○	○
Programas para ayudar a las personas a dejar de fumar.	○	○	○	○	○

6. ¿Cuál de los siguientes problemas de ATENCIÓN SANITARIA, incluida la SALUD MENTAL y la COORDINACIÓN DEL CUIDADO, considera que necesita más atención para mejorar?

	No necesita	Pocas veces necesita	Necesita	Necesita mucho	No sé
Servicios de atención primaria (como un médico de cabecera u otro proveedor de atención rutinaria).	○	○	○	○	○
Servicios de atención de emergencias y traumatología.	○	○	○	○	○
Servicios de atención urgente (es decir, atención sin cita previa para necesidades médicas inmediatas que no requieren al Departamento de Emergencias).	○	○	○	○	○
Servicios de orientación para problemas de salud mental como, depresión, ansiedad, traumas u otros servicios para adultos.	○	○	○	○	○
Servicios de orientación para problemas de salud mental como depresión, ansiedad, traumas u otros **para adolescentes/niños**.	○	○	○	○	○
Servicios de emergencia de salud mental para problemas como pensamientos o acciones suicidas, pensamientos o acciones homicidas, autolesiones o daños a terceros.	○	○	○	○	○
Servicios de educación, prevención e intervención temprana para evitar el abuso de drogas y otras sustancias.	○	○	○	○	○
Servicios de rehabilitación y tratamiento por abuso de drogas y otras sustancias, incluida la desintoxicación.	○	○	○	○	○
Atención integrada, es decir, donde las personas pueden recibir atención médica y orientación al mismo tiempo.	○	○	○	○	○
Coordinación de la atención al paciente entre el hospital y otras clínicas, médicos privados u otros proveedores de servicios sanitarios.	○	○	○	○	○
Asistentes sociales o mediadores para ayudar a las personas con enfermedades crónicas (diabetes, cáncer, asma, etc.) a recibir la atención adecuada a lo largo del tiempo.	○	○	○	○	○
Programas para la salud del corazón o la salud cardiovascular.	○	○	○	○	○
Mayor atención neurológica o cerebral.	○	○	○	○	○
Acceso a servicios dentales.	○	○	○	○	○
Servicios de salud para mujeres (obstetricia y ginecología).	○	○	○	○	○
Servicios de salud para hombres.	○	○	○	○	○
Servicios de salud pediátrica/infantil.	○	○	○	○	○
Cuidado de la salud para personas mayores.	○	○	○	○	○

7. Explique cualquiera de sus respuestas, si es necesario.

8. ¿Cuáles son los TRES problemas principales relacionados con la salud, es decir, los aspectos que necesitan un mayor enfoque y atención **en la comunidad?**

1

2

3

Para esta sección, piense en el mes de marzo de 2020 cuando comenzó la pandemia.

9. ¿A qué fuentes acude o lee para informarse sobre la pandemia de la COVID-19 o las vacunas? (Marque todas las opciones que correspondan)

- ☐ Al sitio web de mi hospital local.
- ☐ A un médico o al sitio web de un médico.
- ☐ A los sitios web médicos como WebMD o la Clínica Mayo.
- ☐ Al sitio web de los Centros para el Control y la Prevención de Enfermedades (CDC).
- ☐ A la búsqueda e investigación en línea de Google (u otro).
- ☐ A un médico u otro trabajador sanitario.
- ☐ A amigos y familiares.
- ☐ A las redes sociales.
- ☐ A mi iglesia o lugar de culto.
- ☐ A los líderes de mi elección.

Otra opción (especifique).

10. ¿La COVID ha afectado su salud mental o la salud mental de alguien que vive con usted?

- ○ Sí ○ No
- ○ No estoy seguro

11. Si tiene niños en casa, ¿se han visto afectados por la pandemia de la COVID-19?

- ○ Sí ○ No
- ○ No hay niños en casa
- ○ No estoy seguro

12. ¿Considera que la pandemia de la COVID-19 ha cambiado alguno de sus siguientes comportamientos de salud?

	Ha mejorado	Ha empeorado	Sin cambios	No estoy seguro
El ejercicio	◯	◯	◯	◯
La alimentación	◯	◯	◯	◯
El uso de tabaco	◯	◯	◯	◯
El uso de alcohol	◯	◯	◯	◯
El aislamiento social	◯	◯	◯	◯
El uso de drogas ilícitas, como la marihuana, las metanfetaminas, la heroína, etc.	◯	◯	◯	◯

Comparta cualquier detalle.

13. ¿La pandemia de la COVID-19 ha cambiado su percepción del sistema de asistencia sanitaria o de salud pública?

- ◯ Pienso mejor sobre los sistemas sanitarios y de salud pública.
- ◯ Pienso peor sobre los sistemas sanitarios y de salud pública.
- ◯ Sin cambios.
- ◯ Comparta cualquier información detallada.

14. ¿Ha recibido la vacuna contra la COVID-19?

- ◯ Sí, estoy totalmente vacunado (Pfizer, Johnson & Johnson o Moderna).
- ◯ Sí, he recibido una de las dos dosis requeridas y estoy programado para recibir la segunda dosis.
- ◯ Sí, he recibido una de las dos dosis requeridas pero NO planeo recibir la segunda dosis.
- ◯ No, pero planeo recibir la vacuna contra la COVID-19.
- ◯ No, y no pienso vacunarme.

Otra opción.

15. Si recibió o tiene previsto recibir una vacuna para protegerse contra la COVID-19, ¿qué influyó en su decisión? (Elija todas las opciones que correspondan)

- ☐ Me preocupa mi salud.
- ☐ Me preocupa la salud de mi familia y amigos.
- ☐ Me preocupo por la salud de la comunidad en general o me parece que es lo correcto.
- ☐ Quiero empezar a disfrutar de la vida de nuevo.
- ☐ La política o los comentarios y orientación de funcionarios electos.
- ☐ La orientación o los comentarios de líderes religiosos.
- ☐ Los consejos del proveedor de atención médica.
- ☐ La exigencia del lugar de trabajo.
- ☐ Otra opción (especifique).

16. Si eligió no recibir una vacuna para protegerse contra la COVID-19, ¿qué influyó en esa decisión? (marque todas las opciones que correspondan).

- ☐ No confío en la ciencia.
- ☐ Creo que hay otras formas efectivas de evitar contraer la COVID-19 o de tratara..
- ☐ No confío en el gobierno.
- ☐ La familia o los amigos están en contra de eso.
- ☐ La orientación o los comentarios de líderes religiosos.
- ☐ Los comentarios y la orientación de partidos políticos o de funcionarios electos.
- ☐ Me preocupan los efectos secundarios (a largo o corto plazo) de la vacuna.
- ☐ Es mi decisión personal.
- ☐ Otra opción (especifique).

Comunicaciones

17. ¿Qué fuentes utiliza normalmente para averiguar sobre su propia salud o para controlar su propia salud? (Marque sus tres opciones principales).

- [ ] El sitio web de un hospital.
- [ ] El sitio web de un médico.
- [ ] Sitios web médicos como WebMD o un portal para pacientes de la Clínica Mayo.
- [ ] Healthcare.gov u otros sitios patrocinados por el gobierno.
- [ ] Un sitio web de seguimiento de la actividad física como Fitbit o My Fitness Pal.
- [ ] Un médico u otro trabajador del sistema sanitario.
- [ ] Amigos y familiares.
- [ ] Recursos de telesalud, como un médico o una enfermera de telesalud, o atención virtual de urgencia.
- [ ] Ninguna.

Otra opción (especifique).

18. ¿Tiene algún comentario o pregunta adicional? En caso afirmativo, ingréselos aquí.

¡Un poco sobre usted!

19. ¿En qué condado y estado vive?

20. ¿En qué condado y estado trabaja?

21. ¿Cuál es su género?

- Hombre
- Mujer
- Género no binario
- Otro
- Prefiero no decirlo

22. ¿Qué edad tiene?

- Menor de 18 años
- Entre 18 e 24 años
- Entre 25 y 34 años
- Entre 35 y 44 años
- Entre 45 y 54 años
- Entre 55 y 64 años
- Entre 65 y 74 años
- 75 años o mayor
- Prefiero no decirlo

23. ¿Cuál es su raza? (Marque todas las que sean pertinentes).

- ☐ Negro o afroamericano
- ☐ Indio americano y nativo de Alaska
- ☐ Asiático
- ☐ Caucásico/Blanco
- ☐ Hispano o Latino
- ☐ Nativo de Hawái y de otras islas del Pacífico
- ☐ Dos o más razas
- ☐ Otra raza
- ☐ Prefiero no decirlo

24. ¿Cuál es el grado o nivel educativo más alto que ha completado?

- ◯ Inferior a escuela secundaria.
- ◯ Graduado de la escuela secundaria.
- ◯ Alguna formación universitaria o profesional.
- ◯ Obtuve un título universitario de dos años o un programa de formación profesional.
- ◯ Me gradué en la universidad (licenciatura de 4 años).
- ◯ Terminé estudios de posgrado o profesionales (máster, doctorado, etc.).
- ◯ Prefiero no decirlo.

25. ¿Cuál de los siguientes niveles describe mejor los ingresos anuales totales de su hogar el año pasado?

- ◯ Menos de $25.000
- ◯ De $25.001 a $50.000
- ◯ De $50.001 a $75.000
- ◯ De $75.001 a $100.000
- ◯ Más de $100.000
- ◯ Prefiero no decirlo

26. ¿Cuál es su situación actual en materia de vivienda?

- ◯ Alquilada ◯ Propia
- ◯ Vivo con la familia o los amigos
- ◯ Sin vivienda
- ◯ Otra opción (especifique)

27. ¿Cuántas personas (incluido usted) viven en su casa?